



**Descriptive Analysis of
Sexual Assault Nurse Examinations in
Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna**

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

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

and

The Alaska Department of Law
State of Alaska



JC #0501

**Descriptive Analysis of
Sexual Assault Nurse Examinations in
Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna**

Table of Contents

Index of Tables and Figures	2
Acknowledgments	4
Executive Summary	5
Descriptive Analysis	8
Sexual Assault Nurse Examinations	9
Purpose of this Study	11
Methodology	12
Sample and Data Limitations	14
Demographic Characteristics of Patients	15
Pre-Assault Characteristics	16
Assault Characteristics	17
Post-Assault Characteristics	25
Exam Characteristics and Findings	28
Suspect Characteristics	34
Legal Resolutions	37
Appendix A – Data Collection Instrument	39

Descriptive Analysis of Sexual Assault Nurse Examinations in Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna

Index of Tables and Figures

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

Exam Characteristics and Findings

Table 20. Patients' Physical and Emotional State at Time of Exam	28
Table 21. Appearance of Patients' Clothing	29
Table 22. Reasons for Emergency Medical Care	29
Table 23. Location of Fluorescence, for Cases Where Fluorescence was Found	30
Table 24. Infections, for Patients who Tested Positive	31
Table 25. Number and Percent of Patients with Non-Genital Injury	32
Table 26. Number and Percent of Patients with Genital Injury	33

Suspect Characteristics

Table 27. Number of Suspects per Report	34
Table 28. Race and Ethnicity of Suspects	34
Table 29. Age of Suspects	35
Table 30. Relationship between Suspects and Patients	35

Legal Resolutions

Table 31. Case Outcomes by Stage	37
----------------------------------	----

Descriptive Analysis of Sexual Assault Nurse Examinations in Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna

Acknowledgments

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

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

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

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

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

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

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 Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna

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 and in Homer, Kodiak, Kotzebue, Nome, and Soldotna in 2005 ($N = 172$). 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 (99%) were female. Most patients (88%) were Native and 11% were White. Over 50% of patients were 24 years of age or younger. More precisely, 26% of patients were under the age of 18, 31% were between the ages of 18 to 24, 23% were between the ages of 25 to 34, 10% were between the ages of 35 to 44, and 9% were over the age of 44. Two patients (1%) reported being homeless at the time of the assault and few reported being physically disabled (3%), mentally disabled (2%), or psychiatrically disabled (1%).

Pre-Assault Characteristics

Very few 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 24% of initial contacts occurring at the patient's house, 17% occurring at the suspect's house, 33% occurring at another's house, and 1% occurring at the patient and suspect's house.

Assault Characteristics

Fewer than half of the assaults (47%) took place in the same town or village as the Sexual Assault Nurse Examiner (others took place in neighboring towns or villages but patients were referred to the Sexual Assault Nurse Examiner for a medical / forensic examination). The most common location for assaults was a private residence. More specifically, 80% of assaults took place in private residences (i.e., 29% at the patient's house, 20% at the suspect's house, 30% at another's house, and 1% at the patient and suspect's house). Another common location included outdoors (for 10% of assaults). Slightly less than half of the assaults (42%) involved weapons, physical blows, physical restraints, strangulation, or verbal threats. The most common methods used during assaults included grabbing, grasping, and holding (37% of assaults), physical blows by hands or feet (13% of assaults), and verbal threats (12% of assaults). Many patients (70%) reported being alcohol intoxicated and many were severely intoxicated. More precisely, 41% 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. 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 9% of patients and digital penetration of the anus was reported by 4% of patients. Almost all assaults (98%) included penetration or attempted penetration of the vagina or anus. Relatively few suspects (11%) 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 (86%), ate or drank (78%), and wiped or washed genitalia (76%) prior to the medical / forensic exam. Other common post-assault actions included changing clothing (53%) and defecating (42%). Few patients inserted or removed sponges, diaphragms, or tampons but 13% removed or placed a pad. No patient engaged in consensual anal or oral sex after the assault and only two (1%) engaged in consensual vaginal sex. Most reports (91%) to the sexual assault nurse examiner were made within three days, with 21% of reports occurring within two hours of the assault, 29% occurring within four hours, 49% occurring within 12 hours, and 69% occurring within 24 hours.

Exam Characteristics and Findings

All but one report to the sexual assault nurse examiner (96%) led to a complete exam. Many patients were described as cooperative (47%), tearful (46%), quiet (40%), and calm (39%). Others were controlled (24%). A smaller number were angry (11%), staring (9%), agitated (6%), tearful (5%), fidgeting (8%), or tense (8%). The majority of patients had clothing that appeared intact or clean (83% and 67% respectively). Upon arrival, 16% of patients required emergency medical care and 4% were admitted to the hospital. The vast majority of patients (92%) had a sexual assault evidence collection kit

completed during the medical / forensic examination. Speculum and colposcope exams were very common. An alternative light source (e.g., Wood's lamp, blue max, LED) was used in 78% of exams and fluorescence was found in 25% of these exams. The most common locations for finding fluorescence included buttocks and hips, the vagina and groin, and legs and feet. Most patients (92%) were tested for sexually transmitted infections and other genital infections; and 7% of them tested positive. Patients tested positive for chlamydia, bacterial vaginosis, genital warts, gonorrhea, trichomoniasis, hepatitis B, syphilis, and hepatitis C. Non-genital injuries were recorded for 53% 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 40% of patients. The most common genital injury type included a laceration and the most common genital injury locations included the posterior fourchette, fossa navicularis, labia minora, and anus. Eleven percent of patients received a follow-up examination or consultation, performed, on average, 18 days after the first exam.

