



Descriptive Analysis of Sexual Assault Nurse Examinations in Alaska

by

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Providence Kodiak Island Medical Center (Kodiak, Alaska)
Yukon-Kuskokwim Health Corporation (Bethel, Alaska)
Central Peninsula General Hospital (Soldotna, Alaska)
Norton Sound Health Corporation (Nome, Alaska)
Fairbanks Memorial Hospital (Fairbanks, Alaska)
South Peninsula Hospital (Homer, Alaska)
Maniilaq Association (Kotzebue, Alaska)

and

The Alaska Department of Law
State of Alaska



JC #0501

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Acknowledgments

This project was supported by Grant No. 2004-WB-GX-0003 awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

In Anchorage, the principal investigators, André B. Rosay and Tara Henry, sincerely thank the Department of Health and Human Services at the Municipality of Anchorage. In particular, we thank Beverly K. Wooley (former Director), Diane Ingle (Director), Angelia Morris (Forensic Examiner), Ronald Schoedel (Operations Manager), Randall Henderson (MIS Coordinator), Lynda McLarrin (Grant Administrator), Carrie Longoria (Interpersonal Violence Prevention [IVP] Program Manager), Emily Davies (IVP Analyst), Renée Aguilar (IVP Specialist), and Jennifer Meyer (Sexual Assault Response Team [SART] Program Manager).

In Kodiak, we sincerely thank the Providence Kodiak Island Medical Center. In particular, we thank Brenda Franz (SART Coordinator).

In Bethel, we sincerely thank the Yukon-Kuskokwim Health Corporation. In particular, we thank Barbara Jacobson (Chief Nursing Officer), Heather Hamblin (Manager, Emergency Department), Jennifer Meyer (Lead Forensic Nurse Clinician), and Stephanie Wade (Forensic Nurse Examiner), and Dawn Hackney (Forensic Nurse Examiner).

In Homer and Soldotna, we sincerely thank the South Peninsula Hospital and the Central Peninsula General Hospital. In particular, we thank Colleen James (Clinical Forensic Services Coordinator).

In Nome, we sincerely thank the Norton Sound Health Corporation. In particular, we thank Mary Kay McCarty (Director, Public Health Nursing) and Annie Blandford, Karen McLane, Terry Romenesko, and Patricia Power (Sexual Assault Nurse Examiners). We also thank the Research Ethics Review Board for their good work and support.

In Fairbanks, we sincerely thank Fairbanks Memorial Hospital. In particular, we thank Angie Ellis (Forensic Nursing Services Patient Care Coordinator) and all forensic nurse examiners that participated. They include Shany Fair, Debbie Verkyk, Kathleen Gumbleton, Paula Ciniero, Ilene DuToit, and Carol Meyer.

In Kotzebue, we sincerely thank the Maniilaq Association. In particular, we thank Dara Whalen (RN, FNP).

Principal investigators also sincerely thank the Alaska Department of Law. In particular, we acknowledge Susan Parkes (former Deputy Attorney General), Richard Svobodny (Deputy Attorney General), and Lu Woods (Criminal Records Information and Management Exchange System [CRIMES] Coordinator).

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Executive Summary

This project examined the characteristics of sexual assault victimizations in Alaska, as observed and recorded by sexual assault nurse examiners in Anchorage, Kodiak, Bethel, Soldotna, Nome, Fairbanks, Homer, and Kotzebue. The sample utilized for this analysis includes all sexual assault nurse examinations conducted in Anchorage from 1996 to 2004, in Bethel and Fairbanks in 2005 and 2006, and in Homer, Kodiak, Kotzebue, Nome, and Soldotna in 2005 ($N = 1,699$). More specifically, this report documents the demographic characteristics of patients, pre-assault characteristics, assault characteristics, post-assault characteristics, exam characteristics and findings, suspect characteristics, and legal resolutions. Key descriptive results are summarized below.

An important limitation of this analysis is that it is based on medical / forensic examinations of sexual assault victims and therefore excludes all victims who did not have a medical / forensic examination. In addition, all information included herein is based on self reports from the patients and on medical / forensic examinations that include observations, physical assessments, and laboratory tests. Finally, it is important to emphasize that the goal of this report is limited to description. Nonetheless, we hope that this description will be useful to practitioners and policy makers to develop and strengthen comprehensive responses to sexual assaults.

Demographic Characteristics of Patients

The vast majority of patients (98%) were female. Over half of the patients (56%) were Native and 36% were White. At the time of the report, 50% of patients were 24 years of age or younger. More precisely, 20% of patients were under the age of 18, 30% were between the ages of 18 to 24, 23% were between the ages of 25 to 34, 17% were between the ages of 35 to 44, and 10% were 45 years of age or older. Most patients (88%) did not report being homeless at the time of the assault and few patients reported being physically disabled (2%), mentally disabled (2%), or psychiatrically disabled (2%).

Pre-Assault Characteristics

Very few patients reported they had engaged in anal or oral sex within three days prior to the assault, but 28% reported they had engaged in vaginal sex. The most common location of initial contact prior to the assault was a private residence, with 19% of initial contacts occurring at the patient's house, 12% occurring at the suspect's house, 16% occurring at another's house, and 3% occurring at the patient and suspect's house. Together, these four locations accounted for 50% of all locations. Other common

locations of initial contact included outdoors (for 20% of locations) and bars (for 13% of locations).

Assault Characteristics

Most assaults (88%) took place in the same city, town, or village as the sexual assault nurse examiner (others took place elsewhere but were referred to sexual assault nurse examiner for a medical / forensic examination). The most common location for assaults was a private residence. More specifically, 63% of assaults took place in private residences, with 21% occurring at the patient's house, 23% occurring at the suspect's house, 17% occurring at another's house, and 2% occurring at the suspect and patient's house. Other common locations included vehicles (for 12% of assaults), outdoors (for 10% of assaults), and hotels (for 10% of assaults). Half of the assaults involved weapons, physical blows, physical restraints, strangulation, or verbal threats. In particular, 10% of assaults involved strangulation. Methods used during the assault varied by the location of initial contact (where assaults *initiated*) and the location of assault (where assaults *occurred*). Assaults that *initiated* outdoors were the most likely to involve weapons, blows, grabbing, and threats. Assaults that *initiated* in bars were the most likely to involve restraints and strangulation. Assaults that *occurred* outdoors were the most likely to involve blows and grabbing. Assaults that *occurred* in vehicles were the most likely to involve weapons or threats. Assaults that *occurred* at the suspect's house were the most likely to involve restraints and assaults that *occurred* in hotels were the most likely to involve strangulation. For all locations of initial contact and assault, the most prevalent method used during the assault was grabbing.

Many patients were intoxicated at the time of the assault (67% reported being alcohol intoxicated and 10% reported being drug intoxicated and some patients were severely intoxicated (26% reported being passed out). Common drugs included THC (marijuana) and cocaine (including crack cocaine). Most assaults were felonious, with 87% of assaults including penile penetration of the vagina. Other common sexual acts reported included digital penetration of the vagina and sexual contact (e.g., kissing, touching breasts, touching vagina). Penile penetration of the anus was reported by 15% of patients and digital penetration of the anus was reported by 9% of patients. Overall, 97% of assaults included penetration or attempted penetration of the vagina or anus. Relatively few suspects (10%) used a condom during the assault.

Post-Assault Characteristics

Post-assault characteristics are important because they may affect the extent to which forensic evidence is still available to collect. Most patients urinated (75%), ate or drank (61%), and wiped or washed genitalia (57%) prior to the medical / forensic exam. Other common post-assault actions included changing clothing (45%). Few patients (less than 4%) inserted or removed sponges, diaphragms, tampons, or pads and even fewer (1%) engaged in consensual vaginal sex after the assault. No patient engaged in consensual anal or oral sex after the assault. Most reports (95%) to the sexual assault nurse examiner were made within three days, with 13% of reports occurring within two

hours of the assault, 33% occurring within four hours, 58% occurring within 12 hours, and 77% occurring within 24 hours.

Exam Characteristics and Findings

Most reports (89%) led to a complete exam. The most common reasons for not completing the medical / forensic exam were attributable to lack or withdrawal of patient consent. Many patients were described as cooperative (76%), controlled (64%), quiet (55%), tearful (45%), and calm (35%). A smaller number were tense (17%), fidgeting (16%), trembling (11%), sleeping (10%), stoic (9%), staring (8%), sobbing (7%), agitated (7%), fearful (6%), or angry (5%). The majority of patients had clothing that appeared intact or clean (75% and 64% respectively). Upon arrival, 10% of patients required emergency medical care and 2% were admitted to the hospital. The vast majority of patients (95%) had a sexual assault evidence collection kit completed during the medical / forensic examination. Speculum and colposcope exams were very common. An alternative light source (e.g., Wood's lamp, blue max, LED) was used in 71% of exams and fluorescence was found in 37% of these exams. The most common locations for finding fluorescence included legs and feet, buttocks and hips, arms and hands, and the face. Most patients (80%) were tested for sexually transmitted infections and other genital infections; and 19% of them tested positive. Patients tested positive for bacterial vaginosis, chlamydia, genital warts, gonorrhea, HIV, herpes, trichomoniasis, hepatitis B, syphilis, yeast, and hepatitis C.

Non-genital injuries were recorded for 52% of patients. The most common non-genital injury types included bruising and abrasions and the most common non-genital injury locations included legs and arms. Genital injuries were recorded in 41% of patients. The most common genital injury type included a laceration and the most common genital injury locations included the posterior fourchette, the labia minora, the perineum, the fossa navicularis, and the anus. Seventeen percent of patients received a follow-up examination or consultation, performed, on average, 23 days after the first exam.

Suspect Characteristics

The average number of suspects per assault was 1.16. Overall, 90% of patients were assaulted by a single suspect and 71% of suspect identities were known. Most suspects (99.7%) were male and most were Native (34%), White (34%), or Black (22%). Victimization across racial and ethnic groups were least common for Black patients (71% were assaulted by Black suspects) and most common for Pacific Islander patients (only 20% were assaulted by Pacific Islander suspects). In terms of age, 15% of suspects were 10 to 19 years of age, with over half of them being 18 or 19. Additionally, 39% of suspects were 20 to 29, 25% were 30 to 39, and 22% were 40 or older. Alcohol use was more common than drug use, with 85% of suspects using alcohol prior to the assault and 18% using drugs. Overall, 16% of patients were assaulted by strangers and 84% were assaulted by non-strangers. The most common relationships between patients and suspects included friends and acquaintances, with 67% of patients reported being assaulted by someone they knew either as a friend or an acquaintance.

Legal Resolutions

Legal resolutions were obtained from the Alaska Department of Law only for a sub-sample of the cases included in this report. More precisely, legal resolutions were obtained only for examinations conducted from 1999 to 2005 (because legal resolutions for the 2006 cases were not yet completed by the time of data collection and legal resolutions for cases prior to 1999 were not available electronically). Of the original 1,699 sexual assault nurse examinations, 1,229 (72%) were searched in the Alaska Department of Law records. Results show that 29% were referred for prosecution, 20% were accepted for prosecution, and 16% resulted in a conviction. Of the referred cases, 69% were accepted. Of the accepted cases, 78% resulted in a conviction. At first glance, the likelihood of reported cases being referred, being accepted, and resulting in a conviction appears significantly higher in this sample of medical / forensic cases than in previous samples of Anchorage police cases.

