



**Descriptive Analysis of
Sexual Assault Nurse Examinations
in Bethel: 2005-2006**

by

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Descriptive Analysis of Sexual Assault Nurse Examinations in Bethel: 2005-2006

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 Bethel in 2005 and 2006 ($N = 105$). 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 all (100%) were Native. Over 50% of patients were 24 years of age or younger. More precisely, 27% of patients were under the age of 18, 26% were between the ages of 18 to 24, 24% were between the ages of 25 to 34, 12% were between the ages of 35 to 44, and 12% were over the age of 44. None of the patients (0%) reported being homeless at the time of the assault and few (3%) reported being disabled.

Pre-Assault Characteristics

None of the patients reported they had engaged in anal or oral sex within three days prior to the assault, but 22% reported they had engaged in vaginal sex. The most common location of initial contact prior to the assault was a private residence, with 26% of initial contacts occurring at the patient's house, 18% occurring at the suspect's house, and 33% occurring at another's house.

Assault Characteristics

Fewer than half of the assaults (41%) took place in Bethel (others took place in the Yukon-Kuskokwim region but were referred to Bethel for a medical / forensic examination). The most common location for assaults was a private residence. More

specifically, 79% of assaults took place in private residences (i.e., 26% at the patient's house, 18% at the suspect's house, and 34% at another's house). Slightly less than half of the assaults (41%) involved weapons, physical blows, physical restraints, strangulation, or verbal threats. The most common methods used during the assaults included grabbing, grasping, and holding (37% of assaults), physical blows by hands or feet (15% of assaults), and verbal threats (13% of assaults). Many patients (71%) reported being alcohol intoxicated and many were severely intoxicated. More precisely, 46% of patients were passed out or had blacked out at the time of the assault. Drug use was relatively infrequent. Only 3% of patients reported being drug intoxicated. THC (marijuana) is the only drug that patients tested positive for. Most assaults were felonious, with 88% 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 8% of patients and digital penetration of the anus was reported by 4% of patients. All assaults (100%) included penetration or attempted penetration of the vagina or anus. Relatively few suspects (14%) used a condom during the assault.

Post-Assault Characteristics

Post-assault characteristics are important because they may affect the extent to which forensic evidence is still available to collect. Most patients urinated (91%), ate or drank (89%), and wiped or washed genitalia (86%) prior to the medical / forensic exam. Other common post-assault actions included changing clothing (54%) and defecating (45%). Few patients inserted or removed sponges, diaphragms, or tampons but 19% removed or placed a pad. No patient engaged in consensual anal or oral sex after the assault and only two (2%) engaged in consensual vaginal sex. Most reports (90%) to the sexual assault nurse examiner were made within three days, with 17% of reports occurring within two hours of the assault, 22% occurring within four hours, 41% occurring within 12 hours, and 68% occurring within 24 hours.

Exam Characteristics and Findings

All but one report to the sexual assault nurse examiner (99%) led to a complete exam. Although many patients were described as quiet (48%), calm (53%), and cooperative (48%), many were tearful (47%). Others were staring (14%), fearful (6%), fidgeting (9%), tense (8%), sobbing (7%), trembling (7%), and angry (9%). The majority of patients had clothing that appeared intact or clean (85% and 80% respectively). Upon arrival, 13% of patients required emergency medical care and 3% were admitted to the hospital. The vast majority of patients (96%) 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 86% of exams and fluorescence was found in 22% of these exams. The most common locations for finding fluorescence included buttocks and hips, legs and feet, the vagina and groin, and the back. Most patients (97%) were tested for sexually transmitted infections and other genital infections; and 5% of them tested positive. The two types of infections that patients tested positive for were bacterial vaginosis and

chlamydia. Non-genital injuries were recorded for 55% 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 fossa navicularis, anus, posterior fourchette, and labia minora. Almost 10% of patients received a follow-up examination or consultation, performed, on average, 26 days after the first exam.

Suspect Characteristics

The average number of suspects per assault was 1.13. Overall, 93% of patients were assaulted by a single suspect and 95% of suspect identities were known. Most suspects (97%) were Native and 3% were White. In terms of age, 33% of suspects were 10 to 19 years of age, with over half of them being 18 or 19. The youngest suspect was 14 years of age. Additionally, 42% of suspects were 20 to 29, 12% were 30 to 39, and 14% were 40 or older. Alcohol use was more common than drug use, with 87% of suspects using alcohol prior to the assault and 8% using drugs. Only 3% of patients were assaulted by strangers. The most common relationships between patients and suspects included friends and acquaintances, with 68% of patients reported being assaulted by someone they knew either as a friend or an acquaintance.

Legal Resolutions

Legal resolutions were obtained from the Alaska Department of Law only for a sub-sample of the cases included in this report. More precisely, legal resolutions were obtained only for examinations conducted in 2005 (because legal resolutions for the 2006 cases were not yet completed by the time of data collection). Of the original 105 sexual assault nurse examinations, 53 (51%) were searched in the Alaska Department of Law records. Results show that 62% were referred for prosecution, 43% were accepted for prosecution, and 32% resulted in a conviction. Of the referred cases, 70% were accepted. Of the accepted cases, 74% resulted in a conviction. At first glance, the likelihood of reported cases being referred, being accepted, and resulting in a conviction appears significantly higher in this sample of Bethel cases than in previous samples of Anchorage cases.

Descriptive Analysis of Sexual Assault Nurse Examinations in Bethel: 2005-2006

This report provides an overview of the characteristics of sexual assault victimizations, as observed and recorded by sexual assault nurse examiners. It is also the first report that documents the characteristics of sexual assault victimizations in the Bethel area. We hope that this report provides a valuable source of information about sexual assault victimizations 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 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 subsequent reports by the University of Alaska Anchorage Justice Center.

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 Bethel, SART/SANE services are provided by the Yukon-Kuskokwim Health Corporation. Victim advocates are provided by the Tundra Women's Coalition and law enforcement personnel primarily include the Bethel Police Department and the Alaska State Troopers.