Suspect Characteristics

The average number of suspects per assault was 1.10. Overall, 94% of patients were assaulted by a single suspect and 93% of suspect identities were known. Most suspects (90%) were Native and 10% were White. In terms of age, 30% of suspects were 10 to 19 years of age, with over half of them being 18 or 19. Additionally, 40% of suspects were 20 to 29, 12% were 30 to 39, and 18% were 40 or older. Alcohol use was more common than drug use, with 89% of suspects using alcohol prior to the assault and 7% using drugs. Only 3% of patients were assaulted by strangers. The most common relationships between patients and suspects included friends and acquaintances, with 67% of patients reported being assaulted by someone they knew either as a friend or an acquaintance.

Legal Resolutions

Legal resolutions were obtained from the Alaska Department of Law only for a sub-sample of the cases included in this report. More precisely, legal resolutions were obtained only for examinations conducted in 2005 (because legal resolutions for the 2006 cases were not yet completed by the time of data collection). Of the original 172 sexual assault nurse examinations, 110 (64%) were searched in the Alaska Department of Law records. Results show that 53% were referred for prosecution, 36% were accepted for prosecution, and 28% resulted in a conviction. Of the referred cases, 67% were accepted. Of the accepted cases, 80% 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 cases from Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna than in previous samples of Anchorage cases.

Descriptive Analysis of Sexual Assault Nurse Examinations in Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna

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 rural areas of Alaska. In this report, we focus on sexual assault nurse examinations conducted in Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna. We hope that this report provides a valuable source of information about sexual assault victimizations in rural Alaska and that this will be useful to practitioners and policy makers to develop and strengthen comprehensive responses to sexual assaults.

We begin this report by providing a brief overview of sexual assault 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. In Homer, SART/SANE services are provided by the South Peninsula Hospital. Victim advocates are provided by the South Peninsula Haven House and law enforcement personnel primarily include the Homer Police Department and the Alaska State Troopers. In Kodiak, SART/SANE services are provided by the Providence Kodiak Island Medical Center. Victim advocates are provided by the Kodiak Women's Resource and Crisis Center and law enforcement personnel primarily include the Kodiak Police Department and the Alaska State Troopers. In Kotzebue, SART/SANE services are provided by the Maniilaq Association. Victim advocates are provided by the Maniilaq Family Crisis Center and law enforcement personnel primarily include the Kotzebue Police Department and the Alaska State Troopers. In Nome, SART/SANE services are provided by the Norton Sound Health Corporation. Victim advocates are provided by the Bering Sea Women's Group and law enforcement personnel primarily include the Nome Police Department and the Alaska State Troopers. Finally, SART/SANE services in Soldotna are provided by the Central Peninsula General Hospital. Victim advocates are provided by the LeeShore Center and law enforcement personnel primarily include the Soldotna Police Department, the Kenai Police Department, and the Alaska State Troopers.

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, Homer, Kodiak, Kotzebue, Nome, and Soldotna were collected for three primary reasons. The first was to gather information about the characteristics of sexual assaults in rural Alaska and to create a report that summarizes this information. This goal is accomplished here in this descriptive report.

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

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

This study was also conducted in Anchorage and Fairbanks. 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, Homer, Kodiak, Kotzebue, Nome, and Soldotna 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 and all examinations conducted in Homer, Kodiak, Kotzebue, Nome, and Soldotna in 2005 were included in the sample. Bethel participated for two years (2005 and 2006) while the other sites participated for one year (2005). A total of 172 examinations were collected, with 105 (61%) coming from Bethel. Over half (54%) of these cases were referred from the Alaska State Troopers. Others were referred from local police departments such as those in Bethel, Homer, Kenai, Kodiak, Kotzebue, Nome, Saint Mary's, Seward, Soldotna, 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 172 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). These cases 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 12 cases with unknown law enforcement numbers. This data collection was therefore only performed on the cases reported in 2005 with known law enforcement case numbers (final N=110). These 110 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 110 (64%) of the original 172 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, Homer, Kodiak, Kotzebue, Nome, and Soldotna. 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 (99%) of patients were female (only two were male). 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	18	10.6 %
Native	150	88.2
Black	0	0.0
Hispanic	1	0.6
Asian	0	0.0
Pacific Islander	1	0.6
Total	170	

Source of data: SANE data (2005-2006)

N = 172; 2 (1.2%) missing

Most patients (88%) were Native and 11% were White. At the time of the report, over 50% of patients were 24 years of age or younger. More precisely, 26% of patients were under the age of 18, 31% were 18 to 24 years of age, 23% were 25 to 34 years of age, 10% were 35 to 44 years of age, and 9% were 45 years of age or older (see Table 2).

