



**Descriptive Analysis of
Sexual Assault Nurse Examinations
in Anchorage: 1996-2004**

by

André B. Rosay, Ph.D.
UAA Justice Center
3211 Providence Drive
Anchorage, AK 99508
(907) 786-1821
afabr@uaa.alaska.edu

Tara Henry, RN, BSN, SANE-A/P
Forensic Nurse Services
16372 Sandpiper Drive
Anchorage, AK 99516
(907) 227-6654
thenry@alaska.net

with

The Department of Health and Human Services
Municipality of Anchorage

and

The Alaska Department of Law
State of Alaska



JC #0501

Descriptive Analysis of Sexual Assault Nurse Examinations in Anchorage: 1996-2004

Table of Contents

Index of Tables and Figures	2
Acknowledgments	4
Executive Summary	5
Descriptive Analysis	8
Sexual Assaults in Anchorage: 1996-2004	9
Sexual Assault Nurse Examinations	11
Purpose of this Study	13
Methodology	14
Sample and Data Limitations	16
Demographic Characteristics of Patients	18
Pre-Assault Characteristics	19
Assault Characteristics	20
Post-Assault Characteristics	28
Exam Characteristics and Findings	31
Suspect Characteristics	37
Legal Resolutions	40
Appendix A – Data Collection Instrument	41

Descriptive Analysis of Sexual Assault Nurse Examinations in Anchorage: 1996-2004

Index of Tables and Figures

Sexual Assaults in Anchorage: 1996-2004	
Figure 1. Rates of Forcible Rape Reported to Law Enforcement, 1996-2004	9
Demographic Characteristics of Patients	
Table 1. Race and Ethnicity of Patients	18
Table 2. Age of Patients	18
Pre-Assault Characteristics	
Table 3. Sex Within Three Days Prior to Assault	19
Table 4. Location of Initial Contact Prior to Assault	19
Assault Characteristics	
Table 5. Location of Assault	20
Table 6. Methods Used During Assault	21
Table 7. Common Methods by Common Locations of Initial Contact	21
Table 8. Common Methods by Common Locations of Assault	22
Table 9. Patient Condition at Time of Assault	23
Table 10. Measures of Drug and Alcohol Use	24
Table 11. Blood Alcohol and Breathalyzer Results	24
Table 12. Urine Toxicology Screening Results, for Patients that Were Screened	25
Table 13. Sex Acts Reported	26
Table 14. Position at Time of Assault	27
Table 15. Ejaculation Location, for Suspects that Ejaculated During the Assault	27
Post-Assault Characteristics	
Table 16. Post-Assault Actions	28
Table 17. Consensual Sex from Assault to Examination	28
Table 18. Post-Assault Insertions and Removals	29
Table 19. Time Elapsed from Assault to Report	29
Figure 2. Hours Elapsed from Assault to Report, for Reports Within Three Days of Assault	30

Exam Characteristics and Findings

Table 20. Patients' Physical and Emotional State at Time of Exam	31
Table 21. Reasons for Not Completing Exams	32
Table 22. Appearance of Patients' Clothing	32
Table 23. Reasons for Emergency Medical Care	33
Table 24. Location of Fluorescence, for Cases Where Fluorescence was Found	33
Table 25. Infections, for Patients who Tested Positive	34
Table 26. Number and Percent of Patients with Non-Genital Injury	35
Table 27. Number and Percent of Patients with Genital Injury	36

Suspect Characteristics

Table 28. Number of Suspects per Report	37
Table 29. Race and Ethnicity of Suspects	37
Table 30. Suspect Race and Ethnicity by Patient Race and Ethnicity	38
Table 31. Age of Suspects	39
Table 32. Relationship between Suspects and Patients	39

Legal Resolutions

Table 33. Case Outcomes by Stage	40
----------------------------------	----

Descriptive Analysis of Sexual Assault Nurse Examinations in Anchorage: 1996-2004

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.

The principal investigators, André B. Rosay and Tara Henry, sincerely thank the Department of Health and Human Services at the Municipality of Anchorage for providing access to all data presented herein. In particular, we acknowledge Beverly K. Wooley (Director), Diane Ingle (Deputy 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).

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

Descriptive Analysis of Sexual Assault Nurse Examinations in Anchorage: 1996-2004

Executive Summary

This project examined the characteristics of sexual assault victimizations, as observed and recorded by sexual assault nurse examiners. The sample utilized for this analysis includes all sexual assault nurse examinations conducted in Anchorage from 1996 to 2004 ($N = 1,383$). 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 and most were White or Native (38% and 52% respectively). The average age of patients was 27.6 years, with 20% of patients under the age of 18, 29% between the ages of 18 to 24, 23% between the ages of 25 to 34, 18% between the ages of 35 to 44, and 10% over the age of 44. Most patients (86%) did not report being homeless at the time of the assault and most (95%) did not report being disabled.

Pre-Assault Characteristics

Very few patients reported they had engaged in anal or oral sex within three days prior to the assault, but 29% reported they had engaged in vaginal sex. The most common location of initial contact with the suspect was outdoors (for 22% of assaults). Other common locations of initial contact included the patient's house (for 18% of assaults), the suspect's house (for 11% of assaults), someone else's house (for 14% of assaults), and bars (for 14% of assaults).

Assault Characteristics

Most assaults (95%) took place within the Municipality of Anchorage (others took place elsewhere but were referred to Anchorage for a medical / forensic

examination). The most common location for assaults was a private residence. More specifically, 58% of assault locations included the suspect's house, the patient's house, or another's house. Other common locations included vehicles (for 14% 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, 11% 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 *occurred* outdoors were the most likely to involve blows, grabbing, and strangulation. Assaults that *initiated* or *occurred* in the patient's house were the most likely to involve restraints. Assaults that *initiated* in bars were the most likely to involve strangulation. Assaults that *occurred* in vehicles were the most likely to involve threats. For all locations (both 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 and some were severely intoxicated. Over 65% of patients were alcohol intoxicated and over 10% were drug intoxicated. Over 20% of patients had passed out or blacked out prior to or during the assault. 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 16% 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. A substantial number of patients (42%) reported that they changed their clothing prior to the examination. Other common post-assault actions included defecating (25%), bathing or showering (24%), brushing teeth (24%), and gargling (19%). Few patients (5%) inserted or removed sponges, diaphragms, tampons, or pads after the assault and even fewer (2%) engaged in consensual sex. Most reports (95%) to the sexual assault nurse examiner were made within three days, with 12% of reports occurring within two hours of the assault, 33% occurring within four hours, 59% occurring within 12 hours, and 78% 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. Although most patients were described as controlled (70%), quiet (60%), and cooperative (80%), 64% of patients were also described as either agitated, fearful, tearful, fidgeting, tense, hysterical, sobbing, yelling, listless, loud, trembling, or angry. The majority of patients had clothing that appeared clean or intact (69% and 66%

respectively). Upon arrival, 9% of patients required emergency medical care and 2% were admitted to the hospital. The vast majority of patients (98%) had a sexual assault evidence collection kit completed during the medical / forensic examination. Speculum and colposcope exams were extremely common. An alternative light source (e.g., Wood's lamp, blue max, LED) was used in 72% of exams and fluorescence was found in 39% of these exams. The most common locations for finding fluorescence included legs, feet, arms, hands, buttocks, hips, and face. Most patients (80%) were tested for sexually transmitted infections and other genital infections; and 20% of them tested positive. The most common sexually transmitted infections included bacterial vaginosis, chlamydia, genital warts, and trichomoniasis. 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 43% 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. Anal penetrations were likely to cause injury and anal injuries were more likely to be detected. Almost 20% of patients received a follow-up examination or consultation, performed, on average, 24 days after the first exam.