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 Bethel in 2005 and 2006 were collected for three primary reasons. The first was to gather information about the characteristics of sexual assaults in Bethel and to create a report that summarizes this information. This goal is accomplished here in this descriptive report.

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

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

This study was also conducted in Kotzebue, Nome, Fairbanks, Kodiak, Kenai Peninsula, and Anchorage. All sexual assault nurse examiners in the State of Alaska (except for Dillingham) participated. Study results from these other sites are presented in other 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 Bethel, 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 Bethel in 2005 and 2006 were included in the sample. A total of 105 examinations were collected. Over half (59%) of these cases were referred from the Alaska State Troopers and 38% were referred from the Bethel Police Department. Three percent of the cases were referred from other local police departments (i.e., Saint Mary's and Togiak).

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 105 medical / forensic examinations included in the sample. More specifically, searches through the Alaska Department of Law records excluded all cases reported to law enforcement in 2006 (N=50). Cases reported in 2006 were excluded because outcome data were not yet available at the time of data collection. In addition, searches through the Alaska Department of Law records excluded two cases with unknown law enforcement case numbers. This data collection was therefore only performed on the cases reported in 2005 with a known law enforcement case number (final N=53). These 53 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 53 (51%) of the original 105 cases.

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

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 Bethel. 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 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). In addition, although the sexual assault nurse examiner protocol is standardized, it must also be individualized. Because the specifics of the examination vary across patients, data documentation and collection necessarily does as well. Overall, the data collection instrument was designed to focus on key aspects of the medical / forensic examination that would generally be included (but of course, these are not always included and cannot be). In order to provide the most valid estimates, missing data are not presented in tables. As the number of missing data increases (i.e., as sample sizes decrease), the reader is cautioned that data uncertainties are necessarily increased.

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

Demographic Characteristics of Patients

The vast majority (98%) of patients were female. 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	0	0.0 %
Native	104	100.0
Black	0	0.0
Hispanic	0	0.0
Asian	0	0.0
Pacific Islander	0	0.0
Total	104	

Source of data: SANE data (2005-2006)
N = 105; 1 (1.0%) missing

Of the 104 patients for whom race information was available, 100% were Native. At the time of the report, over 50% of patients were 24 years of age or younger. More precisely, 27% of patients were under the age of 18, 26% were 18 to 24 years of age, 24% were 25 to 34 years of age, 12% were 35 to 44 years of age, and 12% were 45 years of age or older (see Table 2).

Table 2. Age of Patients

Column Percentages

Age	Patients	
	N	%
0 to 17	28	26.9 %
18 to 24	27	26.0
25 to 34	25	24.0
35 to 44	12	11.5
45 to 54	7	6.7
55 or over	5	4.8
Total	104	

Source of data: SANE data (2005-2006)
N = 105; 1 (1.0%) missing

None of the patients (0%) reported being homeless at the time of the assault. Most patients did not report being disabled at the time of the assault (2% reported being mentally disabled, 1% reported being physically disabled, and 0% 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 none of the patients reported they had engaged in anal or oral sex within three days prior to the assault but 22% 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	101	100.0 %	0	0.0 %	101
Oral	98	100.0	0	0.0	98
Vaginal	78	78.0	22	22.0	100

Source of data: SANE data (2005-2006)

N = 105; 2 to 7 (1.9 to 6.7%) 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 a private residence, with 26% of initial contacts occurring at the patient's house, 18% occurring at the suspect's house, and 33% occurring at another's house. Together, these three locations accounted for 77% of all locations. Another common location of initial contact included outdoors (for 16% of locations).

Table 4. Location of Initial Contact Prior to Assault

Column Percentages

Location	Initial Contacts	
	N	%
Outdoors	15	15.6 %
Work	0	0.0
Vehicle	2	2.1
Patient's house	25	26.0
Suspect's house	17	17.7
Patient and suspect's house	0	0.0
Other's house	32	33.3
Hotel	1	1.0
Bar	0	0.0
Other indoor location	4	4.2
Total	96	

Source of data: SANE data (2005-2006)

N = 105; 9 (8.6%) missing

Assault Characteristics

Fewer than half of the assaults (41%) took place in Bethel. The other assaults (59%) took place elsewhere in the Yukon-Kuskokwim region but patients were referred to Bethel 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, 79% of assaults took place in private residences (i.e., 26% at the patient's house, 18% at the suspect's house, and 34% at another's house). Another common location included outdoors (for 12% of assaults).

Table 5. Location of Assault

Column Percentages

Location	Assaults	
	N	%
Outdoors	12	12.1 %
Work	0	0.0
Vehicle	2	2.0
Patient's house	26	26.3
Suspect's house	18	18.2
Patient and suspect's house	0	0.0
Other's house	34	34.3
Hotel	1	1.0
Bar	0	0.0
Other indoor location	6	6.1
Total	99	

Source of data: SANE data (2005-2006)

N = 105; 6 (5.7%) 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, 77% of contacts initiated in private residences and 79% 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. The next most common location was outdoors. Of all assaults, 16% initiated outdoors and 12% occurred outdoors. Relatively few assaults (N=7) initiated elsewhere and relatively few assaults (N=9) occurred elsewhere.