Table 2. Age of Patients

Column Percentages

Age	Patients	
	N	%
0 to 17	45	26.3 %
18 to 24	53	31.0
25 to 34	40	23.4
35 to 44	17	9.9
45 to 54	10	5.8
55 or over	6	3.5
Total	171	

Source of data: SANE data (2005-2006)

N = 172; 1 (0.6%) missing

Two patients (1%) 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, 3% reported being physically disabled, and 1% 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 (1%) reported they had engaged in anal sex within three days prior to the assault, very few (1%) reported they had engaged in oral sex within three days prior to the assault, but 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	163	99.4 %	1	0.6 %	164
Oral	159	99.4	1	0.6	160
Vaginal	128	78.5	35	21.5	163

Source of data: SANE data (2005-2006)

N = 172; 8 to 12 (4.7 to 7.0%) 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 a private residence, with 24% of initial contacts occurring at the patient's house, 17% occurring at the suspect's house, 33% occurring at another's house, and 1% occurring at the patient and suspect's house. Together, these three locations accounted for 75% of all locations. Another common location of initial contact included outdoors (for 14% of locations).

Table 4. Location of Initial Contact Prior to Assault

Column Percentages

Location	Initial Contacts	
	N	%
Outdoors	21	14.1 %
Work	0	0.0
Vehicle	4	2.7
Patient's house	36	24.2
Suspect's house	25	16.8
Patient and suspect's house	1	0.7
Other's house	49	32.9
Hotel	2	1.3
Bar	5	3.4
Other indoor location	6	4.0
Total	149	

Source of data: SANE data (2005-2006)

N = 172; 23 (13.4%) missing

Assault Characteristics

Fewer than half of the assaults (47%) took place in the same town or village as the Sexual Assault Nurse Examiner. The other assaults (53%) took place in neighboring towns or villages but patients were referred to the Sexual Assault Nurse Examiner for the medical / forensic examination (in most cases because a medical / forensic examination was not available in the patient's home community). Where assaults took place is shown in Table 5. The most common locations of assault included private residences. More specifically, 80% of assaults took place in private residences (i.e., 29% at the patient's house, 20% at the suspect's house, 30% at another's house, and 1% at the patient and suspect's house). Another common location included outdoors (for 10% of assaults).

Table 5. Location of Assault

Column Percentages

Location	Assaults	
	N	%
Outdoors	16	10.2 %
Work	0	0.0
Vehicle	4	2.5
Patient's house	45	28.7
Suspect's house	31	19.7
Patient and suspect's house	1	0.6
Other's house	47	29.9
Hotel	3	1.9
Bar	2	1.3
Other indoor location	8	5.1
Total	157	

Source of data: SANE data (2005-2006)

N = 172; 15 (8.7%) 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, 75% of contacts initiated in private residences and 80% 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, 14% initiated outdoors and 10% occurred outdoors. Relatively few assaults (N=17) initiated elsewhere and relatively few assaults (N=17) 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	170	98.8 %	2	1.2 %	172
Physical blows by hands or feet	150	87.2	22	12.8	172
Grabbing, grasping, holding	108	62.8	64	37.2	172
Physical restraints	162	94.2	10	5.8	172
Strangulation	157	91.3	15	8.7	172
Toxic or chemical burns	172	100.0	0	0.0	172
Verbal threats	152	88.4	20	11.6	172

Source of data: SANE data (2005-2006)

N = 172; 0 (0.0%) missing

Less than half of the assaults (42%) involved at least one of these methods and only 18% 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 (13% of assaults), and verbal threats (12% 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). Fifteen patients (9%) 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	4.8 %	7	33.3 %	1	4.8 %	2	9.5 %	2	9.5 %
Patient's house	2	5.6	10	27.8	20	55.6	4	11.1	5	13.9	9	25.0
Suspect's house	0	0.0	5	20.0	12	48.0	1	4.0	3	12.0	4	16.0
Other's house	0	0.0	3	6.1	13	26.5	2	4.1	2	4.1	1	2.0

Source of data: SANE data (2005-2006)

N = 172; 23 (13.4%) missing

More specifically, Table 7 shows the different methods used for the 21 assaults that *initiated* outdoors, the 36 that *initiated* at the patient's house, the 25 that *initiated* at the suspect's house, and the 49 that *initiated* at another's house. We did not examine the

different methods used for assaults that initiated at work ($N = 0$), in vehicles ($N = 4$), at the patient and suspect's house ($N = 1$), in hotels ($N = 2$), in bars ($N = 5$), or in other indoor locations ($N = 6$) 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 16 assaults that *occurred* outdoors, the 45 that *occurred* at the patient's house, the 31 that *occurred* at the suspect's house, and the 47 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 ($N = 4$), at the patient and suspect's house ($N = 1$), in hotels ($N = 3$), in bars ($N = 2$), or in other indoor locations ($N = 8$) 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 %	8	50.0 %	1	6.3 %	1	6.3 %	0	0.0 %
Patient's house	2	4.4	9	20.0	19	42.2	3	6.7	5	11.1	8	17.8
Suspect's house	0	0.0	5	16.1	15	48.4	2	6.5	4	12.9	6	19.4
Other's house	0	0.0	4	8.5	13	27.7	2	4.3	2	4.3	2	4.3

Source of data: SANE data (2005-2006)