Suspect Characteristics

The average number of suspects per assault was 1.18. Overall, 89% of patients were assaulted by a single suspect and 67% of suspect identities were known. The largest percentage of suspects were White (37%), followed by Native (26%) and Black (25%). 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, 14% of suspects were 10 to 19 years of age, 37% were 20 to 29, 26% were 30 to 39, 16% were 40 to 49, and 7% were 50 or older. Alcohol use was more common than drug use, with 85% of suspects using alcohol prior to the assault and 18% using drugs. Almost one in five patients (19%) was assaulted by a stranger and 81% were assaulted by non-strangers. Among patients assaulted by non-strangers, 82% were assaulted by someone known as a friend or 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 2004 (because legal resolutions prior to 1999 are not available electronically). Of the original 1,383 sexual assault nurse examinations, 1,069 (77%) were searched in the Alaska Department of Law records. Results show that 26% were referred for prosecution, 18% were accepted for prosecution, and 14% resulted in a conviction. Of the referred cases, 71% were accepted. Of the accepted cases, 78% resulted in a conviction.

Descriptive Analysis of Sexual Assault Nurse Examinations in Anchorage: 1996-2004

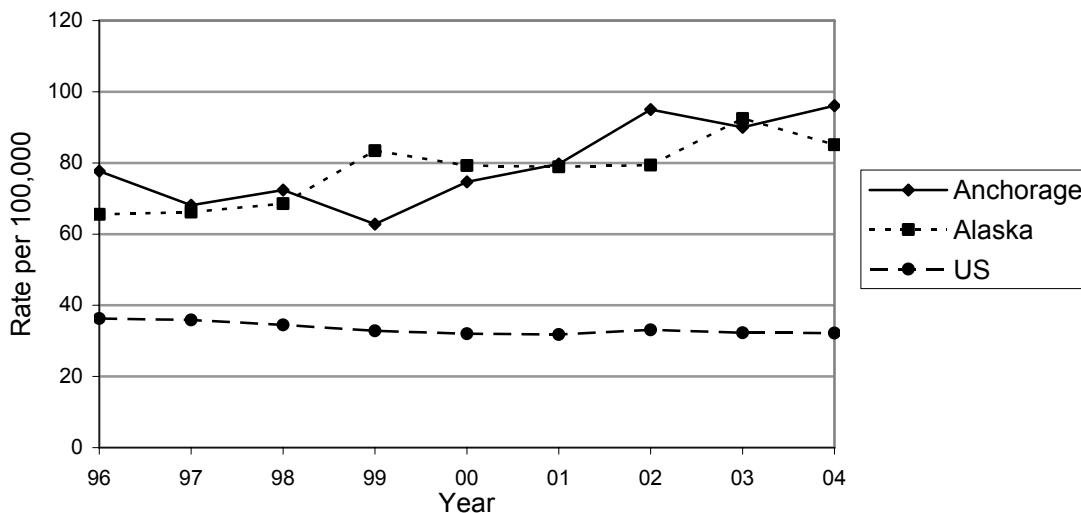
This report provides an overview of the characteristics of sexual assault victimizations, as observed and recorded by sexual assault nurse examiners. It complements earlier reports by the Justice Center and the Anchorage Police Department that provided overviews of the characteristics of sexual assault victimizations, as observed and recorded by law enforcement. We hope that this new report provides an additional source of information about sexual assault victimizations in Anchorage 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 Anchorage, from 1996 to 2004, 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 Anchorage; 1996-2004

The Municipality of Anchorage 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 Anchorage, Alaska, and the U.S. These data are shown in Figure 1.

Figure 1. Rates of Forcible Rape Reported to Law Enforcement, 1996-2004



Source of data: Uniform Crime Reports (1996-2004)

The average rate of forcible rape reported to law enforcement from 1996 to 2004 was 79.6 per 100,000 in Anchorage, 77.7 per 100,000 in Alaska, and 33.4 per 100,000 in the U.S. By comparison, the average rate of forcible rape reported to law enforcement from 1996 to 2004 was 2.4% higher in Anchorage than in Alaska and was 138.3% higher in Anchorage 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). In 2003, 69% of sexual assaults reported to the Anchorage Police Department were classified as forcible rape or attempted forcible rape. Therefore, 31% of sexual assaults reported to the Anchorage Police Department in 2003 are not included in Figure 1.

These and other data continue to depict the magnitude of the sexual assault problem in Anchorage. Sexual assault is also a more common form of violent crime in Anchorage than it is elsewhere. For example, in 2004, the four metropolitan statistical areas with the highest rate of violent crime (above 1,000 per 100,000) included Florence (SC), Memphis (TN), Saginaw (MI), and Sumter (SC). Violent crime includes murder, non-negligent manslaughter, forcible rape, robbery, and aggravated assault. On average,

residents in these four metropolitan statistical areas were 37% more likely to be a victim of violent crime than residents in the Municipality of Anchorage. However, residents in the Municipality of Anchorage were 120% more likely to be victims of forcible rape. While 4% of the violent crime in Florence (SC), Memphis (TN), Saginaw (MI), and Sumter (SC) was attributable to forcible rape, 12% of the violent crime in Anchorage was attributable to forcible 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). 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. The majority of cases examined by the Anchorage SANE occurred within the Municipality of Anchorage, but some occurred elsewhere and were referred to Anchorage for a medical / forensic examination (because medical / forensic examinations are not available in every city, town, and village in Alaska).

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 conducted in Anchorage from 1996 to 2004 were collected for three primary reasons. The first was to gather additional information about the characteristics and prosecutorial outcomes of sexual assaults in Anchorage and to create a report that summarizes this additional 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 also conducted in Kotzebue, Nome, Bethel, Kodiak, Kenai Peninsula, and Fairbanks. All sexual assault nurse examiners in the State of Alaska (except for Dillingham) participated. Study results from these other sites will also be presented in subsequent reports by the University of Alaska Anchorage Justice Center.

In this report, we accomplish our first goal which was to describe the characteristics of sexual assault victimizations in Anchorage, as observed and recorded by sexual assault nurse examiners. We now describe the data collection procedures, discuss limitations, and then present results.

Methodology

All examinations conducted in Anchorage from 1996 to 2004 were included in the sample. A total of 1,383 examinations were collected. Over 90% of cases were referred from the Anchorage Police Department. The others were referred from the Alaska State Troopers and other local police departments in south central Alaska. These include sexual assault victimizations that occurred outside the jurisdiction of the Anchorage Police Department that were referred to Anchorage just for the medical / forensic examination component of the investigation.

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 1,383 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 referred from the military, and excluded one case with an unknown law enforcement case number (N=1,069). 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 1,069 (77.3%) of the original 1,383 cases. The primary restriction was that cases prior to 1999 were excluded (because outcome data were not available in electronic form).