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	104	99.0 %	1	1.0 %	105
Physical blows by hands or feet	89	84.8	16	15.2	105
Grabbing, grasping, holding	66	62.9	39	37.1	105
Physical restraints	98	93.3	7	6.7	105
Strangulation	98	93.3	7	6.7	105
Toxic or chemical burns	105	100.0	0	0.0	105
Verbal threats	91	86.7	14	13.3	105

Source of data: SANE data (2005-2006)

N = 105; 0 (0.0%) missing

Less than half of the assaults (41%) involved at least one of these methods and only 19% involved two or more (results not shown). The most common methods included grabbing, grasping, and holding (37% of assaults), physical blows by hands or feet (15% of assaults), and verbal threats (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). Seven patients (7%) 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	0	0.0 %	1	6.7 %	5	33.3 %	1	6.7 %	0	0.0 %	1	6.7 %
Patient's house	1	4.0	7	28.0	13	52.0	3	12.0	3	12.0	6	24.0
Suspect's house	0	0.0	5	29.4	9	52.9	1	5.9	2	12.0	4	24.0
Other's house	0	0.0	1	3.1	8	25.0	1	3.1	1	3.1	1	3.1

Source of data: SANE data (2005-2006)

N = 105; 9 (8.6%) missing

More specifically, Table 7 shows the different methods used for the 15 assaults that *initiated* outdoors, the 25 that *initiated* at the patient's house, the 17 that *initiated* at the suspect's house, and the 32 that *initiated* at another's house. We did not examine the

different methods used for assaults that initiated at work ($N = 0$), in vehicles ($N = 2$), at the patient and suspect's house ($N = 0$), in hotels ($N = 1$), in bars ($N = 0$), or in other indoor locations ($N = 4$) because of low sample sizes. Similarly, we did not include toxic or chemical burns as a method, given it was not documented ($N = 0$).

Table 8 shows the different methods (excluding toxic or chemical burns) used for the 12 assaults that *occurred* outdoors, the 26 that *occurred* at the patient's house, the 18 that *occurred* at the suspect's house, and the 34 that *occurred* at another's house. Again, we did not examine the different methods used for assaults that occurred at work ($N = 0$), in vehicles ($N = 2$), at the patient and suspect's house ($N = 0$), in hotels ($N = 1$), in bars ($N = 0$), or in other indoor locations ($N = 6$) because of low sample sizes.

Table 8. Common Methods by Common Locations of Assault

Cell Percentages

Initial Contact	Weapon		Blows		Grabbing		Restraints		Strangle		Threats	
	N	%	N	%	N	%	N	%	N	%	N	%
Outdoors	0	0.0 %	0	0.0 %	6	50.0 %	1	8.3 %	0	0.0 %	0	0.0 %
Patient's house	1	3.8	6	23.1	11	42.3	2	7.7	3	11.5	5	19.2
Suspect's house	0	0.0	5	27.8	10	55.6	2	11.1	2	11.1	5	27.8
Other's house	0	0.0	2	5.9	8	23.5	1	2.9	1	2.9	2	5.9

Source of data: SANE data (2005-2006)

N = 105; 6 (5.7%) missing

Results show that weapons were used in 4% of assaults that *initiated* in the patient's house (Table 7) and in 4% of assaults that *occurred* in the patient's house (Table 8). As shown in Table 6, only one assault involved weapons. Blows were most frequent in assaults that *initiated* at the patient's house (in 28% of these assaults) and at the suspect's house (in 29% of these assaults). Blows were also most frequent in assaults that *occurred* at the patient's house (in 23% of these assaults) and at the suspect's house (in 28% of these assaults). Blows were far less frequent in assaults that initiated or occurred in outdoor locations or at another's house. Grabbing was prevalent in all locations of initial contact. More precisely, the prevalence of grabbing varied from a low of 25% in assaults *initiated* in another's house to a high of 53% for assaults *initiated* at the suspect's house. 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 56% in assaults that *occurred* at the suspect's house. Restraints were most commonly used in assaults that *initiated* in the patient's house (for 12% of these assaults). They were less frequently used in assaults that *initiated* outdoors (for 7% of these assaults), at the suspect's house (for 6% of these assaults), or at another's house (for 3% of these assaults). Restraints were most commonly used in assaults that *occurred* at the suspect's house (for 11% of these assaults) and were less commonly used in assaults that *occurred* outdoors (for 8% of these assaults), at the patient's house (for 8% of these assaults), or at another's house (for 3% of these assaults). Overall, strangulation was less common than blows and grabbing, but was as common as restraints. Strangulation was most prevalent for assaults that *initiated* at the patient's house (in 12% of these assaults) or at the suspect's house (for 12% of these assaults). Similarly, strangulation was most prevalent for assaults that *occurred* at the patient's

house (in 12% of these assaults) or at the suspect's house (for 11% of these assaults). Overall, strangulation is, in this study, significantly more prevalent than previously reported. Finally, threats were also most prevalent in assaults that *initiated* and *occurred* at either the patient's or the suspect's house. Threats were most common for assaults that *initiated* at the suspect's house (for 24% of these assaults) or at the patient's house (for 24% of these assaults) and were most common for assaults that *occurred* at the suspect's house (for 28% of these assaults) or at the patient's house (for 19% of these assaults).

Overall, assaults that initiated at the patient's house or at the suspect's house were the most likely to involve weapons, blows, grabbing, restraints, strangulation, and threats. Assaults that occurred at the patient's house or at the suspect's house were also the most likely to involve weapons, blows, strangulation, and threats. Grabbing and restraints were also frequent among assaults that occurred outdoors and, to a lesser extent, among assaults that occurred in another's house. 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 71% of patients reporting being alcohol intoxicated at the time of the assault and 3% reporting being drug intoxicated. Levels of intoxication were often quite high. More precisely, 46% 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	30	28.6 %	75	71.4 %	105
Drug intoxicated	102	97.1	3	2.9	105
Sober	77	73.3	28	26.7	105
Sleeping	102	97.1	3	2.9	105
Passed out / blacked out	56	53.8	48	46.2	104
Unconscious from trauma	105	100.0	0	0.0	105

Source of data: SANE data (2005-2006)
N = 105; 0 to 1 (0.0 to 1.0%) missing

During the examination, 75% of patients indicated that they had used alcohol prior to the assault and 11% 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	102	100.0 %	0	0.0 %	102
Blood alcohol	63	61.2	40	38.8	103
Urine tox screen	65	62.5	39	37.5	104

Source of data: SANE data (2005-2006)
N = 105; 1 to 3 (1.0 to 2.9%) missing

Blood alcohol test results are shown in Table 11. Blood alcohol results were available for 39 (98%) of the 40 patients given a blood alcohol test.

