2020/2021

Updated 11/07/23

Sacramento County

STRANGULATION PROTOCOL:

EDUCATION, IDENTIFICATION, DOCUMENTATION AND FOLLOW-UP

Developed and approved in collaboration with criminal justice, healthcare, and social services staff from organizations throughout the Sacramento County Region.

Endorsed by the Sacramento County Board of Supervisors February 2021.

Man Alive, Sacramento, Inc.

INTRODUCTION

The purpose of this document is to implement a generic countywide protocol that identifies and communicates evidenced-based practice and standard of care for the assessment and follow-up of victims who report strangulation.

A countywide protocol expands the discussion about Intimate Partner Violence (IPV) and strangulation to all agencies and employees. It fosters a shared language between disciplines and sets a cross-disciplinary benchmark for understanding the implications of strangulation as well as response and follow-up.

A protocol reminds agencies that they are all a part of a community response. It encourages agencies to develop their own policies, to use IPV Risk Assessment Tools, and to follow protocol guidance when applicable.

We encourage all agencies and organizations within Sacramento County that offer first-response or follow-up services to develop specific strangulation policies based on the nuances of their organization. This effort is one of cross-disciplinary collaboration. By working together, we can all increase public safety, promote public health, and save lives.

This document provides a generic narrative about strangulation that includes 1) definitions and situations; 2) information and local data; 3) signs and symptoms; 4) recommendations for professional disciplines; 5) observations and documentation; 6) screening; 7) staged suicide scenes; 8) medical attention; 9) historical documentation; 10) follow-up; 11) safety planning; and 12) addendums.

Please take time to familiarize yourself with, and share with your organization, the contents herein. While this protocol is not intended to address every situation or substitute for individual discretion or organizational policies, it is a good place to start. If you have any questions, feel free to contact the Sacramento Regional Family Justice Center: www.SacramentoFJC.org

Thank you for your service to our community and your interest in this document. You play an important role in the practical application of this protocol.

From the victims who have suffered, from those we've yet to serve, and from the Sacramento Regional Family Justice Center and the Countywide Strangulation Working Group.

Recognition and acknowledgement is extended to the following members of the Sacramento County Strangulation Protocol Working Group:

The Sacramento Regional Family Justice Center (SRFJC) solicited input from the following working group to help prepare this document. This group of professionals represents criminal justice, healthcare, social services, and crisis services/advocacy throughout Sacramento County.

Faith Whitmore, *Chief Executive Officer*
Sacramento Regional Family Justice Center

Joyce Bilyeu*, Director of Client Services*
Sacramento Regional Family Justice Center

David M. Cropp, LCSW
Sacramento Regional Family Justice Center

Daniel Thomas, (*Ret.) Executive Director*
ManAlive Sacramento, Inc.

Debra Larson, *Manager*
Adult Protective Services

Jennifer Bettencourt, *Program Specialist*
Child Protective Services

California District Attorneys Association
Investigation and Prosecution of Strangulation Cases (2020)

Dawn Bladet, *Assistant Chief Deputy District Attorney*
Sacramento County District Attorney's Office

Lisa Corral, MSW, *Domestic Violence Advocate*
Sacramento County District Attorney's Office

Paul Durenberger, (Ret.) *Assistant Chief Deputy District Attorney*
Sacramento District Attorney's Office
Sacramento Regional Family Justice Center

Preston S. Schaub, *Prosecutor*
Yolo County District Attorney's Office

Tracy Prior, *Chief Prosecutor*
San Diego County District Attorney's Office

Angela Vickers, MD
Sutter Medical Center, Sacramento
Pediatric Child Abuse & Neglect, Pediatric Gynecology

Hernando Garzon, MD
Medical Director, Sacramento EMS

Kevin Mackey, MD
Sacramento Fire Services Medical Director

Ron Chambers, MD, FAAFP
Physician Advisor, Dignity Health Violence and Human Trafficking Response
Medical Director, Medical Safe Haven

Samantha Kettle, Psy. D.
Faculty Member / Sutter Health Family Medicine Residency Program

Sean Dugan, MD
Shasta Community Health Center

Barbara Law, Assistant Chief, Emergency Medical Services Director
Sacramento Metropolitan Fire District

Benjamin Merin, BS, EMT-P
Sacramento County Emergency Medical Services Agency

Elizabeth M. Strong, *EMS Supervisor*
Sacramento Regional Fire/EMS Communications Center

Kathy Ivy, EMT-P
Sacramento County Emergency Medical Services Agency

Kristin Bianco, EMT-P
Sacramento County Emergency Medical Services Agency

Kylee Soares, *Deputy Director of Operations*
Sacramento Regional Fire/EMS Communications Center

Tyler Wagaman, *Assistant Chief*
Sacramento Metro Fire

Theresa Barbour BSN, RN
Charge Nurse,
Kaiser Sacramento Emergency Department

Angela Jones, E*xecutive Director*
One SAFE Place, Shasta County

Gigi Barrios*, Program Coordinator*
Medical Safe Haven, Dignity Health

Jennifer Cox, *Program Director*
Human Trafficking Medical Safe Haven
Dignity Health

Tiffney Ottoboni, *Patient Advocate*
Medical Safe Haven, Dignity Health

Jessica Garcia, MSW
Victim Advocate
Sacramento District Attorney's Office

Nilda Guanzon Valmores, *Past Executive Director*
My Sister's House

Aaron Lee, ***Police Sergeant***
Elk Grove Police Department

Eric Dias, ***Police Master Sgt.***
General Investigations
Citrus Heights Police Department

Christopher Arbuckle, ***Police Sergeant***
Sacramento County Sheriff's Office

Debra Salvo, ***Police Officer***
Training Manager, Folsom Police Department

John Sydow, ***Sergeant***
Sacramento County Sheriff's Office

Joshua Helton, ***Police Officer***
Davis Police Department

Sacramento Police Department

Vanessa Vogelpohl, ***Deputy Probation Officer***
Sacramento Probation Department

Wellspace Health -Sacramento

OBJECTIVES

To implement a generic countywide protocol that identifies and communicates evidenced-based practice and standard of care for the assessment and follow-up of victims who report strangulation. This applies to victims who, although hesitant to disclose strangulation, nonetheless show signs/symptoms consistent with being strangled.

This protocol encourages all organizations within Sacramento County that offer first-response or follow-up services to further develop specific strangulation policies based on the nuances of their respective services. The effort herein is one of cross-disciplinary collaboration. By working together, we can all increase public safety, promote public health, and save lives.

This protocol is not intended to address every situation, nor is it intended to substitute for individual discretion or organizational policies.

DEFINITIONS / SITUATIONS

Strangulation is one of the most intentionally lethal forms of IPV. It is external compression to the neck resulting in the closure of blood vessels and/or air passages. Strangulation may occur manually (hands or arms), with a ligature (cord or rope without suspension), or by hanging. Effects of strangulation may include immediate or delayed internal injuries up to and including death.

- Bruising and other findings of strangulation are present in only 50% of cases.
- There have been fatalities from strangulation where no bruising was present.
- The lack of bruising does not exclude strangulation, nor does it correlate with the amount of force used.

Choking refers to the physical obstruction of the windpipe such as food, resulting in blockage that prevents the normal flow of air. Victims may use the word “choking” when describing an assaultive incident that is consistent with “strangulation. However, responders must know the difference and be able to clarify that the victim was either choked or strangled (or both).

Suffocation refers to the obstruction of airflow into the mouth and/or nostrils, as with, for example, a hand, pillow, plastic bag, etc. When suffocation and strangulation occur simultaneously, brain damage is accelerated increasing the likelihood of fatality.

The Carotid Arteries and Jugular Veins carry blood to and from the brain. The carotid arteries supply oxygenated blood to the brain. Adults can be rendered unconscious in under 10 seconds with as little as 11 pounds of constant pressure to the carotid arteries. The jugular veins carry deoxygenated blood from the brain back to the heart. Adults can be rendered unconscious in less than 30 seconds by occlusion of only the jugular veins with as little as 4-5 pounds constant

pressure. However, according to Dr. Dugan with the Shasta Community Health Center, it is rare to have someone strangled with such little force that only the jugular is occluded.