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).

This report simply describes the results of this investigation. All results presented in this report are descriptive only. Future reports will examine these results in greater detail. Before discussing these descriptive results, it is important to emphasize some key limitations of this research.

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. Medical / forensic 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. Again, some information may have a high rate of missing data, but the reasons for these data to be missing is difficult, if not impossible, to determine by retrospectively examining records. 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). The significant data limitations include the inherent sensitivity and subjectivity of the data and the sometimes high rate of missing data. It is critical to emphasize that this report simply describes sexual assault victimizations, as observed and recorded by sexual assault nurse examiners. No other inference should be reached from the results presented herein.

Demographic Characteristics of Patients

The vast majority (98%) of patients were female. The primary race or ethnicity reported by patients is shown in Table 1. In rare cases when patients reported multiple races or ethnicities, the minority class was selected.

Table 1. Race and Ethnicity of Patients

Column Percentages

Race	Patients	
	N	%
White	522	38.1 %
Native	712	51.9
Black	72	5.3
Hispanic	31	2.3
Asian	17	1.2
Pacific Islander	17	1.2
Total	1371	

Source of data: SANE data (1996-2004)
N = 1383; 12 (0.9%) missing

Over half (52%) of patients were Native; 38% were White, 5% were Black, and the remaining 5% were Hispanic, Asian, or Pacific Islander. At the time of the report, the average age of patients was 27.6 years ($s = 11.8$). More precisely, 20% of patients were under the age of 18, 29% were 18 to 24 years of age, 23% were 25 to 34 years of age, 18% were 35 to 44 years of age, and 10% were 45 years of age or older (see Table 2).

Table 2. Age of Patients

Column Percentages

Age	Patients	
	N	%
0 to 17	270	19.7 %
18 to 24	404	29.4
25 to 34	312	22.7
35 to 44	253	18.4
45 to 54	113	8.2
55 or over	20	1.5
Total	1372	

Source of data: SANE data (1996-2004)
N = 1383; 11 (0.8%) missing

Most patients (86%) did not report being homeless at the time of the assault (190 patients (14%) did report being homeless). Most patients did not report being disabled at the time of the assault (2% reported being mentally disabled, 1% 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 3 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 reported they had engaged in anal or oral sex within three days prior to the assault but 29% reported they had engaged in vaginal sex within three days prior to the assault.

Table 3. Sex within Three Days Prior to Assault

Row Percentages

Sex	No		Yes		Total
	N	%	N	%	
Anal	1213	99.3 %	9	0.7 %	1222
Oral	1211	99.5	6	0.5	1217
Vaginal	870	71.3	351	28.7	1221

Source of data: SANE data (1996-2004)

N = 1383; 161 to 166 (11.6 to 12.0%) missing

Where the initial contact between the patient and the suspect was reported to have occurred is shown in Table 4. The most common location of initial contact prior to the assault was outdoors (22%). Other common locations of initial contact included the patient's house (18%), the suspect's house (11%), someone else's house (14%), and bars (14%).

Table 4. Location of Initial Contact Prior to Assault

Column Percentages

Location	Initial Contacts	
	N	%
Outdoors	249	22.0 %
Work	6	0.5
Vehicle	29	2.6
Patient's house	207	18.3
Suspect's house	130	11.5
Patient and suspect's house	29	2.6
Other's house	158	14.0
Hotel	78	6.9
Bar	162	14.3
Other indoor location	84	7.4
Total	1132	

Source of data: SANE data (1996-2004)

N = 1383; 251 (18.1%) missing

Assault Characteristics

Most assaults (95%) took place within the Municipality of Anchorage. Other assaults (5%) took place outside the Municipality of Anchorage but patients were referred to Anchorage 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 5. The most common locations of assault included private residences. More specifically, 60% of assaults took place in private residences (i.e., 23.2% at the suspect's house, 19.2% at the patient's house, 15.2% at another's house, and 2.4% at the patient and suspect's house). Other common locations included vehicles (for 14% of assaults), outdoors (for 10% of assaults) and hotels (for 10% of assaults).

Table 5. Location of Assault

Column Percentages

Location	Assaults	
	N	%
Outdoors	118	10.2 %
Work	2	0.2
Vehicle	165	14.2
Patient's house	223	19.2
Suspect's house	269	23.2
Patient and suspect's house	28	2.4
Other's house	176	15.2
Hotel	115	9.9
Bar	2	0.2
Other indoor location	62	5.3
Total	1160	

Source of data: SANE data (1996-2004)

N = 1383; 223 (16.1%) missing

By comparing Table 4 (Location of Initial Contact Prior to Assault) and Table 5 (Location of Assault), we see that private residences were common locations for both initial contacts and assault locations. More specifically, 46% of contacts initiated in private residences and 60% 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. Although few assaults initiated in vehicles (3%), 14% occurred in vehicles. On the other hand, although 14% of initial contacts occurred in bars, only two assaults occurred in bars and while 22% of assaults were initiated outdoors, 10% occurred outdoors. 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).

Table 6 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 6. Methods Used During Assault

Row Percentages

Method	No		Yes		Total
	N	%	N	%	
Weapon	1266	93.2 %	93	6.8 %	1359
Physical blows by hands or feet	1132	83.3	227	16.7	1359
Grabbing, grasping, holding	846	62.3	513	37.7	1359
Physical restraints	1182	87.0	177	13.0	1359
Strangulation	1215	89.4	144	10.6	1359
Toxic or chemical burns	1355	99.7	4	0.3	1359
Verbal threats	1066	78.4	293	21.6	1359

Source of data: SANE data (1996-2004)

N = 1383; 24 (1.7%) missing

Half (51%) of assaults involved at least one of these methods and 30% involved two or more (results not shown). The most common methods included grabbing, grasping, and holding (38% of assaults), verbal threats (22% of assaults), physical blows by hands or feet (17% of assaults), and physical restraints (13% 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). Over 10% 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.

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. The following two tables show how methods vary by locations of initial contact (Table 7) and how methods vary by locations of assault (Table 8).

Table 7. 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	42	16.9 %	61	24.5 %	149	59.8 %	30	12.0 %	33	13.3 %	100	40.2 %
Patient's house	10	4.8	42	20.3	83	40.1	40	19.3	25	12.1	43	20.8
Suspect's house	7	5.4	23	17.7	53	40.8	13	10.0	15	11.5	21	16.2
Other's house	5	3.2	10	6.3	34	21.5	17	10.8	7	4.4	18	11.4
Hotel	5	6.5	15	19.5	29	37.7	14	18.2	9	11.7	15	19.5
Bar	6	3.7	34	21.0	64	39.5	29	17.9	23	14.2	37	22.8
Other indoor	0	0.0	9	10.7	25	29.8	8	9.5	6	7.1	12	14.3

Source of data: SANE data (1996-2004)

N = 1383; 251 to 252 (18.1 to 18.2%) missing

More specifically, Table 7 shows the different methods used for the 249 assaults that *initiated* outdoors, the 207 that *initiated* at the patient's house, the 130 that *initiated* at the suspect's house, the 158 that *initiated* at another's house, the 77 that *initiated* in hotels, the 162 that *initiated* in bars, and the 84 that *initiated* in other indoor locations. We did not examine the different methods used for assaults that initiated at work ($N = 6$), in vehicles ($N = 29$), or at the patient and suspect's house ($N = 29$) because of low sample sizes. Similarly, we did not include toxic or chemical burns as a method, given its low prevalence ($N = 4$). Table 8 shows the different methods (excluding toxic or chemical burns) used for the 118 assaults that *occurred* outdoors, the 165 that *occurred* in vehicles, the 223 that *occurred* at the patient's house, the 269 that *occurred* at the suspect's house, the 176 that *occurred* at another's house, the 114 that *occurred* in hotels, and the 62 that *occurred* in other indoor locations. We did not examine the different methods used for assaults that occurred at work ($N = 2$), at the patient and suspect's house ($N = 28$), or in bars ($N = 2$) because of low sample sizes.