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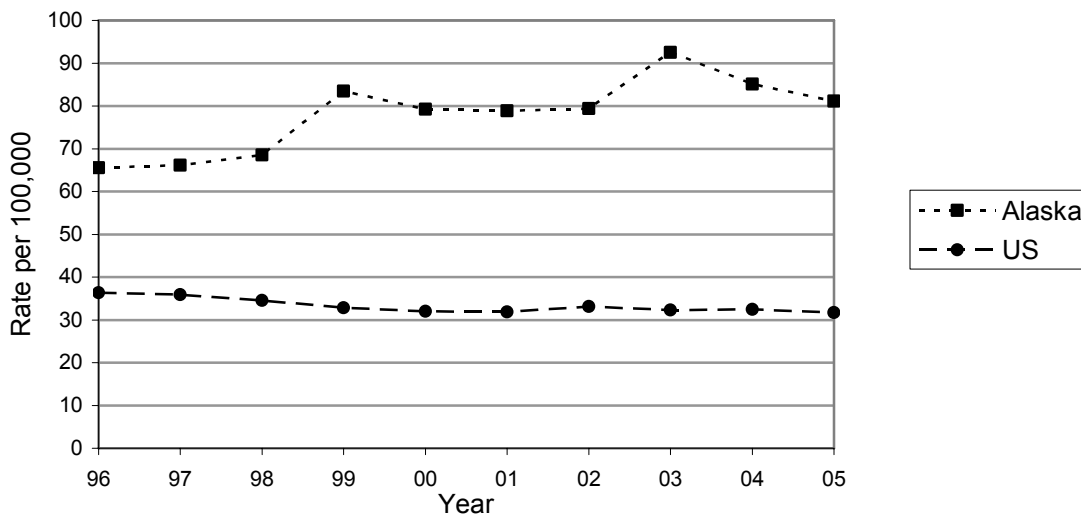
This report provides an overview of the characteristics of sexual assault victimizations, as observed and recorded by sexual assault nurse examiners in Alaska. It is the first report that documents the characteristics of sexual assault victimizations throughout Alaska. In this report, we summarize the characteristics of sexual assault nurse examinations conducted in Anchorage, Kodiak, Bethel, Soldotna, Nome, Fairbanks, Homer, and Kotzebue. We hope that this report provides a valuable source of information about sexual assault victimizations in Alaska and that this will be useful to practitioners and policy makers to develop and strengthen comprehensive responses to sexual assaults.

We begin this report by providing a brief overview of sexual assault in Alaska, from 1996 to 2005, and of sexual assault nurse examinations. We then discuss the purpose of this study, its methodology, and limitations. Results are then presented. Results presented in this report are descriptive only. No inferential analyses are presented in this report. Inferential analyses will be provided in a subsequent report by the University of Alaska Anchorage Justice Center.

Sexual Assaults in Alaska; 1996-2005

The State of Alaska has a long history of high rates of reported forcible rapes. Forcible rapes are defined in the Uniform Crime Reports as “the carnal knowledge of a female forcibly and against her will.” The Uniform Crime Reports tabulate the rate of reported forcible rapes and attempted forcible rapes in Alaska and the U.S. These data (from 1996 to 2005) are shown in Figure 1.

Figure 1. Rates of Forcible Rape Reported to Law Enforcement, 1996-2005



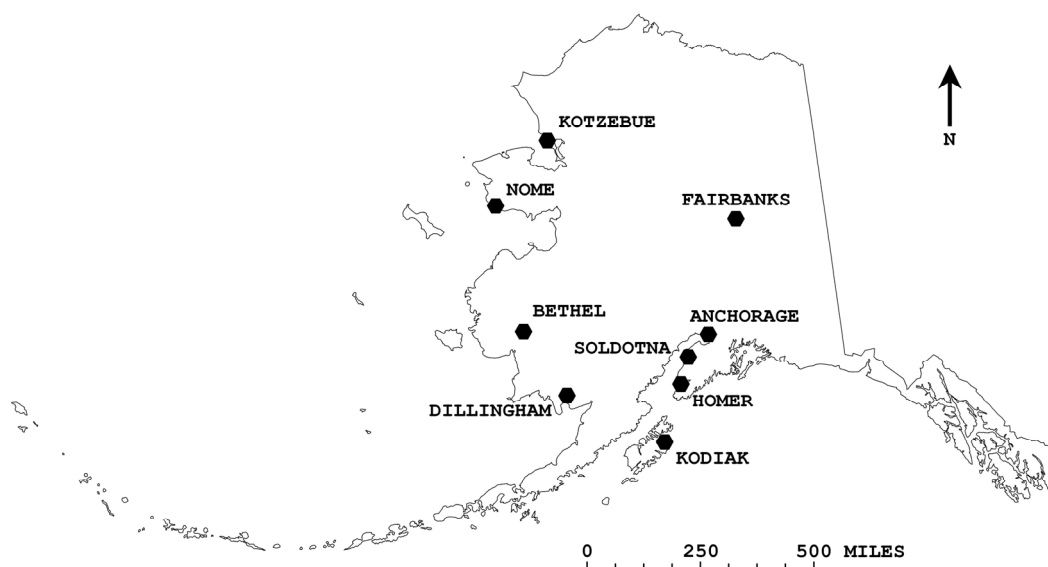
Source of data: Uniform Crime Reports (1996-2005)

The average rate of forcible rape reported to law enforcement from 1996 to 2005 was 78.0 per 100,000 in Alaska versus 33.3 per 100,000 in the U.S. By comparison, the average rate of forcible rape reported to law enforcement from 1996 to 2005 was 134% higher in Alaska than in the U.S. These statistics only provide a partial description of the sexual assault problem because they do not include statutory rapes, incapacitated rapes, and other sex offenses, generally included under the umbrella category of “sexual assault.” Unlike the federal definition of forcible rape, sexual assaults include acts (and attempted acts) perpetrated against males as well as acts (and attempted acts) without forceful carnal knowledge against the victim’s will (e.g., sexual contact, incapacitated rape, statutory rape).

Sexual Assault Nurse Examinations

The sexual assault nurse examiner plays a critical role in our response to sexual assault victims. Once a sexual assault has been reported to law enforcement, it may be referred to the sexual assault nurse examiner (SANE) for a medical / forensic examination. The SANE is a component of the Sexual Assault Response Team (SART). Other members of SART include law enforcement and victim advocates. If law enforcement determines that it would be worthwhile to conduct a medical / forensic examination, SART is called into action. Generally speaking, this determination is based on the need for medical attention, the likelihood of collecting forensic evidence, and minimum legal requirements of proof. In general, referrals to SART will not be made if the time elapsed from assault to report is greater than 96 hours because the likelihood of collecting forensic evidence becomes remote (and because the need for medical attention is no longer urgent).

Figure 2. Sexual Assault Nurse Examiners in Alaska



At the time of the study, sexual assault nurse examiners in Alaska were located in Anchorage, Fairbanks, Kotzebue, Nome, Bethel, Dillingham, Kodiak, Homer, and Soldotna. All sites participated in this study, except for Dillingham. In Anchorage, SART/SANE services were contracted by the Municipality of Anchorage to Alaska Regional Hospital in 1996 and are now housed under the Municipality's Department of Health and Human Services. Victim advocates are provided by Standing Together Against Rape (STAR) and law enforcement personnel primarily include the Anchorage Police Department and the Alaska State Troopers. In Kodiak, SART/SANE services are provided by the Providence Kodiak Island Medical Center. Victim advocates are provided by the Kodiak Women's Resource and Crisis Center and law enforcement personnel primarily include the Kodiak Police Department and the Alaska State Troopers.

In Bethel, SART/SANE services are provided by the Yukon-Kuskokwim Health Corporation. Victim advocates are provided by the Tundra Women's Coalition and law enforcement personnel primarily include the Bethel Police Department and the Alaska State Troopers. In Soldotna, SART/SANE services are provided by the Central Peninsula General Hospital. Victim advocates are provided by the LeeShore Center and law enforcement personnel primarily include the Soldotna Police Department, the Kenai Police Department, and the Alaska State Troopers. In Nome, SART/SANE services are provided by the Norton Sound Health Corporation. Victim advocates are provided by the Bering Sea Women's Group and law enforcement personnel primarily include the Nome Police Department and the Alaska State Troopers. In Fairbanks, SART/SANE services are provided by Fairbanks Memorial Hospital. Victim advocates are provided by the Interior Alaska Center for Non-Violent Living and law enforcement personnel primarily include the Fairbanks Police Department and the Alaska State Troopers. In Homer, SART/SANE services are provided by the South Peninsula Hospital. Victim advocates are provided by the South Peninsula Haven House and law enforcement personnel primarily include the Homer Police Department and the Alaska State Troopers. Finally, SART/SANE services in Kotzebue are provided by the Maniilaq Association. Victim advocates are provided by the Maniilaq Family Crisis Center and law enforcement personnel primarily include the Kotzebue Police Department and the Alaska State Troopers.

Prior to the SART/SANE protocol, victims of sexual assault who needed emergency medical care were referred to emergency rooms where they often waited long periods of time before seeing a nurse or doctor. Although emergency rooms have the capacity to provide excellent emergency care, they do not have the luxury of spending additional time with victims of sexual assault to address their many emotional and medical needs. In addition, victims of sexual assault were triaged with other patients (who often needed more urgent care) and were required to report the details of their victimization several times for medical care, police reports, and to receive victim advocacy. The SART/SANE protocol now provides a significantly better response to victims of sexual assault, by utilizing a collaborative team of a law enforcement official, a forensic nurse, and a victim advocate. Although some victims may still be referred to emergency rooms for urgent care of serious to life threatening injuries (e.g., extensive trauma, respiratory distress), most can be effectively treated by trained sexual assault nurse examiners. In addition, sexual assault nurse examiners have been specifically trained for the documentation and collection of forensic evidence. Examinations follow a standard sexual assault protocol that utilizes specialized (and expensive) instruments such as a colposcope.

The main goals of the SANE intervention include the assessment of injury, the objective documentation of health history to determine bio/psycho/social risks and the risk of medical sequelae, the objective non-judgmental documentation of the history of the crime, the collection and preservation of forensic data, the prevention of potential psychological and physical health risks associated with the assault, the facilitation of client control over assault and abuse issues, and the facilitation of healthy reorganization and re-adaptation following a sexual assault (International Association of Forensic of Forensic Nurses, SANE Standards of Practice, 1996).

The SART/SANE protocol presents a clear benefit for the provision of medical care and the collection and documentation of forensic evidence. It is hoped that the enhancement in our ability to collect and document forensic evidence will facilitate the prosecution of perpetrators. But even if it does not, the SART/SANE protocol still presents a significantly more compassionate response to victims of sexual assault than was previously provided by emergency rooms. In particular, the SART/SANE response is both more specialized and more sensitive to victims' immediate and emergent needs. The victim advocate plays a key role in providing support to the victim. The coordinated response between law enforcement, trained medical personnel, and victim advocates also reduces the need for multiple and redundant interviews with victims that may enhance secondary victimizations and lower victims' desire to pursue a criminal justice response.

Purpose of this Study

Data from sexual assault nurse examinations were collected for three primary reasons. The first was to gather information about the characteristics of sexual assaults in Alaska and to create a report that summarizes this information. This goal is accomplished here in this descriptive report.

A second goal was to examine the effect of patient condition at the time of the assault on anogenital injury to test the hypothesis that incapacitation would decrease the likelihood of anogenital injury. As part of this second goal, we will examine the effect of patient condition at the time of the assault and of anogenital injuries on legal resolutions. Finally, this project was designed to describe and explain the time elapsed between the assault and the report. More specifically, we will examine whether time elapsed reduces the ability of the sexual assault nurse examiners to collect forensic evidence and to provide needed medical care. As part of this third goal, we will also examine if the unsuccessful collection of forensic evidence lowers the probability of successful prosecution. These (second and third) goals will be accomplished in subsequent reports by the University of Alaska Anchorage Justice Center.

To summarize, data were collected from medical / forensic evaluations of sexual assault victims to provide additional information on sexual assault victimizations and to better understand the effects of patient condition at the time of the assault and of time elapsed from assault to report. In particular, this project was designed to better understand the effects of patient condition at the time of the assault and time elapsed from assault to report on the ability of (1) the sexual assault nurse examiner to document anogenital injury and (2) the prosecutor to secure a conviction.