Table 11. Blood Alcohol Results

Column Percentages

Grams per milliliter	Blood Alcohol	
	N	%
Zero	16	41.0 %
.01 to .07	5	12.8
.08 to .14	1	2.6
.15 to .29	16	41.0
.30 or above	1	2.6
Total	39	

Source of data: SANE data (2005-2006)
N = 40; 1 (2.5%) missing

Negative results were observed for 41% of patients given a blood alcohol test. Of the patients given a blood alcohol test, 46% tested at or above .08, 44% of patients tested at a .15 or above, and 3% tested at a .30 or above.

Among the 39 patients who received a urine toxicology screening, 74% tested negative and 26% tested positive (results not shown). Specific results were available for all 39 (100%) of these patients. These results are presented in Table 12. Positive test results were obtained for only one substance, THC (marijuana). More specifically, 26% of patients given a urine toxicology screen tested positive for THC.

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

Drug	No		Yes		Total
	N	%	N	%	
Alcohol	39	100.0 %	0	0.0 %	39
Barbiturates	39	100.0	0	0.0	39
MDMA	39	100.0	0	0.0	39
THC	29	74.4	10	25.6	39
Benzodiazepines	39	100.0	0	0.0	39
Ketamine	39	100.0	0	0.0	39
Cocaine	39	100.0	0	0.0	39
Opiates	39	100.0	0	0.0	39
GHB	39	100.0	0	0.0	39
Amphetamines	39	100.0	0	0.0	39
Other drug	39	100.0	0	0.0	39

*Source of data: SANE data (2005-2006)**N = 39; 0 (0.0%) 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. Some 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 88% of patients. Statutorily, these are aggravated offenses that meet the legal requirements for sexual assaults in the first, second, or third degree (and sexual abuse of a minor in the first, second, or third degree), all punishable as felonies (unclassified, class B, or class C). Generally speaking, any form of penetration or attempted penetration, defined by Alaska Statute § 11.81.900 as "genital intercourse, cunnilingus, fellatio, anal intercourse, or an intrusion, however slight, of an object or any part of a person's body into the genital or anal opening of another person's body" will be punishable as a felony.

These data clearly reveal that the vast majority of assaults were serious enough to be punishable as felonies. All assaults in Table 13 (100%) included penetration or attempted penetration of the vagina or anus and 24% of these assaults also included oral copulation or attempted oral copulation of the patient's or suspect's genitals or anus (results not shown). Other common forms of penetration included digital penetration of the vagina (reported in 46% of assaults). The most common forms of oral copulation included the oral copulation of the patient's genitals (reported in 18% of assaults). Slightly over half of assaults also included kissing and sexual contact with breasts and vagina.

Table 13. Sex Acts Reported*Row Percentages*

Sex Act	No		Attempted		Yes		Total
	N	%	N	%	N	%	
Kissing	26	46.4 %	1	1.8 %	29	51.8 %	56
Touching breast	24	47.1	1	2.0	26	51.0	51
Touching vagina	19	38.0	2	4.0	29	58.0	50
Touching penis	50	94.3	1	1.9	2	3.8	53
Touching anus	42	79.2	4	7.5	7	13.2	53
Oral copulation of patient genitals	42	82.4	0	0.0	9	17.6	51
Oral copulation of suspect genitals	47	87.0	3	5.6	4	7.4	54
Oral copulation of patient anus	54	100.0	0	0.0	0	0.0	54
Oral copulation of suspect anus	55	100.0	0	0.0	0	0.0	55
Masturbation of patient	48	92.3	0	0.0	4	7.7	52
Masturbation of suspect	54	100.0	0	0.0	0	0.0	54
Penetration of vagina by finger	22	45.8	4	8.3	22	45.8	48
Penetration of vagina by penis	7	12.5	0	0.0	49	87.5	56
Penetration of vagina by object	50	98.0	0	0.0	1	2.0	51
Penetration of anus by finger	46	93.9	1	2.0	2	4.1	49
Penetration of anus by penis	44	86.3	3	5.9	4	7.8	51
Penetration of anus by object	53	98.1	0	0.0	1	1.9	54

Source of data: SANE data (2005-2006)
N = 105; 49 to 56 (46.7 to 53.3%) missing

The majority of assaults were not statutory (98%). 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 ($N = 2$) were statutory cases.

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

Position	No		Yes		Total
	N	%	N	%	
Supine	8	12.1 %	58	87.9 %	66
Standing	62	93.9	4	6.1	66
Straddling	66	100.0	0	0.0	66
Prone	63	95.5	3	4.5	66
Knee chest	65	98.5	1	1.5	66
Lying on side	65	98.5	1	1.5	66
Sitting	63	95.5	3	4.5	66
Other	64	97.0	2	3.0	66

Source of data: SANE data (2005-2006)
N = 105; 39 (37.1%) 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 88% of patients being assaulted in the supine position. Other positions were far less common, with standing as the next

most common, reported by 6% of patients. This information, along with other assault characteristics, is important because it may affect the collection and documentation of forensic evidence (whether it does so will be published in subsequent reports). In particular, positions at time of assault may affect the presence and patterning of injury.

Whether ejaculation by the suspect had occurred was rarely known by the patient. Of the 105 patients, 16 (15%) reported that the suspect had ejaculated during the assault and six (6%) reported that the suspect had not ejaculated during the assault (83 patients, or 79%, did not know). Focusing on the 16 patients who reported that the suspect had ejaculated during the assault, Table 15 describes ejaculation locations (for the 12 patients who knew the location). Not surprisingly, given the sex acts reported previously, the most common ejaculation location was the vagina (noted in 58% of assaults).