Table 8. Common Methods by Common Locations of Assault

Cell Percentages

Assault	Weapon		Blows		Grabbing		Restraints		Strangle		Threats	
	N	%	N	%	N	%	N	%	N	%	N	%
Outdoors	15	12.7 %	36	30.5 %	74	62.7 %	15	12.7 %	20	16.9 %	44	37.3 %
Vehicle	29	17.6	33	20.0	94	57.0	22	13.3	25	15.2	69	41.8
Patient's house	10	4.5	46	20.6	86	38.6	38	17.0	28	12.6	44	19.7
Suspect's house	15	4.5	49	18.2	113	42.0	42	15.6	28	10.4	56	20.8
Other's house	5	2.8	21	11.9	43	24.4	18	10.2	9	5.1	24	13.6
Hotel	6	5.3	21	18.4	45	39.5	16	14.0	17	14.9	21	18.4
Other indoor	5	8.1	6	9.7	23	37.1	10	16.1	4	6.5	11	17.7

Source of data: SANE data (1996-2004)
 $N = 1383$; 223 to 224 (16.1 to 16.2%) missing

Results show that weapons were used in 17% of assaults that *initiated* outdoors (Table 7) and in 13% of assaults that *occurred* outdoors (Table 8). 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 (18% of the assaults that *occurred* in vehicles involved weapons). Large differences in other methods were also uncovered. Blows were most frequent in assaults that *initiated* outdoors (in 24% of these assaults) and in assaults that *occurred* outdoors (in 31% of these assaults). Blows were least frequent in assaults that *initiated* in another's house (in 6% of these assaults) and in assaults that *occurred* in other indoor locations (in 10% of these assaults). Grabbing was prevalent in all locations of initial contact. More precisely, the prevalence of grabbing varied from a low of 22% in assaults *initiated* in another's house to a high of 60% for assaults *initiated* outdoors. Grabbing was similarly prevalent in all locations of assault. More precisely, the prevalence of grabbing varied from a low of 24% in assaults that *occurred* in another's house to a high of 63% in assaults that *occurred* outdoors. Restraints were most commonly used in assaults that *initiated* in the patient's house (for 19% of these assaults) and were least commonly used in assaults that *initiated* in other indoor locations (for 10% of these assaults). Restraints were also most commonly used in assaults that *occurred* in

the patient's house (for 17% of these assaults) but were least commonly used in assaults that *occurred* in another's house (for 10% of these assaults). Strangulation was less common than blows, grabbing, or restraints. Nonetheless, strangulation was most prevalent for assaults that *initiated* in bars (in 14% of these assaults) and was most prevalent for assaults that *occurred* outdoors (in 17% of these assaults). The lowest occurrence of strangulation was for assaults that *initiated* at another's house (for 4% 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 40% of these assaults), were least common for assaults that *initiated* at another's house (for 11% of these assaults), most common for assaults that *occurred* in vehicles (for 42% of these assaults), and least common for assaults that *occurred* at another's house (for 14% 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, grabbing, and strangulation. Assaults that initiated or occurred in the patient's house were the most likely to involve restraints. Assaults that initiated in bars were the most likely to involve strangulation (and, again, assaults that occurred outdoors were the most likely to involve strangulation). Assaults that occurred in vehicles were the most likely to involve threats (and, again, assaults that initiated outdoors were the most likely to involve threats). 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 9. Intoxication was relatively frequent, with 66% of patients reporting being alcohol intoxicated at the time of the assault and 11% reporting being drug intoxicated. Levels of intoxication were sometimes quite high. More precisely, 23% of patients were passed out or had blacked out at the time of the assault.

Table 9. Patient Condition at Time of Assault

Row Percentages

Condition	No		Yes		Total
	N	%	N	%	
Alcohol intoxicated	433	33.9 %	846	66.1 %	1279
Drug intoxicated	1135	88.7	144	11.3	1279
Sober	1002	78.3	277	21.7	1279
Sleeping	1313	96.9	42	3.1	1355
Passed out / blacked out	1033	76.6	316	23.4	1349
Unconscious from trauma	1349	99.6	5	0.4	1354

Source of data: SANE data (1996-2004)
N = 1383; 28 to 104 (0.2 to 7.5%) missing

During the examination, 65% of patients indicated that they had used alcohol prior to the assault and 12% indicated that they had used drugs prior to the assault (results not shown). Table 10 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 10. Measures of Drug and Alcohol Use

Row Percentages

Measure	No		Yes		Total
	N	%	N	%	
Breathalyzer	1121	90.5 %	118	9.5 %	1239
Blood alcohol	781	63.5	448	36.5	1229
Urine tox screen	822	67.2	402	32.8	1224

Source of data: SANE data (1996-2004)
N = 1383; 144 to 159 (10.4 to 11.5%) missing

Breathalyzer and blood alcohol test results are shown in Table 11. Blood alcohol results were available for 295 (66%) of the 448 patients given a blood alcohol test and breathalyzer results were available for 116 (98%) of the 118 patients given a breathalyzer test.

Table 11. Blood Alcohol and Breathalyzer Results

Column Percentages

Grams per milliliter	Blood Alcohol		Breathalyzer	
	N	%	N	%
Zero	65	22.0 %	19	16.4 %
.01 to .07	53	18.0	13	11.2
.08 to .14	70	23.7	29	25.0
.15 to .29	88	29.8	43	37.1
.30 or above	19	6.4	12	10.3
Total	295		116	

Source of data: SANE data (1996-2004)
N = 448 and 118; 153 (34.2%) missing and 2 (1.7%) missing

Negative results were observed for 22% of patients given a blood alcohol test and 16% of patients given a breathalyzer test. Of the patients given a blood alcohol test, 60% tested above .08, 36% of patients tested at a .15 or above, and 6% tested at a .30 or above. Of the patients given a breathalyzer test, 72% tested above .08, 47% of patients tested at a .15 or above, and 10% tested at a .30 or above.

Among the 402 patients who received a urine toxicology screening, 38% tested negative and 62% tested positive (results not shown). Specific results were available for 396 (98%) of these 402 patients. These results are presented in Table 12. Results show that the most common substances used by patients included THC (marijuana), cocaine (including crack cocaine), alcohol, and benzodiazepines (sedatives). More specifically, 35% of patients given a urine toxicology screen tested positive for THC, 22% tested positive for cocaine, 20% tested positive for alcohol, and 10% tested positive for

benzodiazepines. Other, less common drugs included opiates and amphetamines (with 4% and 3% of patients testing positive for each, respectively).

