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

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Pediatric Strangulation Part 2 Webinar Course Description

This webinar will continue where we left off with Pediatric Strangulation I. In Pediatric Strangulation Part I, our panelists covered: 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 and provided an introduction to documentation recommendations. In Pediatric Strangulation Part II, our panelists will provide a brief summary from Pediatric Strangulation Part I; discuss the non-acute documentation forms in more detail; share and demonstrate the photography protocol and discharge instructions; provide an in-depth case study of a pediatric patient and leave plenty of time for questions and answers with our panelists.

Please watch **Part 1 here.**

Objectives

1. Provide a brief summary from the Pediatric Strangulation Part I and an update.
2. Discuss clinical tools and resources available for evaluation of the patient who has been strangled.
3. Demonstrate the photography protocol
4. Provide an in-depth case study that includes a history of multiple episodes of strangulation in a pediatric patient.
5. Leave plenty of time for questions and answers with our panelists.

Hosts

Gael Strack, JD
Bill Smock, MD

Panelists

Cathy Baldwin Johnson, MD
Diana Faugno, MSN, RN
Val Sievers, MSN, RN
Jennifer Green, RN, BSN, BA

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 (415) 930-5321
- Access Code: 338-291-359 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 our New Resource Library: https://www.familyjusticecenter.org/resources
- Please complete the evaluation at the end of the presentation. We value your input.

Pediatric Strangulation, Part 2

Hosted by Gael Strack, Esq and Bill Smock, MD with panelists Cathy Baldwin Johnson, MD; Diana Faugno, MSN, RN; Val Sievers, MSN, RN; and Jennifer Green, RN, BSN, BA

Your Hosts:

Gael Strack, Esq
CEO
Alliance for HOPE International

Bill Smock, MD
Police Surgeon
Louisville Metro Police Department

Office on Violence Against Women

- Katie Sullivan, Principal Deputy Director
- Kevin Sweeney, Program Manager

Thank you for making this training possible!

This project is supported all or in part by Grant No. 2016-TA-AX-K067 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

The Alliance Team

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

Jennifer Green, RN, BSN, BA
Clinical Forensic Care Program Manager
Saint Luke's Health System

Webinar Outline

- Welcome and Introductions
- Brief summary from the Pediatric Strangulation Part I webinar
- Discuss clinical tools and resources available for evaluation of the patient who has been strangled
- Discuss and demonstrate the photography protocol and discharge orders
- Provide an in-depth case study that includes a history of multiple episodes of strangulation in a pediatric patient.
- Time for questions and answers with our panelists

Summary of Part 1 Webinar

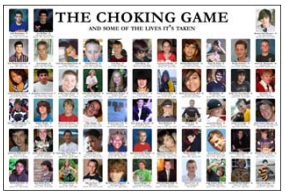
Dr. Cathy Baldwin Johnson and
Dr. Bill Smock

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
  - Case reports
- Majority of deaths/injuries:
  - Asphyxia
  - Cerebral infarction
  - Hypoxic-ischemic encephalopathy
  - Carotid artery injury less common



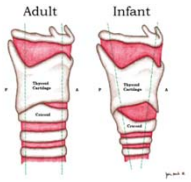
Youth who have died as a result of playing the chocking game | Graphic courtesy of Mike Bleak, St. George News

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

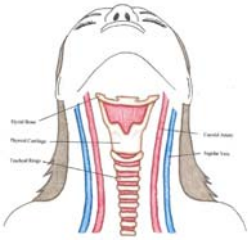
Children are different: Anatomy

- Bigger head
- Larger tongue
- Weaker neck
- Smaller nasal passages
- Narrower, softer epiglottis
- Smaller cricoid cartilage
- Funnel shaped airway located higher in neck



Children are different: Physiology

- Pressures required to occlude likely less
- Airway easier to obstruct
- May be at higher risk:
  - Pulmonary complications
  - Cerebral edema
  - Severe HIE



Children are different: Mechanism

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

Children are different: Presentation

- Delayed presentation common, without current signs/symptoms
  - Challenge then is what needs to be done for them
- Range: 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)
- May describe symptoms in ways different than adult but developmentally appropriate
- May present due to physical findings noted by adults

Children are different: Findings

- Bone/cartilage injuries may be less common
- Soft tissue edema in neck may be more common
- Hypoxic-ischemic encephalopathy
- Cerebral edema
- Cerebral infarction
- Vocal cord paralysis
- Behavioral changes & cognitive deficits

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
  - Family violence and dysfunction

Children are different: Differential

- “Choking Game”
- Accidental
- Suicide
- Medical condition (petechiae)

What imaging should be done?