Petechiae describes small, pinhead-sized reddish/purple spots (petechiae hemorrhage) that can be seen on the skin, eyelids, or inside of the mouth. Petechiae occurs when blood flow to the brain via the carotid arteries is restricted from leaving the brain via the jugular veins due to external pressure/strangulation. The build-up of blood bursts through tiny capillaries, causing spots known as petechiae. Petechiae may occur anywhere on the body but with strangulation, it typically shows up around the face, mouth, or neck; behind the ears, eyelids, and/or the conjunctiva (the tissue inside the eyes covering the sclera). Petechiae normally takes about 15-30 seconds to develop. Petechiae may occur from non-traumatic causes as well, such as vomiting, coughing, childbirth, infection, and bleeding disorders[1].

The Trachea functions to carry air/oxygen to the lungs. External pressure to the trachea may block airflow to the lungs. An adult's trachea may be compressed or blocked with as little as 30 pounds of constant pressure.

The Dangers of Strangulation may include death or life-threatening injuries. These injuries may occur in a matter of seconds when the jugular veins, carotid arteries, and/or trachea are compressed with enough force to restrict blood and/or airflow, thus depriving the brain of oxygen. Death and/or serious injury from strangulation may also occur within 4-5 minutes from 1) traumatic swelling in the neck tissue, 2) internal bleeding in the neck area, 3) fractures to the larynx or trachea, 4) strokes occurring from blood clots resulting from damaged blood vessels and/or 5) lung damage.

In Summary, the force needed to strangle someone is less than one may assume. While it takes just about 11 pounds of pressure to strangle someone into unconsciousness, consider that an average male adult's handshake takes 80-100 pounds of pressure, while 20 pounds will open a soda can, and 6 pounds of pressure is all that is needed to pull a handgun trigger.

INFORMATION & LOCAL DATA

In their article *On the Edge of Homicide: Strangulation as a Prelude* (2011*),* Gael Strack and Casey Gwinn remind us that many victims of strangulation have no visible injuries but due to brain damage and/or internal injuries caused by strangulation, victims may have serious internal injuries and may even die within days or weeks.

The Roll Call training video *The Last Warning Shot* (in association with the Training Institute on Strangulation Prevention) reminds us that in 2017, 78% of cop killers were men with a history of IPV and strangulation. Further, if a woman is strangled once by her intimate partner, she is more than 700% more likely to be killed.

[1] *Faugno, D., Sievers, V., Shores, M., Smock, B., & Speck, P. (2020). Domestic Violence and Non-fatal strangulation Assessment: For Health Care Providers and First Responders.*

A Washington Post Article *Murder with Impunity—Domestic Slayings: Brutal and Foreseeable* (2018), reports that violent strangulation is almost always attributed to fatal domestic attacks on women and that 6 percent of women killed by intimate partners die from strangulation.

The California Legislature properly recognizes strangulation as a serious crime and threat to the health and well-being of its citizens. In 2012, CA Penal Code Section 273.5 was amended to include injuries suffered because of strangulation.

- CA Penal Code Section 273.5(d): "… '*traumatic condition' means a condition of the body, such as a wound, or external or internal injury, including, but not limited to, injury as a result of strangulation or suffocation, whether of a minor or serious nature, caused by a physical force. For purposes of this section, "strangulation" and "suffocation" include impeding the normal breathing or circulation of the blood of a person by applying pressure on the throat or neck.*

LOCAL CONCERNS

SINCE OPENING IN 2016, THE SACRAMENTO REGIONAL FAMILY JUSTICE CENTER (SRFJC) HAS SERVED 12,115 **NEW** AND 15,006 **RETURNING** CLIENTS. A TOTAL OF **27,121** VISITS.

Of these, more than 28% report being strangled and the number increases each year:

2016 - 9 cases of strangulation
2017 - 100 reported cases of strangulation
2018 - 198 reported cases of strangulation
2019 - 302 reported cases of strangulation*
2020 - 460 reported cases of strangulation*
2021- 683 reported cases of strangulations*
2022 - 820 reported cases of strangulation*
2023 (Jan – Oct..) 662 reported cases of strangulation (average of 60/70 cases a month)

APPROXIMATELY 28% OF CLIENTS AT THE SRFJC REPORT PRIOR STRANGULATION. OTHER STUDIES HAVE SHOWN A PREVALENCE RATE BETWEEN 68-80 PERCENT**.

RECOGNIZING STRANGULATION SIGNS AND SYMPTOMS DURING FIRST-RESPONSE OR FOLLOW-UP EXAMINATION CAN SAVE LIVES.

FIRST RESPONDERS SUCH AS LAW ENFORCEMENT, FIRE/EMT, ADVOCATES, COUNSELORS, THERAPISTS, AND HEALTHCARE PROVIDERS MUST BE ADEQUATELY TRAINIED IN RECOGNIZING STRANGULATION.

EFFECTIVE RESPONSE AND FOLLOW-UP MUST INCLUDE A STANDARDIZED STRANGULATION PROTOCOL.

EFFECTIVE RESPONSE AND FOLLOW-UP, INCLUDING DOCUMENTATION AND COLLECTION OF EVIDENCE, MAY INCREASE VICTIM/CLIENT SAFETY AND FELONY PROSECUTION.

**As these numbers imply, when training and awareness on strangulation increases, assessments become more thorough and data collection becomes more accurate.*

- **Mandatory Reporting:** In any case when acts of strangulation occur, first responders, when appropriate, must comply with mandatory reporting laws including but not limited to PC Sections 11160, 11164, and W&I Section 15640.

SIGNS and SYMPTOMS

Symptoms may include a raspy, hoarse voice, coughing, difficulty talking, wheezing, difficulty breathing, hyperventilating, difficulty swallowing and/or throat pain, swelling of the tongue, nausea or vomiting, and dizziness.

Signs may include scratches, abrasions to the neck or face, impressions of hands or fingers in the skin, impressions in the skin that might indicate the use of a ligature, swollen neck, ruptured capillaries in the eyes, eyelids, face, or neck (petechiae), defensive wounds such as fingernail marks on face, neck, or chest; and/or bite marks, scratches, or injuries to the abuser.

Traumatic Brain Injury (TBI): occurs when a victim loses consciousness during strangulation. This can take as little as 6.8 seconds to occur. During a strangulation assault, the pressure applied to the neck impedes oxygen to the brain. The trachea can also be restricted, making breathing difficult or impossible. This combination can quickly cause asphyxia and unconsciousness, leading to brain injury. Most victims will not remember losing consciousness and many may deny that they lost consciousness if directly asked.

Before losing consciousness, most victims will experience vision changes (spots, blurring, tunnel vision), feeling faint, dizzy, and/or disoriented. This is usually followed by a gap in memory. TBI may cause a victim to have a difficult time recalling events of the assault and the history they provide is often jumbled and/or out of order. TBI may also be caused by blunt force head injury. Victims of multiple strangulation attacks or longer durations of unconsciousness are at greater risk of TBI.

Strangulation and TBI

- Cognitive difficulties with concentration, attention and problem solving.
- Difficulties with logical, sequential communication.
- Difficulty with executive functioning, such as making decisions.
- Changes in behavior, personality, or temperament, such as irritability, difficulty tolerating frustration and emotional expression that don't fit the situation.
- Physical effects, such as vision problems, insomnia, loss of coordination and seizures.

An effective response must include emergency medical assistance if victims have any of the above signs or symptoms. Please make every reasonable effort to encourage victims to accept medical attention.

RECOMMENDATIONS for PROFESSIONAL DISCIPLINES

Everyone who interacts with victims of IPV must realize that nonfatal strangulation is a significant risk factor for predicting future homicide. Female survivors of non-fatal strangulation are at least 700% more likely to become a victim of homicide.[2]

When victims disclose that they have been strangled (or choked), they must be assessed for the purpose of medical diagnosis and treatment as soon as possible. Victims must be given an unbiased, nonjudgmental opportunity to express themselves. Victims are to be provided standardized information on strangulation, and the resources available to them.

As caring professionals, first responders must recognize the biases and barriers faced by vulnerable populations and sexually nonconforming persons. The **LGBTQ** population is at an increased risk for exposure to IPV and sexual assault. Additionally, IPV-related homicide and attempted homicide are the major causes of premature death and disabling injuries for **African American** women. Victims for whom English is not their first language are also vulnerable and will need language assistance to convey and receive information accurately. Victims who identify with these populations must be believed and supported with a trauma-informed response no different than any other victim or demographic[3].

Dispatchers: In most cases, dispatchers are truly our first responders. Dispatchers must be trained in the implications of IPV and strangulation. When the opportunity arises, dispatchers must consider asking callers if they were strangled or choked. The 5-item Danger Assessment (DA-5) is a good tool to help dispatchers ask salient and germane questions. Because strangulation can result in delayed health complications including death, dispatchers must consider evaluating the need for medical response. Contact the SRFJC for more information on using the DA-5.

