TRAINING INSTITUTE on STRANGULATION PREVENTION
Is a program of Alliance for HOPE International

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Pediatric Strangulation Part 1 Webinar Course Description

This webinar will highlight the unique challenges faced by medical providers and investigators when working with children who have histories or suspected histories of a strangulation assault. We will review some of the anatomic and physiologic differences between child and adult victims, as well as the ways child victims might present. Current recommendations for the acute, medical evaluation of pediatric strangulation will be discussed, as well as a current project to gain expert consensus on the best imaging studies to use in children. Finally, we will give a sneak peek at best practices for clinical and photo documentation which will be the subject of our *Pediatric Strangulation Part 2* webinar scheduled in 2018.

Objectives

1) Discuss the body of literature and research that addresses pediatric strangulation.
2) Identify differences in anatomy, physiology and mechanism for the child or adolescent who has been strangled.
3) Compare the clinical spectrum of symptoms & physical findings that may present in a child or adolescent who has been strangled.
4) Analyze case studies that include a history of strangulation assault.
5) Discuss recommendations for imaging studies for the pediatric patient who describes strangulation.

Welcome to Our Webinar!

While waiting for the presentation to begin, please read the following reminders:

- The presentation will begin promptly at 10:00 a.m. Pacific Time
- If you are experiencing technical difficulties, email sarah@allianceforhope.com
- To LISTEN to the presentation on your phone, dial +1 (631) 992-3221
- Access Code: 331-153-655 or listen on your computer speakers
- Attendees will be muted throughout the presentation
- To send questions to the presenter during presentation:
  - Click on "Questions" in the toolbar (top right corner)
  - Type your comments & send to presenter
- There will be a Q & A session at the end of the presentation.
- The presentation will be recorded & posted on www.strangulationtraininginstitute.com
- Please complete the evaluation at the end of the presentation. We value your input.

Pediatric Strangulation, Part 1

Hosted by Gael Strack, Esq and Bill Smock, MD with panelists Cathy Baldwin Johnson, MD; Diana Faugno, RN; Val Sievers, RN, and Katie Snyder, MD

Your Hosts:

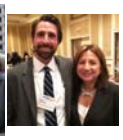
Gael Strack, Esq
CEO
Alliance for HOPE International

Bill Smock, MD
Police Surgeon
Louisville Metro Police Department

In Memory of Casondra Stewart and Tamara Smith

Office on Violence Against Women

- Nadine Neufville, Acting Director
- Kevin Sweeney, Program Manager



Thank you for making this training possible!

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Training Institute on Strangulation Prevention

- Project of Alliance for HOPE International
- Launched October 2011 by USDOJ, Office on Violence Against Women
- Most comprehensive training program in the U.S.
- Fee-based Training for All Professionals

With Special Thanks & Admiration to National Advisory Board - 2012 & 2016

- A national group of experts & faculty assist the Alliance in the development of courses, materials, provide technical assistance and participate in training.
- Board members consist of physicians, nurses, prosecutors, defense attorneys, civil attorneys, law enforcement, advocates, probation and judges.

Our Goals

1. **Increase Awareness:** Raise awareness on the seriousness of strangulation crimes and enhance understanding on the dynamics of strangulation crimes.
2. **Improve Outcomes:** Improve & implement best practices and prevent future violence via education and training.
3. **Multiply Impacts:** Train Grantees and Improve Investigation and Documentation to Improve Number of Cases Prosecuted.

The Alliance Team

strangulationtraininginstitute.com

Next Advanced Strangulation Course October 24-27 in Ft. Worth, Texas

Gael Strack, Esq. CEO and Co-Founder

- Institute is excited to host another webinar on children.
- Important topic and time to expand our focus
- Pediatric Committee has worked hard for almost a year
- Today they will be sharing current research, case studies, findings and recommendations.
- San Diego Study didn't include children, but we equally found too many child abuse cases involving strangulation that were mishandled.

Dr. Bill Smock, Police Surgeon Louisville, KY

- "Every victim of a crime has some sort of evidence on them. That's why staff is trained to recognize and preserve the evidence."
- "It's critical for the doctors and nurses that take care of these patients to recognize and preserve that evidence."
- http://www.emsworld.com/news/10339226/new-hospital-protocol-helps-protect-evidence

Panelists

Cathy Baldwin Johnson, MD
Medical Director,
Alaska CARES

Diana Faugno, MSN, RN
Forensic Nurse,
Barbara Sinatra Children's Center

Val Sievers, MSN, RN
Forensic Nurse,
Safe Passage Child Advocacy Center

Katie Snyder, MD, MPH
Child Abuse Pediatrician
at Denver Health Medical Center and Children's Hospital Colorado

Webinar Outline

- Underestimation & lack of research
- How kids are different
- Clinical presentation of pediatric strangulation
- Short & long term risks of strangulation in children
- Differential diagnosis
- Recommended medical evaluation of strangled children
- Introduction to documentation recommendations

Case:

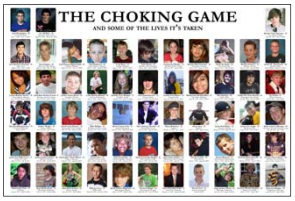
- Friday night
- 6 year old boy
- Neighbor called 911 due to hearing child screaming and crying, dad yelling, sound of hitting
- Patrol officer responded, noted child with facial petechiae, otherwise seemed fine
- Dad stated he spanked child
- Child left in home; report to CPS Monday

Pediatric Strangulation: Challenges

- More likely to be under-appreciated by law enforcement, medical providers, prosecutors, judges/juries
- More likely to be under-reported
- More likely to have delay in care
- More vulnerable to injury
- Less able to protect themselves
- Less likely to clearly articulate what happened – language development
- Even less research