This study was conducted in cooperation with all sexual assault nurse examiners in Alaska (except for Dillingham). These included sexual assault nurse examiners in Anchorage, Kodiak, Bethel, Soldotna, Nome, Fairbanks, Homer, and Kotzebue. This study was also conducted in cooperation with the Alaska Department of Law. In this report, we accomplish our first goal which was to describe the characteristics of sexual assault victimizations in Alaska, as observed and recorded by sexual assault nurse examiners in Anchorage, Kodiak, Bethel, Soldotna, Nome, Fairbanks, Homer, and Kotzebue. We now describe the data collection procedures, discuss limitations, and then present results.

Methodology

All examinations conducted in Anchorage from 1996 to 2004, in Bethel and Fairbanks in 2005 and 2006, and in Homer, Kodiak, Kotzebue, Nome, and Soldotna in 2005 were included in the sample. Bethel and Fairbanks participated for two years (2005 and 2006). Anchorage participated for nine years (1996 to 2004). All other sites (Homer, Kodiak, Kotzebue, Nome, and Soldotna) participated for one year (2005). A total of 1,699 examinations were collected, with the majority (81%) coming from Anchorage. Bethel and Fairbanks (who participated for two years) contributed 105 and 144 cases, respectively. Together, the other sites (who participated for one year) contributed 4% of the total cases. The majority of cases (86%) were referred to the sexual assault nurse examiner from local police departments (such as those in Anchorage, Fairbanks, Bethel, Homer, Kenai, Kodiak, Kotzebue, Nome, Saint Mary's, Seward, Soldotna, and Togiak). In addition, 12% of the cases were referred from state law enforcement agencies (e.g., Alaska State Troopers) and 2% were referred from federal law enforcement agencies (e.g., military).

Table 1. Number of Sexual Assault Nurse Examinations

Column Percentages

Location	Number of Years	Examinations		Average per Year
		N	%	
Anchorage	9	1383	81.4 %	153.7
Bethel	2	105	6.2	52.5
Fairbanks	2	144	8.5	72.0
Homer	1	9	0.5	9.0
Kodiak	1	4	0.2	4.0
Kotzebue	1	21	1.2	21.0
Nome	1	19	1.1	19.0
Soldotna	1	14	0.8	14.0
Total		1699		

*Source of data: Alaska SANE data
N = 1699; 0 (0.0%) missing*

An extensive array of information was collected to describe sexual assault characteristics. More specifically, the information contains demographic characteristics of patients, pre-assault characteristics, assault characteristics, post-assault characteristics, exam characteristics and findings, and suspect characteristics (see Appendix A for data collection instrument).

Demographic characteristics of patients include gender, race / ethnicity, and age, whether the patient was disabled, and whether the patient reported being homeless. Pre-assault characteristics include whether the patient reported engaging in consensual sex within three days prior to the assault and information on the location of the initial contact with the suspect. Assault characteristics include information on the location of the assault, methods employed by the suspect, the patients' condition at the time of the assault, the patients' use of drugs and alcohol, and a detailed description of the assault itself. This detailed description includes the patient's position during the assault, whether protection and lubricants had been used, whether ejaculation occurred, and an inventory

of 17 different sexual acts. Post-assault characteristics include information on post-assault actions taken by the patient, whether the patient engaged in consensual sex between the time of the assault to the examination, and the time elapsed from the assault to the examination.

Exam characteristics and findings include information on whether the exam was completed, the type of exam that was conducted, the patients' appearance and demeanor during the exam, whether the patient required emergency medical care, whether the presence of sperm was documented, whether patients tested positive for sexually transmitted infections, whether the patient was pregnant, and whether injuries were documented. Injury characteristics included descriptions of both non-genital and genital injury. A total of 108 indicators of non-genital injury were captured. These included nine possible injuries (i.e., bruising, redness, abrasions, lacerations, swelling, fractures, bite marks, pain, and other) to 12 possible sites (i.e., head/face, mouth, neck, shoulders, arms, hands, chest, abdomen, back, buttocks/hips, legs, and feet). A total of 60 indicators of genital injury were also captured. These included four possible injuries (i.e., bruising, abrasions, lacerations, and tenderness) to 15 possible sites (i.e., mons pubis, labia majora, labia minora, labia majora / minora junction, clitoral hood, clitoris, periurethra, hymen, fossa navicularis, posterior fourchette, perineum, vaginal walls, cervix, anus, and rectum).

Suspect characteristics included the number of suspects, whether the identity of the suspect was known, demographic characteristics (gender, race/ethnicity, and age), whether the suspect had used alcohol or drugs, and the relationship between the patient and the suspect. Overall, these data provide a thorough description of sexual assault, as observed and recorded by sexual assault nurse examiners.

All prosecutorial outcome data were gathered directly from the Alaska Department of Law. These data were gathered only for a sub-sample of the 1,699 medical / forensic examinations included in the sample. More specifically, searches through the Alaska Department of Law records excluded cases of patients examined prior to 1999, excluded cases of patients examined in 2006, excluded cases referred from the military, and excluded cases with unknown law enforcement case numbers (N=1,229). The primary restrictions were that cases prior to 1999 were excluded (because outcome data were not available in electronic form) and cases in 2006 were also excluded (because outcome data were not yet available at the time of data collection). The remaining cases were tracked by case number to determine if they had been referred by police to the Alaska Department of Law for prosecution, if the Alaska Department of Law had accepted the cases for prosecution, and if the cases resulted in a conviction. Again, this data collection was only performed for 1,229 (72%) of the original 1,699 cases.

This project was approved with a full review conducted by the University of Alaska Anchorage Institutional Review Board and utilized a Privacy Certificate issued by the National Institute of Justice. Although we also sought approval from the Alaska Area Institutional Review Board at the Alaska Native Medical Center, a formal notification of their decision was never obtained. All data collection was performed by Tara Henry (RN, BSN, SANE-A/P).

Sample and Data Limitations

There are several key limitations that are important when interpreting all results presented in this report. First and foremost, the sexual assault cases that are included in this report are not representative of all sexual assault cases. Many sexual assault cases are not reported to law enforcement and consequently are excluded from this analysis. This analysis also excludes all cases reported to law enforcement that were not referred to the sexual assault nurse examiner (SANE/SART). Cases are generally referred to the sexual assault nurse examiner if medical or forensic evidence can still be collected. If the time elapsed from the assault to the report is greater than 96 hours, the likelihood of collecting forensic evidence becomes remote and the likelihood of requesting a medical / forensic examination subsequently decreases dramatically. Overall, results uncovered by this study should only be generalized to victims of sexual assault who reported their victimization to law enforcement and were examined by a sexual assault nurse examiner. Furthermore, this analysis is only based on medical / forensic examinations conducted in Anchorage, Fairbanks, Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna. Examinations conducted elsewhere are not included in this report. Characteristics of patients, assaults, and exams may vary substantially.

In addition to these sample limitations, there are some important data limitations. First, all data collected by this investigation are based on self-reported information by the patient and on observations, physical assessments and laboratory tests performed by the sexual assault nurse examiner. Second, as the reader will notice, sample sizes vary dramatically across tables. Differences in sample size are due to differences in the rate of missing data (i.e., in the rate of unknown information). Because data were collected retrospectively, because the sexual assault nurse examiner protocol has changed over time, and because medical / forensic examinations are necessarily individualized, not every single data element presented here was included in all medical / forensic examinations. Retrospective data collection is inherently limited by the contents of the medical / forensic reports. In particular, when data are missing from the reports, it is difficult, if not impossible, to determine the reason for these data to be missing. Common reasons may include the lack of patient consent or difficulties with recall (victims of violent crime often do not remember the specific details of their victimization). The sexual assault nurse examiner protocol has also been refined over the years. Some of the information that is now routinely collected was not routinely collected five or ten years ago. This information may show high rates of missing data simply because its importance was not revealed until recently and was not incorporated into the sexual assault nurse examiner protocol until recently. Finally, although the sexual assault nurse examiner protocol is standardized, it must also be individualized. Because the specifics of the examination vary across patients, data documentation and collection necessarily does as well. Overall, the data collection instrument was designed to focus on key aspects of the medical / forensic examination that would generally be included (but of course, these are not always included and cannot be). In order to provide the most valid estimates, missing data are not presented in tables. As the number of missing data increases (i.e., as sample sizes decrease), the reader is cautioned that data uncertainties are necessarily increased.

Perhaps the most important limitation of this report is that it is only descriptive. No inferential analysis is included in this report (these will be included in subsequent reports). Again, the sole goal for this report was to describe sexual assault victimizations, as observed and recorded by sexual assault nurse examiners. Sexual assault victims that were not examined by a sexual assault nurse examiner are necessarily excluded from this evaluation (and results should therefore not be overly-generalized).

Demographic Characteristics of Patients

The vast majority (98%) of patients were female (only 39 were male). The primary race or ethnicity reported by patients is shown in Table 2. In rare cases when patients reported multiple races or ethnicities, the minority class was selected.

Table 2. Race and Ethnicity of Patients

Column Percentages

Race	Patients	
	N	%
White	597	35.5 %
Native	938	55.7
Black	77	4.6
Hispanic	36	2.1
Asian	17	1.0
Pacific Islander	18	1.1
Total	1683	

*Source of data: Alaska SANE data
N = 1699; 16 (0.9%) missing*

Over half of the patients (56%) were Native and 36% were White. Only 9% were neither Native nor White. At the time of the report, 50% of patients were 24 years of age or younger. More precisely, 20% of patients were under the age of 18, 30% were 18 to 24 years of age, 23% were 25 to 34 years of age, 17% were 35 to 44 years of age, and 10% were 45 years of age or older (see Table 3).

Table 3. Age of Patients

Column Percentages

Age	Patients	
	N	%
0 to 17	333	19.8 %
18 to 24	511	30.3
25 to 34	387	23.0
35 to 44	294	17.4
45 to 54	132	7.8
55 or over	29	1.7
Total	1686	

*Source of data: Alaska SANE data
N = 1699; 13 (0.8%) missing*

Most patients (88%) did not report being homeless at the time of the assault (204 patients (12%) did report being homeless). Most patients did not report being disabled at the time of the assault (2% reported being mentally disabled, 2% reported being physically disabled, and 2% reported being psychiatrically disabled). Again, these statistics are based on assessments and observations only, including self-reports (see sample and data limitations).

Pre-Assault Characteristics

Table 4 describes whether patients reported they had engaged in anal, oral, or vaginal sex within three days prior to the assault. Results show that very few patients (1%) reported they had engaged in anal sex within three days prior to the assault, very few (1%) reported they had engaged in oral sex within three days prior to the assault, but 28% reported they had engaged in vaginal sex within three days prior to the assault.

Table 4. Sex within Three Days Prior to Assault

Row Percentages

Sex	No		Yes		Total
	N	%	N	%	
Anal	1495	99.3 %	10	0.7 %	1505
Oral	1485	99.3	10	0.7	1495
Vaginal	1085	72.2	418	27.8	1503

Source of data: Alaska SANE data

N = 1699; 194 to 204 (11.4 to 12.0%) missing

Where the initial contact between the patient and the suspect was reported to have occurred is shown in Table 5. The most common location of initial contact prior to the assault was a private residence, with 19% of initial contacts occurring at the patient's house, 12% occurring at the suspect's house, 16% occurring at another's house, and 3% occurring at the patient and suspect's house. Together, these four locations accounted for 50% of all locations. Other common locations of initial contact included outdoors (for 20% of locations) and bars (for 13% of locations).

Table 5. Location of Initial Contact Prior to Assault

Column Percentages

Location	Initial Contacts	
	N	%
Outdoors	282	20.3 %
Work	9	0.6
Vehicle	39	2.8
Patient's house	265	19.1
Suspect's house	171	12.3
Patient and suspect's house	36	2.6
Other's house	222	16.0
Hotel	89	6.4
Bar	180	12.9
Other indoor location	97	7.0
Total	1390	

Source of data: Alaska SANE data

N = 1699; 309 (18.2%) missing

Assault Characteristics

Most assaults (88%) took place in the same city, town, or village as the Sexual Assault Nurse Examiner. The other assaults (12%) took place in neighboring cities, towns, or villages but patients were referred to the Sexual Assault Nurse Examiner for the medical / forensic examination (in most cases because a medical / forensic examination was not available in the patient's home community). Where assaults took place is shown in Table 6. The most common locations of assault included private residences. More specifically, 63% of assaults took place in private residences (i.e., 21% at the patient's house, 23% at the suspect's house, 17% at another's house, and 2% at the patient and suspect's house). Other common locations included vehicles (for 12% of assaults), outdoors (for 10% of assaults), and hotels (for 10% of assaults).