Law Enforcement: Police officers should use whatever departmentally approved recording device(s) they have when speaking with victims. Recordings may show a victim's emotional state consistent with being strangled.

- Law enforcement must consider strangulation to be serious criminal behavior consistent with CA Penal Code Section 273.5, and officers must comply with CA Penal Code Section 13730(c)4, which asks them to note *whether a domestic violence response revealed indications that the incident involved strangulation or suffocation. This includes whether any witness or victim reported any incident of strangulation or suffocation, whether any victim reported symptoms of strangulation or suffocation, or whether the officer observed any signs of strangulation or suffocation.*

---

[2] *Glass, N., Laughon, K., Campbell, J., Chair, A., Block, C., Hanson, G., Sharps, P. Taliaferro, E. (2009, Oct). Non-fatal strangulation is an important risk factor for homicide of women. Journal of Emergency Medicine, 35(3).*

[3] Campbell, D., Sharps, P., Gary, F., Campbell, J., Lopez, L., (2002). "*Intimate Partner Violence in African American Women.*" Online Journal of Issues in Nursing. Vol. 7 No. 1, Manuscript 4. Available: www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume72002/No1Jan2002/AfricanAmericanWomenPartnerViolence.aspx

- California Penal Code Section 13701(c) (I) asks law enforcement responders to *inform victims that strangulation may cause internal injuries and encourage victims to seek medical attention*.

- The International Association of Chiefs of Police (IACP) prepared a Concepts and Issues Paper on Domestic Violence (April 2019), which reminds officers that *Strangulation, erroneously referred to as choking, is one of the most common but overlooked injuries in domestic violence cases.* When it comes to assessment and screening the IACP correctly notes: *In domestic violence incidents where strangulation occurred, first responding officers might not see any visible injuries during the initial interview of victims. Therefore, it is critical that first responders screen for strangulation and assist in obtaining a medical evaluation and treatment.*

- Officers may benefit from pre-packaged materials that contain information on 1) domestic violence, 2) strangulation, 3) community resources, 4) report forms, etc. This may make it easier for officers to access these items quickly when needed. Contact the Citrus Heights Police Department for more information on how they effectively use these packets for officers.

Probation: Probation officers routinely find themselves as first responders during, for example, in-field operations such as search warrants and compliance checks. Probation officers are peace officers and must be familiar with the implications of strangulation. They must have adequate training on this topic and must know how to assess and document situations involving strangulation.

Emergency Medical Services (EMS): Sacramento County EMS personnel are considered mandatory reporting healthcare providers and must involve law enforcement or make necessary notifications, when appropriate. Per CA Penal Code Section 11160, EMS personnel must follow the Sacramento County Emergency Medical Services Agency's (SCEMSA) trauma and medical care treatment protocols when caring for victims.

Healthcare—Obligation to Report: CA Penal Code Section 11160 requires that if any health practitioner, within the scope of their employment, provides medical services for a wound or physical injury inflicted because of assaultive or abusive conduct, or by means of a firearm, they shall make a telephone report immediately or as soon as possible. They shall also prepare and submit a written report within 2 working days of receiving the information to a local law enforcement agency (Official Form—Cal OES 2-920). This form is used by law enforcement only and is confidential in accordance with Section 11163.2 of the Penal Code. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts.

Child Protective Services (CPS): CPS workers interview children and parents relating to family violence/domestic violence situations. Most CPS cases involve domestic violence. Therefore, CPS workers may find themselves contacting parents or children who show signs/symptoms of strangulation. Because of pediatric anatomy, children may be at a greater risk of injury/death due to strangulation. For these reasons, it is imperative that CPS workers understand the implications of strangulation within this context. CPS workers must know how to assess, document, and report

situations involving strangulation, and report suspected criminal incidents to law enforcement per PC Section 11164.

Adult Protective Services (APS): APS workers attend to situations involving one of society's most vulnerable citizens—elders and dependent adults. APS workers are required to report criminal incidents to law enforcement per Welfare and Institutions Code §15640(a)(1). Because many elders and/or dependent adults may not have the capacity to fully describe incidents of abuse, cases of strangulation may go unnoticed. It is imperative that workers understand the implications of strangulation and be skilled in assessing, documenting, and reporting cases of strangulation or suspected strangulation.

Prosecution: Prosecutors, including their investigators and advocates, must be well-trained in the implications of domestic violence and strangulation. Filing charges may include but are not limited to PC Sections 245(a)(4), 273.5, 237, 136.1, 422, and attempted murder (664/187 PC). Prosecutors should, when possible, consult with medical professionals and/or expert witnesses to assist in prosecution efforts.

Advocates: Victims must have trust in advocates to provide an unbiased and nonjudgmental environment for disclosure. Advocates must be well trained in the implications of IPV and strangulation. Victims may minimize the abuse including strangulation and may not recognize health-related consequences. Victims must be competently evaluated and receive referrals for full medical evaluation. They must receive educational information about IPV and strangulation as well as services available to them.

Media: This protocol strongly urges Sacramento area media personnel to become trained and knowledgeable in the implications of strangulation. The publication, *Media Guide: Understanding the Realities of Strangulation* is available from the Training Institute on Strangulation Prevention[4]:

> *This guide is designed to assist media professionals in understanding the importance of using appropriate language to describe non-fatal strangulation, specifically when discussing strangulation and suffocation within the context of power and control, domestic violence relationships, sexual assaults, and homicides. This guide also provides background and educational resources for the media to assist in accurate reporting of this horrific crime (p. 2).*

In Summary: It is highly encouraged that each agency and organization in Sacramento County have at their disposal expert witnesses who can assist them. Contact the SRFJC for more information on countywide access to expert witnesses. All cases involving the disclosure of strangulation or suspected strangulation absent self-disclosure should reasonably follow this protocol and/or their respective agency policy for evaluation, medical attention, documentation, education, and follow-up.

[4] *The Media Guide can be found at https://www.familyjusticecenter.org/search-result/?st=Media%20Guide.*

OBSERVATIONS / DOCUMENTATION

First responders and follow-up service providers must be aware of salient questions to ask victims. Questions should address strangulation using generic terms and in the language with which the victim is most familiar. Be aware that many victims may have no external signs but may still have symptoms consistent with strangulation.

Generally, responders should consider including some of the following questions when possible[5]. Consider using the victim's own words when asking questions. For example, if they say, "choked" "cut off my air" or "grabbed my throat," use those descriptions rather than substituting the word strangulation.

- *Have you been hurt? Who hurt you?*
- *How did it happen?*
- *Do you have any current pain or discomfort?*
- *On a scale of 1 to 10, how much pain or discomfort?*
- *Have you noticed a change in your voice or speech?*
- *Have you noticed difficulty speaking or breathing?*
- *Did you notice feeling faint or dizzy, or that you might pass out? Do you feel that way now?*
- *Did you notice any vision changes (blurring, dots, tunnel, darkness, etc.), hearing changes (decrease, ringing, vibration), develop a headache, feel dizzy, feel disoriented, or feel faint?*
- *Did you lose consciousness? If so for how long?*[6]
    - *If this answer is "yes," follow up with:*
    - *Between the onset of those symptoms and the end of the strangulation, do you remember every single moment, or is there a gap in your memory? Do you remember him letting go?*
- *Did you suffer any type of sexual assault?*
- *Did you have trouble breathing or catching your breath?*
- *Did you lose control of your bladder or bowels? Did you vomit?*
- *Did the person who hurt you use one hand or both hands, arms, knees or another body part on your throat or head area?*
- *Can you demonstrate how you were … (choked or strangled)?*
- *How long do you think the strangulation lasted?*
- *Did the person who hurt you block your nose or mouth? How so?*
- *Were you pinned or shoved up against a wall, thrown to the ground, or violently shaken?*
- *Did your head strike anything? If so, do you have any additional injuries?*
- *Were any objects used, e.g., cords, ropes, or straight objects?*
- *Did the abuser say anything before, during, and after the assault?*
    - *If this answer is "yes," please describe in the victims' own words.*
- *Did the abuser do anything immediately prior to attacking you?*
- *Can you describe the abuser's demeanor, body language, tone of voice, and facial expressions?*
- *Did you think you might die?*
    - *If the answer is "yes," follow up with:*
    - *How did you react to this feeling?*

---

[5] *Training Memo: Law Enforcement Response to Strangulation, [Praxis International 2007], this memo includes material adapted from the Minnesota Coalition for Battered Women and from Gael B. Strack, How to Improve Your Investigation and Prosecution of Strangulation Cases).*

[6] *Many victims may not be able to estimate how long they were out; however, it is still helpful to ask—note any confusion in time and write down their own words.*

    - *Were you able to do anything to protect yourself?*
    - *Were you able to push, kick, bite, scratch, or pull his/her hair?*
- *Were you able to injure the person who did this? How and where?*
- *Do you know what caused the abuser to stop the assault?*
- *Has this person ever strangled you before? How many times? Was this time more or less severe? than the others? What was the most serious attack?*

At a very minimum, allegations of strangulation along with signs/symptoms must be well documented in a report or other narrative along with any follow-up actions taken by the responder.