Table 12. Urine Toxicology Screening Results, for Patients that Were Screened

Row Percentages

Drug	No		Yes		Total
	N	%	N	%	
Alcohol	317	80.1 %	79	19.9 %	396
Barbiturates	393	99.2	3	0.8	396
MDMA	396	100.0	0	0.0	396
THC	259	65.4	137	34.6	396
Benzodiazepines	358	90.4	38	9.6	396
Ketamine	395	99.7	1	0.3	396
Cocaine	307	77.5	89	22.5	396
Opiates	381	96.2	15	3.8	396
GHB	396	100.0	0	0.0	396
Amphetamines	382	96.5	14	3.5	396
Other drug	387	97.7	9	2.3	396

Source of data: SANE data (1996-2004)

N = 402; 6 (1.5%) missing

A total of 17 sex acts were recorded from the SANE examinations (see Table 13), 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. Sample sizes are low due to recall difficulties. Patients may not always know or remember the details of the assault.

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). Attempted penile penetration of the vagina, reported by an additional 11 patients, may also fit the statutory definitions of these felonious assaults. 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 assault included penetration or attempted penetration of the vagina or anus and 47% of assaults 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 47% of assaults) and penile penetration of the anus (reported in 16% of assaults). The most common forms of oral copulation included the oral copulation of the patient's genitals (reported in 24% of assaults) and the oral copulation of the suspect's genitals (reported in 21% of assaults). Over half of assaults also included kissing and sexual contact with breasts and vagina.

The majority of assaults were not statutory (98.9%). 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 ($N = 15$) were statutory cases.

Table 13. Sex Acts Reported

Row Percentages

Sex Act	No		Attempted		Yes		Total
	N	%	N	%	N	%	
Kissing	359	40.2 %	12	1.3 %	521	58.4 %	892
Touching breast	312	37.4	3	0.4	520	62.3	835
Touching vagina	343	40.5	2	0.2	502	59.3	847
Touching penis	819	88.9	0	0.0	102	11.1	921
Touching anus	771	88.0	4	0.5	101	11.5	876
Oral copulation of patient genitals	668	74.8	11	1.2	214	24.0	893
Oral copulation of suspect genitals	747	78.5	2	0.2	202	21.2	951
Oral copulation of patient anus	871	97.0	1	0.1	26	2.9	898
Oral copulation of suspect anus	964	99.9	0	0.0	1	0.1	965
Masturbation of patient	862	94.7	3	0.3	45	4.9	910
Masturbation of suspect	918	94.3	2	0.2	54	5.5	974
Penetration of vagina by finger	428	52.7	6	0.7	378	46.6	812
Penetration of vagina by penis	110	11.5	11	1.1	837	87.4	958
Penetration of vagina by object	855	96.8	0	0.0	28	3.2	883
Penetration of anus by finger	801	89.2	13	1.4	84	9.4	898
Penetration of anus by penis	730	79.5	44	4.8	144	15.7	918
Penetration of anus by object	909	99.1	0	0.0	8	0.9	917

Source of data: SANE data (1996-2004)

N = 1383; 409 to 571 (29.6 to 41.3%) missing

Table 14 identifies the position of the patient at the time of the assault. The most common position during the assault was supine, with 86% 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.

Table 14. Position at Time of Assault*Row Percentages*

Position	No		Yes		Total
	N	%	N	%	
Supine	127	13.7 %	797	86.3 %	924
Standing	887	96.0	37	4.0	924
Straddling	905	97.9	19	2.1	924
Prone	846	91.6	78	8.4	924
Knee chest	882	95.5	42	4.5	924
Lying on side	888	96.1	36	3.9	924
Sitting	900	97.4	24	2.6	924
Other	911	98.6	13	1.4	924

*Source of data: SANE data (1996-2004)**N = 1,383; 459 (33.2%) missing*

Whether ejaculation by the suspect had occurred was rarely known by the patient. Of the 1,383 patients, 343 (25%) reported that the suspect had ejaculated during the assault and 132 (9%) reported that the suspect had not ejaculated during the assault. Focusing on the 343 patients who reported that the suspect had ejaculated during the assault, Table 15 describes ejaculation locations. Not surprisingly, given the sex acts reported previously, the most common ejaculation location was the vagina. Other locations included the rectum (noted as the ejaculation location in 7% of assaults), the mouth (noted in 10% of assaults), and the stomach (noted in 5% of assaults).

Table 15. Ejaculation Location, for Suspects that Ejaculated During the Assault*Row Percentages*

Location	No		Yes		Total
	N	%	N	%	
Vagina	100	30.2 %	231	69.8 %	331
Rectum	308	93.1	23	6.9	331
Mouth	299	90.3	32	9.7	331
Stomach	313	94.6	18	5.4	331
Back	326	98.5	5	1.5	331
Napkin / cloth	328	99.1	3	0.9	331
Bed	320	96.7	11	3.3	331
Clothing	330	99.7	1	0.3	331
Condom	321	97.0	10	3.0	331
Other	293	85.4	50	14.6	343

*Source of data: SANE data (1996-2004)**N = 343; 0 to 12 (0.0 to 3.5%) missing*

Relatively few suspects used a condom during the assault (10%) and none used contraceptive jelly or foam. Only 7% of assaults included the use of lubricants.

Post-Assault Characteristics

Post-assault actions taken by the patient are shown in Table 16. 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 16. Post-Assault Actions

Row Percentages

Actions	No		Yes		Total
	N	%	N	%	
Urinated	365	26.7 %	1001	73.3 %	1366
Defecated	1020	74.7	346	25.3	1366
Genital Wipe / Wash	621	45.5	745	54.5	1366
Bath / Shower	1031	75.5	335	24.5	1366
Douche	1334	97.7	32	2.3	1366
Ate / Drank	546	40.0	820	60.0	1366
Brushed Teeth	1033	75.6	333	24.4	1366
Oral Gargle / Wash	1106	81.0	260	19.0	1366
Changed Clothing	788	57.7	578	42.3	1366
Steam	1365	99.9	1	0.1	1366

Source of data: SANE data (1996-2004)
N = 1383; 17 (1.2%) missing

In Table 16, the majority of patients reported that they urinated, wiped or washed genitalia, and ate or drank after the assault. Almost half (42%) of patients also reported that they changed their clothing prior to the examination. Other common post-assault actions included defecating (25%), bathing or showering (24%), brushing teeth (24%), and gargling (19%).

Table 17. Consensual Sex Between Assault and Examination

Row Percentages

Sex	No		Yes		Total
	N	%	N	%	
Anal	1212	100.0 %	0	0.0 %	1212
Oral	1209	100.0	0	0.0	1209
Vaginal	1192	98.1	23	1.9	1215

Source of data: SANE data (1996-2004)
N = 1383; 168 to 174 (12.1 to 12.6%) 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 17). 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 23 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 18. Insertions and removals of sponges, diaphragms, tampons, and pads were also relatively rare. More precisely, 41 patients (3%) placed or removed a pad, 36 patients (3%) inserted or removed a tampon, and no patients inserted or removed sponges or diaphragms.