Table 6. Location of Assault

Column Percentages

Location	Assaults	
	N	%
Outdoors	143	10.0 %
Work	3	0.2
Vehicle	178	12.4
Patient's house	302	21.1
Suspect's house	325	22.7
Patient and suspect's house	35	2.4
Other's house	239	16.7
Hotel	130	9.1
Bar	4	0.3
Other indoor location	73	5.1
Total	1432	

Source of data: Alaska SANE data

N = 1699; 267 (15.7%) missing

By comparing Table 5 (Location of Initial Contact Prior to Assault) and Table 6 (Location of Assault), we see that private residences were common locations for both initial contacts and assault locations. More specifically, 50% of contacts initiated in private residences and 63% of assaults occurred in private residences. These private residences included the patient's house, the suspect's house, the patient and suspect's house, and another's house. Another common location for both initial contacts and assaults was outdoors. Of all assaults, 20% initiated outdoors and 10% occurred outdoors. Although 13% of initial contacts occurred in bars, less than 1% of assaults occurred in bars. Conversely, although 12% of assaults occurred in vehicles, only 3% of initial contacts occurred in vehicles. Given that sexual assaults are more likely to initiate in public places than to occur in public places, successful interventions should focus on the point of contact prior to the assault (because official interventions are easier to conduct in public places than in private places). For example, 33% of initial contacts occurred either outdoors or in bars (but only 10% of assaults occurred in these two locations).

Table 7 describes the methods used during the assault. More specifically, we examined the extent to which each assault involved weapons, physical blows by hands or feet, grabbing, grasping, or holding, physical restraints, strangulation, toxic or chemical burns, and verbal threats.

Table 7. Methods Used During Assault

Row Percentages

Method	No		Yes		Total
	N	%	N	%	
Weapon	1566	93.9 %	102	6.1 %	1668
Physical blows by hands or feet	1402	84.1	266	15.9	1668
Grabbing, grasping, holding	1042	62.5	626	37.5	1668
Physical restraints	1476	88.5	192	11.5	1668
Strangulation	1498	89.8	170	10.2	1668
Toxic or chemical burns	1664	99.8	4	0.2	1668
Verbal threats	1336	80.1	332	19.9	1668

*Source of data: Alaska SANE data
N = 1699; 31 (1.8%) missing*

Half of the assaults involved at least one of these methods and only 28% involved two or more (results not shown). The most common methods included grabbing, grasping, and holding (38% of assaults), verbal threats (20% of assaults), physical blows by hands or feet (16% of assaults), physical restraints (12% of assaults), and strangulation (10% of assaults). It is important to emphasize that these estimates only reflect the contents of the SANE examination reports, not the characteristics of assaults. It is possible that these methods were more common than reflected here (i.e., they were not documented). On the other hand, the SANE examination may have captured information on strangulation to a much better extent than other records (e.g., police reports). Ten percent of patients reported being strangled as part of the assault. The high incidence of physical force noted in the SANE examinations (by physical blows, grabbing, grasping, holding, restraints, and strangulation) further documents the violent nature of these offenses.

Table 8. Common Methods by Common Locations of Initial Contact

Cell Percentages

Initial Contact	Weapon		Blows		Grabbing		Restraints		Strangle		Threats	
	N	%	N	%	N	%	N	%	N	%	N	%
Outdoors	43	15.2 %	64	22.7 %	163	57.8 %	31	11.0 %	35	12.4 %	105	37.2 %
Patient's house	12	4.5	55	20.8	112	42.3	45	17.0	31	11.7	56	21.1
Suspect's house	8	4.7	30	17.5	73	42.7	15	8.8	19	11.1	27	15.8
Other's house	6	2.7	15	6.8	52	23.4	19	8.6	12	5.4	22	9.9
Hotel	5	5.7	18	20.5	33	37.5	14	15.9	12	13.6	17	19.3
Bar	7	3.9	34	18.9	69	38.3	31	17.2	25	13.9	40	22.2
Other indoor	0	0.0	11	11.3	30	30.9	9	9.3	7	7.2	14	14.4

*Source of data: Alaska SANE data
N = 1699; 309 to 310 (18.2%) missing*

Methods used during the assault may vary substantially by locations of initial contact (where assaults *initiated*) and locations of assault (where assaults *occurred*). These results may also be quite valuable from a policy point of view. Table 8 shows how methods vary by locations of initial contact and Table 9 shows how methods vary by locations of assault. More specifically, Table 8 shows the different methods used for the 282 assaults that *initiated* outdoors, the 265 that *initiated* at the patient's house, the 171 that *initiated* at the suspect's house, the 222 that *initiated* at another's house, the 89 that *initiated* in hotels, the 180 that *initiated* in bars, and the 97 that *initiated* in other indoor locations. We did not examine the different methods used for assaults that initiated at work ($N = 9$), in vehicles ($N = 39$), or at the patient and suspect's house ($N = 36$) because of low sample sizes. Similarly, we did not include toxic or chemical burns as a method, given its low prevalence ($N = 4$). Table 9 shows the different methods (excluding toxic or chemical burns) used for the 143 assaults that *occurred* outdoors, the 178 that *occurred* in vehicles, the 302 that *occurred* at the patient's house, the 325 that *occurred* at the suspect's house, the 239 that *occurred* at another's house, the 130 that *occurred* in hotels, and the 73 that *occurred* in other indoor locations. We did not examine the different methods used for assaults that occurred at work ($N = 3$), at the patient and suspect's house ($N = 35$), or in bars ($N = 4$) because of low sample sizes.

Table 9. Common Methods by Common Locations of Assault

Cell Percentages

Assault	Weapon		Blows		Grabbing		Restraints		Strangle		Threats	
	N	%	N	%	N	%	N	%	N	%	N	%
Outdoors	17	11.9 %	38	26.6 %	88	61.5 %	16	11.2 %	22	15.4 %	46	32.2 %
Vehicle	31	17.4	35	19.7	106	59.6	25	14.0	26	14.6	72	40.4
Patient's house	13	4.3	58	19.2	115	38.1	42	13.9	34	11.3	58	19.2
Suspect's house	13	4.0	58	17.8	138	42.5	46	14.2	33	10.2	67	20.6
Other's house	5	2.1	27	11.3	59	24.7	20	8.4	13	5.4	27	11.3
Hotel	6	4.7	24	18.6	50	38.8	17	13.2	21	16.3	23	17.8
Other indoor	6	8.2	9	12.3	27	37.0	10	13.7	5	6.8	13	17.8

Source of data: Alaska SANE data
 $N = 1699$; 267 to 268 (15.7 to 15.8%) missing

Results show that weapons were used in 15% of assaults that *initiated* outdoors (Table 8) and in 12% of assaults that *occurred* outdoors (Table 9). Weapons were more prevalent in assaults that *initiated* outdoors than in assaults that *initiated* elsewhere. However, weapons were more prevalent in assaults that *occurred* in vehicles than in assaults that *occurred* outdoors (17% of the assaults that *occurred* in vehicles involved weapons). Large differences in other methods were also uncovered. Blows were frequent in assaults that *initiated* outdoors (in 23% of these assaults), in the patient's house (in 21% of these assaults), in hotels (in 21% of these assaults), in bars (in 19% of these assaults), in the suspect's house (in 18% of these assaults), and in other indoor locations (in 11% of these assaults). Blows were least frequent in assaults that *initiated* in another's house (in 7% of these assaults). Blows were also common in all locations of assault. More specifically, blows were frequent in assaults that *occurred* outdoors (in 27% of these assaults), in vehicles (in 20% of these assaults), in the patient's house (in 19% of these assaults), in hotels (in 19% of these assaults), in the suspect's house (in

18% of these assaults), in other indoor locations (in 12% of these assaults), and in another's house (in 11% of these assaults). Grabbing was prevalent in all locations of initial contact. More precisely, the prevalence of grabbing varied from a low of 23% in assaults *initiated* in another's house to a high of 58% for assaults *initiated* outdoors. Grabbing was similarly prevalent in all locations of assault. More precisely, the prevalence of grabbing varied from a low of 25% in assaults that *occurred* in another's house to a high of 62% in assaults that *occurred* outdoors. Restraints were most commonly used in assaults that *initiated* in bars (for 17% of these assaults) and in assaults that *initiated* at the patient's house (for 17% of these assaults). Restraints were least commonly used in assaults that *initiated* in the suspect's house, another's house, or another indoor location (for 9% of these assaults). Restraints were most commonly used in assaults that *occurred* in vehicles, the patient's house, the suspect's house, and other indoor locations (for 14% of these assaults). Restraints were also commonly used in assaults that *occurred* in hotels (for 13% of these assaults). Strangulation was less common than blows, grabbing, or restraints. Nonetheless, strangulation was prevalent for assaults that *initiated* in bars (in 14% of these assaults), in hotels (in 14% of these assaults), outdoors (in 12% of these assaults), in the patient's house (in 12% of these assaults), and in the suspect's house (in 11% of these assaults). Strangulation was also prevalent in assaults that *occurred* in hotels (in 16% of these assaults), outdoors (in 15% of these assaults), in vehicles (in 15% of these assaults), in the patient's house (in 11% of these assaults), and in the suspect's house (in 10% of these assaults). The lowest occurrence of strangulation was for assaults that *initiated* at another's house (for 5% of these assaults) and for assaults that *occurred* at another's house (for 5% of these assaults). But again, strangulation is, in this study, significantly more prevalent than previously reported. Finally, threats were relatively common across both locations of initial contact and locations of assault. They were most common for assaults that *initiated* outdoors (for 37% of these assaults), were least common for assaults that *initiated* at another's house (for 10% of these assaults), most common for assaults that *occurred* in vehicles (for 40% of these assaults), and least common for assaults that *occurred* at another's house (for 11% of these assaults).

Overall, assaults that initiated outdoors were the most likely to involve weapons, blows, grabbing, and threats. Assaults that occurred outdoors were the most likely to involve blows and grabbing. Assaults that initiated in bars were the most likely to involve restraints and strangulation. Assaults that occurred in vehicles were the most likely to involve weapons or threats. Assaults that occurred at the suspect's house were the most likely to involve restraints and assaults that occurred in hotels were the most likely to involve strangulation. For all locations of initial contact, the most prevalent method used during the assault included grabbing. Similarly, for all locations of assault, the most prevalent method included grabbing.

Patient condition at the time of the assault is described in Table 10. Intoxication was relatively frequent, with 67% of patients reporting being alcohol intoxicated at the time of the assault and 10% reporting being drug intoxicated. Levels of intoxication were often quite high. More precisely, 26% of patients were passed out or had blacked out at the time of the assault.

Table 10. Patient Condition at Time of Assault*Row Percentages*

Condition	No		Yes		Total
	N	%	N	%	
Alcohol intoxicated	519	33.1 %	1050	66.9 %	1569
Drug intoxicated	1414	90.1	155	9.9	1569
Sober	1220	77.8	349	22.2	1569
Sleeping	1597	97.1	48	2.9	1645
Passed out / blacked out	1216	74.3	421	25.7	1637
Unconscious from trauma	1638	99.6	6	0.4	1644

*Source of data: Alaska SANE data
N = 1699; 54 to 130 (3.2 to 7.7%) missing*

During the examination, 70% of patients indicated that they had used alcohol prior to the assault and 13% indicated that they had used drugs prior to the assault (results not shown). Table 11 shows patient drug and alcohol use measured at the time of the exam by breathalyzer, blood alcohol test, and urine toxicology screen. These results are imperfect measures of alcohol and drug use prior to the assault because of the time elapsed from the assault to the exam and the use of substances may have occurred after the assault. Nonetheless, these results do further support the relatively frequent use of alcohol and drugs.