SCREENING

First responders are encouraged to use domestic violence risk assessment/screening instruments such as the 20-item Danger Assessment (DA) or the 5-item Danger Assessment (DA-5), both developed by Jaqueline Campbell (at the Johns Hopkins School of Nursing)[7]. These risk assessment tools contain questions relating to strangulation. The DA has embedded a brief strangulation follow-up protocol (see below). Training is required for clinical access and use of the DA. The SRFJC can assist anyone interested in learning more about the use of these risk assessment tools. The SRFJC uses a prepared questionnaire/assessment template for cases involving strangulation that is available upon request.

Forensic professionals should consider imaging, such as CT angiography, to evaluate vessels and bony/cartilaginous structures for all victims of strangulation. As a reference, the International Association of Forensic Nurses has created a Non-Fatal Strangulation Documentation Toolkit (2016) that includes an in-depth questionnaire and assessment.[8]

Consider using standardized questionnaires/assessment templates to record the specifics of each allegation. The Training Institute on Strangulation Prevention as well as the SRFJC offer guidance for the assessment of strangulation and provide information on strangulation that can be shared with victims/clients. The SRFJC is prepared to provide consultation and training.

THE DA (DA & DA-5) BRIEF STRANGULATION PROTOCOL[9]

When victims report being choked/strangled (item 10a on DA or item 4a on DA-5), follow this strangulation protocol for further assessment and/or referral:

---

[7] Training is typically required to appreciate the clinical implications of using and scoring risk assessment tools. However, you can use any variable from any tool or tools, or you can create your own list of variables to use as a practical guide for understanding a victim's experience and developing a safety plan—but you should not refer to scoring or a clinical interpretation of these variables without training. Contact the SRFJC or visit https://www.dangerassessment.org/ if you are interested in consultation or training.

[8] International Association of Forensic Nurses (2016). Non-Fatal Strangulation Documentation Toolkit, www.ForensicNurses.org.

[9] The DA-TA Center is supported by Grant No. 2015-SI-AX-K005 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. This protocol came from the Practitioner's Guide for the DA-5, which is a brief adaptation of the Danger Assessment (2003). It is designed for use by a health care provider following a positive screen for intimate partner violence. Ref: Messing, J.T., Campbell, J.C., & Snider, C. (2017). Validation and adaptation of the Danger Assessment-5 (DA-5): A brief intimate partner violence risk assessment. Journal of Advanced Nursing, 73, 3220-3230.

- **If the strangulation was less than a week ago:**
  - Examine the inside of the throat, neck, face, and scalp for physical signs of strangulation.
  - Refer to the strangulation assessment and radiographic evaluation information at www.strangulationtraininginstitute.com.
  - Proceed with emergency medical care for strangulation, especially if the victim lost consciousness or possibly lost consciousness (victims may be unsure about loss of consciousness). If the victim lost consciousness, s/he may have become incontinent - ask if victims if they "wet her/himself".

- **If the victim reports more than one strangulation:**
  - Conduct a neurological exam for brain injury or refer for examination.
  - Inform her/him of increased risk of homicide.

- **Notify police and/or prosecutors** when victims want this action.
  - Know state/local law on strangulation and mandatory reporting so that the victim can be informed.

- For more information on homicide risk, please visit www.dangerassessment.org.
- For more information on strangulation, please visit https://www.strangulationtraininginstitute.com.

Abusers (suspects/arrestees) may also benefit from educational information about strangulation. According to Daniel Thomas, (Ret.) Executive Director with MANALIVE Sacramento, Inc., this information has been impactful in the treatment of batterers; it scares them to know about the increased risk of killing their partner the next time.

STAGED SUICIDE SCENES – LISTING THE PREDICTORS (2023/24 Revision)

First responders must be aware that victims of IPV sometimes die at the hands of their abusers only to have their death staged as a suicide. There are valid predictive factors that point to staged IPV related suicides, many of which involve strangulation. To overlook these predictive factors at the cost of a full investigation, and incorrectly label the death a suicide leads to irreversible pain and suffering for family members.

For example: A woman is found dead, hanging by ligature in her closet and discovered by her husband who appears heartbroken and grieving. By all accounts the scene looks like a suicide. Now consider that the husband (who found his wife hanging) has a documented history of domestic violence against his deceased wife. Consider also, that the husband was the last person to see his wife alive and the one who found her dead, meaning that he alone had control of the crime scene. In situations like this, we strongly suggest securing the scene as a potential homicide and calling out investigators. Further, autopsy procedures must be thorough, including internal examination.

In their article, "*The Perfect Murder: An Exploratory Study of Staged Murder Scenes and Concealed Femicide*," Bitton and Dayan (2019) list predictive factors suggestive of staged

suicides[10]. These factors give us reasonable cause to consider protecting scenes, like the one above, for a more thorough investigation. The most common victim-offender relationship involving Homicide Scene Staging is an intimate partner relationship, and the most staged homicide scenes involve the killing of an intimate partner.

This article gives us six predictive factors that suggest foul play:

- A premature death when the deceased was in apparent good health.
- Death by suicide.
- Evidence that one of the partners wished to terminate the relationship.
- Prior domestic violence on the part of the deceased's partner.
- The deceased was found dead in her home.
- The deceased was found dead by her current or previous partner.

In her 2020 Psychology Today article, Joni E. Johnston Psy.D., reminds us that when someone calls 911 and reports a suicide, "*It's easy to take that at face value. It can be difficult and seem unnecessarily harsh to treat the situation as a crime scene and the loved one as a suspect*[11]."

Dr. Johnston points to the 1985 strangulation death of Meg Purk, which was determined at the time to be a suicide. But in 2015, after the case was properly re-investigated, a jury convicted Meg's husband of her murder[12].

The Alliance for Hope International has been looking into these types of cases for years. They have a team of experts dedicated to re-investigating suspicious, domestic violence-related deaths. Most of these cases involve death by strangulation. Take for example, the case of Stacy Feldman, which was featured on dateline[13]. In March 2015, Stacy's husband, Robert called 911, reporting that he found Stacy unresponsive in the shower. She was pronounced dead at the scene. It wasn't until 2017 when Dr. Bill Smock, a member of the review team for the Alliance and an expert in strangulation, reviewed Stacy's case as well as various photographs. He testified that Stacy died as a result of asphyxia and/or suffocation and that her injuries were the result of an assault including blunt force trauma, strangulation and suffocation. In April 2022, after deliberating less than three hours, Robert was convicted of first-degree murder. The Alliance has many more examples.

In reviewing the literature and as a result of their work in this area, the Alliance added four factors to the six listed above by Bitton and Dayan:

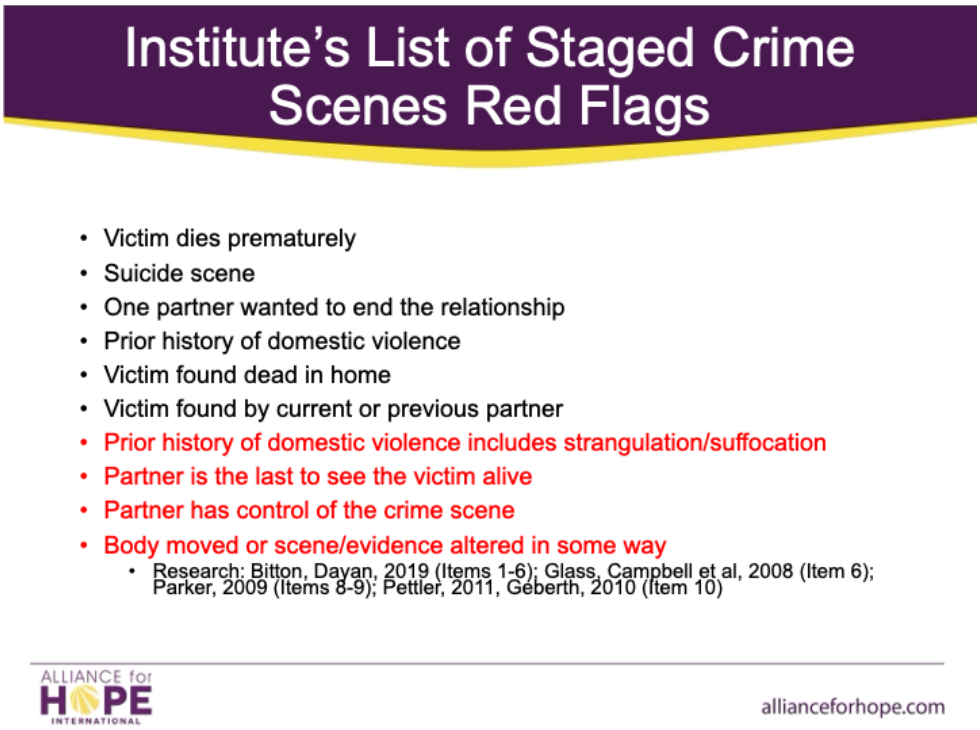
- A prior history of domestic violence that includes strangulation/suffocation.
- The deceased's partner was the last to see her/him alive.
- The surviving partner had control of the crime scene.
- The body had been moved or the scene/evidence had been altered in some way.