Literature Review

- Can't take adult literature and apply across the board to children
- Most pediatric strangulation literature:
  - Accidental hangings (including choking game)
  - Suicidal hangings



Youth who have died as a result of playing the chocking game | Graphic courtesy of Mike Bleak, St. George News

Child Abuse Strangulation

- Strangulation victims <18 years of age occasionally mentioned in some articles
- 2 part article - strangulation injuries in children, none identified as due to assault
- Majority of articles related to inflicted pediatric strangulation are case reports
- Fatalities primarily due to:
  - Acute asphyxia
  - Carotid artery injury
  - Hypoxic ischemic encephalopathy
  - Cerebral infarction

Research on Cervical Artery Dissection in Children

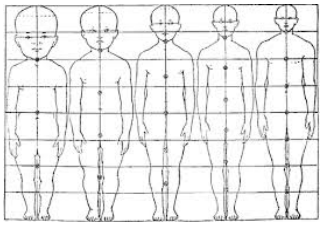
- 21 articles found – mostly case reports, 2 reviews
- Age range 1 month to 18 years
- Onset of symptoms minutes to months
- Etiologies reported:
  - Strangulation – one case report
  - Head/neck trauma (only one mentioned child abuse as potential cause)
  - "Vigorous physical activity" (including stretching the neck)
  - Underlying medical condition
  - "Spontaneous"
- Imaging used/recommended:
  - MRA/MRI
  - CTA

Vulnerability to Injury

Differences in anatomy, physiology, mechanisms

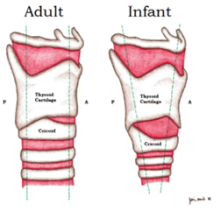
Airway

- Proportionately smaller nasal passages
- Proportionately larger tongue size
- Bigger head, weaker neck muscles: more susceptible to airway block from neck flexion

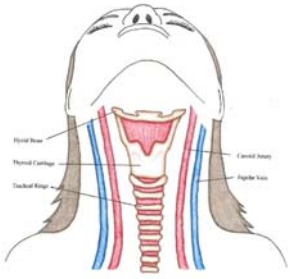


Airway

- Airway higher in neck & funnel shaped
- Epiglottis narrower, softer, more horizontal until age 4-5
- Cricoid cartilage smaller, forms complete ring around trachea
  - Mucosal edema will severely compromise airway



Pressures Required Likely Less



Adults:
- ~4# to occlude jugular
- ~11# to occlude carotid
- ~33# to occlude airway
- >/= 33# to fracture cartilage, bone

Other Differences:

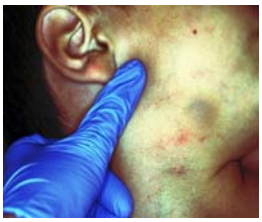
- Infants: much easier to obstruct airway
- Cartilage less calcified: less likely to find fractures
- May be at greater risk of:
  - Pulmonary complications
  - Cerebral edema (especially late)
  - Severe hypoxic-ischemic encephalopathy

Mechanism May be Different

- May be manual, choke hold, ligature HOWEVER:
  - Easier to lift children off the ground:
    - By neck
    - By clothing
- Female caregivers as perpetrators
- Motivation may be different

Case: 6 year old boy

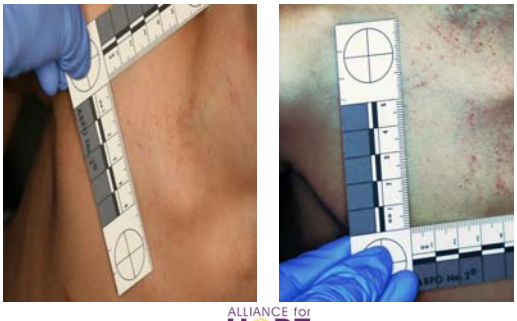
- Child reports to school and the teacher notes bruises on his face that were not there yesterday. She asks the child what happened?
- "My dad grabbed me by the shirt last night."
- She reports to Child Protective Services and the Police are notified
- The next day the child is brought in for an examine to the Child Advocacy Center per detective who has been assigned the case regarding bruising to his face



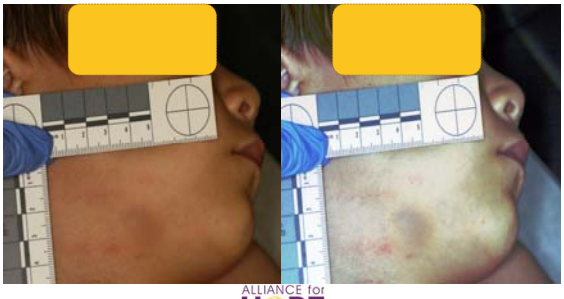
6 yr. old male. "My dad grabs me by shirt when I am not a good boy."

Multiple bruises and abrasions on neck and upper chest

Right upper chest and neck



Bruises to jaw line with negative filter



Eyes are clear

Outcome

- Mother and father charged
- Both are now serving time
- Child is living with grandparent and very happy

How Kids Present

Clinical Presentation

- Children may present for care days to weeks after strangulation
  - Challenge then is what needs to be done for them
- Clinical spectrum may range from mild self-limiting symptoms to severe neurologic sequelae or death
- Some symptoms in adults may not be as helpful in young children (i.e. incontinence)
- Up to 50% of children will not have clinically apparent signs of strangulation (similar to adults)
- Children may describe symptoms in ways different than adult but that are developmentally appropriate

Typical Symptoms Reported by Children:

- Voice changes
- Sore throat or neck pain
- Difficulty breathing
- Problems swallowing
- Dizziness
- Loss or near loss of consciousness
- Older children: urinary and/or fecal incontinence

Other ways Children may Present:

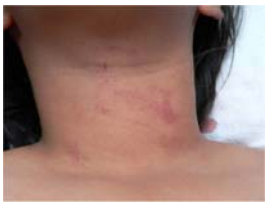
- Hypoxic brain injury resulting in:
  - Seizures or altered level of consciousness
  - Altered mental status including agitation or confusion
  - Respiratory depression
- Respiratory distress due to:
  - Acute lung injury
  - Aspiration
- Ischemic stroke symptoms from carotid occlusion or dissection

Physical Findings

- Children may present due to physical findings noted by:
  - Teachers
  - Daycare providers
  - Neighbors
  - Family members
- Report then made to child protection and/or law enforcement

Case: 7 year old girl

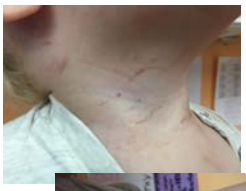
Teacher noted marks on face. Disclosed strangulation assault by mother's boyfriend night before for not doing chores. No symptoms.



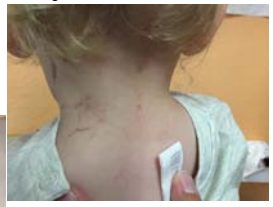
Physical Findings Reported in Children:

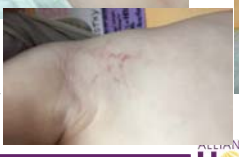
- Petechiae of face, neck, conjunctivae
- Bruising of neck
  - May be patterned from fingers, thumb, ligatures, clothing
- Swelling in neck, face
- Defensive scratch marks on neck
- Abrasions or patterned injury from jewelry worn by child or assailant
- Injuries elsewhere on child's body

Case: 2 year old



Marks noted by daycare worker. Child unable to be interviewed. Imprints from clothing.





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Short & Long Term Risks

Neck Injuries

- Case series with imaging:
  - Up to 25% pediatric strangulation deaths had fractures of bony & cartilaginous structures in neck
  - Including thyroid cartilage & hyoid bone
- Other studies found bone/cartilage injuries less common in children than adults
- Soft tissue edema in neck more common in children

Severe Delayed Effects of Strangulation Reported in Children:

- Vocal cord paralysis
- Hypoxic-ischemic encephalopathy
- Cerebral edema
- Cerebral infarction
- Aspiration pneumonia
- Behavioral changes
- Cognitive deficits
- Injury to the carotid artery
- Thyroid storm reported as life-threatening complication in adults

Severe Delayed Effects

- Death
  - Most due to cerebral asphyxia from carotid occlusion
  - Early & delayed deaths due to carotid hematomas, cerebral infarction
  - Possible role of cardiac dysrhythmias

Poor Prognostic Signs

- Coma
- Seizures
- Need for ventilator support
- Elevated intracranial pressure
- Diabetes insipidus
- Blood sugar >300 on admission

Differential Diagnosis

Choking Game

- Activity in which persons strangle themselves or others to achieve euphoria through brief hypoxia
- Majority of deaths in boys; mean age 13.3, youngest age 6

Accidental

- Infants and young children are especially vulnerable
- Entanglement in furniture, ropes/cords, clothing, playground equipment
- Careful history, scene investigation, re-enactment critical

Differential Diagnosis

Suicide

- May be challenging to distinguish strangulation suicide from the “choking game” or auto-erotic asphyxiation
  - Age distribution older
- Careful history, scene investigation critical

Medical

- Facial and conjunctival petechiae from significant Valsalva maneuvers
- Underlying bleeding diathesis
- Thorough medical evaluation critical

Recommended Medical Evaluation of Strangled Children

Location of Evaluation

- May depend on:
  - Where child presents
  - Medical stability of child
  - Medical provider availability
  - Resources available in community
  - Jurisdictional requirements
  - Availability of Child Advocacy Center
- Where available, consider use of CAC

Gathering Information

Forensic Interview	Medical History
• Structured conversation with child • Obtains information to assist in criminal investigation • Assesses safety of child's home • Helps assess needs for medical evaluation (including diagnostic testing) and treatment	• Information from child, parent, medical records, other sources • Includes past medical history, family medical history, review of systems • Assesses need for diagnostic and forensic testing as well as treatment • Assesses for alternative explanations for symptoms and exam findings

Medical History

- Situation in which strangulation occurred
- Method of strangulation
- Symptoms the child experienced during and after strangulation
- Current symptoms
- Time elapsed between strangulation episode and presentation to care
- Presence or absence of witnesses
- Presence of any medical conditions that might predispose child to petechiae
- Child's developmental level

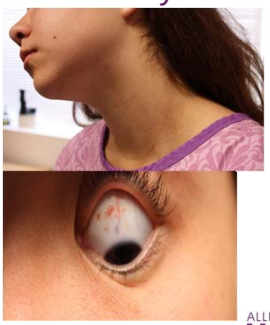
Medical History, continued

- Description of symptoms may be very different than an adult but developmentally appropriate
  - "I talked like a duck"
  - "I saw sparkles in my eyes"
  - "I fell asleep"
- Some children may be able to articulate that they thought they were going to die

Not Just One Bad Thing

- Always consider (and look for) concurrent additional types of child abuse:
  - Sexual abuse/assault
  - Abusive head trauma
  - Other forms of physical abuse

Case: 14 year old



- Sexually assaulted by adult male acquaintance of her older sister

Physical Exam

- Complete head to toe exam with specific attention to:
- Vitals including pulse oximetry
- Complete survey of all skin surfaces:
  - Petechiae
  - Bruising
  - Bites
  - Redness
  - Tenderness
  - Patterned marks (from ligatures, fingers, clothing, etc)

Physical Exam, continued

- Assessment for intraoral injury
  - Frenular tears
  - Petechiae
  - Bruising
  - Tongue injuries
- Serial measurements of neck circumference
  - Every 10-12 hours
  - In same marked spot each time
- Assessment for respiratory distress, stridor, difficulty swallowing or speaking, voice changes, cough, hemoptysis