Table 11. Measures of Drug and Alcohol Use*Row Percentages*

Measure	No		Yes		Total
	N	%	N	%	
Breathalyzer	1426	92.2 %	120	7.8 %	1546
Blood alcohol	1034	67.2	505	32.8	1539
Urine tox screen	1072	69.8	463	30.2	1535

*Source of data: Alaska SANE data
N = 1699; 153 to 164 (9.0 to 9.7%) missing*

Table 12. Blood Alcohol and Breathalyzer Results*Column Percentages*

Grams per milliliter	Blood Alcohol		Breathalyzer	
	N	%	N	%
Zero	81	23.7 %	19	16.1 %
.01 to .07	58	17.0	13	11.0
.08 to .14	72	21.1	29	24.6
.15 to .29	108	31.6	45	38.1
.30 or above	23	6.7	12	10.2
Total	342		118	

*Source of data: Alaska SANE data
N = 505 and 120; 163 (32.3%) missing and 2 (1.7%) missing*

Breathalyzer and blood alcohol test results are shown in Table 12. Blood alcohol results were available for 342 (67%) of the 505 patients given a blood alcohol test and breathalyzer results were available for 118 (98%) of the 120 patients given a breathalyzer test. Negative results were observed for 24% of patients given a blood alcohol test and 16% of patients given a breathalyzer test. Of the patients given a blood alcohol test, 59% tested above .08, 38% of patients tested at a .15 or above, and 7% tested at a .30 or above. Of the patients given a breathalyzer test, 73% tested above .08, 48% of patients tested at a .15 or above, and 10% tested at a .30 or above.

Among the 463 patients who received a urine toxicology screening, 42% tested negative and 58% tested positive (results not shown). Specific results were available for 450 (97%) of these patients. These results are presented in Table 13. Results show that the most common substances used by patients included THC (marijuana), cocaine (including crack cocaine), alcohol, and benzodiazepines (sedatives). More specifically, 33% of patients given a urine toxicology screen tested positive for THC, 20% tested positive for cocaine, 18% tested positive for alcohol, and 9% tested positive for benzodiazepines. Other, less common drugs included opiates and amphetamines (with 4% and 3% of patients testing positive for each, respectively).

Table 13. Urine Toxicology Screening Results, for Patients that Were Screened

Row Percentages

Drug	No		Yes		Total
	N	%	N	%	
Alcohol	368	81.8 %	82	18.2 %	450
Barbiturates	447	99.3	3	0.7	450
MDMA	450	100.0	0	0.0	450
THC	302	67.1	148	32.9	450
Benzodiazepines	409	90.9	41	9.1	450
Ketamine	449	99.8	1	0.2	450
Cocaine	358	79.6	92	20.4	450
Opiates	434	96.4	16	3.6	450
GHB	450	100.0	0	0.0	450
Amphetamines	435	96.7	15	3.3	450
Other drug	440	97.8	10	2.2	450

*Source of data: Alaska SANE data
N = 463; 13 (2.8%) missing*

A total of 17 sex acts were recorded from the SANE examinations (see Table 14), as self-reported by patients. More specifically, we examined whether patients reported the following sexual acts had been completed or attempted. These included kissing, touching breasts, touching the vagina, touching the penis, touching the anus, oral copulation of patient's genitals, oral copulation of suspect's genitals, oral copulation of patient's anus, oral copulation of suspect's anus, masturbation of the patient, masturbation of the suspect, penetration of the vagina by a finger, penile penetration of the vagina, penetration of the vagina by an object, penetration of the anus by a finger, penile penetration of the anus, and penetration of the anus by an object. Some sample sizes are low due to recall difficulties. Patients may not always know or remember the details of the assault.

Table 14. Sex Acts Reported*Row Percentages*

Sex Act	No		Attempted		Yes		Total
	N	%	N	%	N	%	
Kissing	433	40.8 %	16	1.5 %	611	57.6 %	1060
Touching breast	391	39.9	4	0.4	584	59.7	979
Touching vagina	402	40.6	5	0.5	582	58.8	989
Touching penis	961	89.6	2	0.2	110	10.3	1073
Touching anus	904	88.1	9	0.9	113	11.0	1026
Oral copulation of patient genitals	800	75.8	12	1.1	243	23.0	1055
Oral copulation of suspect genitals	906	78.3	31	2.7	220	19.0	1157
Oral copulation of patient anus	1036	97.4	1	0.1	27	2.5	1064
Oral copulation of suspect anus	1150	99.9	0	0.0	1	0.1	1151
Masturbation of patient	1016	94.6	3	0.3	55	5.1	1074
Masturbation of suspect	1091	94.5	4	0.3	59	5.1	1154
Penetration of vagina by finger	504	52.4	12	1.2	446	46.4	962
Penetration of vagina by penis	134	11.8	15	1.3	986	86.9	1135
Penetration of vagina by object	1017	97.0	0	0.0	31	3.0	1048
Penetration of anus by finger	959	90.2	14	1.3	90	8.5	1063
Penetration of anus by penis	877	80.6	50	4.6	161	14.8	1088
Penetration of anus by object	1082	99.2	0	0.0	9	0.8	1091

*Source of data: Alaska SANE data
N = 1699; 542 to 737 (31.9 to 43.4%) missing*

The most common sexual act reported was penile penetration of the vagina. This was reported by 87% of patients. Statutorily, these are aggravated offenses that meet the legal requirements for sexual assaults in the first, second, or third degree (and sexual abuse of a minor in the first, second, or third degree), all punishable as felonies (unclassified, class B, or class C). Generally speaking, any form of penetration or attempted penetration, defined by Alaska Statute § 11.81.900 as “genital intercourse, cunnilingus, fellatio, anal intercourse, or an intrusion, however slight, of an object or any part of a person’s body into the genital or anal opening of another person’s body” will be punishable as a felony.

These data clearly reveal that the vast majority of assaults were serious enough to be punishable as felonies. Overall, 97% of assaults included penetration or attempted penetration of the vagina or anus and 40% included oral copulation or attempted oral copulation of the patient’s or suspect’s genitals or anus (results not shown). Other common forms of penetration included digital penetration of the vagina (reported in 46% of assaults). The most common forms of oral copulation included the oral copulation of the patient’s genitals (reported in 23% of assaults). Over half of assaults also included kissing and sexual contact with breasts and vagina.

The majority of assaults were not statutory (99%). Statutory sexual assaults include sexual acts prohibited by law because of the victim’s age, the suspect’s age, and the age difference between the victim and suspect. For example, an 18 year old suspect may be charged with sexual abuse of a minor in the third degree (AS §11.41.438) if the victim is 15 years of age. In these statutory cases, consent is not at issue. Regardless of whether the victim consented to the sexual acts, the suspect may be charged and convicted. Very few assaults ($N = 17$) were statutory cases.

Table 15. Position at Time of Assault*Row Percentages*

Position	No		Yes		Total
	N	%	N	%	
Supine	148	13.4 %	959	86.6 %	1107
Standing	1061	95.8	46	4.2	1107
Straddling	1085	98.0	22	2.0	1107
Prone	1017	91.9	90	8.1	1107
Knee chest	1064	96.1	43	3.9	1107
Lying on side	1064	96.1	43	3.9	1107
Sitting	1075	97.1	32	2.9	1107
Other	1086	98.1	21	1.9	1107

*Source of data: Alaska SANE data**N = 1699; 592 (34.8%) missing*

Table 15 identifies the position of the patient at the time of the assault. The most common position during the assault was supine, with 87% of patients being assaulted in the supine position. Other positions were far less common, with prone as the next most common, reported by 8% of patients. This information, along with other assault characteristics, is important because it may affect the collection and documentation of forensic evidence (whether it does so will be published in subsequent reports). In particular, positions at time of assault may affect the presence and patterning of injury.

Whether ejaculation by the suspect had occurred was rarely known by the patient. Of the 1,699 patients, 396 (23%) reported that the suspect had ejaculated during the assault and 167 (10%) reported that the suspect had not ejaculated during the assault (1,136 patients, or 67%, did not know). Focusing on the 396 patients who reported that the suspect had ejaculated during the assault, Table 16 describes ejaculation locations. Not surprisingly, given the sex acts reported previously, the most common ejaculation location was the vagina (noted in 70% of assaults).

Table 16. Ejaculation Location, for Suspects that Ejaculated During the Assault*Row Percentages*

Location	No		Yes		Total
	N	%	N	%	
Vagina	114	30.3 %	262	69.7 %	376
Rectum	349	92.8	27	7.2	376
Mouth	342	91.0	34	9.0	376
Stomach	356	94.7	20	5.3	376
Back	371	98.7	5	1.3	376
Napkin / cloth	373	99.2	3	0.8	376
Bed	364	96.8	12	3.2	376
Clothing	374	99.5	2	0.5	376
Condom	364	96.8	12	3.2	376
Other	331	85.3	57	14.7	388

*Source of data: Alaska SANE data**N = 396; 8 to 20 (2.0 to 5.1%) missing*

Relatively few suspects used a condom during the assault (10%) and none used contraceptive jelly or foam. Few assaults (6%) included the use of lubricants.

Post-Assault Characteristics

Post-assault actions taken by the patient are shown in Table 17. These actions may be important because they may affect the collection of forensic evidence. More specifically, they may affect the extent to which forensic evidence is still available to collect. Forensic evidence will decay over time and post-assault actions may enhance the decay of forensic evidence and, in some cases, may eliminate forensic evidence (e.g., by washing it away).

Table 17. Post-Assault Actions

Row Percentages

Actions	No		Yes		Total
	N	%	N	%	
Urinated	410	24.9 %	1239	75.1 %	1649
Defecated	1187	72.0	462	28.0	1649
Genital Wipe / Wash	714	43.3	935	56.7	1649
Bath / Shower	1232	74.7	417	25.3	1649
Douche	1613	97.8	36	2.2	1649
Ate / Drank	637	38.6	1012	61.4	1649
Brushed Teeth	1217	73.8	432	26.2	1649
Oral Gargle / Wash	1332	80.8	317	19.2	1649
Changed Clothing	913	55.4	736	44.6	1649
Steam	1646	99.8	3	0.2	1649

*Source of data: Alaska SANE data
N = 1699; 50 (2.9%) missing*

In Table 17, the majority of patients reported that they urinated, ate or drank, and wiped or washed genitalia after the assault. Close to half (45%) of patients also reported that they changed their clothing prior to the examination. Other common post-assault actions included defecating (28%), bathing or showering (25%), brushing teeth (26%), and gargling (19%).

Table 18. Consensual Sex Between Assault and Examination

Row Percentages

Sex	No		Yes		Total
	N	%	N	%	
Anal	1497	100.0 %	0	0.0 %	1497
Oral	1493	100.0	0	0.0	1493
Vaginal	1471	98.0	30	2.0	1501

*Source of data: Alaska SANE data
N = 1699; 198 to 206 (11.7 to 12.1%) missing*

Other factors that may affect the collection of forensic evidence are whether patients engaged in consensual sex between the assault and the examination (Table 18). Engaging in consensual sex between the assault and the examination could contaminate the forensic evidence from the assault. Very few patients engaged in any form of consensual sex and none engaged in anal or oral sex after the assault. More precisely,

only 30 patients (2%) engaged in consensual vaginal sex between the assault and the examination.

Whether patients inserted or removed sponges, diaphragms, tampons, or pads is shown in Table 19. All were relatively rare.

