Responding to Strangulation in Kentucky

Guidelines for Prosecutors, Law Enforcement, Health Care Providers, and Victim Advocates

2025

Office of the Kentucky Attorney General

Office of Victims Advocacy

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ATTORNEY GENERAL RUSSELL COLEMAN

January 15, 2025

Dear Colleagues,

Thank you for your commitment to pursuing justice for crime victims and their families. Your efforts are advancing public safety and helping to protect Kentucky families.

This Manual, Kentucky's first-ever comprehensive toolkit on the investigation and prosecution of strangulation, discusses our response to this horrific crime in our Commonwealth. It's the product of zealous collaboration among the Office of the Attorney General, law enforcement, medical professionals and experts from across Kentucky. This is one of the many tools developed to aid you in your pursuit of justice for victims, survivors and their families.

Strangulation is a deadly crime. People who strangle are some of the most dangerous criminals– not only with intimate partner violence, but they are also known to commit lethal crimes against other family members and police officers. People who are able to use their hands as lethal weapons need to be stopped.

In 2019, Kentucky's General Assembly passed legislation making Strangulation a serious felony crime. We are publishing "Responding to Strangulation in Kentucky" to promote best practices in handling these cases at every step from the investigation, to medical treatment, to prosecution and advocacy.

I hope you find this Manual a helpful resource to keep our Commonwealth safe. Please never hesitate to reach out to the Attorney General's Office of Victims Advocacy at (502) 696-5312 if you need additional assistance or have questions about this manual.

Gratefully,

Russell M. Coleman

RUSSELL COLEMAN
ATTORNEY GENERAL

ACKNOWLEDGMENTS

The development of "Responding to Strangulation in Kentucky: Guidelines for Prosecutors, Law Enforcement, Health Care Providers, and Victim Advocates," Kentucky's first-ever manual to combat this horrific crime, was the result of zealous collaboration from professionals, experts and public servants from across Kentucky. We are incredibly grateful to these individuals for their commitment to protecting Kentuckians from this deadly crime and pursuing justice for crime victims. Their contributions made this Manual an effective resource that we hope will be heavily relied on in the years ahead.

The Responding to Strangulation in Kentucky Manual Working Group was a multidisciplinary team effort. This was led by the Kentucky Office of the Attorney General (KYOAG) Office of Victims Advocacy Executive Director Robyn Diez d'Aux. Prosecutors and legal professionals included Rewa Zakharia, KYOAG Criminal Chief, Aimee Clymer-Hancock, KYOAG Office of Victims Advocacy Deputy Executive Director, Kathy Phillips, KYOAG Prosecutors Advisory Council Domestic Violence Resource Prosecutor, Bill Knoebel, Boone County's First Assistant County Attorney, and Denise Durbin, KYOAG Special Counsel. Sergeant Sarah Mantle of the Louisville Metro Police Department's Professional Standards Unit represented law enforcement. Victim advocates included Erica Paske, KYOAG Victim Advocate, and Brittany Scordo, Clinical Program Manager for The Nest. Medical providers were Carla Hay, Kentucky Children's Hospital Pediatric Forensic Nurse, Dr. Christina Howard, Kentucky Children's Hospital Chief, Division of Pediatric Forensic Medicine, Jill Brummett, SANE, Forensic Nurse Manager with St. Elizabeth Healthcare, and Selena McCormick, Forensic Nurse and Violence Prevention Coordinator with St. Elizabeth Healthcare. Several University of Cincinnati Law students assisted with legal research. Meghan Rimer ('24), previously worked for two victim rights attorneys; Katherine Vuyk ('24), interned in the 54th Judicial Circuit, and Ainsley Ayres ('25), interned for both the Kenton County Commonwealth Attorneys Office and the U.S. Attorneys Office for the Southern District of Ohio.

We would also like to acknowledge the contribution and collaboration of The Training Institute on Strangulation Prevention, a program of Alliance for HOPE International. Specifically, Chief Executive Officer Gael Strack, President Casey Gwinn, Law Enforcement Support Coordinator Joe Bianco and Program Manager Fernanda España. Thank you to all professionals who contributed to the creation of the Alaska and California Strangulation Manuals, which provided the foundation for the Kentucky Manual. Finally, we acknowledge the expert guidance found in the multiple resources, publications and best practices guides developed by the National District Attorneys Association, AEquitas and the Blueprint for Safety.