[10] Bitton, Y. & Dayan, H. (2019). "*The Perfect Murder: An Exploratory Study of Staged Murder Scenes and Concealed Femicide.*" Oxford University Press on behalf of the Center for Crime and Justice Studies. DOI: 10.1093/bjc/azz015

[11] When 'Suicide' Is Really Murder | Psychology Today

[12] Scott Purk Caught For Murder Of Margaret 'Meg' Purk By Exhumation | Crime News (oxygen.com)

[13] Death of Denver mother Stacy Feldman on 'Dateline' (nbc4i.com)



When responding to a suicide call for service, we must take the time to check for any history of domestic violence and review the ten predictive factors above. For more information, refer to the Training Institute on Strangulation Prevention: "Getting Away with Murder: The Challenges of Staged Crime Scenes (A Focus on Intimate Partner Homicides)[14]. The Alliance offers training courses on this topic. When cases like this arise, please take pause, and consider protecting the scene and calling out investigators.

[14] REGISTER NOW - Getting Away with Murder: The Challenges of Staged Crime Scenes (constantcontact.com)

MEDICAL ATTENTION

Victims may decline or become resistant to medical aid. If there is an obvious reason for medical attention, first responders should consider requesting medical response regardless of the victim's receptiveness. Even if the reported or suspected strangulation is not a recent incident, first responders should strongly recommend that victims seek medical attention. If, after the medic's arrival, the victim refuses medical attention, this must be documented in the report.

HISTORICAL DOCUMENTATION

It is always a good idea to assess the history and environment of IPV, including strangulation. Some variables to consider include 1) past abuse including threats, 2) access to firearms, 3) strangulation, 4) obsessive jealousy/stalking, and 5) threats to commit suicide.

We should all remain mindful of the guidance provided to law enforcement under CA Penal Code Section 13701(b), reminding us that the intent of the law is to protect victims of IPV from continuing abuse and threats creating fear of physical injury. Further, it is important to assess the history of IPV between the persons involved and whether either person acted in self-defense.

A reported history of abuse, including physical, emotional, psychological, sexual and financial abuse, puts the victim's experience in context. It helps identify dominant aggression and the environment of coercive control such as intimidation and isolation. If historical documentation is not done initially, it should be considered when following-up with the victim.

- **Suicidal ideation**: If a history of IPV exists, so may a victim's suicidal ideation. In one study heterosexual women exposed to IPV were seven times more likely to report suicidal ideation than women who had not experienced IPV. Another study found that the more severe the IPV, the greater the risk for suicidal ideation. Nonfatal strangulation is one of the most severe forms of IPV. First responders and follow-up personnel must be sensitive to the potential mental health implications of IPV and nonfatal strangulation[15].

FOLLOW-UP INVESTIGATION

Follow-up investigation is important in strangulation cases. About half of strangulation victims will not have visible injuries. Sometimes injuries develop after the incident. Follow-up photographs can become crucial evidence. Following up on medical care and obtaining authorization for release of confidential medical information can clinically validate a victim's allegations. Follow-up investigations may also include more comprehensive assessment tools, such as the 20-item Danger Assessment.

In addition to assessing injuries and medical care, law enforcement may wish to consider following up with prosecutors and their advocates. Sacramento County sees many thousands of IPV cases each year. When cases involve strangulation, a discussion with the intake attorney or prosecutor

[15] *Cavanaugh, C., Messing, J., Del-Colle, M., O'Sullivan, C., & Campbell, J. (2011). Prevalence and Correlates of Suicidal Behavior among Adult Female Victims of Intimate Partner Violence. Suicide Life Threat Behav. 2011; 41(4): 372-383. This article cites studies by Afifi, et al., 2009; Coker, et al., 2002; and Santo-DiLorenzo & Sharps, 2007).*

may otherwise inform them of salient information that can help with critical decisions regarding case filing and prosecution.

SAFETY PLANNING

Helping victims and families with safety planning is important. Safety planning is something that all of us, regardless of agency or discipline, should do. Safety plans must consider a victim's financial burden as well as language, culture, and gender identity. The National Coalition Against Domestic Violence (NCADV) has information on safety planning: https://ncadv.org.

A safety plan is not a static product but changes as situations change. It may be as simple as one or two questions or much more comprehensive. Safety plans should be assessed and revised as needed. Consider the following situations:

- Safety before and during an attack.
- Safety when preparing to leave.
- Safety when exiting the relationship.
- Safety during separation.
- Safety when living alone.
- Safety when getting a protective order.
- Safety at work and in public.
- Emotional health and safety.
- Items to take when leaving.
- Emergency contacts.

ADDENDUMS

- Five Myths about Strangulation
- Strangulation Assessment Card
- Signs and Symptoms of Strangulation
- Recommendations for Medical Evaluation
- Strangulation Facts for First Responders
- Strangulation Documentation Forms (four pages)[16]

[16] From San Diego County

FIVE MYTHS ABOUT STRANGULATION

Prepared by Gerald Fineman, Assistant District Attorney, Riverside County, and Dr. William Green, Medical Director, California Clinical Forensic Medical Training Center/ CDAA

MYTH 1

STRANGULATION AND CHOKING ARE THE SAME THING

FACT

STRANGULATION is the external application of physical force that impedes either air or blood to or from the brain.

CHOKING is an internal obstruction of the airway by a foreign object.

SOLUTION

Use a diagram.

Compare to the flow of electrical current.

Compare to the flow of air/water through a closed system (fish tank).

MYTH 2

STRANGULATION ALWAYS LEAVES VISIBLE INJURIES

FACT

Studies show that over half the victims of strangulation lack visible external injury. A victim without visible external injury can still die from strangulation.

SOLUTION

Demonstrate cutting off blood flow to your fingertips by squeezing your wrist with your other hand. Upon release of the grip, you will likely have no identifiable marks. If you do, they will be very short in duration.

MYTH 3

IF THE VICTIM CAN SPEAK, SCREAM, OR BREATHE, THEY ARE NOT BEING STRANGLED

FACT

Since strangulation involves obstruction of blood flow, a person can have complete obstruction and continue breathing until the moment they die from lack of oxygenated blood flow to the brain.

SOLUTION

Again, grab your wrist and squeeze. You can still breathe, yet blood flow is obstructed to the fingertips. If this was the victim's neck, they could still have an open trachea (windpipe) but have lack of blood flow to the brain.

MYTH 4

STRANGULATION CANNOT BE HARMFUL BECAUSE MANY PEOPLE PRACTICE IT (MARTIAL ARTS, MILITARY, LAW ENFORCEMENT)

FACT

Martial arts are a form of combat. The military and law enforcement use strangulation as a lethal form of force.

RISK

There are numerous incidents of death resulting from strangulation. This can even occur during otherwise supervised events, such as sporting events, law enforcement training, etc.

MYTH 5

STRANGULATION VICTIMS SHOULD BE ABLE TO DETAIL THEIR ATTACK

FACT

Trauma impacts the brains ability to store memory. In addition, the hippocampus (part of the brain where memory is stored) is the most sensitive to oxygen deprivation.

When a victim is strangled, both factors can impact the ability to recall.

SOLUTION

Give the example of how limiting the flow of electricity to a digital recording device will prevent it from recording.

strangulationtraininginstitute.com | institute@allianceforhope.com | (888) 511-3522 | 101 West Broadway, Suite 1770, San Diego, CA 92101

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.