Table 19. Post-Assault Insertions and Removals

Row Percentages

Item	No		Yes		Total
	N	%	N	%	
Sponge	1651	100.0 %	0	0.0 %	1651
Diaphragm	1650	99.9	1	0.1	1651
Tampon	1605	97.2	46	2.8	1651
Pad	1587	96.1	64	3.9	1651

*Source of data: Alaska SANE data
N = 1699; 48 (2.8%) missing*

Table 20 shows that most reports to the sexual assault nurse examiner (95%) occurred within three days of the assault. More precisely, 13% of reports occurred within two hours of the assault, 33% occurred within four hours, 58% occurred within 12 hours, 77% occurred within one day, and (again) 95% occurred within three days.

Table 20. Time Elapsed Between Assault and Report

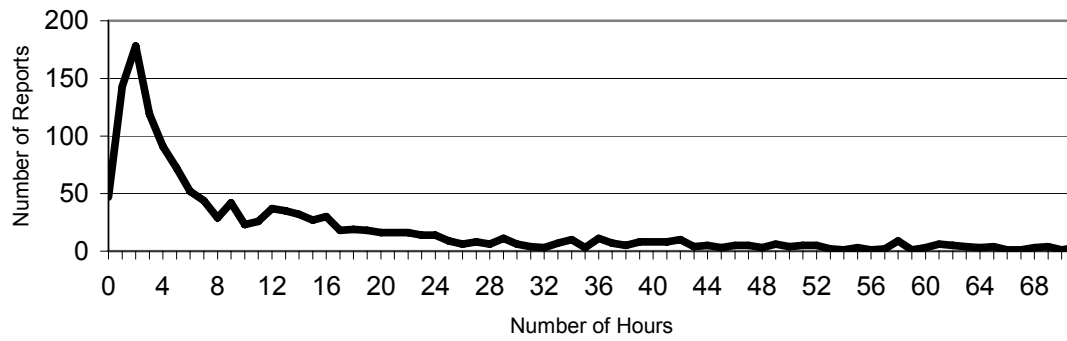
Column Percentages

Time	Patients		
	N	%	cum. %
< 2 hours	201	12.9 %	12.9 %
2 to < 4 hours	306	19.6	32.5
4 to < 12 hours	396	25.4	57.9
12 to < 24 hours	295	18.9	76.8
1 to < 3 days	279	17.9	94.7
3 days or more	83	5.3	100.0
Total	1560		

*Source of data: Alaska SANE data
N = 1699; 139 (8.2%) missing*

For those reports that occurred within 3 days of the assault, the number of hours from the assault to the report is shown in Figure 3. For reports that occurred within 3 days of the assault, the average number of hours between the assault and the report to the sexual assault nurse examiner was 13.2 hours ($s = 15.6$). Over half (51%) of these assaults were reported to the sexual assault nurse examiner within six hours.

Figure 3. Hours Elapsed Between Assault and Report, for Reports Within Three Days of Assault



Source of data: Alaska SANE data; N = 1390

Exam Characteristics and Findings

Exam characteristics and findings are based on the sexual assault nurse examiner's observations, physical assessments, and laboratory tests. Low sample sizes may preclude strong interpretations and results should not be generalized to sexual assault victims who did not receive a medical / forensic examination.

The traumatic effects of sexual victimizations can be clearly observed by patients' physical and emotional state during exams. All reports were read to record whether patients were described as controlled, quiet, calm, expressive, staring, sleeping, cooperative, stoic, agitated, fearful, tearful, fidgeting, tense, hysterical, sobbing, yelling, listless, loud, trembling, or angry. These statistics reflect the patient's physical and emotional behaviors observed and documented by the SANE but may not depict all of the physical and emotional feelings the patients were experiencing at the time. Nonetheless, data in Table 21 show that most patients were cooperative (76%) and many were controlled (64%), quiet (55%), tearful (45%), and calm (35%). A smaller number were tense (17%), fidgeting (16%), trembling (11%), sleeping (10%), stoic (9%), staring (8%), sobbing (7%), agitated (7%), fearful (6%), or angry (5%). Overall, 63% of patients were either agitated, fearful, tearful, fidgeting, tense, hysterical, sobbing, yelling, listless, loud, trembling, or angry at some point during the medical / forensic exam (result not shown).

Table 21. Patients' Physical and Emotional State at Time of Exam

Row Percentages

State	No		Yes		Total
	N	%	N	%	
Controlled	534	35.7 %	962	64.3 %	1496
Quiet	673	45.0	823	55.0	1496
Calm	976	65.2	520	34.8	1496
Expressive	1480	98.9	16	1.1	1496
Staring	1375	91.9	121	8.1	1496
Sleeping	1346	90.0	150	10.0	1496
Cooperative	357	23.9	1139	76.1	1496
Stoic	1358	90.8	138	9.2	1496
Agitated	1393	93.1	103	6.9	1496
Fearful	1400	93.6	96	6.4	1496
Tearful	829	55.4	667	44.6	1496
Fidgeting	1259	84.2	237	15.8	1496
Tense	1238	82.8	258	17.2	1496
Hysterical	1487	99.4	9	0.6	1496
Sobbing	1388	92.8	108	7.2	1496
Yelling	1450	96.9	46	3.1	1496
Listless	1450	96.9	46	3.1	1496
Loud	1467	98.1	29	1.9	1496
Trembling	1327	88.7	169	11.3	1496
Angry	1425	95.3	71	4.7	1496
Other	1295	86.6	201	13.4	1496

Source of data: Alaska SANE data

N = 1699; 203 (11.9%) missing

Most reports to the sexual assault nurse examiner (89%) led to a complete exam. Not surprisingly, given patients' physical and emotional state, 11% did not complete the

examination. Reasons for not completing exams are shown in Table 22. The most common reasons were attributable to lack (or withdrawal) of patient consent.

Table 22. Reasons for Not Completing Exams

Column Percentages

Reasons	Patients	
	N	%
Patient declined exam	118	62.4 %
Partial exam	13	6.9
RN stopped call out process	16	8.5
No probable cause	30	15.9
False report	5	2.6
Other	7	3.7
Total	189	

Source of data: Alaska SANE data

N = 192; 3 (0.2%) missing

At the time of the SANE examination, 50% of patients were not wearing the same clothing as that worn during the assault. The appearance of patients' clothing at the time of the examination is described in Table 23. Relatively few patients had clothing that appeared dirty (15%), partially missing (8%), torn (3%), bloody (2%), or wet (2%). The majority of patients had clothing that appeared intact or clean (75% and 64% respectively).

Table 23. Appearance of Patients' Clothing

Row Percentages

Clothing	No		Yes		Total
	N	%	N	%	
Intact	225	25.5 %	659	74.5 %	884
Clean	320	36.2	564	63.8	884
Dirty	755	85.4	129	14.6	884
Wet	867	98.1	17	1.9	884
Bloody	863	97.6	21	2.4	884
Torn	856	96.8	28	3.2	884
All missing	879	99.4	5	0.6	884
Partially missing	818	92.5	66	7.5	884
Buttons missing	879	99.4	5	0.6	884

Source of data: Alaska SANE data

N = 1699; 815 (48.0%) missing

As a result of the assault, 2% of patients were admitted to the hospital and 10% required emergency medical care (results not shown). Patients requiring emergency medical care were not necessarily admitted to the hospital. Reasons for requiring emergency medical care are shown in Table 24. The most common reasons for requiring emergency medical care were related to non-genital injuries suffered by patients, to patients' alcohol levels, and to other reasons.

Table 24. Reasons for Emergency Medical Care

Row Percentages

Reason	No		Yes		Total
	N	%	N	%	
Non-genital injury	1442	93.8 %	95	6.2 %	1537
Genital injury	1526	99.3	11	0.7	1537
Alcohol level	1506	97.9	33	2.1	1539
Other	1485	97.6	36	2.4	1521

Source of data: Alaska SANE data
N = 1699; 160 to 178 (9.4 to 10.5%) missing

Few patients were pregnant at the time of the examination (2% of female patients) but over half were mothers (56% of female patients; results not shown). Of the female patients, 11% were menstruating at the time of the assault (result not shown).

The vast majority of patients (95%) had a sexual assault evidence collection kit completed during the medical / forensic examination (the evidence collection kit a preassembled kit used to collect and preserve forensic samples following a sexual assault). Speculum and colposcope exams were very common (in 91% and 95% of exams, respectively). The speculum exam is an examination that utilizes an instrument to enhance the visualization of the vaginal walls and cervix while the colposcope exam is an examination of the genitalia with an instrument that provides illumination and magnification. Anoscope exams (examinations of the rectum using a small tube-shaped speculum) were less common (in 13% of exams).

An alternative light source was used in 71% of exams. An alternative light source is a light source that emits a different wavelength of electromagnetic radiation that stimulates fluorescence. Fluorescence is the production of light by radiant energy. Fluorescence was found in 37% of exams conducted with an alternative light source.

Table 25. Location of Fluorescence, for Cases Where Fluorescence was Found

Row Percentages

Location	No		Yes		Total
	N	%	N	%	
Abdomen	360	92.5 %	29	7.5 %	389
Arms and hands	303	77.9	86	22.1	389
Legs and feet	207	53.2	182	46.8	389
Buttocks and hips	293	75.3	96	24.7	389
Chest	366	94.1	23	5.9	389
Vagina and groin	361	92.8	28	7.2	389
Neck	378	97.2	11	2.8	389
Back	369	94.9	20	5.1	389
Face	341	87.7	48	12.3	389

Source of data: Alaska SANE data
N = 400; 11 (2.8%) missing

Table 25 describes where fluorescence was found, for exams in which an alternative light source was used and fluorescence was found. The most common

locations where fluorescence was found included legs and feet, buttocks and hips, arms and hands, and the face.

A wet prep examination (a microscopic examination of fluid obtained from the vaginal vault) was conducted for 841 (50%) of the patients, and the nurse observed spermatozoa on 71 (8%) of these examinations. In nine of these 71 cases (13%), the spermatozoa was still motile.

Most patients (80%) were tested for sexually transmitted infections and other genital infections; and 19% of them tested positive. The specific types of infections that these patients tested positive for are displayed in Table 26 ($N = 224$). The most common infection that patients tested positive for was bacterial vaginosis (51%), followed by chlamydia (17%), genital warts (14%), and trichomoniasis (12%). Other infections that patients tested positive for included gonorrhea, HIV, herpes, hepatitis B, syphilis, yeast, and hepatitis C.

Table 26. Infections, for Patients Who Tested Positive

Row Percentages

Infection	Negative		Positive		Total
	N	%	N	%	
Bacterial vaginosis	110	49.3 %	113	50.7 %	223
Chlamydia	186	83.4	37	16.6	223
Genital warts	193	86.5	30	13.5	223
Gonorrhea	212	95.1	11	4.9	223
HIV	218	97.8	5	2.2	223
Herpes	214	96.0	9	4.0	223
Trichomoniasis	197	88.3	26	11.7	223
Hepatitis B	219	98.2	4	1.8	223
Syphilis	222	99.6	1	0.4	223
Yeast	202	90.6	21	9.4	223
Hepatitis C	210	94.2	13	5.8	223

*Source of data: Alaska SANE data
N = 224; 1 (0.4%) missing*

Very detailed injury information was recorded from each medical examination. Injury information included both non-genital and genital injury. Non-genital injuries included nine injuries (i.e., bruising, redness, abrasions, lacerations, swelling, fractures, bite marks, pain, and other) to 12 sites (i.e., head/face, mouth, neck, shoulders, arms, hands, chest, abdomen, back, buttocks/hips, legs, and feet). Genital injuries for females included bruising, abrasions, lacerations, and tenderness to 15 different genital sites. These sites included the mons pubis, labia majora, labia minora, labia majora / minora junction, clitoral hood, clitoris, periurethra, hymen, fossa navicularis, posterior fourchette, perineum, vaginal walls, cervix, anus, and rectum. Genital injuries for males included bruising, abrasions, lacerations, and tenderness of the anus and rectum.