N = 172; 15 (8.7%) missing

Results show that weapons were used in 6% 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 two assaults 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 20% of these assaults). Blows were also most frequent in assaults that *occurred* at the patient's house (in 20% of these assaults) and at the suspect's house (in 16% 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 27% in assaults *initiated* in another's house to a high of 56% for assaults *initiated* at the patient's house. Grabbing was similarly prevalent in all locations of assault. More precisely, the prevalence of grabbing varied from a low of 28% in assaults that *occurred* in another's house to a high of 50% in assaults that *occurred* outdoors. Restraints were most commonly used in assaults that *initiated* in the patient's house (for 11% of these assaults). They were less frequently used in assaults that *initiated* outdoors (for 5% of these assaults), at the suspect's house (for 4% of these assaults), or at another's house (for 4% of these assaults). Restraints were equally used in assaults that *occurred* outdoors (for 6% of these assaults), at the patient's house (for 7% of these assaults), and at the suspect's house (for 7% of these assaults). Overall, strangulation was more common than restraints. Strangulation was most prevalent for assaults that *initiated* at the patient's house (in 14% 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 11% of these assaults) or at the suspect's house (for 13% 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 patient's house (for 25% of these assaults) or at the suspect's house (for 16% of these assaults) and were most common for assaults that *occurred* at the suspect's house (for 19% of these assaults) or at the patient's house (for 18% 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, restraints, strangulation, and threats. Grabbing was frequent among assaults that occurred outdoors, at the suspect's house, at the patient's house, 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 70% 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, 41% 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	52	30.4 %	119	69.6 %	171
Drug intoxicated	166	97.1	5	2.9	171
Sober	129	75.4	42	24.6	171
Sleeping	167	97.7	4	2.3	171
Passed out / blacked out	101	59.4	69	40.6	170
Unconscious from trauma	171	100.0	0	0.0	171

Source of data: SANE data (2005-2006)
N = 172; 1 to 2 (0.6 to 1.2%) missing

During the examination, 72% of patients indicated that they had used alcohol prior to the assault and 8% 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	164	99.4 %	1	0.6 %	165
Blood alcohol	114	67.9	54	32.1	168
Urine tox screen	116	69.0	52	31.0	168

*Source of data: SANE data (2005-2006)**N = 172; 4 to 7 (2.3 to 4.1%) missing*

Blood alcohol test results are shown in Table 11. Blood alcohol results were available for 44 (81.5%) of the 54 patients given a blood alcohol test.

Table 11. Blood Alcohol Results*Column Percentages*

Grams per milliliter	Blood Alcohol	
	N	%
Zero	16	36.4 %
.01 to .07	5	11.4
.08 to .14	2	4.5
.15 to .29	18	40.9
.30 or above	3	6.8
Total	44	

*Source of data: SANE data (2005-2006)**N = 54; 10 (18.5%) missing*

Negative results were observed for 36% of patients given a blood alcohol test. Of the patients given a blood alcohol test, 52% tested at or above .08, 48% of patients tested at a .15 or above, and 7% tested at a .30 or above.

Among the 52 patients who received a urine toxicology screening, 74.5% tested negative and 25.5% tested positive (results not shown). Specific results were available for 47 (90%) of these patients. These results are presented in Table 12. Positive test results were obtained for alcohol, THC (marijuana), benzodiazepines, and other drugs. More specifically, 2% of patients given a urine toxicology screen tested positive for alcohol, 21% tested positive for THC, 2% tested positive for benzodiazepines, and 2% tested positive for other drugs.

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

Drug	No		Yes		Total
	N	%	N	%	
Alcohol	46	97.9 %	1	2.1 %	47
Barbiturates	47	100.0	0	0.0	47
MDMA	47	100.0	0	0.0	47
THC	37	78.7	10	21.3	47
Benzodiazepines	46	97.9	1	2.1	47
Ketamine	47	100.0	0	0.0	47
Cocaine	47	100.0	0	0.0	47
Opiates	47	100.0	0	0.0	47
GHB	47	100.0	0	0.0	47
Amphetamines	47	100.0	0	0.0	47
Other drug	46	97.9	1	2.1	47

*Source of data: SANE data (2005-2006)**N = 52; 5 (9.6%) 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. Overall, 98% of assaults included penetration or attempted penetration of the vagina or anus and 23% 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 43% of assaults). The most common forms of oral copulation included the oral copulation of the patient's genitals (reported in 15% 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	36	42.4 %	3	3.5 %	46	54.1 %	85
Touching breast	34	45.9	1	1.4	39	52.7	74
Touching vagina	29	37.7	3	3.9	45	58.4	77
Touching penis	75	94.9	1	1.3	3	3.8	79
Touching anus	64	83.1	5	6.5	8	10.4	77
Oral copulation of patient genitals	66	83.5	1	1.3	12	15.2	79
Oral copulation of suspect genitals	79	89.8	3	3.4	6	6.8	88
Oral copulation of patient anus	86	100.0	0	0.0	0	0.0	86
Oral copulation of suspect anus	92	100.0	0	0.0	0	0.0	92
Masturbation of patient	76	93.8	0	0.0	5	6.2	81
Masturbation of suspect	86	95.6	1	1.1	3	3.3	90
Penetration of vagina by finger	40	49.4	6	7.4	35	43.2	81
Penetration of vagina by penis	11	11.5	1	1.0	84	87.5	96
Penetration of vagina by object	82	97.6	0	0.0	2	2.4	84
Penetration of anus by finger	78	95.1	1	1.2	3	3.7	82
Penetration of anus by penis	72	84.7	5	5.9	8	9.4	85
Penetration of anus by object	88	98.9	0	0.0	1	1.1	89

Source of data: SANE data (2005-2006)
N = 172; 71 to 98 (41.3 to 57.0%) missing

The majority of assaults were not statutory (99%). Statutory sexual assaults include sexual acts prohibited by law because of the victim's age, the suspect's age, and the age difference between the victim and suspect. For example, an 18 year old suspect may be charged with sexual abuse of a minor in the third degree (AS §11.41.438) if the victim is 15 years of age. In these statutory cases, consent is not at issue. Regardless of whether the victim consented to the sexual acts, the suspect may be charged and convicted. Very few assaults ($N = 2$) were statutory cases.