- Not enough research yet
- TISP survey for current practices:
  - Poll during Part 1 Webinar (>300 participants)
  - Initial Survey Monkey (N=25)
- Another survey pending

Poll Results from Part 1

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

Poll Results (single answer required):

Poll Results from Part 1

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

Poll Results (single answer required):

Initial Survey Monkey

- 12% (3) have treated a pediatric patient w/o visible injuries who had a carotid or vertebral artery injury
- 88% use imaging in more acute setting
- Imaging studies acutely &/or with visible signs/sx: CTA (#1), MRA neck (#2)
- Non-acute, no signs/sx: 13/20 respondents said no studies or not indicated

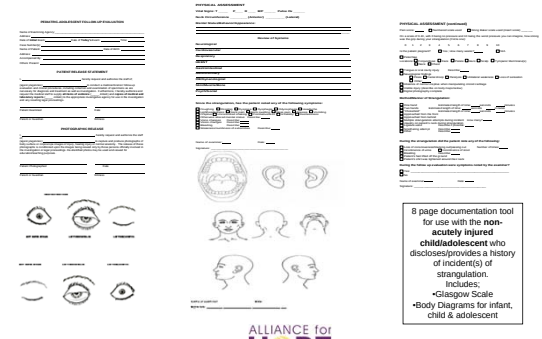
Tools for Evaluation, Documentation & Education

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

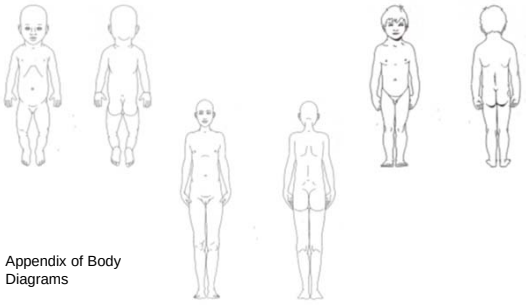
Tools for Evaluation, Documentation & Education

- PEDIATRIC-ADOLESCENT FOLLOW-UP EVALUATION (non-acute evaluation)
- STRANGULATION ASSESSMENT & FORENSIC EVALUATION TOOLKIT (SAFE-T kit)
- Pediatric NFS Facts Brochure
- NON-FATAL PEDIATRIC STRANGULATION PHOTOGRAPHY PROTOCOL
- PEDIATRIC STRANGULATION DISCHARGE INSTRUCTIONS

Pediatric-Adolescent Follow-up Evaluation



8 page documentation tool for use with the **non-acutely injured child/adolescent** who discloses/provides a history of incident(s) of strangulation.
Includes;
•Glasgow Scale
•Body Diagrams for infant, child & adolescent



Appendix of Body Diagrams

SDFI® Strangulation Assessment & Forensic Evaluation Toolkit SAFE-T

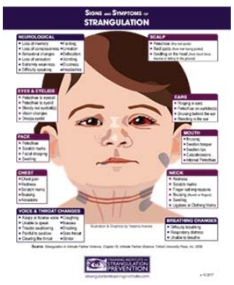
Intended for use by *healthcare professionals* who are providing care & evaluation of adults, adolescents and/or children following a strangulation event.

SDFI® Strangulation Assessment & Forensic Evaluation Toolkit SAFE-T

Supplies for assessment in acute & non acute strangulation:

- Documentation form access
- Surgical Marker
- Bookend Card(s)
- Forensic Hand Map(s),
- Measuring Scales
- Evidence Envelopes/Seals

Pediatric Brochures



Photography Protocol and Discharge Orders

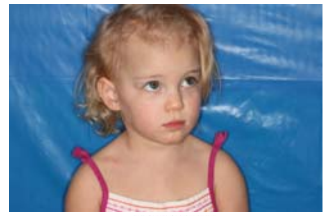
Diana Faugno, MSN, RN
Forensic Nurse,
Barbara Sinatra Children's Center

Pediatric Photography Protocol Non Fatal Strangulation

- Give procedural direction to health care providers who are examining children and adolescents who have been strangled acute or non acute
- Provides a standardized approach for documentation of injury or no injury
- Trauma informed care is covered in the protocol
- Reviewed by Distract attorney, forensic interview, MD's and forensic nurses

2 yr. Female Pediatric Photography Protocol Non Fatal Strangulation

https://www.familyjusticecenter.org/resources/pediatric-non-fatal-strangulation-photodocumentation-protocol/