Table 18. Post-Assault Insertions and Removals

Row Percentages

Item	No		Yes		Total
	N	%	N	%	
Sponge	1366	100.0 %	0	0.0 %	1366
Diaphragm	1366	100.0	0	0.0	1366
Tampon	1330	97.4	36	2.6	1366
Pad	1325	97.0	41	3.0	1366

Source of data: SANE data (1996-2004)

N = 1383; 17 (1.2%) missing

Table 19 shows that most reports to the sexual assault nurse examiner (95%) occurred within three days of the assault. More precisely, 12% of reports occurred within two hours of the assault, 33% occurred within four hours, 59% occurred within 12 hours, 78% occurred within one day, and (again) 95% occurred within three days.

Table 19. Time Elapsed Between Assault and Report

Column Percentages

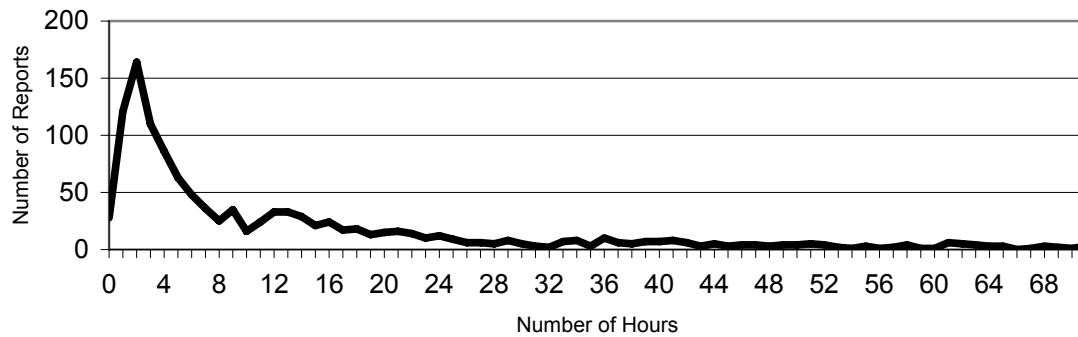
Time	Patients		
	N	%	cum. %
<2 hours	149	11.7 %	11.7 %
2 to <4 hours	274	21.5	33.2
4 to <12 hours	333	26.2	59.4
12 to <24 hours	243	19.1	78.5
1 to <3 days	215	16.9	95.4
3 days or more	59	4.6	100.0
Total	1273		

Source of data: SANE data (1996-2004)

N = 1383; 110 (8.0%) 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 2. 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 12.9 hours ($s = 15.4$). Over half (51%) of assaults were reported to the sexual assault nurse examiner within six hours.

Figure 2. Hours Elapsed Between Assault and Report, for Reports Within Three Days of Assault



Source of data: SANE data (1996-2004; N = 1207)

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 20 clearly show that although most patients were controlled (70%), quiet (60%), and cooperative (80%), many were tearful (44%), a noticeable number were tense (19%), fidgeting (17%), and trembling (12%), and others were agitated (7%), fearful (6%), and sobbing (7%). Overall, 64% 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 20. Patients' Physical and Emotional State at Time of Exam

Row Percentages

State	No		Yes		Total
	N	%	N	%	
Controlled	366	30.0 %	855	70.0 %	1221
Quiet	489	40.0	732	60.0	1221
Calm	801	65.6	420	34.4	1221
Expressive	1208	98.9	13	1.1	1221
Staring	1116	91.4	105	8.6	1221
Sleeping	1079	88.4	142	11.6	1221
Cooperative	248	20.3	973	79.7	1221
Stoic	1093	89.5	128	10.5	1221
Agitated	1133	92.8	88	7.2	1221
Fearful	1147	93.9	74	6.1	1221
Tearful	678	55.5	543	44.5	1221
Fidgeting	1017	83.3	204	16.7	1221
Tense	988	80.9	233	19.1	1221
Hysterical	1220	99.9	1	0.1	1221
Sobbing	1133	92.8	88	7.2	1221
Yelling	1183	96.9	38	3.1	1221
Listless	1179	96.6	42	3.4	1221
Loud	1198	98.1	23	1.9	1221
Trembling	1074	88.0	147	12.0	1221
Angry	1181	96.7	40	3.3	1221
Other	1038	85.0	183	15.0	1221

Source of data: SANE data (1996-2004)

N = 1383; 162 (11.7%) 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 21. The most common reasons were attributable to lack (or withdrawal) of patient consent.

Table 21. Reasons for Not Completing Exams

Column Percentages

Reasons	Patients	
	N	%
Patient declined exam	96	60.8 %
Partial exam	10	6.3
RN stopped call out process	11	7.0
No probable cause	30	19.0
False report	4	2.5
Other	7	4.4
Total	158	

Source of data: SANE data (1996-2004)

N = 158; 0 (0.0%) missing

At the time of the SANE examination, 48% 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 was recorded for 621 (45%) of the patients and is described in Table 22. Very few patients had clothing that appeared dirty, wet, bloody, or torn, and few had clothing that appeared missing. The majority of patients had clothing that appeared clean or intact (69% and 66% respectively).

Table 22. Appearance of Patients' Clothing

Row Percentages

Clothing	No		Yes		Total
	N	%	N	%	
Intact	191	30.8 %	430	69.2 %	621
Clean	213	34.3	408	65.7	621
Dirty	518	83.4	103	16.6	621
Wet	612	98.6	9	1.4	621
Bloody	605	97.4	16	2.6	621
Torn	594	95.7	27	4.3	621
All missing	616	99.2	5	0.8	621
Partially missing	563	90.7	58	9.3	621
Buttons missing	616	99.2	5	0.8	621

Source of data: SANE data (1996-2004)

N = 1383; 762 (55.1%) missing

As a result of the assault, 2% of patients were admitted to the hospital and 9% 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 23. The most common reason for requiring emergency medical care was related to non-genital injuries suffered by patients.

Table 23. Reasons for Emergency Medical Care

Row Percentages

Reason	No		Yes		Total
	N	%	N	%	
Non-genital injury	1163	94.6 %	67	5.4 %	1230
Genital injury	1222	99.4	7	0.6	1229
Alcohol level	1214	98.6	17	1.4	1231
Other	1191	97.9	26	2.1	1217

Source of data: SANE data (1996-2004)
N = 1383; 152 to 166 (11.0 to 12.0%) missing

Few patients were pregnant at the time of the examination (2% of female patients) but most were mothers (57% of female patients; results not shown). Of the female patients, 12% were menstruating at the time of the assault (result not shown).

The vast majority of patients (98%) 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 extremely common (in 93% and 97% 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 72% 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 351 cases (i.e., in 39% of exams conducted with an alternative light source).

Table 24. Location of Fluorescence, for Cases Where Fluorescence was Found

Row Percentages

Location	No		Yes		Total
	N	%	N	%	
Abdomen	320	92.5 %	26	7.5 %	346
Arms and hands	262	75.7	84	24.3	346
Legs and feet	179	51.7	167	48.3	346
Buttocks and hips	266	76.9	80	23.1	346
Chest	326	94.2	20	5.8	346
Vagina and groin	325	93.9	21	6.1	346
Neck	336	97.1	10	2.9	346
Back	329	95.1	17	4.9	346
Face	299	86.4	47	13.6	346

Source of data: SANE data (1996-2004)
N = 351; 5 (1.4%) missing

Table 24 describes where fluorescence was found, for exams in which an alternative light source was used and fluorescence was found ($N = 351$). The most

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

A wet prep examination (a microscopic examination of fluid obtained from the vaginal vault) was conducted for 718 (52%) of the patients, and the nurse observed spermatozoa on 63 (9%) of these examinations. In 13% of these cases, the spermatozoa was still motile.