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

Position	No		Yes		Total
	N	%	N	%	
Supine	12	11.4 %	93	88.6 %	105
Standing	99	94.3	6	5.7	105
Straddling	105	100.0	0	0.0	105
Prone	101	96.2	4	3.8	105
Knee chest	104	99.0	1	1.0	105
Lying on side	101	96.2	4	3.8	105
Sitting	102	97.1	3	2.9	105
Other	99	94.3	6	5.7	105

Source of data: SANE data (2005-2006)
N = 172; 67 (39.0%) 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 89% of patients being assaulted in the supine position. Other positions were far less common, with standing and "other" as

the next most common, each 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 172 patients, 28 (16%) reported that the suspect had ejaculated during the assault and 12 (7%) reported that the suspect had not ejaculated during the assault (132 patients, or 77%, did not know). Focusing on the 28 patients who reported that the suspect had ejaculated during the assault, Table 15 describes ejaculation locations (for the 21 patients who knew the location). Not surprisingly, given the sex acts reported previously, the most common ejaculation location was the vagina (noted in 71% of assaults).

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

Row Percentages

Location	No		Yes		Total
	N	%	N	%	
Vagina	6	28.6 %	15	71.4 %	21
Rectum	20	95.2	1	4.8	21
Mouth	21	100.0	0	0.0	21
Stomach	21	100.0	0	0.0	21
Back	21	100.0	0	0.0	21
Napkin / cloth	21	100.0	0	0.0	21
Bed	21	100.0	0	0.0	21
Clothing	21	100.0	0	0.0	21
Condom	20	95.2	1	4.8	21
Other	17	81.0	4	19.0	21

Source of data: SANE data (2005-2006)

N = 28; 7 (25.0%) missing

Relatively few suspects used a condom during the assault (11%) and none used contraceptive jelly or foam. Few assaults (4%) 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	23	14.0 %	141	86.0 %	164
Defecated	96	58.5	68	41.5	164
Genital Wipe / Wash	39	23.8	125	76.2	164
Bath / Shower	128	78.0	36	22.0	164
Douche	162	98.8	2	1.2	164
Ate / Drank	36	22.0	128	78.0	164
Brushed Teeth	112	68.3	52	31.7	164
Oral Gargle / Wash	134	81.7	30	18.3	164
Changed Clothing	77	47.0	87	53.0	164
Steam	162	98.8	2	1.2	164

Source of data: SANE data (2005-2006)
N = 172; 8 (4.7%) missing

In Table 16, the majority of patients reported that they urinated, ate or drank, and wiped or washed genitalia after the assault. Over half (53%) of patients also reported that they changed their clothing prior to the examination and almost half (42%) reported that they defecated. Other common post-assault actions included brushing teeth (32%), bathing or showering (22%), brushing teeth (28%), and gargling (18%).

Table 17. Consensual Sex Between Assault and Examination

Row Percentages

Sex	No		Yes		Total
	N	%	N	%	
Anal	165	100.0 %	0	0.0 %	165
Oral	164	100.0	0	0.0	164
Vaginal	164	98.8	2	1.2	166

Source of data: SANE data (2005-2006)
N = 172; 6 to 8 (3.5 to 4.7%) 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 (1%) 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 13% of patients inserted or removed a pad.

Table 18. Post-Assault Insertions and Removals

Row Percentages

Item	No		Yes		Total
	N	%	N	%	
Sponge	165	100.0 %	0	0.0 %	165
Diaphragm	164	99.4	1	0.6	165
Tampon	159	96.4	6	3.6	165
Pad	143	86.7	22	13.3	165

Source of data: SANE data (2005-2006)
N = 172; 7 (4.1%) missing

Table 19 shows that most reports to the sexual assault nurse examiner (91%) occurred within three days of the assault. More precisely, 21% of reports occurred within two hours of the assault, 29% occurred within four hours, 49% occurred within 12 hours, 69% occurred within one day, and (again) 91% occurred within three days.