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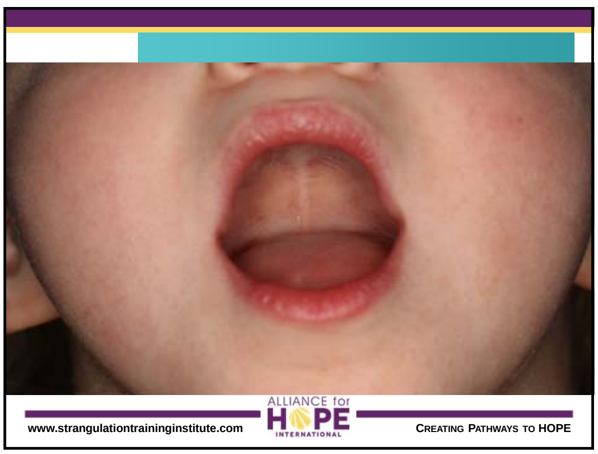
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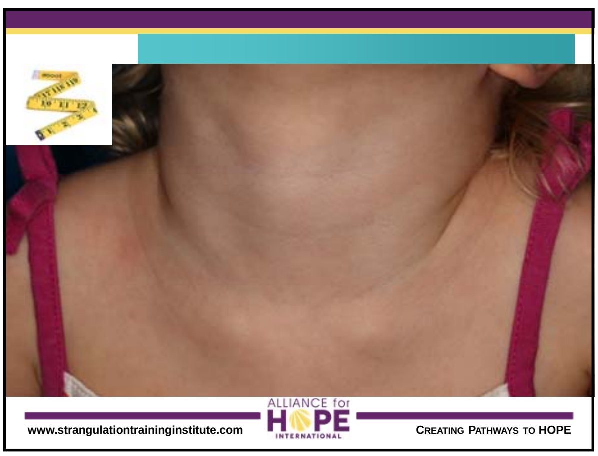
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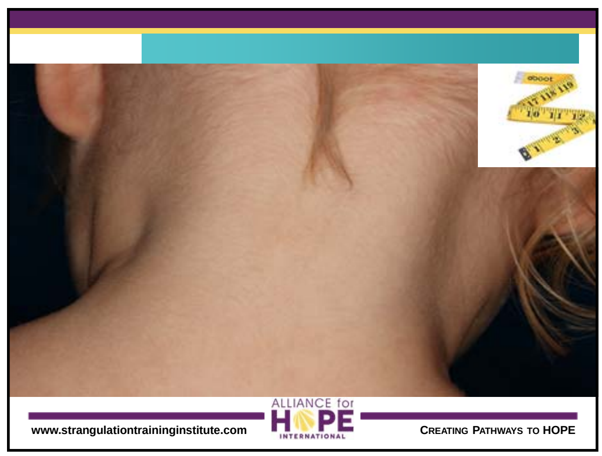
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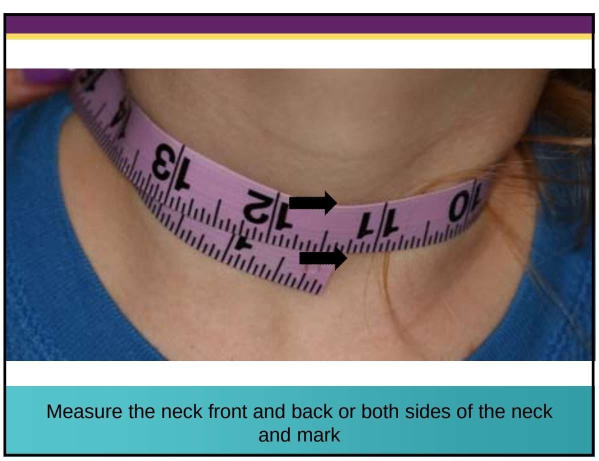
Measure the neck front and back or both sides of the neck and mark


Sometimes Children just do Not have the Words to tell you
Canon
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6 pack Trauma Informed Care

https://www.familyjusticecenter.org/resources/pediatric-non-fatal-strangulation-photodocumentation-protocol

Pediatric Discharge Instructions

Pediatric Specific

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

Pediatric Discharge Instruction for Non Fatal Strangulation- Because 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 offer 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

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

- 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 ie: ("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 in 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.

Pediatric Discharge Instruction for Non Fatal Strangulation

- After your child's evaluation, keep a list of any changes in 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.

Pediatric Discharge Instruction for Non Fatal Strangulation

- I have been made aware of and understand the importance of following the above outlined instructions.
- Provider Signature
  Patient/Parent Signature
- Date

- 1 copy patient file
- 1 copy patient

Case Study

Jennifer Green, RN, BSN, BA
Clinical Forensic Care
Program Manager
Saint Luke's Health System

Case Study: Dominic's Story

Dominic's Voice

" I thought mommies disciplined one way and daddies disciplined another…"

This is AVA

This is Dominic

April 2nd 2011

Patient: [redacted]Ava Marie MRN: 01318579 FIN: 321090896
Age: 23 months Sex: Female DOB: 04/15/09
Associated Diagnoses: None
Author: Burris, MD, Allison

Basic Information
Time seen: Date & time 04/03/11 01:58:00.
History source: Mother, social worker.
Arrival mode: Private vehicle.
History limitation: None.

History of Present Illness
The patient presents with reports of being hit, grabbed by the neck. Her older brother and mother relays to the social worker that he witnessed his Dad hit Ava on the back and head, grab her by the neck tonight. He says that dad had been drinking, and got upset with Ava for coloring on herself and the walls with a permanent marker. .

Physical Examination
Vital signs: Vital Signs.

04/03/11 00:56 CDT	Heart Rate	136 bpm
	Respiratory Rate	24 br/min
	NBP Activity	Crying
04/02/11 23:39 CDT	Temperature Celsius	36.9 DegC
	Temperature Route	Axillary
	Heart Rate	128 bpm
	Respiratory Rate	24 br/min
	NBP Activity	Calm
04/02/11 23:30 CDT	Total Pain Calculation	0

General: Appropriate for age. uncooperative.
Skin: Warm. no pallor. 2cm purple annular bruise left cheek, 2 x 1 cm triangular shaped purple bruise right lateral rib cage, 5 x 7 cm amorphic erythema marking on right lower flank/ buttock, scattered petechiae present over this marking. 1cm x 0.5cm shallow abrasion diagonally across right buttock. right leg has a faintly purple annular bruise upper anterior shin, left leg has a 1/2 cm scabbed abrasion anterior surface of the knee, 1cm annular bruises lower left medial thigh, and 1 cm, and 1 x 2 cm annular bruises upper anterior shin, also, erythematous 0.1 to 0.2cm maculopapular rash on extensor surface of upper arms and forearms, cheeks, abdomen, extensor surface of legs. .
Head: Normocephalic. atraumatic.
Neck: Supple. trachea midline. no tenderness. no lymphadenopathy.
Eye: Pupils are equal, round and reactive to light. extraocular movements are intact. normal conjunctiva.
Ears, nose, mouth and throat: Tympanic membranes clear. Oral mucosa moist. No pharyngeal erythema or exudate.