Physical Exam, continued

- Eye exam for petechiae, conjunctival hemorrhage
  - Consideration for dilated retinal exam
- External exam of anal-genital area
- Neurologic exam including:
  - Age appropriate mental status assessment
  - Presence of irritability or lethargy
  - Behavioral changes
  - Seizures
  - Localizing findings

Forensic Evidence in Pediatric Strangulation

- If applicable (depending on time elapsed, interim hygiene activities, other forms of abuse):
- Collect debris or foreign material
- Swab child's neck for possible assailant epithelial cells left on skin
- Additional forensic evidence collection as indicated
  - For example: strangulation occurred during sexual abuse or sexual assault

Next Steps

- Consider admission for minimum 12-24 hours of observation if:
  - History of loss of consciousness or other neurologic signs or symptoms
  - Facial/conjunctival petechiae, hemorrhage
  - Soft tissue injury to neck
  - Incontinence (if age appropriate concern)
  - Voice changes
  - Respiratory distress
  - Indicated by other injuries
  - Or if you are not sure the child is going home to a safe place

Next Steps, continued

- Consider ENT consult/laryngoscopy
  - Unilateral vocal cord paralysis may go unrecognized clinically
    - But risk of aspiration, recurrent pulmonary infection
  - Soft tissue edema more likely to cause airway obstruction

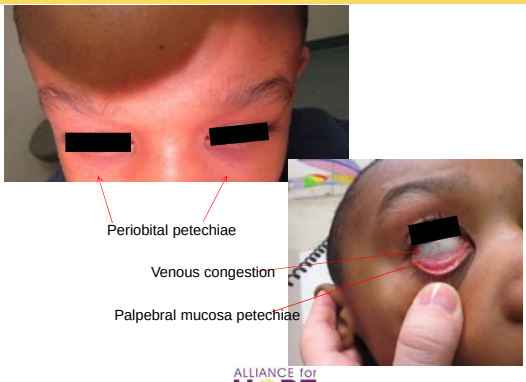
Imaging Recommendations

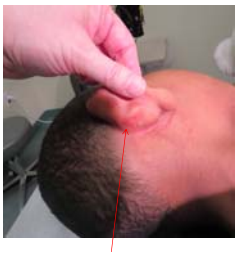
Case: 7 year old boy

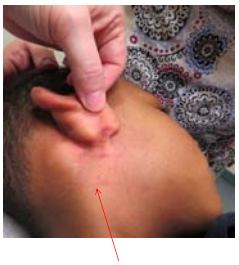
- Presented to outpatient child abuse pediatrics clinic at request of police for concerns of physical abuse
- Presented a couple of days after the alleged incident
- Father made patient take off his pants (not underwear) and hit him on the buttocks with a belt
- Father squeezed patient's face (?neck) with his knees
- One hand on anterior neck without posterior compression and picked patient up off the ground and against a wall
- Patient said "My feet were dangling and it felt like I was flying."

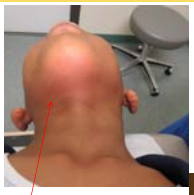
7 year old boy, continued

- Shortness of breath
- Difficulty speaking and when he did speak it was rough sounding
  - When explaining this, patient spontaneously put his own hand on his throat and talked with a rough sounding voice saying "I could talk a little bit but my voice sounded weird like this."
- Patient was "scared" and had anterior neck pain
- No vision changes, urination, defecation
- LOC is unclear
- In the past week, no vomiting, coughing with post-tussive emesis or wretching, no URI sxs, no MVAs
- When asked about coughing patient said, "I want to cough until I pass out and not wake up." -Passive suicidality



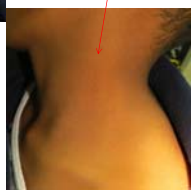


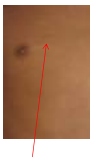




Multiple petechial hemorrhages

Lateral neck bruising

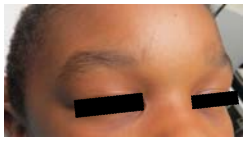


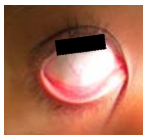


Chest bruising

7 year old boy, continued

- Also had palatal, forehead and ear petechiae, bruising on shoulders
- CTA normal
- Followed up 1 month later



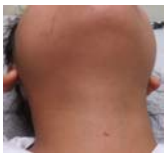


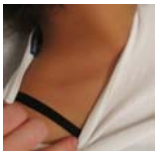
Case: 14 year old girl

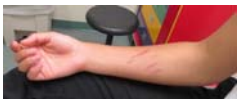
- Police asked patient to come to outpatient child abuse pediatrics clinic for evaluation of concerns of physical abuse
- Grandmother (guardian) upset at patient and patient ran away
- Grandmother and adult cousin to patient found patient
- Cousin grabbed patient by the hair and punched her in the face and hitting patient's head into the concrete
- Grandmother grabbed patient by the hair

14 year old girl, continued

- Grandmother sat patient's abdomen and put forearm on patient's neck
- Difficulty breathing, panic, vision changes (darkness (tunnel vision)), headache, extreme dizziness.
- No auditory changes, defecation, urination
- LOC unclear
- Post assault, had headaches, dizziness, thick feeling throat; no other post-assault symptoms with breathing or swallowing
- Police were unaware of the strangulation portion of events until she was medically evaluated