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

Row Percentages

Location	No		Yes		Total
	N	%	N	%	
Vagina	5	41.7 %	7	58.3 %	12
Rectum	11	91.7	1	8.3	12
Mouth	12	100.0	0	0.0	12
Stomach	12	100.0	0	0.0	12
Back	12	100.0	0	0.0	12
Napkin / cloth	12	100.0	0	0.0	12
Bed	12	100.0	0	0.0	12
Clothing	12	100.0	0	0.0	12
Condom	12	100.0	0	0.0	12
Other	8	66.7	4	33.3	12

Source of data: SANE data (2005-2006)

N = 16; 4 (25.0%) missing

Relatively few suspects used a condom during the assault (14%) and none used contraceptive jelly or foam. No assault 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	9	8.7 %	94	91.3 %	103
Defecated	57	55.3	46	44.7	103
Genital Wipe / Wash	14	13.6	89	86.4	103
Bath / Shower	82	79.6	21	20.4	103
Douche	101	98.1	2	1.9	103
Ate / Drank	11	10.7	92	89.3	103
Brushed Teeth	74	71.8	29	28.2	103
Oral Gargle / Wash	84	81.6	19	18.4	103
Changed Clothing	47	45.6	56	54.4	103
Steam	101	98.1	2	1.9	103

Source of data: SANE data (2005-2006)
N = 105; 2 (1.9%) missing

In Table 16, the majority of patients reported that they urinated, wiped or washed genitalia, and ate or drank after the assault. Over half (54%) of patients also reported that they changed their clothing prior to the examination and almost half (45%) reported that they defecated. Other common post-assault actions included bathing or showering (20%), brushing teeth (28%), and gargling (18%).

Table 17. Consensual Sex Between Assault and Examination

Row Percentages

Sex	No		Yes		Total
	N	%	N	%	
Anal	103	100.0 %	0	0.0 %	103
Oral	102	100.0	0	0.0	102
Vaginal	101	98.1	2	1.9	103

Source of data: SANE data (2005-2006)
N = 105; 2 to 3 (1.9 to 2.9%) 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 two 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, and tampons were relatively rare, but 19% of patients inserted or removed a pad.

Table 18. Post-Assault Insertions and Removals

Row Percentages

Item	No		Yes		Total
	N	%	N	%	
Sponge	102	100.0 %	0	0.0 %	102
Diaphragm	101	99.0	1	1.0	102
Tampon	98	96.1	4	3.9	102
Pad	83	81.4	19	18.6	102

Source of data: SANE data (2005-2006)
N = 105; 3 (2.9%) missing

Table 19 shows that most reports to the sexual assault nurse examiner (90%) occurred within three days of the assault. More precisely, 17% of reports occurred within two hours of the assault, 22% occurred within four hours, 41% occurred within 12 hours, 68% occurred within one day, and (again) 90% occurred within three days.

Table 19. Time Elapsed Between Assault and Report

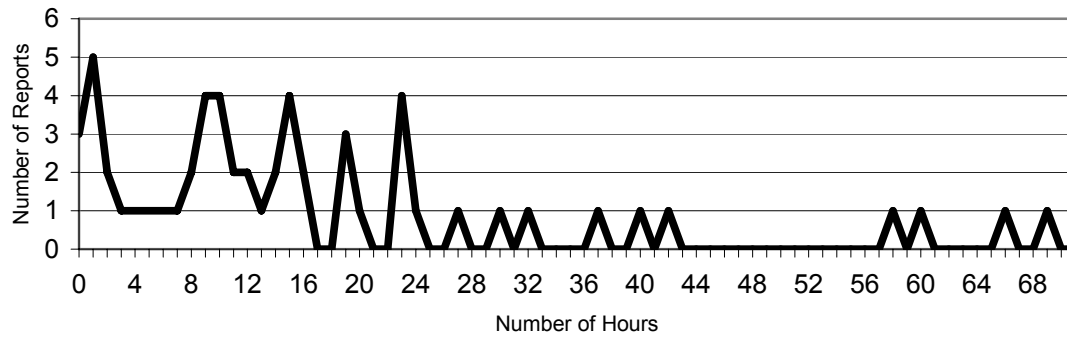
Column Percentages

Time	Patients		
	N	%	cum. %
< 2 hours	16	16.5 %	16.5 %
2 to < 4 hours	5	5.2	21.6
4 to < 12 hours	19	19.6	41.2
12 to < 24 hours	26	26.8	68.0
1 to < 3 days	21	21.6	89.7
3 days or more	10	10.3	100.0
Total	97		

Source of data: SANE data (2005-2006)
N = 105; 8 (7.6%) 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 1. 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 16.8 hours ($s = 16.4$). Over half (51%) of assaults were reported to the sexual assault nurse examiner within 12 hours.

Figure 1. Hours Elapsed Between Assault and Report, for Reports Within Three Days of Assault



Source of data: SANE data (2005-2006; N=57)

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 show that many patients were calm (53%), cooperative (48%), and quiet (48%). However, many patients were also tearful (47%). Others were staring (14%), fearful (6%), fidgeting (9%), tense (8%), sobbing (7%), trembling (7%), and angry (9%). Overall, 60% 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	78	78.8 %	21	21.2 %	99
Quiet	52	52.5	47	47.5	99
Calm	47	47.5	52	52.5	99
Expressive	97	98.0	2	2.0	99
Staring	85	85.9	14	14.1	99
Sleeping	97	98.0	2	2.0	99
Cooperative	52	52.5	47	47.5	99
Stoic	97	98.0	2	2.0	99
Agitated	95	96.0	4	4.0	99
Fearful	93	93.9	6	6.1	99
Tearful	53	53.5	46	46.5	99
Fidgeting	90	90.9	9	9.1	99
Tense	91	91.9	8	8.1	99
Hysterical	98	99.0	1	1.0	99
Sobbing	92	92.9	7	7.1	99
Yelling	95	96.0	4	4.0	99
Listless	99	100.0	0	0.0	99
Loud	98	99.0	1	1.0	99
Trembling	92	92.9	7	7.1	99
Angry	90	90.9	9	9.1	99
Other	88	88.9	11	11.1	99

Source of data: SANE data (2005-2006)

N = 105; 6 (5.7%) missing

All but one report to the sexual assault nurse examiner (99%) led to a complete exam. One exam was not completed because the patient declined the exam.