Table 19. Time Elapsed Between Assault and Report

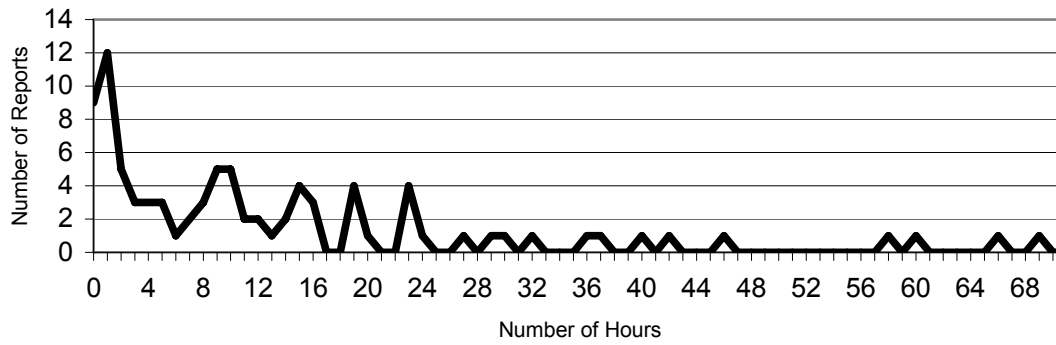
Column Percentages

Time	Patients		
	N	%	cum. %
< 2 hours	32	21.3 %	21.3 %
2 to < 4 hours	12	8.0	29.3
4 to < 12 hours	29	19.3	48.7
12 to < 24 hours	31	20.7	69.3
1 to < 3 days	32	21.3	90.7
3 days or more	14	9.3	100.0
Total	150		

Source of data: SANE data (2005-2006)
N = 172; 22 (12.8%) 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 13.4 hours ($s = 15.4$). Over half (52%) of these assaults were reported to the sexual assault nurse examiner within nine hours.

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



Source of data: SANE data (2005-2006; N=88)

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 cooperative (47%), tearful (46%), quiet (40%), and calm (39%). Others were controlled (24%). A smaller number were angry (11%), staring (9%), agitated (6%), fearful (5%), fidgeting (8%), or tense (8%). Overall, 58% 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	119	76.3 %	37	23.7 %	156
Quiet	93	59.6	63	40.4	156
Calm	95	60.9	61	39.1	156
Expressive	154	98.7	2	1.3	156
Staring	142	91.0	14	9.0	156
Sleeping	153	98.1	3	1.9	156
Cooperative	82	52.6	74	47.4	156
Stoic	153	98.1	3	1.9	156
Agitated	146	93.6	10	6.4	156
Fearful	148	94.9	8	5.1	156
Tearful	84	53.8	72	46.2	156
Fidgeting	144	92.3	12	7.7	156
Tense	144	92.3	12	7.7	156
Hysterical	151	96.8	5	3.2	156
Sobbing	148	94.9	8	5.1	156
Yelling	148	94.9	8	5.1	156
Listless	156	100.0	0	0.0	156
Loud	152	97.4	4	2.6	156
Trembling	149	95.5	7	4.5	156
Angry	139	89.1	17	10.9	156
Other	140	89.7	16	10.3	156

Source of data: SANE data (2005-2006)

N = 172; 16 (9.3%) missing

Only seven reports to the sexual assault nurse examiner (4%) did not lead to a complete exam. Of those seven, four were not completed because the patient declined

the exam, two were not completed because the nurse stopped the call out process, and one was not completed for an unknown reason.

At the time of the SANE examination, 42% 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 (12%), partially missing (5%), bloody (3%), wet (2%), or torn (1%). The majority of patients had clothing that appeared clean or intact (83% and 67% respectively).

Table 21. Appearance of Patients' Clothing

Row Percentages

Clothing	No		Yes		Total
	N	%	N	%	
Intact	25	16.7 %	125	83.3 %	150
Clean	50	33.3	100	66.7	150
Dirty	132	88.0	18	12.0	150
Wet	147	98.0	3	2.0	150
Bloody	146	97.3	4	2.7	150
Torn	149	99.3	1	0.7	150
All missing	150	100.0	0	0.0	150
Partially missing	143	95.3	7	4.7	150
Buttons missing	150	100.0	0	0.0	150

Source of data: SANE data (2005-2006)

N = 172; 22 (12.8%) missing

As a result of the assault, 4% of patients were admitted to the hospital and 16% 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	151	91.5 %	14	8.5 %	165
Genital injury	163	98.2	3	1.8	166
Alcohol level	154	92.8	12	7.2	166
Other	159	97.0	5	3.0	164

Source of data: SANE data (2005-2006)

N = 172; 6 to 8 (3.5 to 4.7%) missing

Few patients were pregnant at the time of the examination (2% of female patients) but half were mothers (49% 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 (92%) had a sexual assault evidence collection kit completed during the medical / forensic examination (the evidence collection kit a preassembled kit used to collect and preserve forensic samples following a sexual assault). Speculum and colposcope exams were very common (in 89% and 92% 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 16% of exams).

An alternative light source was used in 78% 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 32 cases (i.e., in 25% 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	25	96.2 %	1	3.8 %	26
Arms and hands	25	96.2	1	3.8	26
Legs and feet	21	80.8	5	19.2	26
Buttocks and hips	16	61.5	10	38.5	26
Chest	24	92.3	2	7.7	26
Vagina and groin	19	73.1	7	26.9	26
Neck	26	100.0	0	0.0	26
Back	24	92.3	2	7.7	26
Face	26	100.0	0	0.0	26

Source of data: SANE data (2005-2006)

N = 32; 6 (18.8%) missing

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

A wet prep examination (a microscopic examination of fluid obtained from the vaginal vault) was conducted for 53 (31%) of the patients, and the nurse observed spermatozoa on three (6%) of these examinations. In one case of these three cases, the spermatozoa was still motile.

Most patients (92%) were tested for sexually transmitted infections and other genital infections; and 7% of them tested positive. The specific types of infections that these patients tested positive for are displayed in Table 24 ($N = 10$). The most common infections that patients tested positive for were chlamydia (60%) and bacterial vaginosis (30%). Other infections that patients tested positive for included genital warts, gonorrhea, trichomoniasis, hepatitis B, syphilis, and hepatitis C.