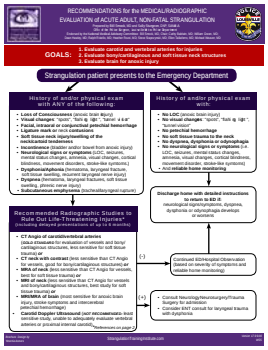


14 year old girl, continued

- CTA never completed, though was ordered

Imaging Guidelines

- No current guidance on imaging modalities/recommendations in the pediatric population
- Adult literature:
  - CT angiogram for carotid/vertebral arteries is gold standard to evaluate vessels, bony/cartilaginous structures; not as sensitive for soft tissue trauma



Pediatric Expert consensus coming soon…

Imaging Guidelines

- Other studies:
  - CT of the neck with contrast
    - Less sensitive for vasculature injury
  - MRA of the neck
    - Less sensitive for vascular injury
    - Best for soft tissue neck trauma
  - MRI of the neck
    - Less sensitive for vasculature and bony/cartilaginous injury
    - Best for soft tissue neck trauma
  - MRI/MRA of the brain
    - Best for anoxic brain injury, stroke symptoms and intracerebral petechial hemorrhage
  - Carotid doppler ultrasound
    - Don't do this; limited study and not sensitive

Additional Diagnostic Studies to Consider:

- Skeletal survey in children <2-3 years of age, with consideration for children up to age 5
- EEG if concerns for abusive head trauma, hypoxic-ischemic encephalopathy

Imaging Guidelines

- Need to establish appropriate imaging management for pediatric population
- Limited studies exist as to possible long term outcomes, though we know some

Imaging Guidelines

- What are we doing?
  - Created a Survey Monkey to send to medical professionals who may interface with these patients to see what the current practice is

https://www.surveymonkey.com/r/PediatricStrangulation

  - Based on this, recommendations for imaging in the pediatric population will be created and disseminated
  - Through future research, these guideline will hopefully be refined

Poll Question #1

- Imaging study most likely ordered in your area for child with visible injuries, signs, or symptoms of strangulation?

A. CT angiography
B. MR angiography
C. MRI brain and neck
D. C-spine x-rays
E. No imaging

Poll Question #2

- Imaging study most likely ordered in your area for child with strangulation history but NO visible injuries, signs or symptoms?

A. CT angiography
B. MR angiography
C. MRI brain and neck
D. C-spine x-rays
E. No imaging

Documentation

- Standardized documentation with traumagrams
- Photography
- Voice recorder if indicated

Clinical Documentation

PhotoDocumentation

Follow Up

- Discharge instructions
- Follow up exam within 24 hours if not admitted
- Mandatory reporting


PEDIATRIC STRANGULATION DISCHARGE INSTRUCTIONS

Discuss your child has reported being "choked" or strangled, we are providing you with the following instructions:

Consider a small ice pack to the neck area for relief of pain.
Offer popsicles or other fluids that are cooling to the throat. Kids like this.
Make sure someone is with your child for the next 24-48 hours.

Please report to the nearest ER or call 911 immediately if you notice the following symptoms or changes in your child:

- Difficulty breathing or shortness of breath
- Loss of consciousness or "passing out"
- Changes in your child's voice or difficulty speaking
- Difficulty swallowing, lump in throat, or muscle spasms in throat or neck
- Tongue swelling and/or drooling
- Swelling to throat or neck, new, worsening or persisting throat pain ("My throat still hurts")
- Prolonged nose bleed (greater than ten minutes)
- Continues to cough or coughing up blood
- Continues to vomit or vomiting up blood
- Left or right sided weakness, numbness, or tingling (child cannot use arm or leg)
- New or Worsening headache
- Seizures (Abnormal, rhythmic or shaking movements)
- Behavioral changes or memory loss
- Thoughts of harming self or others or ("I do not want to live") ("I am going to hurt him")

It is important that the above symptoms be evaluated by a physician.

After your child's evaluation, keep a list of any changes or symptoms for your child's physician and law enforcement.

If symptoms worsen, report to your child's physician or nearest ER. You should follow-up with law enforcement regarding documentation of any and all information about your child's symptoms.

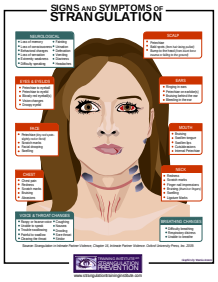
It is important that you have a follow-up medical screening in 1-2 weeks at the clinic or with your child's physician. Make sure to bring these discharge instructions with you.

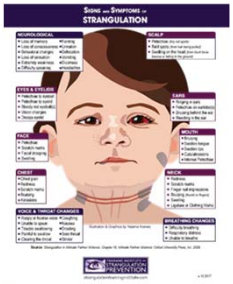
If you misplace these instructions call _____ or your provider for a copy.

I have been made aware of and understand the importance of following the above outlined instructions.

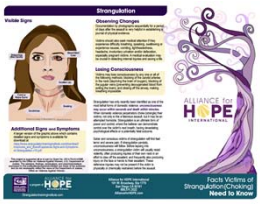
Patient/Parent Signature | Provider Signature | Date

Signs & Symptoms

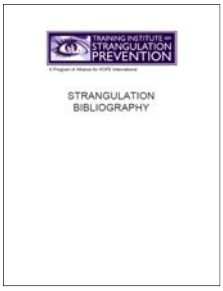


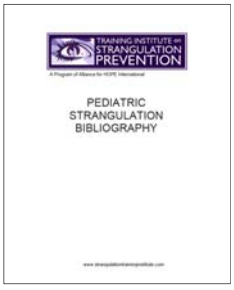


Victim Brochure



References





Coming in February

- **Webinar Part 2, February 22, 2018**
  - Review of the Pediatric strangulation non-acute documentation form
  - Review of the Pediatric photography protocol
  - Case reviews
  - Pediatric Discharge instruction discussion and review
  - Expert Consensus for imaging

Questions?

Save the Date!