At the time of the SANE examination, 59% of patients were not wearing the same clothing as that worn during the assault. The appearance of patients' clothing at the time of the examination is described in Table 21. Relatively few patients had clothing that appeared dirty (11%), wet (3%), bloody (2%), or torn (1%), and few had clothing that appeared missing. The majority of patients had clothing that appeared clean or intact (80% and 85% respectively).

Table 21. Appearance of Patients' Clothing

Row Percentages

Clothing	No		Yes		Total
	N	%	N	%	
Intact	15	15.2 %	84	84.8 %	99
Clean	20	20.2	79	79.8	99
Dirty	88	88.9	11	11.1	99
Wet	96	97.0	3	3.0	99
Bloody	97	98.0	2	2.0	99
Torn	98	99.0	1	1.0	99
All missing	99	100.0	0	0.0	99
Partially missing	93	93.9	6	6.1	99
Buttons missing	99	100.0	0	0.0	99

Source of data: SANE data (2005-2006)

N = 105; 6 (5.7%) missing

As a result of the assault, 3% of patients were admitted to the hospital and 13% 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 22. The most common reasons for requiring emergency medical care were related to non-genital injuries suffered by patients and to patients' alcohol levels.

Table 22. Reasons for Emergency Medical Care

Row Percentages

Reason	No		Yes		Total
	N	%	N	%	
Non-genital injury	97	94.2 %	6	5.8 %	103
Genital injury	102	99.0	1	1.0	103
Alcohol level	97	94.2	6	5.8	103
Other	100	98.0	2	2.0	102

Source of data: SANE data (2005-2006)

N = 105; 2 to 3 (1.9 to 2.9%) missing

Few patients were pregnant at the time of the examination (2% of female patients) but half were mothers (50% of female patients; results not shown). Of the female patients, 10% were menstruating at the time of the assault (result not shown).

The vast majority of patients (96%) 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 96% and 99% 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 18% of exams).

An alternative light source was used in 86% 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 19 cases (i.e., in 22% of exams conducted with an alternative light source).

Table 23. Location of Fluorescence, for Cases Where Fluorescence was Found

Row Percentages

Location	No		Yes		Total
	N	%	N	%	
Abdomen	17	100.0 %	0	0.0 %	17
Arms and hands	17	100.0	0	0.0	17
Legs and feet	13	76.5	4	23.5	17
Buttocks and hips	9	52.9	8	47.1	17
Chest	16	94.1	1	5.9	17
Vagina and groin	14	82.4	3	17.6	17
Neck	17	100.0	0	0.0	17
Back	15	88.2	2	11.8	17
Face	17	100.0	0	0.0	17

Source of data: SANE data (2005-2006)

N = 19; 2 (10.5%) missing

Table 23 describes where fluorescence was found, for exams in which an alternative light source was used and fluorescence was found ($N = 19$). The most common locations where fluorescence was found included buttocks and hips, legs and feet, the vagina and groin, and the back.

A wet prep examination (a microscopic examination of fluid obtained from the vaginal vault) was conducted for 34 (32%) of the patients, and the nurse observed spermatozoa on only one (3%) of these examinations. In this one case, the spermatozoa was not still motile.

Most patients (97%) were tested for sexually transmitted infections and other genital infections; and 5% of them tested positive. The specific types of infections that these patients tested positive for are displayed in Table 24 ($N = 5$). The two types of infections that patients tested positive for were bacterial vaginosis (60%) and chlamydia (40%).

Table 24. Infections, for Patients Who Tested Positive*Row Percentages*

Infection	Negative		Positive		Total
	N	%	N	%	
Bacterial vaginosis	2	40.0 %	3	60.0 %	5
Chlamydia	3	60.0	2	40.0	5
Genital warts	5	100.0	0	0.0	5
Gonorrhea	5	100.0	0	0.0	5
HIV	5	100.0	0	0.0	5
Herpes	5	100.0	0	0.0	5
Trichomoniasis	5	100.0	0	0.0	5
Hepatitis B	5	100.0	0	0.0	5
Syphilis	5	100.0	0	0.0	5
Yeast	5	100.0	0	0.0	5
Hepatitis C	5	100.0	0	0.0	5

*Source of data: SANE data (2005-2006)**N = 5; 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 55% of patients. Overall, 15% of patients had non-genital injuries to the head or face, 7% to the mouth, 16% to the neck, 7% to shoulders, 36% to arms, 15% to hands, 9% to the chest, 1% to the abdomen, 8% to the back, 9% to buttocks or hips, 40% to legs, and 5% to feet. The most common non-genital injury types included bruising (documented for 51% of patients) and abrasions (documented for 22% of patients). Other non-genital injury types were far less common, with redness documented for 7% of patients and lacerations documented for 5%. Detailed results by non-genital injury site and type are shown in Table 25. Each cell in this table represents the number and percentage of patients with documented non-genital injuries.

The detailed data Table 25 show that the most common non-genital injury was bruising to the legs, documented in 35% of patients, and bruising of the arms, documented in 34% of patients. Other common non-genital injuries included bruising to the head or face (documented in 14% of patients), bruising to the neck (documented in 14% of patients), and abrasions to the legs (documented in 11% of patients).