Non-genital injuries were recorded for 52% of patients. Overall, 15% of patients had non-genital injuries to the head or face, 6% to the mouth, 13% to the neck, 3% to shoulders, 31% to arms, 9% to hands, 9% to the chest, 3% to the abdomen, 9% to the back, 8% to buttocks or hips, 34% to legs, and 2% to feet. The most common non-genital injury types included bruising (documented for 48% of patients) and abrasions (documented for 22% of patients). Other non-genital injury types were far less common,

with pain documented for 8% of patients, swelling documented for 7%, and lacerations, redness, and other injuries all documented for 4%. Detailed results by non-genital injury site and type are shown in Table 27. Each cell in this table represents the number and percentage of patients with documented non-genital injuries.

The detailed data Table 27 show that the most common non-genital injury was bruising to the legs, documented in 31% of patients, followed by bruising of the arms (documented in 29% of patients), bruising of the head / face (documented in 11% of patients), bruising to the abdomen (documented in 11% of patients), and bruising of the neck (documented in 11% of patients).

Table 27. Number and Percent of Patients With Non-Genital Injury

Cell Percentages

Location	Bruising		Redness		Abrasions		Lacerations		Swelling	
	N	%	N	%	N	%	N	%	N	%
Head / face	169	11.2 %	14	0.9 %	73	4.9 %	27	1.8 %	88	5.9 %
Mouth	81	5.4	0	0.0	23	1.5	28	1.9	25	1.7
Neck	163	10.8	24	1.6	45	3.0	2	0.1	12	0.8
Shoulders	33	2.2	3	0.2	12	0.8	0	0.0	1	0.1
Arms	431	28.7	7	0.5	100	6.6	2	0.1	2	0.1
Hands	95	6.3	5	0.3	39	2.6	8	0.5	12	0.8
Chest	102	6.8	4	0.3	42	2.8	0	0.0	1	0.1
Abdomen	16	11.1	0	0.0	18	1.2	0	0.0	0	0.0
Back	79	5.3	3	0.2	66	4.4	0	0.0	2	0.1
Buttocks / hips	75	5.0	4	0.3	50	3.3	0	0.0	1	0.1
Legs	460	30.6	6	0.4	145	9.6	4	0.3	5	0.3
Feet	15	1.0	1	0.1	11	0.7	1	0.1	2	0.1
Total	724	48.1	53	3.5	337	22.4	60	4.0	109	7.2

Location	Fracture		Bite Mark		Pain		Other		Total	
	N	%	N	%	N	%	N	%	N	%
Head / face	10	0.7 %	5	0.3 %	50	3.3 %	17	1.1 %	218	14.5 %
Mouth	0	0.0	0	0.0	16	1.1	4	0.3	95	6.3
Neck	0	0.0	2	0.1	32	2.1	4	0.3	201	13.4
Shoulders	0	0.0	3	0.2	2	0.1	2	0.1	47	3.1
Arms	0	0.0	7	0.5	13	0.9	7	0.5	473	31.4
Hands	1	0.1	3	0.2	9	0.6	15	1.0	135	9.0
Chest	0	0.0	4	0.3	5	0.3	3	0.2	137	9.1
Abdomen	0	0.0	1	0.1	2	0.1	3	0.2	39	2.6
Back	0	0.0	0	0.0	8	0.5	2	0.1	136	9.0
Buttocks / hips	1	0.1	0	0.0	5	0.3	4	0.3	117	7.8
Legs	0	0.0	7	0.5	12	0.8	7	0.5	508	33.8
Feet	0	0.0	0	0.0	1	0.1	6	0.4	27	1.8
Total	1	0.6	1	0.6	13	7.8	7	4.2	785	52.2

*Source of data: Alaska SANE data
N = 1699; 195 (11.5%) missing*

Genital injuries were documented in 41% of patients. Overall, the most common genital injury type documented for patients was a laceration (33%), followed by abrasions (15%), bruising (11%), and tenderness (6%). The most common genital injury locations identified for female patients included the posterior fourchette (19%), the labia

minora (16%), the perineum (14%), the fossa navicularis (13%), the hymen (7%), the labia majora / minora junction (6%), and vaginal walls (4%). Injury to the anus was identified for 10% of all patients.

Three anatomical sites had lacerations for 10% of patients. More specifically, 17% of examinations documented lacerations of the posterior fourchette, 12% documented lacerations to the perineum, and 10% documented lacerations to the fossa navicularis. An additional 9% of examinations documented lacerations of the anus. These were the most common genital injuries, followed by abrasions of the labia minora (documented for 8% of patients) and lacerations of the labia minora (documented for 6% of patients).

Table 28. Number and Percent of Patients With Genital Injury

Cell Percentages

Location	Bruising		Abrasions		Lacerations		Tenderness		Total	
	N	%	N	%	N	%	N	%	N	%
Mons pubis	1	0.1 %	2	0.1 %	2	0.1 %	1	0.1 %	5	0.3 %
Labia majora	4	0.3	19	1.3	10	0.7	9	0.6	34	2.4
Labia minora	62	4.3	113	7.8	83	5.8	52	3.6	226	15.7
Labia maj/min junction	7	0.5	21	1.5	63	4.4	19	1.3	82	5.7
Clitoral hood	6	0.4	13	0.9	10	0.7	10	0.7	30	2.1
Clitoris	2	0.1	1	0.1	4	0.3	1	0.1	8	0.6
Periurethra	16	1.1	4	0.3	8	0.6	12	0.8	31	2.1
Hymen	69	4.8	14	1.0	32	2.2	26	1.8	97	6.7
Fossa navicularis	3	0.2	30	2.1	146	10.1	38	2.6	192	13.3
Posterior fourchette	2	0.1	20	1.4	251	17.4	32	2.2	280	19.4
Perineum	1	0.1	33	2.3	178	12.3	13	0.9	204	14.1
Vaginal walls	39	2.7	10	0.7	25	1.7	3	0.2	61	4.2
Cervix	15	1.0	6	0.4	5	0.3	1	0.1	23	1.6
Anus	4	0.3	22	1.5	137	9.3	18	1.2	150	10.2
Rectum	22	1.5	9	0.6	16	1.1	0	0.0	38	2.6
Total	161	10.9	227	15.4	490	33.2	89	6.0	604	40.9

Source of data: Alaska SANE data

N = 1,660; 218 (13.1%) missing; for anus, rectum, and total rows, N = 1699; 224 (13.2%) missing

Seventeen percent of patients received a follow-up examination or consultation. On average, follow-up examinations occurred 23 days after the first exam ($s = 21.2$). More specifically, 22% occurred within one week and 69% within four weeks (results not shown).

Suspect Characteristics

Suspect characteristics were self-reported by the patients. Rates of missing data for suspect characteristics were often high. Suspect characteristics were not always documented by the sexual assault nurse examiner and, in some cases, suspects were not well-known by patients. Readers are cautioned to take into account the rate of unknown information prior to making strong inferences.

The average number of suspects per assault was 1.16 ($s = 0.6$), for a total of 1,746 suspects. The number of suspects per assault is shown in Table 29. Results show that 90% of patients were assaulted by one suspect, 7% by two suspects, and 4% by three or more suspects.

Table 29. Number of Suspects per Report

Column Percentages

Number of Suspects	Reports		
	N	%	cum. %
One	1416	89.6 %	89.6 %
Two	107	6.8	96.3
Three	36	2.3	98.6
Four	16	1.0	99.6
Five	2	0.1	99.7
Six	2	0.1	99.9
Seven	1	0.1	99.9
Eight	1	0.1	100.0
Total	1581		

*Source of data: Alaska SANE data
N = 1699; 118 (6.9%) missing*

Suspect information includes the gender, race or ethnicity, and age of the suspect, whether the suspect has used alcohol or drugs, and the relationship between the suspect and the patient. Not surprisingly, the vast majority (99.7%) of suspects were male (only six were female).

Table 30. Race and Ethnicity of Suspects

Column Percentages

Race	Suspects	
	N	%
White	506	33.6 %
Native	517	34.4
Black	326	21.7
Hispanic	109	7.2
Asian	27	1.8
Pacific Islander	19	1.3
Total	1504	

*Source of data: Alaska SANE data
N = 1,746; 242 (13.9%) missing*

Of the 1,746 suspects, 71% of their identities were known. Table 30 identifies the race and ethnicity of suspects. In rare cases when patients reported multiple races or ethnicities for suspects, the minority class was selected. Overall, the majority of suspects were Native (34%) or White (34%). An additional 22% were Black.

Overall, the race of suspects is similar to the race of patients, with two clear exceptions. More precisely, 34% of suspects were White (and 36% of patients were White), 34% of suspects were Native (but 56% of patients were Native), 22% of suspects were Black (but 5% of patients were Black), 7% of suspects were Hispanic (and 2% of patients were Hispanic), 2% of suspects were Asian (and 1% of patients were Asian), and 1% of suspects were Pacific Islander (and 1% of patients were Pacific Islander). Additional detail on suspect and patient race is shown in Table 31.

Table 31. Suspect Race and Ethnicity by Patient Race and Ethnicity

Row Percentages

Patients	Suspects												Total
	White		Native		Black		Hispanic		Asian		Pacific Islander		
	N	%	N	%	N	%	N	%	N	%	N	%	
White	269	55.2 %	53	10.9 %	108	22.2 %	42	8.6 %	8	1.6 %	7	1.4 %	487
Native	207	23.9	455	52.5	132	15.2	54	6.2	12	1.4	7	0.8	867
Black	13	16.3	5	6.3	57	71.3	5	6.3	0	0.0	0	0.0	80
Hispanic	7	24.1	1	3.4	13	44.8	7	24.1	1	3.4	0	0.0	29
Asian	5	35.7	0	0.0	4	28.6	1	7.1	4	28.6	0	0.0	14
Pacific Islander	4	16.0	2	8.0	12	48.0	0	0.0	2	8.0	5	20.0	25

*Source of data: Alaska SANE data
N = 1,746; 262 (17.2%) missing*

Results in Table 31 show that victimizations across racial and ethnic groups were least common for Black patients (71% were assaulted by Black suspects) and most common for Pacific Islander patients (only 20% were assaulted by Pacific Islander suspects). Additional results in Table 31 show that 55% of White patients were assaulted by White suspects, 53% of Native patients were assaulted by Native suspects, 24% of Hispanic patients were assaulted by Hispanic suspects, and 29% of Asian patients were assaulted by Asian suspects.

Alcohol use was frequent among suspects, with 85% of suspects using alcohol (result not shown). Drug use was less frequent, with 18% using drugs (result not shown). Again, these statistics are all based on self-reported information by the patient and their true validity therefore remains unknown.

Table 32 describes the age of suspects. Unless the suspect was well known by the patient, this information is likely to be missing. Suspect age was known for 1,061 (61%) of the suspects. Results show that 15% of suspects were 10 to 19 years of age (over half of those were 18 or 19 years of age), 39% were 20 to 29 years of age, 25% were 30 to 39 years of age, 15% were 40 to 49 years of age, and 7% were 50 years of age or older.

Table 32. Age of Suspects*Column Percentages*

Age	Suspects	
	N	%
10 to 19	162	15.3 %
20 to 29	408	38.5
30 to 39	260	24.5
40 to 49	160	15.1
50 to 59	53	5.0
60 to 69	14	1.3
70 to 79	4	0.4
Total	1061	

*Source of data: Alaska SANE data
N = 1,746; 685 (39.2%) missing*

Patient-suspect relationship is shown in Table 33. Overall, 16% of patients were assaulted by strangers and 84% were assaulted by non-strangers, ranging from current spouses to acquaintances known for less than 12 hours. The most common relationships included friends and acquaintances. Overall, 67% of patients reported being assaulted by someone they knew as a friend or an acquaintance. Among patients assaulted by non-strangers, 80% were assaulted by someone known as a friend or acquaintance.