Advanced Course on Strangulation Prevention
February 6-9, 2018 in San Diego, CA

It's easy to join our mailing list!

Just send your email address by text message:

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HOPEGIVER

To 22828 to get started.

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How to Reach Us

www.allianceforhope.com
www.strangulationtraininginsitute.com

For general information on the Training Institute, information about this webinar, or if you are interested in having a strangulation training to your community, please contact:

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tisp@allianceforhope.com

Training Request form:
https://www.strangulationtraininginstitute.com/training/request-training/

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Diana Faugno MSN, RN, CPN, SANE-A, SANE-P, FAAFS, DF-IAFN

A native of Minnesota, Diana Faugno graduated with a Bachelor of Science in Nursing from the University of North Dakota and a Master of Science in Nursing from the University of Phoenix. Ms. Faugno is a Founding Director for End Violence Against Women International (EVAWI) and currently serves on the board as Treasurer. She is a member of the Board of Directors for the California American Professional Society on the Abuse of Children.She is a fellow in the American Academy of Forensic Science and a Distinguished Fellow in the International Association of Forensic Nurses. Ms. Faugno provides educational trainings both nationally and internationally. Her trainings serve to assist in team and staff development, are based on peer-reviewed currriculums and published educational standards, and represent a variety of topics relating to sexual assault and domestic violence across the life span. She currently is the nurse examiner at the Barbara Sinatra Childrens Center and a nurse examiner for Eisenhower Medical Center′s SART team. Ms. Faugno co-authored the Color Atlas of Sexual Assault through Mosby Publications in 1997 which was the first book of its kind in the nation. She is also co-author of Sexual Assault across the Life Span in 2003 and the second edition in 2016, Adolescent and Adult Sexual Assault Assessment Learning Series workbooks in 2012, and numerous other publications.

Valerie A. Sievers MSN, RN, CNS, SANE-A, SANE-P
saneval@wildblue.net
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Education:

Master of Science in Nursing, 1999 Beth El College of Nursing & Health Sciences at the University of Colorado @ Colorado Springs, Colorado

Bachelor of Science in Nursing, 1994 Summa Cum Laude
Regis University, Denver, Colorado

Associate of Science in Nursing, 1976
North Central Technical College, Wausau, Wisconsin

Professional Experience:

UCCS-Beth-El College of Nursing & Health Sciences **2005-2016**
Educator/Lecturer for forensic nursing & nursing education,
Retired senior instructor and faculty 2016-present
Coordinator Forensic Nursing & Correctional Health Education 2013-2016
Forensic Clinical Nurse Specialist, SANE Project Director 2004-2012
Sexual Assault Nurse Examiner Project for the state of Colorado
Undergraduate & Graduate Faculty

Memorial Health System, Colorado Springs, Colorado **2004-2008**
Forensic Clinical Nurse Specialist, Sexual Assault Nurse Examiner/
Forensic Nurse Examiner, SANE Program Coordinator/Manager

Colorado Coalition Against Sexual Assault, Denver, Colorado **1997-2004**
Clinical Forensic Nurse Specialist, SANE Coordinator-Project Director
Sexual Assault Nurse Examiner Program for the state of Colorado

Safe Passage formerly the Children's Advocacy Center of the Pike's Peak Region **1996-present**
Sexual Assault Nurse Examiner/Forensic Nurse Examiner

Penrose-St. Francis Healthcare System Flight for Life **1994-1996**
Flight Nurse, Helicopter/Fixed wing transport

Memorial Hospital, Colorado Springs, Colorado **1983-2009**
Sexual Assault Nurse Examiner 1995-2009
Clinical Nurse, Emergency Department 1985-2000
Paramedic Educator & Associate Emergency Medical Services
Field Coordinator 1989-1991

Clinical Nurse, Intermediate Care 1984-1985

Clinical Nurse, Critical Care Pool 1983-1984

Medical Personnel Pool, Colorado Springs, Colorado **1982-1983**
Contract staffing in critical care units in various Colorado Springs hospitals

St. Luke's Hospital, Milwaukee, Wisconsin **1976 -1981**
Clinical Nurse/Charge Nurse, Surgical, Neuro, Trauma Intensive Care 1977-1981
Clinical Nurse, Intermediate Cardiac Care**,** Telemetry 1976-1977

Publications:

Joyce, B., Peterson, K., **Sievers, V**. and Hoener, V. (2015). Relationship between parental acceptance and rejection, documented health status and life time experiences of violence among incarcerated women. International Journal of Nursing & Clinical Practices, 148 (2), 1-7.

Joyce, B., Hoener, V., Peterson, K. and **Sievers, V**. (2014). Parental acceptance and rejection in women's prison settings: A review of the literature. Interpersonal Acceptance, 9 (1), 11-16.

Joyce, B., Najera-Aguirre, S., Brown, N. and **Sievers, V.** (2014) The impact of violence on nursing students in Mexico: A lived experience. The International Journal of Health, Wellness & Society, 3 (3), 57-65.

Sievers, V. and Lechner, M., (2009) Forensic Nursing: Evolving practice in response to the epidemic of violence. Colorado Nurse, 109 (2), 11-12.

Glittenberg, J., Lynch, V., and **Sievers, V**., (2007) Forensic Nursing: A healthcare response to the epidemic of violence. Colorado Nurse, 107 (1), 1-5.

Sievers, V., Murphy, S. and Miller, J. (2003). Sexual assault evidence collection more accurate when completed by sexual assault nurse examiners: Colorado's experience. Journal of Emergency Nursing, 29 (6), 511-514.

Sievers, V. and Stinson, S. (2002). Excellence in forensic practice: A clinical ladder model for recruiting and retaining sexual assault nurse examiners. Journal of Emergency Nursing, 28 (2), 172-175.