STRANGULATION
ASSESSMENT CARD

SIGNS

- Red eyes or spots (Petechiae)
- Neck swelling
- Nausea or vomiting
- Unsteady
- Loss or lapse of memory
- Urinated
- Defecated
- Possible loss of consciousness
- Ptosis – droopy eyelid
- Droopy face
- Seizure
- Tongue injury
- Lip injury
- Mental status changes
- Voice changes

SYMPTOMS

- Neck pain
- Jaw pain
- Scalp pain (from hair pulling)
- Sore throat
- Difficulty breathing
- Difficulty swallowing
- Vision changes (spots, tunnel vision, flashing lights)
- Hearing changes
- Light headedness
- Headache
- Weakness or numbness to arms or legs
- Voice changes

CHECKLIST

S **Scene & Safety**. Take in the scene. Make sure you and the victim are safe.

T **Trauma**. The victim is traumatized. Be kind. Ask: what do you remember? See? Feel? Hear? Think?

R **Reassure & Resources**. Reassure the victim that help is available and provide resources.

A **Assess**. Assess the victim for signs and symptoms of strangulation and TBI.

N **Notes**. Document your observations. Put victim statements in quotes.

G **Give**. Give the victim an advisal about delayed consequences.

L **Loss of Consciousness**. Victims may not remember. Lapse of memory? Change in location? Urination? Defecation?

E **Encourage**. Encourage medical attention or transport if life-threatening injuries exist.

TRANSPORT

If the victim is **Pregnant** or has life-threatening injuries which include:

- Difficulty breathing
- Difficulty swallowing
- Petechial hemorrhage
- Vision changes
- Loss of consciousness
- Urinated
- Defecated

DELAYED CONSEQUENCES

Victims may look fine and say they are fine, but just underneath the skin there would be internal injury and/or delayed complications. Internal injury may take a few hours to be appreciated. The victim may develop delayed swelling, hematomas, vocal cord immobility, displaced laryngeal fractures, fractured hyoid bone, airway obstruction, stroke or even delayed death from a carotid dissection, bloodclot, respiratory complications, or anoxic brain damage.

Taliaferro, E., Hawley, D., McClane, G.E. & Strack, G. (2009), Strangulation in Intimate Partner Violence. *Intimate Partner Violence: A Health-Based Perspective.* Oxford University Press, Inc.

This project is supported all or in part by Grant No. 2014-TA-AX-K008 awarded by the Office on Violence Against Women, U.S. Dept. of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

ADVISAL TO PATIENT

- After a strangulation assault, you can experience internal injuries with a delayed onset of symptoms, usually within 72 hours. These internal injuries can be serious or fatal.
- Stay with someone you trust for the first 24 hours and have them monitor your signs and symptoms.
- Seek medical attention or call 911 if you have any of the following symptoms: difficulty breathing, trouble swallowing, swelling to your neck, pain to your throat, hoarseness or voice changes, blurred vision, continuous or severe headaches, seizures, vomiting or persistent cough.
- The cost of your medical care may be covered by your state's victim compensation fund. An advocate can give you more information about this resource.
- The National Domestic Violence Hotline number is **1-888-799-SAFE.**

NOTICE TO MEDICAL PROVIDER

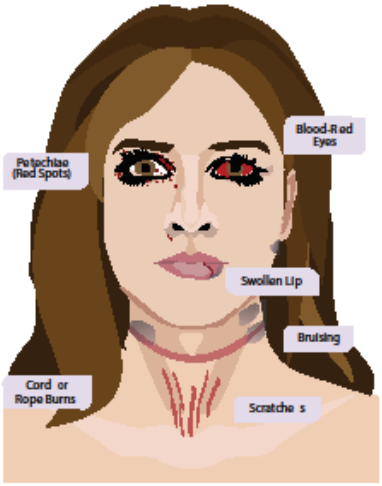
- The Medical Advisory Board of the Training Institute on Strangulation Prevention has developed recommendations for the radiologic evaluation of the adult strangulation victim. In patients with a history of a loss of consciousness, loss of bladder or bowel control, vision changes or petechial hemorrhage the medical provider must evaluate the carotid and vertebral arteries, bony/cartilaginous and soft tissue neck structures and to the brain for injuries. The recommendations with the medical references is available at www.strangulationtraininginstitute.com
- Life-threatening injuries include evidence of petechial hemorrhage, loss of consciousness, urination, defecation and/or visual changes. If your patient exhibits any of the above symptoms, medical/radiographic evaluation is strongly recommended. Radiographic testing should include: a CT angiography of carotid/vertebral arteries (most sensitive and preferred study for vessel evaluation) or CT neck with contrast, or MRA/MRI of neck and brain.
- ED/Hospital observation should be based on severity of symptoms and reliable home monitoring.
- Consult Neurology, Neurosurgery and/or Trauma Surgery for admission.
- Consider an ENT consult for laryngeal trauma with dysphonia, odynophagia, dyspnea.
- Discharge home with detailed instructions to return to ED if neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens.

TRAINING INSTITUTE on STRANGULATION PREVENTION

StrangulationTrainingInstitute.com

Strangulation

Visible Signs (may not be present)



Additional Signs and Symptoms

A larger version of the graphic above which contains detailed signs and symptoms is available for download at strangulationtraininginstitute.com/Esperanza

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.

Strangulation has only recently been identified as one of the most lethal forms of domestic violence: unconsciousness may occur within seconds and death within minutes. When domestic violence perpetrators choke (strangle) their victims, not only is this a felonious assault, but it may be an attempted homicide. Strangulation is an ultimate form of power and control, where the batterer can demonstrate control over the victim's next breath; having devastating psychological effects or a potentially fatal outcome.

Sober and conscious victims of strangulation will first feel terror and severe pain. If strangulation persists, unconsciousness will follow. Before lapsing into unconsciousness, a strangulation victim will usually resist violently, often producing injuries of their own neck in an effort to claw off the assailant, and frequently also producing injury on the face or hands to their assailant. These defensive injuries may not be present if the victim is physically or chemically restrained before the assault.

Observing Changes

Documentation by photographs sequentially for a period of days after the assault is very helpful in establishing a journal of physical evidence.

Victims should also seek medical attention if they experience difficulty breathing, speaking, swallowing or experience nausea, vomiting, lightheadedness, headache, involuntary urination and/ or defecation, especially pregnant victims. A medical evaluation may be crucial in detecting internal injuries and saving a life.

Losing Consciousness

Victims may lose consciousness by any one or all of the following methods: blocking of the carotid arteries in the neck (depriving the brain of oxygen), blocking of the jugular veins (preventing deoxygenated blood from exiting the brain), and closing off the airway, making breathing impossible.

a program of HOPE INTERNATIONAL
strangulationtraininginstitute.com

Sacramento Regional Family Justice Center
916-875-4673
3701 Power Inn Road, Suite 3100
Sacramento, CA 95826

Facts Victims of Strangulation (Choking) Need to Know

Monitor Your SIGNS

Date & Time	Journal Your Signs

Monitor Your SYMPTOMS

Date & Time	Journal Your Syptoms

Date & Time	Journal Any Other Sensation

Signs of Strangulation

Head- pinpoint red spots (petechiae) on scalp, hair pulled, bump(s), skull fracture, concussion.
Face- red or flushed, petechiae, scratch marks.
Eyes and Eyelids- petechiae to the left or right eyeball, bloodshot eyes.
Ear- petechiae (external and/or ear canal), bleeding from ear canal.
Nose- bloody nose, broken nose, petechiae.
Mouth- bruising, swollen tongue, swollen lips, cuts/ abrasions.
Under the chin- redness, scratch marks, bruise(s), abrasions.
Neck- redness, scratch marks, fingernail impressions, bruise(s), abrasions, swelling, ligature marks.
Chest and Shoulders- redness, scratch marks, bruise(s), abrasions.

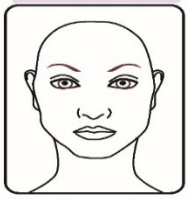
Symptoms of Strangulation

Voice changes- raspy and/or hoarse voice, coughing, unable to speak, complete loss of voice.
Swallowing changes- trouble swallowing, painful swallowing, neck pain, nausea/vomiting, drooling.
Breathing changes- difficulty breathing, hyperventilation, unable to breathe.
Behavioral changes- restlessness or combativeness, problems concentrating, amnesia, agitation, Post-traumatic Stress Syndrome, hallucinations.
Vision changes- complete loss or black & white vision, seeing 'stars', blurry, darkness, fuzzy around the eyes.
Hearing changes- complete loss of hearing, gurgling, ringing, buzzing, popping, pressure, tunnel-like hearing.
Other changes- memory loss, unconsciousness, dizziness, headaches, involuntary urination or defecation, loss of strength, going limp.