Cardiovascular: Regular rate and rhythm. No murmur. No gallop. Normal peripheral perfusion. Extremity pulses equal.
Respiratory: Lungs are clear to auscultation. respirations are non-labored. breath sounds are equal.
Gastrointestinal: Soft. Nontender. Non distended. Normal bowel sounds. No organomegaly.
Genitourinary: Normal genitalia for age. mild perivaginal erythema, with erythematous macular diaper rash.
Back: Nontender. Normal range of motion. Normal alignment.
Musculoskeletal: Normal ROM. normal strength. no tenderness. no swelling. no deformity. moves all extremities.
Neurological: CN II-XII intact. normal sensory observed. normal motor observed. normal speech observed. normal coordination observed. developmentally normal.

Medical Decision Making
Notes social worker involved. Hotline made. police contacted to make report. Child to be seen in SCAN clinic this week. .

Impression and Plan
Bruising (SNMCT 1490546012, Discharge, Medical/Surgical)
ED Discharge Plan
Prescriptions

April 3rd 2011

The first 48 hours

- In car, leaving the hospital for treating Ava, Dominic outcries to his mother that his father has strangled him 3-4 times a month, for as long as he can remember
- (he was 12).
- Ex parte
- 4 kids needed video taped forensic interviews
- Follow up with Scan Clinic

April 11th 2011 Suspended for violence

Admission to Acute Psych April 11th 2011

HISTORY OF PRESENT ILLNESS: The patient is admitted to Crittenton Children's Center at the present time with threatening to kill a year. He grabbed him by the throat. The patient's father has been recently arrested for child abuse. There is a history of suicidal thoughts in the past. He was hospitalized at Crittenton in 2006 and reports he is in good health. He denies any physical complaints.

PAST MEDICAL HISTORY: The patient has had no surgical procedures. He has had no significant medical illnesses. His only significant injury was a fractured thumb which healed without complication.

ALLERGIES: NONE KNOWN TO MEDICATIONS. IT IS REPORTED HE IS ALLERGIC TO WILD ONIONS.

MEDICATIONS: None.

SOCIAL HISTORY: The patient reports that he smokes cigarettes every other day. He denies the use of alcohol and marijuana or any other drugs.

M 13Y 08/09/1997
PATIENT ID: L0001501541
ACCOUNT #: L1103200628
CLIENT PATIENT ID:

RECEIVED 04/14/2011
PRINTED 04/15/2011 01:52

Drugs of Abuse Screen - Urine

Collected	04/12/2011 07:51	Reference	Units
Amphetamines Urine	Negative	1000	ng/mL
Barbiturates Urine	Negative	200	ng/mL
Cocaine Urine	Negative	300	ng/mL
Opiates Urine	Negative	300	ng/mL
Benzodiazepines Urine	Negative	200	ng/mL
Phencyclidine Urine	Negative	25	ng/mL
Tetrahydrocannabinol Urine	Positive *	20	ng/mL
THC-Semi-Quantitative	22*		ng THC/mg Creat
Creatinine Urine Random	163.2*		mg/dL

*Cannabinoids are measured as 11-Nor-Delta-THC-COOH equivalents (the primary marijuana metabolite). Urine cannabinoids can not be related to degree of intoxication or influence. Urine cannabinoid levels are here

2011=Very rough summer

REFERRAL SOURCE:
Johnson County Mental Health

CIRCUMSTANCES LEADING TO ADMISSION:
Dominic is a 14-year-old male who was admitted to the Horizon unit. Dominic transferred from acute hospitalization at Marillac where he was admitted on August 5, 2011 due to increasing verbal and physical aggression towards family members and visual and auditory hallucinations. Dominic's mother reported that on April 2, 2011, she and Dominic's father separated, after Dominic's father was substantiated for emotional abuse of Dominic and his 10-year-old sister, and physical abuse of his 2-year-old sister. Dominic's father was incarcerated due to this and other charges relating to substance abuse. Dominic's behaviors began increasing during this time and he began displaying physical and verbal aggression in the home towards his mother and siblings. According to reports, he had destroyed property in the home, thrown sharp objects at family members, been verbally aggressive with consistent use of profanity, and had been eloping from the home in the middle of the night to use drugs with his peers.