Colorado Coalition Against Sexual Assault & Colorado Bureau of Investigation (2000). Colorado evidence collection protocol. Denver, Colorado: (Editor, contributing author).

Invited Presentations:

October 1, 2016: International Association of Forensic Nurses: Denver, CO: "Are We Teaching Evidence Based, Competency Driven Forensic Nursing?"

October 1, 2016: International Association of Forensic Nurses: Denver, CO: Preventing Dating Violence with Bystander Education: Implications for Forensic Nurses.

September 29, 2016: International Association of Forensic Nurses: Denver, CO: "OSCARs, Out-Standing Collections of Abuse Related Studies"

July 15, 2016: Nurse Educator Conference: Breckenridge, CO: "Are We Teaching Evidence Based Forensic Nursing?"

October 28, 2015: International Association of Forensic Nurses: Orlando, FL: "Are We Teaching Evidence Based Forensic Nursing?"

May 3, 2013: Centura Trauma Symposium: Colorado Springs, CO: "Forensic Nursing: A Healthcare Response to the Epidemic of Violence."

January 24, 2012: Rady Children's Hospital International Conference on Child Maltreatment: San Diego, CA: "Implementation of a Model for Statewide SANE PEER Review"

September 30, 2011: Southern Colorado Chapter of the American Association of Critical Care Nurses Forensic Conference: Colorado Springs, CO: "Forensic Nursing: A Response to the Epidemic of Violence."

June 24, 2011: 38th Annual Rocky Mountain Trauma & Emergency Medicine Conference: Breckenridge, CO: "Improving the Response to Violence: A Forensic Nurse Examiner Team in the ED"

July 15, 2010: Colorado VAWA Prosecutors Training, Colorado Springs, CO "Staying SANE: Utilizing the Medical Expert in court"

July 14, 2010: International Association of Forensic Nurses (IAFN); live webinar "Forensic Nursing Process"

December 9, 2008: Colorado Regional Conference on Domestic Violence: Denver, CO: "The Role of the Domestic Violence Nurse Examiner"

September 23, 2008: Colorado District Attorney Council Conference: Keystone, CO: "Staying SANE in Court…utilizing the medical-forensic expert for effective prosecution."

May 14th, 2008: OVC SANE Coordinator Regional Meeting: St. Louis, MO: Military Partnerships & Forensic Healthcare Services

March 30, 2007: The Society of Adolescent Medicine Annual Meeting: Denver, CO: "Adolescent Sexual Assault; What Can I Do in My Office?"

September 28, 2006: American Prosecutor Research Institute: Denver, CO: "Understanding &

Effectively Using Medical Evidence."

November 19, 2004: Colorado County Attorneys Statewide Conference: Colorado Springs, CO: "Evidence Collection, Injury Evaluation & the Role of the Forensic Nurse Examiner."

October 19, 2004: International Association of Forensic Nurses Scientific Assembly, Chicago "Improving our Pediatric SANE Practice II"

March 30, 2004: SANE Leadership Conference-Jackson, MS: "The Future of Forensic Nursing."

March 30, 2004: SANE Leadership Conference-Jackson, MS "Growing Beyond Beginning-Excellence in Forensic Practice."

September 26, 2003: International Association of Forensic Nurses Scientific Assembly, Las Vegas, NV. "Another Look at the Efficacy of SANE Evidence Collection."

September 24, 2003: International Association of Forensic Nurses Scientific Assembly, Las Vegas, NV. "Improving our Pediatric SANE Practice."

August 22, 2003: Colorado Association of Sex Crimes Investigators, Snowmass, CO: "Evidence Collection, Injury Evaluation & the Role of the Forensic Nurse Examiner."

November 11, 2002: Colorado Organization for Victim Assistance, Annual Conference Keystone, CO: "A Blueprint for Community Development of a SANE Program."

September 29, 2001-International Association of Forensic Nurses Scientific Assembly, Orlando, FL: "Excellence in Forensic practice: A model for recruiting and retaining forensic nurse examiners based on Benner's novice to expert framework."

August 1-2, 2000-Colorado Emergency Medicine & Trauma Conference, Steamboat, CO: "Violence across the Lifespan" and "Evidence Collection in Victims of Violence."

May 17, 2000-National Sexual Violence Prevention Conference Dallas, TX:"A Healthcare Response to the Epidemic of Violence, Forensic Nursing."

July 31-August 1, 1999- Colorado Emergency Medicine & Trauma Conference, Breckinridge, CO: "An Introduction to Forensic Nursing" & "A Forensic First Response to Violence."

July 21, 1998-National Coalition Against Domestic Violence, Denver, CO: "A SANE Approach; the Colorado model of care for sexual assault survivors."

April 30, 1998- Colorado Department of Public Health & Environment, Annual Safety & Prevention Conference, Breckenridge, CO: "Sexual assault, Pre-hospital care & forensic evidence collection."

Courses Taught:

The Evaluation and Management of the Adult/Adolescent Sexual Assault Patient
The Evaluation and Management of the Pediatric Sexual Assault Patient
Sexual Assault: Implications for Professional Practice
Sexual Assault, Abuse & Exploitation
Practice Paradigms in Forensic Nursing
Advanced Forensic Nurse Examiner
Emergency Nursing
Professional Nursing Practice

Recognitions:

2004 Nightingale Award Nominee
2005 Distinguished Alumni Award, Beth-El College of Nursing and Health Science
2006 Nightingale Award Nominee
2007 IAFN Service Award
2013 Certificate of Commendation, 4th Judicial District, Office of the District Attorney

Professional Organizations:

American Nurses Association
American Professional Society on the Abuse of Children
Academy on Violence & Abuse
Colorado Nurses Association
Emergency Nurses Association
International Association of Forensic Nurses
Sigma Theta Tau

William S. Smock, MD, MS, FACEP, FAAEM

Louisville Metro Police Department
The Clinical Forensic Medical Program
Director and Police Surgeon
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400 South First Street
Louisville, KY 40202

Dr. Bill Smock is the Police Surgeon and directs the Clinical Forensic Medicine Program for the Louisville Metro Police Department. He graduated from Centre College in Danville, Kentucky in 1981 and obtained a Master's degree in Anatomy from the University of Louisville in 1987. Bill graduated from the University of Louisville, School of Medicine in 1990 and completed a residency in emergency medicine at the University of Louisville in 1993.