Table 33. Relationship Between Suspects and Patients*Column Percentages*

Relationship	Suspects		
	N	%	% of non-stranger
Stranger	269	16.0 %	
Friend / acquaintance (> 24 hrs)	694	41.2	49.0 %
Acquaintance (< 24 hrs)	34	2.0	2.4
Acquaintance (< 12 hrs)	407	24.2	28.8
Current spouse	21	1.2	1.5
Former spouse	10	0.6	0.7
Current partner	58	3.4	4.1
Former partner	70	4.2	4.9
Relative	100	5.9	7.1
Authority figure	21	1.2	1.5
Total	1684		

*Source of data: Alaska SANE data
N = 1,746; 62 (3.6%) missing*

Legal Resolutions

Prosecutorial outcomes were collected directly from the Alaska Department of Law, but were collected only for a sub-sample of the examinations included in this report. More precisely, searches through the Alaska Department of Law records were limited to examinations conducted from 1999 to 2005, because the legal resolutions for the examinations conducted in 2006 were not yet completed by the time of data collection and the legal resolutions for the examinations conducted prior to 1999 were not electronically available. In addition, searches through the Alaska Department of Law records excluded cases referred from the military and excluded cases with unknown law enforcement numbers. Consequently, we examined the legal resolutions for the 1,229 examinations conducted from 1999 to 2004 (i.e., for 72% of the original 1,699 examinations included in the sample). These legal resolutions are summarized in Table 34.

Table 34. Case Outcomes by Stage

Stage	N	% of reported	% of referred	% of accepted
Reported	1229	100.0 %		
Referred	353	28.7	100.0 %	
Accepted	244	19.9	69.1	100.0 %
Convicted	190	15.5	53.8	77.9

Source of data: Alaska Department of Law
N = 1,229; 0 (0.0%) missing

Of the 1,229 reports examined, 29% were referred to the Alaska Department of Law for prosecution. Once referred for prosecution, cases had a high likelihood of getting accepted (69%) and once accepted, cases had a high likelihood of resulting in a conviction (78%). Stated differently, 69% of referred cases were accepted and 78% of accepted cases resulted in a conviction. Overall, 29% of reported cases were referred, 20% were accepted, and 16% resulted in a conviction. As previous analyses of Alaska Department of Law data have revealed, the greatest point of attrition is from report to referral.

The odds of referring a case, accepting a case, and gaining a conviction are slightly higher in this sample of sexual assault cases with a SANE examination than previously reported. Snodgrass (2006)¹ examined the legal resolutions of all sexual assault cases reported to the Anchorage Police Department from 2000 to 2004. Results showed that 18% of all sexual assaults reported to APD from 2000 to 2004 were referred to prosecution (versus the 29% reported here), that 12% were accepted by prosecution (versus the 20% reported here), and that 11% resulted in a conviction (versus the 16% reported here). The SANE examination may significantly enhance the likelihood that a case can be referred to the Alaska Department of Law for prosecution.

Future analyses will examine the factors that increase the likelihood of police referring a case to the Alaska Department of Law for prosecution, the likelihood of the

¹ Sexual Assault Case Processing: A Descriptive Model of Attrition and Decision Making. Alaska Justice Forum, 23(1), <http://justice.uaa.alaska.edu/forum/23/1spring2006/231spring2006.pdf>.

Alaska Department of Law to accept a case for prosecution, and the likelihood of gaining a conviction.

Appendix A – Data Collection Instrument



Examining the Characteristics, Processes, and Outcomes of Sexual Assaults in Alaska

NIJ Grant No. 2004-WB-GX-0003

André Rosay and Tara Henry
Co-Principal Investigators

SECTION 1. BASIC INFORMATION

- UAA Case Number: _____
- SART Location: _____
- Law enforcement agency: _____
- Victim race (Check all that apply):
 - Caucasian Black
 - Alaska Native / American Indian Asian Hispanic
 - Pacific Islander Other (specify): _____
- Victim sex: Female Male
- Victim age: _____
- Consensual / statutory? Yes No
- Was victim homeless at time of assault? Yes No Unknown
- Was exam completed: Yes No
- If exam was not completed, why not? _____
- Time from assault to report: _____

SECTION 2. PATIENT MEDICAL HISTORY

- Is the patient pregnant? Yes No
 Para: _____

- Was patient menstruating at time of attack? Yes No

- Within 96 hours prior to assault:
 - Consensual vaginal sex? Yes No If yes, when? _____
 - Consensual anal sex? Yes No If yes, when? _____
 - Consensual oral sex? Yes No If yes, when? _____

- Post assault actions of patient (check all that apply):
 - Urinated Defecated Genital wipe / wash
 - Bath / shower Douched Ate / drank
 - Brushed teeth Oral gargle / wash Changed clothing
 - Steam

- Post assault removal / insertion of (check all that apply):
 - Sponge Diaphragm Tampon
 - Pad

- Consensual vaginal sex since assault? Yes No
- Consensual anal sex since assault? Yes No
- Consensual oral sex since assault? Yes No

- Is patient's clothing on arrival same as clothing during assault?
 Yes No

- Appearance of patient's clothing on arrival (check all that apply):
 - Intact Clean Dirty
 - Wet Bloody Torn
 - All missing Partially missing Buttons missing

SECTION 3. INCIDENT DESCRIPTION (PART 1)

- Location of initial contact with suspect (just prior to assault):
 - Outdoors Work Vehicle
 - Patient's house Suspect's house Patient and suspect's house
 - Other's house Hotel Bar
 - Other indoor location

- Location of assault:
 - Outdoors Work Vehicle
 - Patient's house Suspect's house Patient and suspect's house
 - Other's house Hotel Bar
 - Other indoor location

- Did assault take place within Municipality of Anchorage?
 - Yes No Unknown

- Methods employed by assailant (check all that apply):
 - Weapon used
 - Physical blows by hands / feet
 - Grabbing / grasping / holding
 - Physical restraints used
 - Strangulation
 - Burns (toxic / chemical)
 - Verbal threats

- Patient's position during assault:
 - Supine Standing Straddling suspect
 - Prone Knee chest Lying on side
 - Sitting Other

SECTION 4. INCIDENT DESCRIPTION (PART 2); SEX ACTS REPORTED

- Kissing, licking, biting, scratching:

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
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- Touching / fondling with hands of the:

Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Vagina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Anus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted

- Oral copulation of genitals:

Of victim by suspect	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Of suspect by victim	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted

- Oral copulation of anus:

Of victim by suspect	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Of suspect by victim	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted

- Masturbation:

Of victim by suspect	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Of suspect by victim	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted

- Penetration of vagina by:

Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Foreign Object	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted

- Penetration of anus by:

Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Foreign Object	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted

- Did ejaculation occur?

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
--	------------------------------	-----------------------------	---------------------------------	------------------------------------

If yes, specify ejaculation location (check all that apply):

<input type="checkbox"/> Vagina	<input type="checkbox"/> Rectum	<input type="checkbox"/> Mouth	<input type="checkbox"/> Stomach
<input type="checkbox"/> Back	<input type="checkbox"/> Napkin / cloth	<input type="checkbox"/> Bed	<input type="checkbox"/> Clothing
<input type="checkbox"/> Condom	<input type="checkbox"/> Other		

- Lubricants, condoms, contraceptives:

Condom used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Contraceptive foam used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Contraceptive jelly used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
Lubricant used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted

SECTION 5. EXAMINATION (PART 1)

- Patient's behavior observed during exam (check all that apply):

<input type="checkbox"/> Controlled	<input type="checkbox"/> Quiet	<input type="checkbox"/> Calm
<input type="checkbox"/> Expressive	<input type="checkbox"/> Staring	<input type="checkbox"/> Sleeping
<input type="checkbox"/> Cooperative	<input type="checkbox"/> Stoic	<input type="checkbox"/> Agitated
<input type="checkbox"/> Fearful	<input type="checkbox"/> Tearful	<input type="checkbox"/> Fidgeting
<input type="checkbox"/> Tense	<input type="checkbox"/> Hysterical	<input type="checkbox"/> Sobbing
<input type="checkbox"/> Yelling	<input type="checkbox"/> Listless	<input type="checkbox"/> Loud
<input type="checkbox"/> Trembling	<input type="checkbox"/> Angry	
<input type="checkbox"/> Other		

- Evidence kit collected: Yes No
- Speculum exam: Yes No
- Colposcope exam: Yes No
- Anoscope exam: Yes No

- Alternative light source? Yes No
- Fluorescence found? Yes No

If yes, indicate where: _____

- Admitted to hospital? Yes No

- Received ER treatment for nongenital injuries: Yes No
- Received ER treatment for genital injuries: Yes No
- Received ER treatment for alcohol level: Yes No
- Received ER treatment for other reason: Yes No

- Victim's use of alcohol: Yes No Unsure

- Victim's use of drugs: Yes No Unsure

- Blood alcohol done: Yes No Alcohol level: _____

- Breathalyzer done: Yes No Alcohol level: _____

SECTION 6. EXAMINATION (PART 2)

- Urine tox screen done: Yes No
 - If done, results: Positive Negative
 - If positive, check all that apply:

<input type="checkbox"/> EtOH	<input type="checkbox"/> Barbiturates
<input type="checkbox"/> MDMA	<input type="checkbox"/> THC
<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Ketamine
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Opiates
<input type="checkbox"/> GHB	<input type="checkbox"/> Amphetamines
<input type="checkbox"/> Other	

 - Disabilities (check all that apply):
 - Mental
 - Physical
 - Psychiatric

 - Condition at time of assault (check all that apply):

<input type="checkbox"/> Alcohol intoxicated	<input type="checkbox"/> Drug intoxicated	<input type="checkbox"/> Sober
<input type="checkbox"/> Sleeping	<input type="checkbox"/> Passed out	<input type="checkbox"/> Unconscious from trauma

 - Infections at exam?
 - Yes
 - No
 - Not tested

Infections tested positive for (check all that apply):

<input type="checkbox"/> Bacterial vaginosis	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> Genital warts	<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> HIV	<input type="checkbox"/> Herpes
<input type="checkbox"/> Trichomoniasis	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Yeast
<input type="checkbox"/> Hepatitis C	

 - Sperm seen on wet prep? Yes No No data Not done

 - Sperm motile? Yes No Not seen

 - Follow-up done? Yes No
- Time from exam to follow-up: _____

SECTION 7. NONGENITAL INJURIES

- Nongenital trauma? Yes No If yes, check all that apply:
- | | | | |
|------------------|--------------------------------------|-----------------------------------|------------------------------------|
| Head / face: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Mouth: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Neck: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Shoulders: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Arms: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Hands: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Chest: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Abdomen: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Back: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Buttocks / hips: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Legs: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |
| Feet: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Redness | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fracture |
| | <input type="checkbox"/> Bite Mark | <input type="checkbox"/> Pain | <input type="checkbox"/> Other |

SECTION 8. ANOGENITAL INJURIES

- Anogenital trauma? Yes No If yes, check all that apply:
- | | | |
|---------------------------|--------------------------------------|-------------------------------------|
| Mons pubis: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Labia majora: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Labia minora: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Labia maj / min junction: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Clitoral hood: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Clitoris: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Periurethra: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Hymen: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Fossa navicularis: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Posterior fourchette: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Perineum: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Vaginal walls: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Cervix: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Anus: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |
| Rectum: | <input type="checkbox"/> Bruising | <input type="checkbox"/> Abrasions |
| | <input type="checkbox"/> Lacerations | <input type="checkbox"/> Tenderness |

SECTION 9. SUSPECT INFORMATION

- Number of suspects: _____

If more than one suspect, please fill out section 9 for each suspect separately.

- Is suspect's identity known? Yes No
- Suspect race (Check all that apply):
 - Caucasian
 - Black
 - Alaska Native / American Indian
 - Asian
 - Hispanic
 - Pacific Islander
- Suspect sex: Female Male
- Estimated suspect age: _____
- Alcohol use by suspect: Yes No Unknown
- Drug use by suspect: Yes No Unknown
- Victim / suspect relationship (from victim's point of view):
 - Acquaintance / friend (\geq 24 hours)
 - Acquaintance (< 24 hours)
 - Acquaintance (<12 hours)
 - Current spouse
 - Former spouse
 - Current partner
 - Former partner
 - Relative
 - Stranger
 - Authority figure