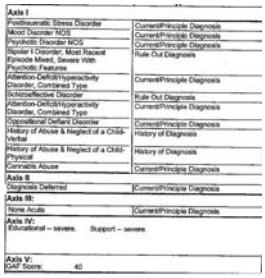
Getting the house ready to sell

August 5th 2011-Acute admission with transition to residential for 9 months

Dominic's Inpatient **Diagnosis** list

January 5th 2012

- Posttraumatic Stress Disorder
- Mood Disorder NOS
- Psychotic Disorder NOS
- R/O Bipolar I severe with psychotic features
- Attention-Deficit/Hyperactivity Disorder
- R/O Schizoaffective Disorder
- Oppositional Defiant Disorder
- History of abuse & neglect-verbal
- History of abuse & neglect-physical
- Cannabis Abuse



Axis I	
Posttraumatic Stress Disorder	Current/Principle Diagnosis
Mood Disorder NOS	Current/Principle Diagnosis
Psychotic Disorder NOS	Current/Principle Diagnosis
Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features	Rule Out Diagnosis
Attention-Deficit/Hyperactivity Disorder, Combined Type	Current/Principle Diagnosis
Schizoaffective Disorder	Rule Out Diagnosis
Attention-Deficit/Hyperactivity Disorder, Combined Type	Current/Principle Diagnosis
Oppositional Defiant Disorder	Current/Principle Diagnosis
History of Abuse & Neglect of a Child-Verbal	History of Diagnosis
History of Abuse & Neglect of a Child-Physical	History of Diagnosis
Cannabis Abuse	Current/Principle Diagnosis
Axis II	
Diagnosis Deferred	Current/Principle Diagnosis
Axis III:	
None Acute	Current/Principle Diagnosis
Axis IV: Educational – severe. Support – severe.	
Axis V: GAF Score: 40	

Dominic's Prescribed Medications

- Zoloft(Discontinued while inpatient due to interactive hallucinations)
- Risperdal 1 mg PO HS
- Lamictal 25 mg PO am
- Lamictal 125 mg PO pm
- Abilify 10 mg PO BID
- Tenex 1 mg PO HS
- Trazadone 25 mg PO HS PRN

Guilty Plea
March 9th 2012

- Misdemeanor, 1 year probation
- v = Ava
- Never prosecuted for assaults against Dominic

STATE OF KANSAS
Tenth Judicial District

OFFICE OF DISTRICT ATTORNEY

STEPHEN M. HOWE, DISTRICT ATTORNEY
Victim Assistance Unit

March 9, 2012

[redacted]

RE: State of Kansas v. [redacted]
Case No. 11CR02596

The prosecution phase of the case referenced above has come to a conclusion. The following is an explanation of the disposition of the case.

[redacted] sentence was increase to 90 days

Probation was granted for 12 months.

No restitution was ordered.

Dressing involved in the criminal justice system is time-consuming and, at times, inconvenient. If this office would like to thank you for your cooperation and assistance in the successful prosecution of [redacted], or if you have questions regarding the disposition of the case or restitution, please call us at (913) 715-3000.

Johnson County District Attorney's Office
Victim Assistance Unit

April 27th 2012
Discharge to home

INSTRUCTIONS FOR THE CLIENT AND/OR FAMILY:
Outpatient services will be provided by Johnson County Mental Health. It is recommended that Dominic receive case management, attendant care, individual and family therapy, and medication management. He will also be referred to the FACT program for substance abuse counseling. An intake was scheduled for 4/20/12 at 3:00pm.

Another Rough Summer

- Within a week of discharge, Dominic started to exhibit familiar outbursts and behavior problems:
- Was told he did not meet criteria for admission
- Tried to manage out patient
- June 18th 2012- Admit to ACT for 28 day drug treatment program
- July 7th 2012-Punched another patient and charges were filed –JDC
- August 30th 2012-Admission to trauma informed program
- December 7th 2012 –discharge home

- January 30th 2013-eloped
- February 5th 2013-taken into PD custody for running away-part of his plea deal was to go into state custody
- March 20th 2013, in JJA custody-placed in a boys home with sex offenders
- April 5th 2013-Overdosed K-2 at public school-EMS called –medical admission
- April 15th 2013-ACT…..again and this time completed the program
- May 12th 2013-D/c home –immediately back to his old behaviors
- May 26th 2013-ran away
- May 30th 2013-found and sent to Topeka The Villages – ran twice from them

Discharged back to TLC-trauma informed program

IEP Observations

- **Classroom Observation**
- Auditory disruptions to the class occurred about every 2 minutes over a 30 minute period. These included making off-task comments, **laughing at "public executions",** comments to students, talking to self while filling out a work sheet. Non-verbal disruptions occurred every 4 minutes including getting up to sharpen a pencil, standing up and adjusting pants, playing with a globe, playing with his hair.
- Dominic is noted to talk to himself when doing classwork including when reading to himself, or answering worksheets. Dominic is in constant motion. At all times there is a body part that is moving.
- Dominic makes comments that in our setting can be minimized, but this would not be the case in a public school.
- **Comments he makes include "I am a pot of boiling water", "I slash myself to find the truth", and laughing in social studies when the teacher stated the words "public executions".**

Strengths and Difficulties Questionnaire

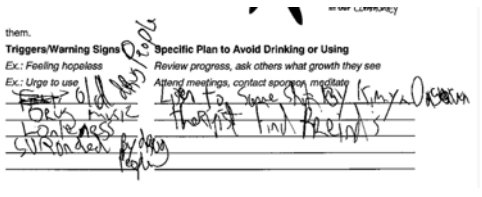
On the Strengths and Difficulties Questionnaire, Dominic reported the following:

- I am restless and cannot stay still for long
- I am constantly fidgeting or squirming
- I don't finish my work, my attention is poor
- I am easily distracted, I find it difficult to concentrate
- I worry a lot
- I am nervous in new situations, I easily lose confidence
- I am often unhappy, depressed, or tearful
- I don't usually do as I am told
- I am not helpful if someone is hurt or upset
- I don't have friends
- I don't help others

Self-report, rated in the Clinically Significant Range:

- Hyperactivity/Impulsivity (I like to be on the go rather than being in one place, it is hard for me to sit still, I get out of my seat when I am not supposed to, I feel like I am driven by a motor, I have trouble playing or doing things quietly, I get really excited or hyper, I make sounds without realizing it until someone tells me to be quiet)
- Learning Problems (I am behind in my school work, I have trouble with math, I need help doing my work, I have trouble with spelling),
- Aggression & Conduct (I break into houses/buildings/cars, I tell lies to get out of doing things or to get stuff, I get in trouble with the police, steal important things when no one is watching, I like to set things on fire, I go out at night even when I am supposed to be at home)
- In the At Risk range:
- Inattentive (I have trouble keeping my mind on what I am doing, I get easily distracted, I have trouble concentrating)

In the area of writing, Dominic is able to put his thoughts to paper, but his spelling is in the very low range, his handwriting is difficult to read (even he had difficulty when asked what he had written), his sentences lack structure, capitalization, punctuation, and clear thinking.


them.

Triggers/Warning Signs

Ex.: Feeling hopeless

Ex.: Urge to use

Specific Plan to Avoid Drinking or Using

Review progress, ask others what growth they see

Attend meetings, contact sponsor, meditate

Invited to attend a week long strangulation course

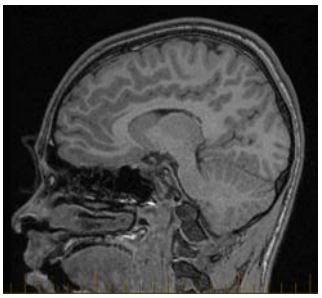
- AUGUST 2013

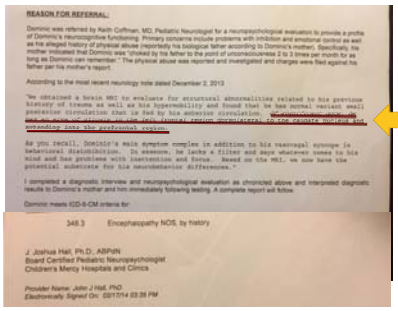
TRAINING INSTITUTE on STRANGULATION PREVENTION

What training is incorporated in basic nursing training?

- Graphic pictures
- Misunderstood
- Basic trauma classes required by trauma centers have nothing on strangulation.

Dominic Green's MRI October 18th 2013





REASON FOR REFERRAL:

Dominic was referred by Keith Coffman, MD, Pediatric Neurologist for a neuropsychological evaluation to provide a profile of Dominic's neurocognitive functioning. Primary concerns include problems with inhibition and emotional control as well as his alleged history of physical abuse (reportedly his biological father according to Dominic's mother). Specifically, his mother indicated that Dominic was "choked by his father to the point of unconsciousness 2 to 3 times per month for as long as Dominic can remember." The physical abuse was reported and investigated and charges were filed against his father per his mother's report.

According to the most recent neurology note dated December 2, 2013

"We obtained a brain MRI to evaluate for structural abnormalities related to his previous history of trauma as well as his hypermobility and found that he has normal variant small posterior circulation that is fed by his anterior circulation. [redacted] extending into the prefrontal region.

As you recall, DOMINIC's main symptom complex in addition to his vasovagal syncope is behavioral disinhibition. In essence, he lacks a filter and says whatever comes to his mind and has problems with inattention and focus. Based on the MRI, we now have the potential substrate for his neurobehavior differences."

I completed a diagnostic interview and neuropsychological evaluation as chronicled above and interpreted diagnostic results to Dominic's mother and him immediately following testing. A complete report will follow.

Dominic meets ICD-9-CM criteria for:

348.3 Encephalopathy NOS, by history

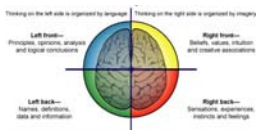
J. Joshua Hall, Ph.D., ABPdN
Board Certified Pediatric Neuropsychologist
Children's Mercy Hospitals and Clinics

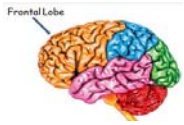
Provider Name: John J Hall, PhD
Electronically Signed On: 02/17/14 03:35 PM

?