Diagrams to Mark Visible Injuries

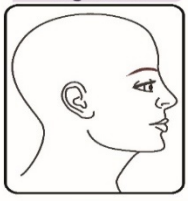
Use a pen or a marker to indicate any visble signs and/or symptoms.

Front

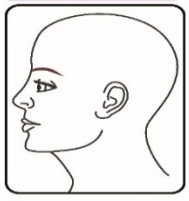


Under Chin

Right Side

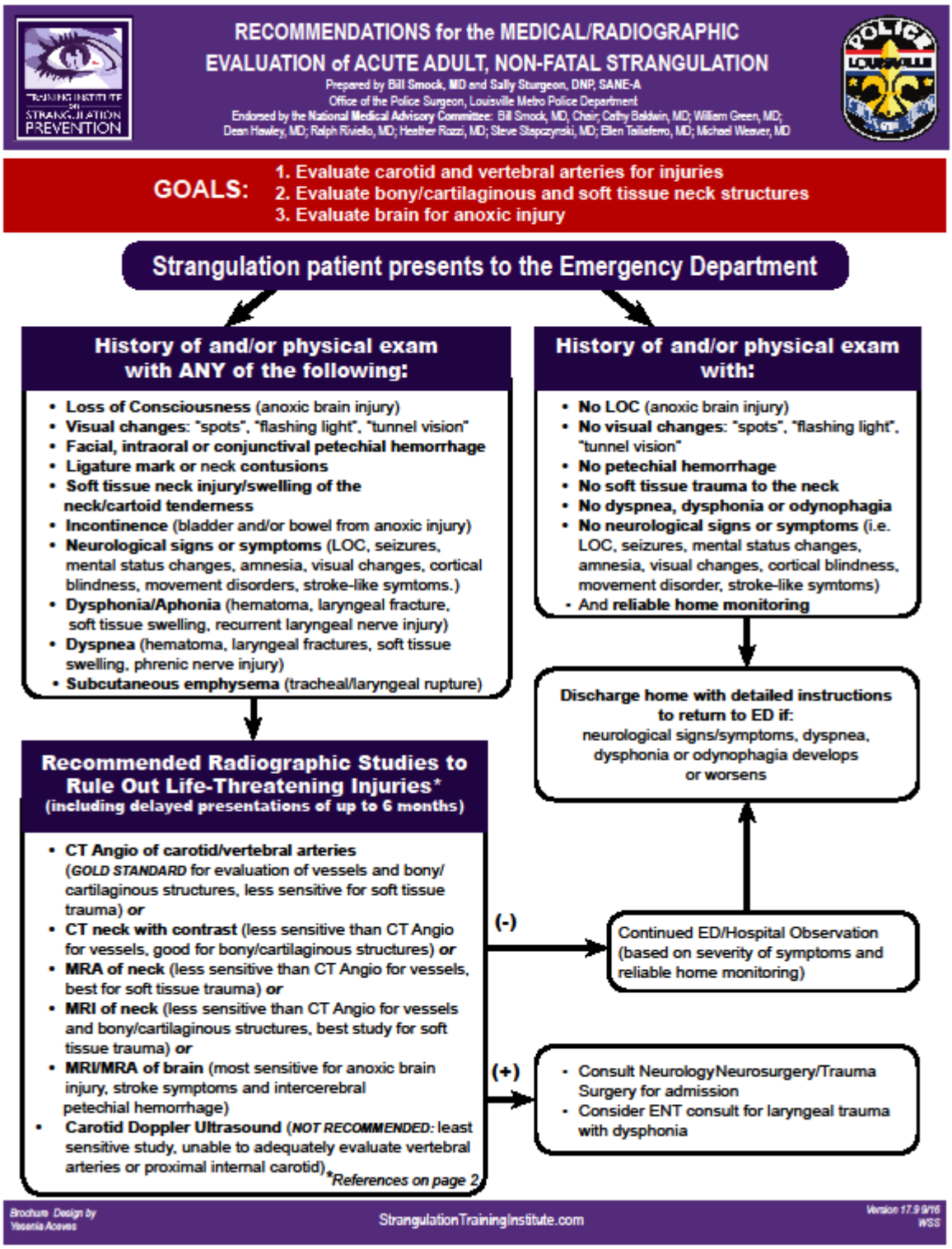


Left Side



Back

Inside Mouth


RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION
Prepared by Bill Smock, MD and Sally Sturgeon, DNP, SANE-A
Office of the Police Surgeon, Louisville Metro Police Department
Endorsed by the National Medical Advisory Committee: Bill Smock, MD, Chair; Cathy Baldwin, MD; William Green, MD; Dean Hawley, MD; Ralph Riviello, MD; Heather Rozzi, MD; Steve Stapczynski, MD; Ellen Taliaferro, MD; Michael Weaver, MD
GOALS:
1. Evaluate carotid and vertebral arteries for injuries
2. Evaluate bony/cartilaginous and soft tissue neck structures
3. Evaluate brain for anoxic injury
Strangulation patient presents to the Emergency Department
History of and/or physical exam with ANY of the following:
• Loss of Consciousness (anoxic brain injury)
• Visual changes: "spots", "flashing light", "tunnel vision"
• Facial, intraoral or conjunctival petechial hemorrhage
• Ligature mark or neck contusions
• Soft tissue neck injury/swelling of the neck/cartoid tenderness
• Incontinence (bladder and/or bowel from anoxic injury)
• Neurological signs or symptoms (LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorders, stroke-like symtoms.)
• Dysphonia/Aphonia (hematoma, laryngeal fracture, soft tissue swelling, recurrent laryngeal nerve injury)
• Dyspnea (hematoma, laryngeal fractures, soft tissue swelling, phrenic nerve injury)
• Subcutaneous emphysema (tracheal/laryngeal rupture)
History of and/or physical exam with:
• No LOC (anoxic brain injury)
• No visual changes: "spots", "flashing light", "tunnel vision"
• No petechial hemorrhage
• No soft tissue trauma to the neck
• No dyspnea, dysphonia or odynophagia
• No neurological signs or symptoms (i.e. LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorder, stroke-like symtoms)
• And reliable home monitoring
Discharge home with detailed instructions to return to ED if:
neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens
Recommended Radiographic Studies to Rule Out Life-Threatening Injuries*
(including delayed presentations of up to 6 months)
• CT Angio of carotid/vertebral arteries (GOLD STANDARD for evaluation of vessels and bony/cartilaginous structures, less sensitive for soft tissue trauma) or
• CT neck with contrast (less sensitive than CT Angio for vessels, good for bony/cartilaginous structures) or
• MRA of neck (less sensitive than CT Angio for vessels, best for soft tissue trauma) or
• MRI of neck (less sensitive than CT Angio for vessels and bony/cartilaginous structures, best study for soft tissue trauma) or
• MRI/MRA of brain (most sensitive for anoxic brain injury, stroke symptoms and intercerebral petechial hemorrhage)
• Carotid Doppler Ultrasound (NOT RECOMMENDED: least sensitive study, unable to adequately evaluate vertebral arteries or proximal internal carotid)
*References on page 2
(-)
Continued ED/Hospital Observation (based on severity of symptoms and reliable home monitoring)
(+)
• Consult Neurology Neurosurgery/Trauma Surgery for admission
• Consider ENT consult for laryngeal trauma with dysphonia
Brochure Design by Yesenia Aceves
StrangulationTrainingInstitute.com
Version 17.9 9/16 WSS

Topic: Strangulation

Goal:
To provide officers with pertinent information about the occurrence of strangulation and highlight strangulation as a high indicator of lethality in order to strengthen response to this underreported crime.

Strangulation Facts

- Strangulation refers to external compression of the neck impeding blood flow and oxygen transport to or from the brain.
- Strangulation in VAW crimes is alarmingly high, yet documentation on police reports is extremely low.
- Strangulation has been identified as one of the most lethal forms of domestic violence.
- Injuries often appear to be mild with no visible marks, but internal damages which are not visible may progress to a fatal outcome.
- Unconsciousness may occur within seconds and death within minutes.
- Efforts should be made to investigate strangulation cases like an attempted homicide case.
- The odds of becoming an homicide victim increased by 800% for women who had been strangled by their partner.