TABLE OF CONTENTS

Chapter 1: Introduction

"Men use strangulation for control and power over women. Once they learn it, they don't stop." Dr. Ellen Taliaferro

Strangulation impacts all professionals working on sexual assault, domestic violence, dating violence, and stalking cases. Today, it is understood unequivocally that strangulation is a lethal form of domestic violence.

Strangulation is one of the most accurate predictors for the subsequent homicide of victims of domestic violence. Strangulation is the calling card of a serial rapist. The problem of intimate partner violence (IPV) is multifaceted, but experts agree there are few offenses as indicative of an intent to control, harm, and/or kill than strangulation. In fact, if a person is strangled even one time, the victim's chance of being killed by their abuser is increased by 750%.[1] IPV offenses result in approximately forty (40) deaths in Kentucky annually.[2] Perpetrators are most often male; their victims are usually female, and two-thirds of the time, the victim and the assailant live together.[3]

A historic failure to provide resources to strangulation assault victims, as well as systemic poverty, has caused Kentucky to have one of the highest IPV rates in the country and be placed it in the top ten states where men murder women.[4] As members of a multidisciplinary groups striving to end strangulation and to bring justice to victims, it is futile to act purely in a retroactive sense. In order to address the problem, it is imperative to understand where it came from and why Kentucky fosters an environment that cyclically excludes victims and enables and empowers these violent and dangerous offenders.

At the beginning of the twentieth century, Kentucky had not yet adopted the women's rights reforms that other states had.[5] Because it had not seceded from the Union during the Civil War, it had not experienced the same post-war constitutional revisions that had improved women's social state and economic rights in the former Confederate states.[6] It was not until the 1970s that Kentucky began instituting reforms for women's rights in the state.[7]

Kentucky's first rape crisis center was opened in Lexington in 1971, and its first domestic violence shelter opened in Louisville in 1977.[8] [9] A decade later, shelters were operating in each

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[1] Glass, Nancy et al. "Non-fatal strangulation is an important risk factor for homicide of women." *The Journal of emergency medicine* vol. 35,3 (2008): 329-35.
[2] https://www.ncbi.nlm.nih.gov/books/NBK499924/
[3] *Id.*
[4] https://www.kentucky.gov/Pages/Activity-stream.aspx?n=SOS&prId=483; See also "When Men Murder Women: An Analysis of 2020 Homicide Data", (2022), Violence Policy Center. https://vpc.org/when-men-murder-women-section-one/ (accessed July 8, 2024)
[5] Jordan, Carol E. "Violence against Women in Kentucky: A History of U.S. and State Legislative Reform." University Press of Kentucky, 2014.
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] https://www.zerov.org/our_history (accessed July 8, 2024).

of Kentucky's fifteen area development districts.[10] Despite these changes, there were still challenges – the Lexington rape crisis center was one of only four centers of their kind in the state.[11] Through the founding of rape crisis centers and domestic violence programs and the creation of state-level associations that addressed sexual assault and IPV, the bedrock for Kentucky's legislative reforms began to form.[12] In 2019 strangulation became a felony offense , making Kentucky one of the last five states to make strangulation a crime. Investigators can now charge a felony that fits the crime instead of an assault fourth degree misdemeanor. .[13]

Domestic violence knows no barriers regarding education, social or economic status, or religion. However, risk factors such as poverty, low levels of education, and substance or drug abuse tend to be aggravating factors. For example, low-income individuals in abusive relationships tend to have little to no economic resources and often have no means to leave the abusive relationship.[14] Incidences of IPV are significantly higher in relationships with substance abusers as opposed to those without, as tobacco, alcohol, narcotics, and other substances can trigger violence.[15]

Kentucky, as it stands, is one of the poorest states in the country.[16] It ranked the fifth poorest in 2021, with 16.5% of the population living in poverty.[17] The unemployment rate is higher than the countrywide average by .4%, with approximately 80,000 individuals without work.[18] Opioid dependence is a significant concern.[19] Only 32.7% of Kentucky individuals 25 or older have a high school level of education, and only 27% have a Bachelor's degree or higher.[20] Comparatively, 37% of individuals have a Bachelor's degree or higher countrywide.[21] In comparison to the rest of the country, Kentucky has a significantly higher level of risk factors for domestic violence playing into the equation.