Gliosis-A process leading to scars in the central nervous system that involves the production of a dense fibrous network of neuroglia (supporting cells) in areas of damage

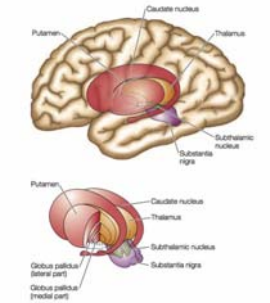
Left frontal region dorsolateral to the caudate nucleus and extending into the prefrontal region



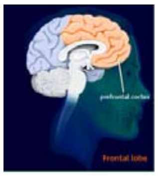


Left frontal region

dorsolateral (in back of and outside) to the caudate nucleus and extending into the prefrontal region



Pre-frontal cortex area is Executive Function

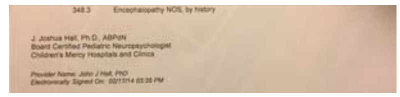


Executive Function relates to abilities to differentiate between:

- conflicting thoughts
- determine good and bad
- better and best,
- same and different
- future consequences of current activities, working toward a defined goal
- prediction of outcomes
- expectation based on actions
- and social "control"
- **The ability to suppress urges that, if not suppressed, could lead to socially unacceptable or illegal outcomes.**

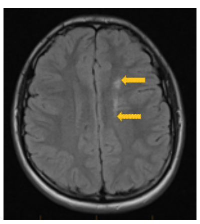
Encephalopathy NOS (not otherwise specified), by history

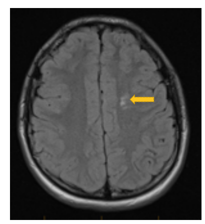
Encephalopathy is a general term describing a disease that affects the function or structure of the brain

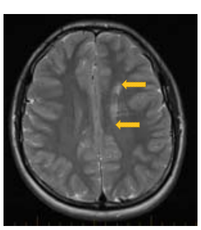

348.3 Encephalopathy NOS, by history

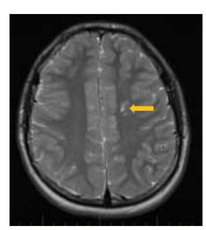
J. Joshua Hall, Ph.D., ABPdN
Board Certified Pediatric Neuropsychologist
Children's Mercy Hospitals and Clinics

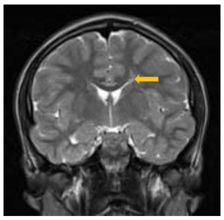
Provider Name: John J Hall, PhD
Electronically Signed On: 02/17/14 03:38 PM

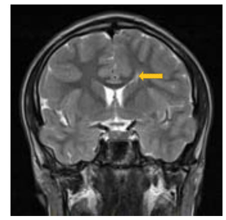


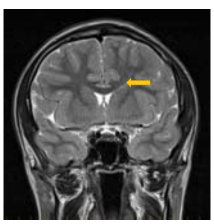


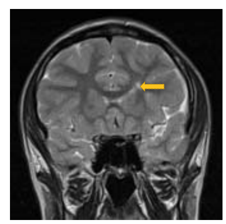


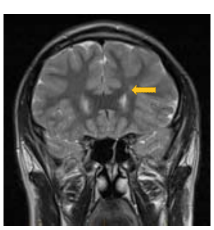












Neuropsychological Evaluations measures function categories

- Intellectual functioning
- Academic achievement
- Language processing
- Visuospatial processing
- Attention/concentration
- Verbal learning and memory
- Visual learning and memory
- Executive functions
- Speed of processing
- Sensory-perceptual functions
- Motor speed and strength
- Motivation/symptom validity
- Personality assessment

TESTS ADMINISTERED:

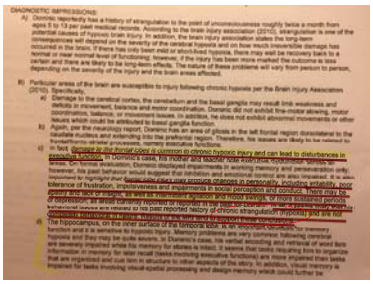
Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
Adaptive Behavior Assessment System, Second Edition (ABAS-II)
The Grooved Pegboard Test
The Beery-Buktenica Developmental Test of Visual-Motor Integration, Sixth Edition (VMI)
Rey Complex Figure Test (RCFT)
Wide Range Assessment of Memory and Learning, Second Edition (WRAML-2)
Conners' Continuous Performance Test, Second Edition (CPT-II)
Behavior Rating Inventory of Executive Function (BRIEF)
Test of Verbal Conceptualization and Fluency (TVCF)
Behavior Assessment System for Children, Second Edition (BASC-2)

Dominic's Results: 02/17/2014

Impairments in:

- Executive function in all areas
- Short term memory
- Delayed recall
- Sequencing skills
- Adaptive living skills
- Social skills and self care
- Math calculations
- Significant social-emotional and adaptive behavior

Validation Moment



RECOMMENDATIONS:

It is recommended that Dominic's caregivers discuss the results of the present neuropsychological evaluation with his neurologist, Dr. Coffman. The results of the neuropsychological assessment represent one part of a complex evaluation, and should therefore, be interpreted in light of previous medical findings. In other words, clinical correlation is advised.

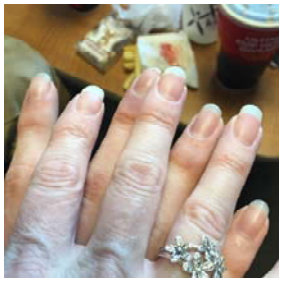
Dominic is at significant risk for continued social-emotional issues given his background and medical history. Therefore, it is crucial that he continue to receive services through community mental health as well as other supports through his school district. He is currently doing very well in the academic setting and socially per parent report. Therefore, current accommodations seem to be aiding Dominic in controlling his emotions and minimizing his physical and verbal confrontations.