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

Infection	Negative		Positive		Total
	N	%	N	%	
Bacterial vaginosis	7	70.0 %	3	30.0 %	10
Chlamydia	4	40.0	6	60.0	10
Genital warts	9	90.0	1	10.0	10
Gonorrhea	8	80.0	2	20.0	10
HIV	10	100.0	0	0.0	10
Herpes	10	100.0	0	0.0	10
Trichomoniasis	9	90.0	1	10.0	10
Hepatitis B	9	90.0	1	10.0	10
Syphilis	9	90.0	1	10.0	10
Yeast	10	100.0	0	0.0	10
Hepatitis C	9	90.0	1	10.0	10

*Source of data: SANE data (2005-2006)**N = 10; 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 53% of patients. Overall, 16% of patients had non-genital injuries to the head or face, 4% to the mouth, 16% to the neck, 8% to shoulders, 30% to arms, 13% to hands, 8% to the chest, 2% to the abdomen, 10% to the back, 8% to buttocks or hips, 36% to legs, and 3% to feet. The most common non-genital injury types included bruising (documented for 47% of patients) and abrasions (documented for 21% of patients). Other non-genital injury types were far less common, with redness documented for 8% of patients and lacerations documented for 4%. 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 30% of patients, followed by bruising of the arms (documented in 27% of patients), bruising of the head / face (documented in 14% of patients), and bruising of the neck (documented in 13% 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	23	13.9 %	4	2.4 %	4	2.4 %	1	0.6 %	6	3.6 %
Mouth	7	4.2	0	0.0	0	0.0	1	0.6	0	0.0
Neck	22	13.3	6	3.6	3	1.8	0	0.0	2	1.2
Shoulders	11	6.5	3	1.8	2	1.2	0	0.0	0	0.0
Arms	45	27.1	3	1.8	10	6.0	0	0.0	0	0.0
Hands	14	8.4	2	1.2	7	4.2	2	1.2	0	0.0
Chest	12	7.2	0	0.0	2	1.2	0	0.0	0	0.0
Abdomen	3	1.8	0	0.0	0	0.0	0	0.0	0	0.0
Back	9	5.4	1	0.6	5	3.0	0	0.0	0	0.0
Buttocks / hips	8	4.8	0	0.0	6	3.6	0	0.0	0	0.0
Legs	50	30.1	2	1.2	15	9.0	1	0.6	2	1.2
Feet	3	1.8	0	0.0	1	0.6	1	0.6	0	0.0
Total	78	47.0	14	8.4	35	21.1	6	3.6	9	5.4

Location	Fracture		Bite Mark		Pain		Other		Total	
	N	%	N	%	N	%	N	%	N	%
Head / face	1	0.6 %	1	0.6 %	2	1.2 %	2	1.2 %	27	16.3 %
Mouth	0	0.0	0	0.0	1	0.6	0	0.0	7	4.2
Neck	0	0.0	0	0.0	2	1.2	1	0.6	26	15.7
Shoulders	0	0.0	0	0.0	0	0.0	2	1.2	14	8.4
Arms	0	0.0	0	0.0	4	2.4	0	0.0	49	29.5
Hands	0	0.0	0	0.0	0	0.0	2	1.2	22	13.3
Chest	0	0.0	0	0.0	0	0.0	1	0.6	14	8.4
Abdomen	0	0.0	0	0.0	0	0.0	1	0.6	4	2.4
Back	0	0.0	0	0.0	4	2.4	1	0.6	17	10.2
Buttocks / hips	0	0.0	0	0.0	0	0.0	2	1.2	14	8.4
Legs	0	0.0	0	0.0	5	3.0	2	1.2	59	35.5
Feet	0	0.0	0	0.0	0	0.0	1	0.6	5	3.0
Total	1	0.6	1	0.6	13	7.8	7	4.2	88	53.0

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

Genital injuries were documented in 40% of patients. Overall, the most common genital injury type documented for patients was a laceration (30%), followed by abrasions (17%), bruising (10%), and tenderness (2%). The most common genital injury locations identified for female patients included the posterior fourchette (15%), the fossa navicularis (13%), the labia minora (13%), the perineum (10%), the hymen (7%), and vaginal walls (5%). Injury to the anus was identified for 12% of all patients.

Two anatomical sites had lacerations for 10% of patients. More specifically, 10% of examinations documented lacerations of the posterior fourchette and 10% documented lacerations of the anus. An additional 9% documented lacerations of the fossa navicularis. These were the three most common genital injuries, followed by abrasions of the labia minora (documented for 8% of patients), lacerations of the perineum (documented for 7% of patients), and bruising of the hymen (documented for 6% of patients).