Eighty percent of patients were tested for sexually transmitted infections and other genital infections; and 20% of them tested positive. The specific types of infections that these patients tested positive for are displayed in Table 25 ($N = 191$). The most common type of infection that patients tested positive for was bacterial vaginosis (50%), followed by chlamydia (16%), genital warts (15%), and trichomoniasis (12%).

Table 25. Infections, for Patients Who Tested Positive

Row Percentages

Infection	Negative		Positive		Total
	N	%	N	%	
Bacterial vaginosis	96	50.3 %	95	49.7 %	191
Chlamydia	160	83.8	31	16.2	191
Genital warts	163	85.3	28	14.7	191
Gonorrhea	182	95.3	9	4.7	191
HIV	186	97.4	5	2.6	191
Herpes	183	95.8	8	4.2	191
Trichomoniasis	168	88.0	23	12.0	191
Hepatitis B	188	98.4	3	1.6	191
Syphilis	191	100.0	0	0.0	191
Yeast	175	91.6	16	8.4	191
Hepatitis C	179	93.7	12	6.3	191

Source of data: SANE data (1996-2004)

N = 191; 0 (0.0%) 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, 14% of patients had non-genital injuries to the head or face, 7% to the mouth, 13% to the neck, 2% to shoulders, 32% to arms, 8% to hands, 9% to the chest, 3% to the abdomen, 9% to the back, 8% to buttocks or hips, 34% to legs, and 1% to feet. The most common non-genital injury types included bruising (documented for 48% of patients) and abrasions (documented for 23% of patients). Other non-genital injury types were far less common. Detailed results by non-genital injury site and type are shown in Table 26. Each cell in

this table represents the number and percentage of patients with documented non-genital injuries.

The detailed data Table 26 show that the most common non-genital injury was bruising to the legs, documented in 31% of patients, and bruising of the arms, documented in 29% of patients. Other common non-genital injuries included bruising to the head or face (documented in 11% of patients), bruising to the neck (documented in 11% of patients), and abrasions to the legs (documented in 10% of patients).

Table 26. Number and Percent of Patients With Non-Genital Injury

Cell Percentages

Location	Bruising		Redness		Abrasions		Lacerations		Swelling	
	N	%	N	%	N	%	N	%	N	%
Head / face	132	10.8 %	8	0.7 %	66	5.4 %	22	1.8 %	75	6.1 %
Mouth	72	5.9	0	0.0	21	1.7	26	2.1	24	2.0
Neck	129	10.6	16	1.3	40	3.3	2	0.2	8	0.7
Shoulders	17	1.4	0	0.0	10	0.8	0	0.0	1	0.1
Arms	354	29.0	0	0.0	82	6.7	1	0.1	1	0.1
Hands	71	5.8	3	0.2	29	2.4	6	0.5	12	1.0
Chest	80	6.6	3	0.2	37	3.0	0	0.0	1	0.1
Abdomen	12	1.0	0	0.0	17	1.4	0	0.0	0	0.0
Back	62	5.1	0	0.0	55	4.5	0	0.0	1	0.1
Buttocks / hips	56	4.6	1	0.1	39	3.2	0	0.0	0	0.0
Legs	373	30.6	1	0.1	121	9.9	3	0.2	1	0.1
Feet	9	0.7	0	0.0	7	0.6	0	0.0	2	0.2
Total	587	48.1	31	2.5	280	23.0	50	4.1	91	7.5

Location	Fracture		Bite Mark		Pain		Other		Total	
	N	%	N	%	N	%	N	%	N	%
Head / face	9	0.7 %	3	0.2 %	43	3.5 %	15	1.2 %	175	14.3 %
Mouth	0	0.0	0	0.0	15	1.2	4	0.3	84	6.9
Neck	0	0.0	2	0.2	28	2.3	3	0.2	160	13.1
Shoulders	0	0.0	3	0.2	2	0.2	0	0.0	28	2.3
Arms	0	0.0	6	0.5	7	0.6	7	0.6	390	32.0
Hands	1	0.1	3	0.2	9	0.7	13	1.1	101	8.3
Chest	0	0.0	4	0.3	5	0.4	2	0.2	110	9.0
Abdomen	0	0.0	1	0.1	2	0.2	2	0.2	33	2.7
Back	0	0.0	0	0.0	4	0.3	1	0.1	107	8.8
Buttocks / hips	1	0.1	0	0.0	4	0.3	2	0.2	91	7.5
Legs	0	0.0	7	0.6	6	0.5	5	0.4	410	33.6
Feet	0	0.0	0	0.0	0	0.0	5	0.4	16	1.3
Total	10	0.8	23	1.9	78	6.4	42	3.4	635	52.0

Source of data: SANE data (1996-2004)

N = 1383; 163 (11.8%) missing

Genital injuries were documented in 43% of patients. Overall, the most common genital injury type documented for patients was a laceration (36%), followed by abrasions (16%), bruising (12%), and tenderness (7%). The most common genital injury locations identified for female patients included the posterior fourchette (21%), the labia minora (17%), the perineum (16%), and the fossa navicularis (14%). Injury to the anus was identified for 11% of all patients.

Four anatomical sites had lacerations for more than 10% of patients. More specifically, 20% of examinations documented lacerations of the posterior fourchette, 14% documented lacerations of the perineum, 11% documented lacerations of the fossa navicularis, and 10% documented lacerations of the anus. Given that 20% of patients reported penetration of the anus (by finger, penis, or object; result not shown), injury to the anus was more common and more frequently documented.

Table 27. 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 %	1	0.1 %	2	0.2 %	1	0.1 %	4	0.3 %
Labia majora	3	0.3	16	1.4	8	0.7	9	0.8	28	2.4
Labia minora	56	4.8	98	8.4	74	6.3	51	4.4	199	17.1
Labia maj/min junction	6	0.5	18	1.5	59	5.1	19	1.6	75	6.4
Clitoral hood	6	0.5	13	1.1	6	0.5	10	0.9	26	2.2
Clitoris	2	0.2	1	0.1	4	0.3	1	0.1	8	0.7
Periurethra	16	1.4	4	0.3	7	0.6	12	1.0	30	2.6
Hymen	58	5.0	10	0.9	25	2.1	24	2.1	82	7.0
Fossa navicularis	2	0.2	22	1.9	124	10.6	36	3.1	163	14.0
Posterior fourchette	1	0.1	11	0.9	228	19.6	31	2.7	248	21.3
Perineum	1	0.1	25	2.1	164	14.1	13	1.1	183	15.7
Vaginal walls	34	2.9	10	0.9	20	1.7	3	0.3	52	4.5
Cervix	14	1.2	6	0.5	4	0.3	1	0.1	21	1.8
Anus	3	0.3	19	1.6	119	10.0	17	1.4	129	10.8
Rectum	20	1.7	8	0.7	14	1.2	0	0.0	34	2.8
Total	142	11.9	191	16.0	427	35.8	85	7.1	516	43.2

Source of data: SANE data (1996-2004)

N = 1347; 181 (13.4%) missing; for anus, rectum, and total rows, N = 1380; 186 (13.5%) missing

Almost 20% of patients received a follow-up examination or consultation. On average, follow-up examinations occurred 24 days after the first exam ($s = 21.8$). More specifically, 19% occurred within one week, 27% within two weeks, and 44% within three 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 1.18 ($s = 0.6$), for a total of 1,521 suspects. The number of suspects per assault is shown in Table 28. Results show that 89% of patients were assaulted by one suspect, 7% by two suspects, 2% by three suspects, 1% by four suspects, and less than 1% by five or more suspects.