"On the Edge of Homicide: Strangulation as a Prelude" Gael Strack and Casey Gwinn, *Criminal Justice,* The American Bar Association, Vol. 26, No. 3 (2011)

National Law Enforcement First-Line Supervisor Training on Violence Against Women

What other procedures need to be followed?

- Look for injuries behind the ears, all around the neck, chin, jaw, eyelids, shoulders and chest area.
- Be sure to take photographs of any visible injury however minor and describe injuries in report.
- Document and describe medical treatment that was offered or given to the victim.

What questions should you ask of victims to establish if strangulation occurred and gather the details?

1. Did the suspect put his hands/object on your neck?
2. If so, describe method. One or two hands? Forearm? Object?
3. What did the suspect say while he was strangling you?
4. Were you shaken simultaneously while being strangled? Describe.
5. How long did the suspect strangle you?
6. How many times were you strangled? Describe each incident and method.
7. Did you black out? Any light headedness?
8. Any difficulty breathing? Any complaint of a hoarse or raspy voice?
9. Any complaint of pain to throat, coughing, or trouble swallowing?
10. Did you vomit, urinate, or defecate as a result of being strangled?
11. Any prior incidents of strangulation?

"On the Edge of Homicide: Strangulation as a Prelude" Gael Strack and Casey Gwinn, *Criminal Justice,* The American Bar Association, Vol. 26, No. 3 (2011)

STRANGULATION/SUFFOCATION INVESTIGATIVE WORKSHEET

AGENCY NAME

VICTIM/OFFENDER/WITNESS INFORMATION

REPORT NUMBER:

Victim's name: DOB:

Offender's name: DOB:

Relationship: Length of relationship: Relationship status?

History of D.V.

Is there an active Order of Protection? Yes No If so, issue date: Court:

Who else was present during the attack? , ,

Who have you called, texted or spoken with about this incident?

MEDICAL

Was the victim transported to the hospital? Yes No Refused Transporting EMS:

Name of Hospital: Medical Professional:

Medical Release obtained? Yes No Is the victim pregnant? Yes No If so, how far along?

Recent Hospital, ER, or Urgent Care visits?

MANNER AND METHOD OF STRANGULATION/SUFFOCATION

CHECK ALL THAT APPLY: One Hand (L or R) Two Hands Forearm Knee/Foot Strangulation Hold

Object over Nose & Mouth (Manual or Object) Ligature Pressure to Chest/Abdomen Other:

Describe:

Duration the victim was strangled/suffocated: Sec. Min. Unsure Multiple times? Yes No Do you have pain now? Yes No

Describe:

Were you simultaneously shaken while being strangled? Yes No Unsure Was your head hit in any way? Yes No Unsure

Pressure exerted on your neck/nose/mouth. Select one (1=Weak - 10=Very Strong): 1 2 3 4 5 6 7 8 9 10

Extent of pain experienced during strangulation/suffocation. Select one (1=Weak - 10=Very Strong): 1 2 3 4 5 6 7 8 9 10

Did you lose of consciousness? Yes No Unsure Have there been prior incidents of strangulation/suffocation? Yes How many times? No

Describe:

VICTIM'S BREATHING:

Was there a time when you could not talk or scream while being strangled? Yes No Was it difficult for you to breathe? Yes No

Describe your ability to breathe. Select one (1=Normal-10=Unable to breathe): 1 2 3 4 5 6 7 8 9 10

Pain while breathing? Yes No Shallow breathing? Yes No Clearing of the throat? Yes No Rapid breathing? Yes No

Any other changes to your breathing? Yes No Describe:

INTENTION/OFFENDER MENTAL STATE

What did the offender say during/after the attack?

What did you think was going to happen to you?

What caused the attack to stop?

Describe the offender's demeanor and facial expressions during the attack:

INVESTIGATIVE/CRIME SCENE/ADVOCACY

Lethality/Risk/Danger Assessment completed DV Forensic Exam completed by a Forensic Nurse Examiner

Does the Offender have access to firearms? Yes No Location of firearms: Firearms seized?

Photographs of all Injuries and physical evidence: Victim Suspect Scene(s). Taken by:

Audio Recordings of all interviews Body-worn Camera Recording

Evidence Collection (ligature, weapon, soiled clothing, surveillance videos, cell phone messages/voice recordings, etc.)

Detective notified or responded: , ,

Victim Advocate notified: DV Pamphlets/Crisis/Referral Information given to the victim

strangulationtraininginstitute.com | institute@allianceforhope.com | (888) 511-3522

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.

TRAINING INSTITUTE on STRANGULATION PREVENTION

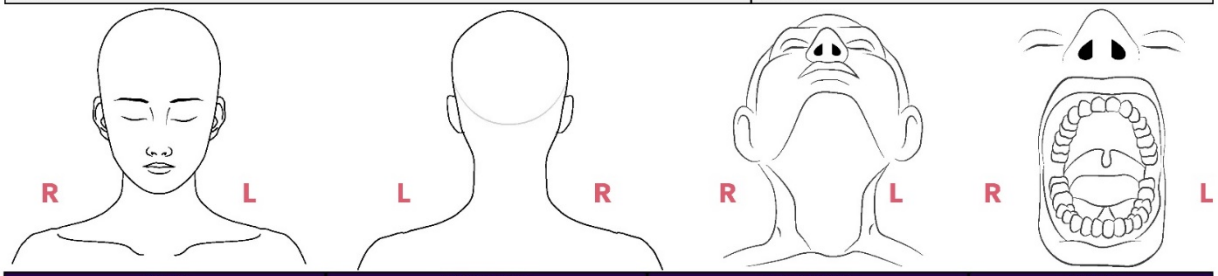
SYMPTOMS

SYMPTOMS	DURING	AFTER	UNSURE	NO	DESCRIPTION
Headache					
Dizziness/Feel Faint					
Disoriented					
Loss or changes in vision					
Loss or changes in hearing					
Raspy/Hoarse Voice					
Difficulty Speaking					
Unable to Speak					
Painful to Swallow					
Trouble Swallowing					
Sore Throat					
Neck Pain					
Coughing					
Nausea					
Vomiting/Dry Heaving					
Physical Pain					
*Involuntary Urination					
*Involuntary Defecation					
Other					

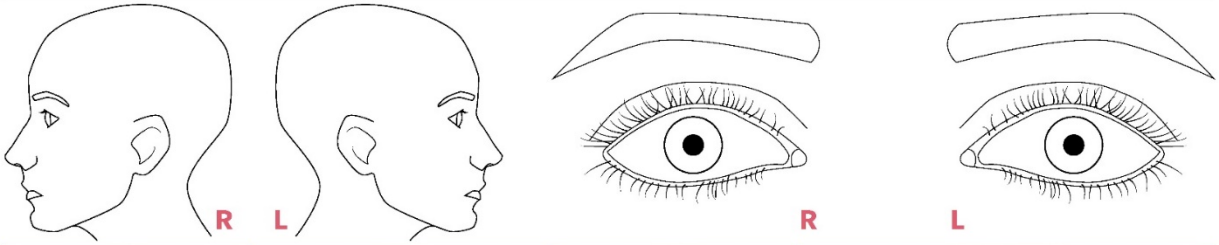
*Is the victim wearing the same clothes that they were wearing during the attack? Did they change clothes?

VISIBLE SIGNS

NECK			HEAD	
Redness or Bruising	Location:		Bumps	Hair pulled
Scratches/Abrasions	Impression marks	Location:	Petechiae on scalp	Hair missing
Ligature Marks	Petechiae	Location:	Scratches/Abrasions	Laceration(s)
Describe:			Describe:	



CHEST	SHOULDERS	UNDER CHIN	MOUTH
Redness or Bruising	Redness or Bruising	Redness or Bruising	Swollen Lip(s)
Scratches/Abrasions	Scratches/Abrasions	Scratches/Abrasions	Abrasions/Lacerations
Laceration(s)	Laceration(s)	Laceration(s)	Swollen tongue
Describe:	Describe:	Describe:	Petechiae (palate)



FACE	EARS	NOSE	EYES & EYELIDS
Redness or Flushed	Swelling	Scratches/Abrasions	Petechiae in eye(s) Right Left
Scratches/Abrasions	Bruising	Swelling	Petechiae in eyelid(s) Right Left
Petechiae	Petechiae Right Left	Nasal fracture	Blood in eyeball(s) Right Left
Bruising	Bleeding from ear(s) Right Left	Petechiae	Orbital fracture(s) Right Left