It is recommended that Dominic be provided services through an Individualized Education Plan (IEP) for Traumatic Brain Injury (TBI) rather than Emotional Disturbance (ED). While Dominic is prone to issues with social-emotional functioning, in light of current findings and research with individuals with a history of chronic hypoxia, his impairments can be attributed to his alleged history of chronic hypoxia secondary to strangulation. Given the deficits seen in the present evaluation, accommodations will likely be necessary to assist him academically and socially. However, Dominic's educational committee, of which his caregivers are members, is the ultimate authority regarding eligibility. As such, it is recommended that the results of the present evaluation be shared with his school so further discussion regarding eligibility of services is possible.

Made Jr Varsity Captain Of his Basket Ball Team

First Pay Check

Mother's Day 2014



Questions?

Upcoming Classes

3 Day Master Advanced Strangulation Course
August 21-23, 2018 in San Diego, CA

1 Day Forensic Gun Shot Wounds with Dr. Bill Smock August 24, 2018 in San Diego, CA

4 Day Advanced Course in San Diego, CA
October 16-19, 2018

NAC 4 Day Advanced Course in Columbia, SC
November 6-9, 2018

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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:

Sarah Sherman Julien
Program Manager, Training Institute on Strangulation Prevention
sarah@allianceforhope.com
Direct: (619) 413-4369
Or
tisp@allianceforhope.com

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

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Gael Strack, Esq.

Alliance for HOPE International
Chief Executive Officer and Co-Founder
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101 W. Broadway, Suite 1770
San Diego, CA 92101
Toll Free: (888) 511-3522

Gael B. Strack is the Chief Executive Officer and Co-Founder of 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 (www.familyjusticecenter.org) provides consulting to over 150 existing and pending Family Justice Centers across the world, helping communities open and sustain Family Justice Centers.
- The Training Institute on Strangulation Prevention (www.strangulationtraininginstitue.com) provides basic and advanced training on strangulation prevention to 5,000 professionals annually.
- The Justice Legal Network is an innovative public interest law firm made up of 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 Alliance for Hope International 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 in one location. The San Diego Family Justice Center was featured on Oprah in January 2003, was recognized as a model program by President Bush and was the inspiration for the President's Family Justice Center Initiative launched in October 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, former 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 where she teaches "Domestic Violence and the Law." Gael has been honored with numerous awards, including San Diego Attorney of the Year for 2006, and was the 2010 Recipient of the National Crime Victim Service Award for Professional Innovation in Victim Services by United States Attorney General Eric Holder.

Gael has also co-authored a series of strangulation articles and five books with Casey Gwinn, JD, on the Family Justice Center movement.

Gael and her husband, Jan, have two grown children, Samantha and Taylor, and are the proud grandparents of one grandchild – Emmett.

William S. Smock, MD, MS, FACEP, FAAEM
Louisville Metro Police Department
The Clinical Forensic Medical Program
Director and Police Surgeon
bill.smock@louisvilleky.gov
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. Dr. Smock 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.

Dr. Smock has edited three 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.

Bio for Cathy Baldwin-Johnson, MD, FAAFP

Dr. Baldwin-Johnson is a board-certified family physician, life-long Alaskan, and mother of two wonderful adults. She serves as the medical director for Alaska CARES, the Child Advocacy Center in Anchorage and a department of The Children's Hospital at Providence. As part of her duties she oversees the SCAN (Suspected Child Abuse and Neglect) Teams at Providence Alaska and Mat-Su Regional Medical Centers, and provides trainings for medical providers and multidisciplinary team members on child abuse topics. She is the co-founder and volunteer medical director of The Children's Place, a Child Advocacy Center in the Mat-Su Borough. She has served on the Alaska Children's Justice Act Task Force since its inception and as chair from 2007 – 2011 and is an active member of the Alaska Maternal & Child Death Review Committee, the Medical Advisory Team for the Training Institute on Strangulation Prevention and the board of the Alaska Children's Alliance. She is a 1980 graduate of the University of Washington School of Medicine and completed the Swedish Hospital Medical Center Family Practice Residency program in 1983.

Honors have included:

- 2015 Mother Joseph Award from the Sisters of Providence
- 2014 Light in the Night Award from the Alaska Children's Alliance
- 2010 Light of Hope Award Mat-Su Valley
- 2009 Alaska March of Dimes "Friend of Nursing" Award
- 2006 Horowitz-Barker Professional Leadership Award from the National Children's Alliance
- 2002 National Family Physician of the Year from the American Academy of Family Physicians
- 2002 Certificate of Appreciation from United States Department of Justice, Office of Justice Programs, Office for Victims of Crime
- 2000 Alaskan Family Physician of the Year from the Alaska Academy of Family Physicians)
- 1999 First Lady's Volunteer of the Year Award from Alaska First Lady Susan Knowles

Valerie A. Sievers MSN, RN, CNS, SANE-A, SANE-P
saneval@wildblue.net
vsievers@uccs.edu

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

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.

Certificate of Attendance

Webinar Training:
Pediatric Strangulation, Part 2

Presented by Gael Strack, JD; Bill Smock, MD; Cathy Baldwin Johnson, MD; Diana Faugno, MSN, RN; Val Sievers, MSN, RN; and Jennifer Green, RN, BSN, BA

February 22, 2018
1.5 Training Hours

Gael Strack

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