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 %	1	0.6 %	0	0.0 %	0	0.0 %	1	0.6 %
Labia majora	1	0.6	1	0.6	2	1.2	0	0.0	4	2.5
Labia minora	5	3.1	13	8.0	6	3.7	0	0.0	21	13.0
Labia maj/min junction	0	0.0	3	1.9	3	1.9	0	0.0	6	3.7
Clitoral hood	0	0.0	0	0.0	4	2.5	0	0.0	4	2.5
Clitoris	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Periurethra	0	0.0	0	0.0	1	0.6	0	0.0	1	0.6
Hymen	9	5.6	3	1.9	6	3.7	2	1.2	12	7.4
Fossa navicularis	1	0.6	6	3.7	15	9.3	1	0.6	21	13.0
Posterior fourchette	1	0.6	8	4.9	16	9.9	1	0.6	24	14.8
Perineum	0	0.0	6	3.7	11	6.8	0	0.0	16	9.9
Vaginal walls	5	3.1	0	0.0	4	2.5	0	0.0	8	4.9
Cervix	1	0.6	0	0.0	0	0.0	0	0.0	1	0.6
Anus	1	0.6	3	1.8	16	9.8	1	0.6	19	11.6
Rectum	2	1.2	0	0.0	2	1.2	0	0.0	3	1.8
Total	17	10.4	27	16.5	49	29.9	3	1.8	67	40.1

*Source of data: SANE data (2005-2006)**N = 170; 8 (4.7%) missing; for anus, rectum, and total rows, N = 172; 8 (4.7%) missing*

Eleven percent of patients received a follow-up examination or consultation. On average, follow-up examinations occurred 18.4 days after the first exam ($s = 13.7$). More specifically, 38% occurred within one week and 75% 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 1.10 ($s = 0.5$), for a total of 183 suspects. The number of suspects per assault is shown in Table 27. Results show that 94% 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	157	94.0 %	94.0 %
Two	6	3.6	97.6
Three	3	1.8	99.4
Four	0	0.0	99.4
Five	0	0.0	99.4
Six	1	0.6	100.0
Total	167		

Source of data: SANE data (2005-2006)
N = 172; 5 (2.9%) missing

Suspect information includes the gender, race or ethnicity, and age of the suspect, whether the suspect has used alcohol or drugs, and the relationship between the suspect and the patient. Not surprisingly, the vast majority (99%) of suspects were male (only two were female).

Table 28. Race and Ethnicity of Suspects

Column Percentages

Race	Suspects	
	N	%
White	18	9.9 %
Native	162	89.5
Black	0	0.0
Hispanic	1	0.6
Asian	0	0.0
Pacific Islander	0	0.0
Total	181	

Source of data: SANE data (2005-2006)
N = 183; 2 (1.1%) missing

The majority (93%) 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 (90%) were Native. Alcohol use was frequent among suspects, with 89% of suspects using alcohol (result not shown). Few suspects (7%) 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	17	29.8 %
20 to 29	23	40.4
30 to 39	7	12.3
40 to 49	4	7.0
50 to 59	3	5.3
60 to 69	3	5.3
70 to 79	0	0.0
Total	57	

Source of data: SANE data (2005-2006)
N = 183; 126 (68.9%) 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 57 (31%) of the suspects. Results in Table 29 show that 30% of suspects were 10 to 19 years of age. Of those, over half were 18 or 19 years. Additionally, 40% of suspects were 20 to 29 years of age, 12% were 30 to 39 years of age, 7% were 40 to 49 years of age, and 11% were 50 years of age or older.

Table 30. Relationship Between Suspects and Patients

Column Percentages

Relationship	Suspects		
	N	%	% of non-stranger
Stranger	5	2.9 %	
Friend / acquaintance (> 24 hrs)	95	54.9	56.5 %
Acquaintance (< 24 hrs)	2	1.2	1.2
Acquaintance (< 12 hrs)	19	11.0	11.3
Current spouse	0	0.0	0.0
Former spouse	3	1.7	1.8
Current partner	6	3.5	3.6
Former partner	8	4.6	4.8
Relative	32	18.5	19.0
Authority figure	3	1.7	1.8
Total	173		

Source of data: SANE data (2005-2006)
N = 183; 10 (5.5%) 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, 67% of patients reported being assaulted by someone they knew as a friend or an acquaintance. Among patients assaulted by non-strangers, 69% 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 122 cases in 2005, 12 did not have a known law enforcement case number. Consequently, we examined the legal resolutions for the remaining 110 examinations, conducted in 2005 (i.e., for 64% of the original 172 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	110	100.0 %		
Referred	58	52.7	100.0 %	
Accepted	39	35.5	67.2	100.0 %
Convicted	31	28.2	53.4	79.5

Source of data: Alaska Department of Law (2005)
N = 110; 0 (0.0%) missing

Of the 110 reports examined, 53% were referred to the Alaska Department of Law for prosecution. Once referred for prosecution, cases had a high likelihood of getting accepted (67%) and once accepted, cases had a high likelihood of resulting in a conviction (80%). Stated differently, 67% of referred cases were accepted and 80% of accepted cases resulted in a conviction. Overall, 53% of reported cases were referred, 36% were accepted, and 28% 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 53% reported here), that 12% were accepted by prosecution (versus the 36% reported here), and that 11% resulted in a conviction (versus the 28% 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 this sample of cases from Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna. 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 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

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.

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 (versus the 53% reported here), that 18% were accepted by prosecution (versus the 36% reported here), and that 14% resulted in a conviction (versus the 29% reported here).

Overall, the likelihood of reported cases being referred, being accepted, and resulting in a conviction appears significantly higher in this sample of SANE cases from Bethel, Homer, Kodiak, Kotzebue, Nome, and Soldotna than in previous samples of Anchorage police cases (Snodgrass, 2006) or Anchorage SANE cases (Rosay and Henry, 2007).

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):

<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