These statistics illustrate Kentucky's nature to cultivate an environment that is favorable for strangulation offenders, who go on to influence another generation. Young girls raised in an

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[10] *Id.*
[11] *Id.*
[12] Jordan, Carol E. "Violence against Women in Kentucky: A History of U.S. and State Legislative Reform." University Press of Kentucky, 2014.
[13] Emery, Author: Tyler. "Kentucky Becomes One of the Last States to Make Non-Fatal Strangulation a Felony Crime." whas11.com, November 15, 2019. https://www.whas11.com/article/news/local/kentuckystrangulationlaw/417-be00e9de-73e9-4af1-ae29-dcbe4b398c88#:~:text=Kentucky%20is%20one%20of%20the,handled%20as%20an%20assault%20four. (accessed July 8, 2024).
[14] Slabbert, I. (2017). Domestic Violence and Poverty: Some Women's Experiences. *Research on Social Work Practice*, *27*(2), 223-230. https://journals.sagepub.com/doi/pdf/10.1177/1049731516662321(accessed July 8, 2024).
[15] Bhatt, R.V., Domestic Violence and Substance Abuse (1998), Int. J. of Gyn. & Obstetrics, Volume 63, Issue S1. Pages S25-S31. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1016/S0020-7292%2898%2900181-7 (accessed July 8, 2024)
[16] https://www.fcnl.org/updates/2023-11/top-10-poorest-states-us (accessed July 8, 2024).
[17] *Id.*
[18] *Id.*
[19] https://kentucky.kvc.org/2022/12/30/what-you-need-to-know-about-the-opioid-epidemic-in-kentucky-2/ (accessed July 8, 2024).
[20] https://www.kentucky.com/news/local/education/article128422124.html (accessed July 8, 2024).
[21] https://www.census.gov/newsroom/press-releases/2023/educational-attainment-data.html#:~:text=Bachelor's%20degree%20share%20has%20not,difference%20is%20not%20statistically%20significant. (accessed July 8, 2024).

abusive home where they witness domestic violence are six times more likely to be abused than a girl who grows up in a home without abuse, whereas men are nearly ten times more likely to become abusers themselves.[22] How children are nurtured and exposed to violence has long-lasting impacts that perpetuate the cycle of abuse.

High rates of poverty, substance abuse, and a lack of education combined with inadequate resources for victims make it difficult for victims to escape this vicious cycle. The same factors multiplied with exposure to these violent behaviors as a child makes the problem all the worse. The result is a pervasive and systemic problem.

The Training Institute on Strangulation Prevention, a program of Alliance for HOPE International, and this document, "Responding to Strangulation in Kentucky", are here to support, equip, and empower criminal justice professionals and their community partners to respond to these life-threatening crimes. Together, we can fight to end domestic violence in Kentucky.

[22] https://www.womenshealth.gov/relationships-and-safety/domestic-violence/effects-domestic-violence-children (accessed July 8, 2024).

Chapter 2: Strangulation Laws[23]

Victims of non-fatal strangulation have known for years what legal and law enforcement professionals are only now learning - many domestic violence offenders do not strangle their partners to kill them. Instead, they strangle to send a message that they *can* kill them, any time they wish. Once a victim believes this to be true, they live under the power and control of their perpetrator daily.

There are multi-faced reasons for not appreciating strangulation's lethality. When it comes to presenting cases of strangulation, prosecutors face numerous hurdles including non-participating or terrified victims, few, or no witnesses, lack of visible injury, and a lack of any documented physical evidence. As a result, many prosecutors decline to prosecute.