In 1994 he became the first physician in the United States to complete a post-graduate fellowship in Clinical Forensic Medicine. Dr. Smock was an Assistant Medical Examiner with the Kentucky Medical Examiner's Office from 1991 to 1997. Bill joined the faculty at University of Louisville's Department of Emergency Medicine in 1994 and was promoted to the rank of full professor in 2005. Dr. Smock is currently a Clinical Professor of Emergency Medicine at the University of Louisville, School of Medicine and regularly takes medical students on mission trips to Africa.

Bill has edited 3 textbooks on clinical forensic medicine and published more than 30 chapters and articles on forensic and emergency medicine. He is an internationally recognized forensic expert and trains nurses, physicians, law enforcement officers and attorneys in multiple fields including: officer-involved shootings, strangulation, gunshot wounds, injury mechanisms and motor vehicle trauma. Dr. Smock is also the Police Surgeon for the Jeffersontown, Kentucky and St. Matthews, Kentucky Police Departments. He also serves as a sworn tactical physician and detective for the Floyd County Indiana Sheriff's Department.

Katherine Snyder, MD, MPH, FAAP

Katherine is a Child Abuse Pediatrician at Denver Health Medical Center and Children's Hospital Colorado. She completed her undergraduate studies at Virginia Tech. Katherine obtained her medical degree and her masters in public health at West Virginia University School of Medicine followed by completing her residency and chief residency in pediatrics at the University of Louisville. Since completing her fellowship in Child Abuse Pediatrics at Hasbro Children's Hospital/Brown University, she has worked in Denver. Katherine has given presentations at the local, regional and national level in the field of Child Abuse Pediatrics, is currently serving as a governor appointee on the Colorado Child Fatality Prevention System and is currently serving on several national committees. Katherine's research interests are focused on education and she is board certified in both general pediatrics and child abuse pediatrics.

Gael Strack, Esq.

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Gael B. Strack is the Chief Executive Officer and Co-Founder for Alliance for HOPE International. Programs of the Alliance include: National Family Justice Center Alliance, Training Institute on Strangulation Prevention, Camp HOPE America, Justice Legal Network and VOICES Survivor Network.

- The National Family Justice Center Alliance provides consulting to over 150 existing and pending Family Justice Centers across the world, helping communities open and sustain their Family Justice Center. www.familyjusticecenter.org
- The Training Institute on Strangulation Prevention provides basic and advanced training on strangulation prevention to 5,000 professionals annually. www.strangulationtraininginstitue.com.
- The Justice Legal Network is an innovative public interest law firm made up solo attorneys who have pledged to work with the Alliance in providing civil legal services to victims and their children.
- Camp HOPE America, under the leadership of Casey Gwinn, provides summer camping, mentoring, hope and healing to children exposed to violence.
- The VOICES Survivor Network is comprised of survivors who volunteer their time to provide awareness, education, outreach and feedback to their local Family Justice Center.

Prior to launching the Alliance for Hope with Casey Gwinn, Gael served as the Founding Director of the San Diego Family Justice Center from October 2002 through May 2007. In that capacity, she worked closely with 25 on-site agencies (government and non-profit) who came together in 2002 to provide services to victims of domestic violence and their children from one location. The San Diego Family Justice Center was featured on Oprah in January 2003, recognized as a model program by President Bush and was the inspiration for the President's Family Justice Center Initiative launched in Oct 2003.

Prior to her work at the Family Justice Center, Gael was a prosecutor at the San Diego City Attorney's Office. She joined the office in 1987 and served in many capacities including Head Deputy City Attorney responsible for the Child Abuse and Domestic Violence Unit. Gael has also worked as a deputy public defender and a deputy county counsel for the San Diego County Counsel's office handling juvenile dependency matters. She graduated from Western State College of Law in December 1985.

Gael is a former board member of the California Partnership to End Domestic Violence, past President of the San Diego Domestic Violence Council and former commissioner of the ABA's Commission on Domestic Violence. In her spare time, Gael is an adjunct law professor for California Western School of Law teaching "Domestic Violence and the Law." Gael has been honored with numerous awards, including San Diego Attorney of the Year for 2006 and most recently by United States Attorney General Eric Holder as the 2010 Recipient of the National Crime Victim Service Award for Professional Innovation in Victim Services.

Gael has also co-authored a series of strangulation articles in the Journal of Emergency Medicine, the National College of District Attorney's Practical Prosecutor, and the Journal of the California Dental Association. Gael has co-authored five books with Casey Gwinn, JD, on the Family Justice Center movement including a Guide to Co-Located Services in the Middle East and in Mexico. Gael has also co-authored a book with Judi Adams, called "The Big Girls Club – Little Girl Rules for the Big Girl Workplace" which describes the ten rules of friendship that can help women thrive and succeed in the changing workplace.

Certificate of Attendance

Webinar Training:
Pediatric Strangulation, Part 1
Presented by Gael Strack, JD; Bill Smock, MD; Cathy Baldwin Johnson, MD; Diana Faugno, RN;
Val Sievers, RN, Katie Snyder, MD

October 10, 2017
1.5 Training Hours

Gael Strack

Co-Founder and CEO
Alliance for HOPE International
Director, Training Institute on Strangulation Prevention