Table 28. Number of Suspects per Report

Column Percentages

Number of Suspects	Reports		
	N	%	cum. %
One	1148	88.7 %	88.7 %
Two	95	7.3	96.1
Three	32	2.5	98.5
Four	14	1.1	99.6
Five	2	0.2	99.8
Six	1	0.1	99.8
Seven	1	0.1	99.9
Eight	1	0.1	100.0
Total	1294		

Source of data: SANE data (1996-2004)

N = 1383; 89 (6.4%) missing

From 1,521 suspects, some information was available for up to 1,494 suspects (98%). 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 four were female). The majority (67%) of suspect identities were known.

Table 29. Race and Ethnicity of Suspects

Column Percentages

Race	Suspects	
	N	%
White	467	37.0 %
Native	324	25.7
Black	317	25.1
Hispanic	111	8.8
Asian	27	2.1
Pacific Islander	17	1.3
Total	1263	

Source of data: SANE data (1996-2004)

N = 1521; 258 (17.0%) missing

Table 29 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 race of suspects is similar to the race of patients, with two clear exceptions. More precisely, 37% of suspects were White (and 38% of patients were White), 26% of suspects were Native (but 52% of patients were Native), 25% of suspects were Black (but 5% of patients were Black), 8% 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 30.

Table 30. 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	238	53.0	46	10.2	106	23.6	43	9.6	8	1.8	8	1.8	449
Native	197	29.7	271	40.9	124	18.7	55	8.3	12	1.8	4	0.6	663
Black	14	17.9	4	5.1	55	70.5	5	6.4	0	0.0	0	0.0	78
Hispanic	8	26.7	1	3.3	13	43.3	7	23.3	1	3.3	0	0.0	30
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: SANE data (1996-2004)

N = 1521; 262 (17.2%) missing

Results in Table 30 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 30 show that 53% of White patients were assaulted by White suspects, 41% of Native patients were assaulted by Native suspects, 23% 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). Almost one in five suspects (18%) had used 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 31 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 987 (65%) of the suspects. Although the age of patients and age of suspects were not recorded on the same scale, the age distributions seem comparable. More precisely, 14% of suspects were 10 to 19 years of age, 37% were 20 to 29 years of age, 26% were 30 to 39 years of age, 16% were 40 to 49 years of age, and 7% were 50 years of age or older.

Table 31. Age of Suspects*Column Percentages*

Age	Suspects	
	N	%
10 to 19	140	14.2 %
20 to 29	369	37.4
30 to 39	254	25.7
40 to 49	158	16.0
50 to 59	51	5.2
60 to 69	11	1.1
70 to 79	4	0.4
Total	987	

Source of data: SANE data (1996-2004)
N = 1521; 534 (35.1%) missing

Patient-suspect relationship is shown in Table 32. Overall, 19% of patients were assaulted by strangers and 81% 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, 66% of patients reported being assaulted by someone they knew as a friend or an acquaintance. Among patients assaulted by non-strangers, 82% were assaulted by someone known as a friend or acquaintance. Among patients assaulted by friends and acquaintances, 72% knew the identity of the suspect (result not shown).

Table 32. Relationship Between Suspects and Patients*Column Percentages*

Relationship	Suspects		
	N	%	% of non-stranger
Stranger	274	19.1 %	
Friend / acquaintance (> 24 hrs)	546	38.1	47.2 %
Acquaintance (< 24 hrs)	41	2.9	3.5
Acquaintance (< 12 hrs)	363	25.3	31.3
Current spouse	18	1.3	1.6
Former spouse	7	0.5	0.6
Current partner	49	3.4	4.2
Former partner	54	3.8	4.7
Relative	65	4.5	5.6
Authority figure	15	1.0	1.3
Total	1432		

Source of data: SANE data (1996-2004)
N = 1521; 89 (5.9%) 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 from 1999 to 2004, because earlier legal resolutions (from 1996 to 1998) were not available electronically. In addition, searches through the Alaska Department of Law records excluded cases referred from the military and excluded one case with an unknown law enforcement number. Consequently, we examined the legal resolutions for the 1,069 examinations conducted from 1999 to 2004 (i.e., for 77.3% of the original 1,383 examinations included in the sample). These legal resolutions are summarized in Table 33.

Table 33. Case Outcomes by Stage

Stage	N	% of reported	% of referred	% of accepted
Reported	1069	100.0 %		
Referred	280	26.2	100.0 %	
Accepted	198	18.5	70.7	100.0 %
Convicted	154	14.4	55.0	77.8

Source of data: Alaska Department of Law (1999-2004)
N = 1069; 0 (0.0%) missing

As previous analyses of Alaska Department of Law data have revealed, the greatest point of attrition is from report to referral. Of the 1,069 reports examined, 26% were referred to the Alaska Department of Law for prosecution. Once referred for prosecution, cases had a high likelihood of getting accepted (71%) and once accepted, cases had a high likelihood of resulting in a conviction (78%). Overall, 26% of reported cases were referred, 18% were accepted, and 14% resulted in a conviction.

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 26% reported here), that 12% were accepted by prosecution (versus the 18% reported here), and that 11% resulted in a conviction (versus the 14% 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 Alaska Department of Law to accept a case for prosecution, and the likelihood of gaining a conviction.

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>.

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: _____
- 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):

<input type="checkbox"/> Outdoors	<input type="checkbox"/> Work	<input type="checkbox"/> Vehicle
<input type="checkbox"/> Patient's house	<input type="checkbox"/> Suspect's house	<input type="checkbox"/> Patient and suspect's house
<input type="checkbox"/> Other's house	<input type="checkbox"/> Hotel	<input type="checkbox"/> Bar
<input type="checkbox"/> Other indoor location		

- Location of assault:

<input type="checkbox"/> Outdoors	<input type="checkbox"/> Work	<input type="checkbox"/> Vehicle
<input type="checkbox"/> Patient's house	<input type="checkbox"/> Suspect's house	<input type="checkbox"/> Patient and suspect's house
<input type="checkbox"/> Other's house	<input type="checkbox"/> Hotel	<input type="checkbox"/> Bar
<input type="checkbox"/> Other indoor location		

- Did assault take place within Municipality of Anchorage?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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:

<input type="checkbox"/> Supine	<input type="checkbox"/> Standing	<input type="checkbox"/> Straddling suspect
<input type="checkbox"/> Prone	<input type="checkbox"/> Knee chest	<input type="checkbox"/> Lying on side
<input type="checkbox"/> Sitting	<input type="checkbox"/> 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
--	------------------------------	-----------------------------	---------------------------------	------------------------------------

- 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