Table 25. Number and Percent of Patients With Non-Genital Injury*Cell Percentages*

Location	Bruising		Redness		Abrasions		Lacerations		Swelling	
	N	%	N	%	N	%	N	%	N	%
Head / face	15	14.4 %	1	1.0 %	1	1.0 %	1	1.0 %	2	1.9 %
Mouth	7	6.7	0	0.0	0	0.0	1	1.0	0	0.0
Neck	15	14.4	5	4.8	1	1.0	0	0.0	1	1.0
Shoulders	6	5.8	1	1.0	1	1.0	0	0.0	0	0.0
Arms	35	33.7	0	0.0	8	7.7	0	0.0	0	0.0
Hands	10	9.6	0	0.0	6	5.8	2	1.9	0	0.0
Chest	8	7.7	0	0.0	1	1.0	0	0.0	0	0.0
Abdomen	1	1.0	0	0.0	0	0.0	0	0.0	0	0.0
Back	6	5.8	0	0.0	3	2.9	0	0.0	0	0.0
Buttocks / hips	5	4.8	0	0.0	5	4.8	0	0.0	0	0.0
Legs	36	34.6	0	0.0	11	10.6	0	0.0	0	0.0
Feet	3	2.9	0	0.0	1	1.0	1	1.0	0	0.0
Total	53	51.0	7	6.7	23	22.1	5	4.8	3	2.9

Location	Fracture		Bite Mark		Pain		Other		Total	
	N	%	N	%	N	%	N	%	N	%
Head / face	1	1.0 %	1	1.0 %	1	1.0 %	0	0.0 %	16	15.4 %
Mouth	0	0.0	0	0.0	1	1.0	0	0.0	7	6.7
Neck	0	0.0	0	0.0	2	1.9	1	1.0	17	16.3
Shoulders	0	0.0	0	0.0	0	0.0	0	0.0	7	6.7
Arms	0	0.0	0	0.0	3	2.9	0	0.0	37	35.6
Hands	0	0.0	0	0.0	0	0.0	1	1.0	16	15.4
Chest	0	0.0	0	0.0	0	0.0	0	0.0	9	8.7
Abdomen	0	0.0	0	0.0	0	0.0	0	0.0	1	1.0
Back	0	0.0	0	0.0	2	1.9	0	0.0	8	7.7
Buttocks / hips	0	0.0	0	0.0	0	0.0	1	1.0	9	8.7
Legs	0	0.0	0	0.0	3	2.9	1	1.0	42	40.4
Feet	0	0.0	0	0.0	0	0.0	1	1.0	5	4.8
Total	10	0.8	23	1.9	78	6.4	42	3.4	57	54.8

*Source of data: SANE data (2005-2006)**N = 105; 1 (1.0%) missing*

Genital injuries were documented in 43% of patients. Overall, the most common genital injury type documented for patients was a laceration (32%), followed by abrasions (15%), bruising (15%), and tenderness (2%). The most common genital injury locations identified for female patients included the fossa navicularis (14%), the posterior fourchette (13%), the labia minora (13%), the perineum (9%), the hymen (9%), and vaginal walls (8%). Injury to the anus was identified for 14% of all patients.

Three anatomical sites had lacerations for more than 10% of patients. More specifically, 12% of examinations documented lacerations of the fossa navicularis, 11% documented lacerations of the posterior fourchette, and 11% documented lacerations of the anus.

Table 26. Number and Percent of Patients With Genital Injury*Cell Percentages*

Location	Bruising		Abrasions		Lacerations		Tenderness		Total	
	N	%	N	%	N	%	N	%	N	%
Mons pubis	0	0.0 %	0	0.0 %	0	0.0 %	0	0.0 %	0	0.0 %
Labia majora	1	1.0	1	1.0	2	2.0	0	0.0	4	3.9
Labia minora	5	4.9	6	5.9	4	3.9	0	0.0	13	12.7
Labia maj/min junction	0	0.0	1	1.0	1	1.0	0	0.0	2	2.0
Clitoral hood	0	0.0	0	0.0	3	2.9	0	0.0	3	2.9
Clitoris	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Periurethra	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Hymen	9	8.8	1	1.0	5	4.9	2	2.0	9	8.8
Fossa navicularis	1	1.0	2	2.0	12	11.8	1	1.0	14	13.7
Posterior fourchette	1	1.0	2	2.0	11	10.8	1	1.0	13	12.7
Perineum	0	0.0	2	2.0	7	6.9	0	0.0	9	8.8
Vaginal walls	5	4.9	0	0.0	4	3.9	0	0.0	8	7.8
Cervix	1	1.0	0	0.0	0	0.0	0	0.0	1	1.0
Anus	0	0.0	3	2.9	11	10.6	0	0.0	14	13.5
Rectum	2	1.9	0	0.0	2	1.9	0	0.0	3	2.9
Total	16	15.4	16	15.4	33	31.7	2	1.9	45	43.3

*Source of data: SANE data (2005-2006)**N = 103; 1 (1.0%) missing; for anus, rectum, and total rows, N = 105; 1 (1.0%) missing*

Almost 10% of patients received a follow-up examination or consultation. On average, follow-up examinations occurred 26 days after the first exam ($s = 9.0$). More specifically, 11% occurred within one week and 67% within four weeks (results not shown).

Suspect Characteristics

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

The average number of suspects per assault was 1.13 ($s = 0.6$), for a total of 117 suspects (one patient could not recall the number of suspects). The number of suspects per assault is shown in Table 27. Results show that 93% of patients were assaulted by one suspect, 4% by two suspects, 2% by three suspects, and 1% by six suspects.

Table 27. Number of Suspects per Report

Column Percentages

Number of Suspects	Reports		
	N	%	cum. %
One	97	93.3 %	93.3 %
Two	4	3.8	97.1
Three	2	1.9	99.0
Four	0	0.0	99.0
Five	0	0.0	99.0
Six	1	1.0	100.0
Total	104		

Source of data: SANE data (2005-2006)
N = 105; 1 (1.0%) missing

Suspect information includes the gender, race or ethnicity, and age of the suspect, whether the suspect has used alcohol or drugs, and the relationship between the suspect and the patient. Not surprisingly, the vast majority (98%) of suspects were male (only two were female).

Table 28. Race and Ethnicity of Suspects

Column Percentages

Race	Suspects	
	N	%
White	4	3.5 %
Native	110	96.5
Black	0	0.0
Hispanic	0	0.0
Asian	0	0.0
Pacific Islander	0	0.0
Total	114	

Source of data: SANE data (2005-2006)
N = 117; 3 (2.6%) missing

The majority (95%) of suspect identities were known. Table 28 identifies the race and ethnicity of suspects. In rare cases when patients reported multiple races or

ethnicities for suspects, the minority class was selected. Overall, the majority of suspects (97%) were Native. Alcohol use was frequent among suspects, with 87% of suspects using alcohol (result not shown). Few suspects (8%) 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 29. Age of Suspects

Column Percentages

Age	Suspects	
	N	%
10 to 19	14	32.6 %
20 to 29	18	41.9
30 to 39	5	11.6
40 to 49	1	2.3
50 to 59	2	4.7
60 to 69	3	7.0
70 to 79	0	0.0
Total	43	

Source of data: SANE data (2005-2006)
N = 117; 74 (63.2%) missing

Table 29 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 43 (37%) of the suspects. Results in Table 29 show that 33% of suspects were 10 to 19 years of age. Of those, over half were 18 or 19 years of age (and the youngest suspect was 14 years of age). Additionally, 42% of suspects were 20 to 29 years of age, 12% were 30 to 39 years of age, 2% were 40 to 49 years of age, and 12% were 50 years of age or older.

Table 30. Relationship Between Suspects and Patients

Column Percentages

Relationship	Suspects		
	N	%	% of non-stranger
Stranger	3	2.6 %	
Friend / acquaintance (> 24 hrs)	65	57.0	58.6 %
Acquaintance (< 24 hrs)	1	0.9	0.9
Acquaintance (< 12 hrs)	12	10.5	10.8
Current spouse	0	0.0	0.0
Former spouse	0	0.0	0.0
Current partner	5	4.4	4.5
Former partner	6	5.3	5.4
Relative	20	17.5	18.0
Authority figure	2	1.8	1.8
Total	114		

Source of data: SANE data (2005-2006)
N = 117; 3 (2.6%) missing

Patient-suspect relationship is shown in Table 30. Overall, only 3% of patients were assaulted by strangers (97% were assaulted by non-strangers, ranging from current partners to acquaintances known for less than 12 hours). The most common relationships included friends and acquaintances. Overall, 68% of patients reported being assaulted by someone they knew as a friend or an acquaintance. Among patients assaulted by non-strangers, 70% were assaulted by someone known as a friend or acquaintance.

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 in 2005, because the legal resolutions for the examinations conducted in 2006 were not yet completed by the time of data collection. Of the 55 cases in 2005, two did not have a known law enforcement case number. Consequently, we examined the legal resolutions for the remaining 53 examinations, conducted in 2005 (i.e., for 51% of the original 105 examinations included in the sample). These legal resolutions are summarized in Table 31.

Table 31. Case Outcomes by Stage

Stage	N	% of reported	% of referred	% of accepted
Reported	53	100.0 %		
Referred	33	62.3	100.0 %	
Accepted	23	43.4	69.7	100.0 %
Convicted	17	32.1	51.5	73.9

Source of data: Alaska Department of Law (2005)
N = 53; 0 (0.0%) missing

Of the 53 reports examined, 62% were referred to the Alaska Department of Law for prosecution. Once referred for prosecution, cases had a high likelihood of getting accepted (70%) and once accepted, cases had a high likelihood of resulting in a conviction (74%). Overall, 62% of reported cases were referred, 43% were accepted, and 32% resulted in a conviction.

The odds of referring a case, accepting a case, and gaining a conviction are much 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 (APD) 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 62% reported here), that 12% were accepted by prosecution (versus the 43% reported here), and that 11% resulted in a conviction (versus the 32% reported here). The SANE examination may significantly enhance the likelihood that a case can be referred to the Alaska Department of Law for prosecution.

Furthermore, this seems particularly true in Bethel. The odds of referring a case, accepting a case, and gaining a conviction are much higher in this sample of sexual assault cases with a SANE examination in Bethel than in a comparable sample of sexual assault cases with a SANE examination in Anchorage. Rosay and Henry (2007)² examined the legal resolutions of all sexual assault cases with a SANE examination in Anchorage from 1996 to 2004. Results showed that 26% of all sexual assault cases with a SANE examination in Anchorage from 1996 to 2004 were referred to prosecution

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>.

² Descriptive Analysis of Sexual Assault Nurse Examinations in Anchorage: 1996-2004.

(versus the 62% reported here), that 18% were accepted by prosecution (versus the 43% reported here), and that 14% resulted in a conviction (versus the 32% reported here).

Overall, the likelihood of reported cases being referred, being accepted, and resulting in a conviction appears significantly higher in this sample of Bethel SANE cases than in previous samples of Anchorage police cases (Snodgrass, 2006) or Anchorage SANE cases (Rosay and Henry, 2007). The primary difference is that a significantly higher proportion of Bethel SANE cases are referred for prosecution.

Future analyses will examine the factors that increase the likelihood of referring cases to the Alaska Department of Law for prosecution, the likelihood of the Alaska Department of Law to accept cases for prosecution, and the likelihood of gaining convictions.

Appendix A – Data Collection Instrument



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

NIJ Grant No. 2004-WB-GX-0003

André Rosay and Tara Henry
Co-Principal Investigators

SECTION 1. BASIC INFORMATION

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

SECTION 2. PATIENT MEDICAL HISTORY

- Is the patient pregnant? Yes No
 Para: _____

- Was patient menstruating at time of attack? Yes No

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

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

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

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

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

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

SECTION 3. INCIDENT DESCRIPTION (PART 1)

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

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

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

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

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

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

- Kissing, licking, biting, scratching:

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

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

- Oral copulation of genitals:

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

- Oral copulation of anus:

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

- Masturbation:

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

- Penetration of vagina by:

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

- Penetration of anus by:

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

- Did ejaculation occur?

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Attempted
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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 (≥ 24 hours)
 - Acquaintance (< 24 hours)
 - Acquaintance (< 12 hours)
 - Current spouse
 - Former spouse
 - Current partner
 - Former partner
 - Relative
 - Stranger
 - Authority figure