Fortunately for victims of strangulation, this attitude has begun to change. As a result of the efforts of medical professionals, an emphasis upon specialized training for police and prosecutors, and ongoing research, strangulation has become a focus area for policymakers and professionals working to reduce intimate partner violence and sexual assault.

Non-Fatal Strangulation Cases Should be Prosecuted as Felonies

There are clear reasons why strangulation in domestic violence cases require separate felony statutes:

- Almost half of all domestic violence homicide victims have experienced at least one episode of strangulation prior to a lethal or near-lethal violent incident. Victims of one episode of strangulation are 700 percent more likely to be a victim of attempted homicide by the same partner and are 800 percent more likely of becoming a homicide victim at the hands of the same partner.[24]
- Strangulation is more common than professionals have realized. Recent studies have shown that 34 percent of abused pregnant women report being "choked" (Bullock, 2006). In another study, 47 percent of female domestic violence victims reported being "choked" (Block, 2000).[25]
- Victims of multiple non-fatal strangulation "who had experienced more than one strangulation attack, on separate occasions, by the same abuser, reported neck and throat injuries, neurologic disorders and psychological disorders with increased frequency."[26]
- Even given the lethal and predictive nature of these assaults, the largest non-fatal

[23] Special acknowledgement to Casey Gwinn, Esq., author of the Chapter 2, "Strangulation and the Law", The Investigation and Prosecution of Strangulation Cases, a publication of the Training Institute on Strangulation Prevention and the California District Attorneys Association (Copyright 2013).
[24] Nancy Glass et. al., *"Non-fatal Strangulation Is an Important Risk Factor for Homicide of Women,"* (2008) 35. J. Emergency Med. 3: 329.
[25] U.S. Department of Justice, Office of Public Affairs, online release (Feb. 4, 2013) "Justice Department Holds First National Indian Country Training on Investigation and Prosecution of Non-Fatal Suffocation Offenses." https://www.justice.gov/opa/pr/justice-department-holds-first-national-indian-country-training-investigation-and-prosecution (accessed July 8, 2024).
[26] Donald J. Smith, Jr. et al., *"Frequency and Relationship of Reported Symptomology in Victims of Intimate Partner Violence: The Effect of Multiple Strangulation Attacks*," (2001) 21 J. Emergency Med., 3:2323, 325-326.

strangulation case study (the San Diego Study) ever conducted to date, found that most cases lacked physical evidence or visible injury of strangulation—only 15 percent of the victims had a photograph of sufficient quality to be used in court as physical evidence of strangulation, and no symptoms were documented or reported in 67 percent of the cases.[27]

- The San Diego Study found major signs and symptoms of strangulation that corroborated the assaults, but little visible injury.[28]
- Strangulation is more serious than professionals have realized. Loss of consciousness can occur within 5–10 seconds, and death within 4–5 minutes.[29] The seriousness of the internal injuries, even with no external injuries, may take a few hours to be appreciated and delayed death can occur days later.
- Because most strangulation victims do not have visible external injuries, strangulation cases are minimized by law enforcement, medical, advocacy, and mental health professionals.
- Even in fatal strangulation cases, there is often no external evident injury (confirming the findings regarding the seriousness of non-fatal, no-visible-injury strangulation assaults).[30]
- Experts across the medical profession now agree that manual or ligature strangulation is "lethal force" and is one of the best predictors of a future homicide in domestic violence cases.[31]
- Leading forensic pathologists have now determined that even homicides in strangulation assaults have not been identified at the scene of the crime, leading to poor crime-scene investigation (no photos, interviews, or trace evidence) due to misidentification of the case as a drug overdose.[32]
- When non-fatal strangulation is minimized by professionals, it sends the wrong message to victims and perpetrators, resulting in inadequate risk assessment and safety planning.[33]

Strangulation is a unique crime. It is cruel, inhumane, and dangerous. The victim's realization that she is unable to breathe is one of the most terrifying events a person can endure. Domestic violence strangulation is usually about asserting control over the victim, that is, showing that the offender has the power of life and death over the victim. The intention behind strangling may not be about causing physical injury. Because an offender can strangle someone without leaving a visible injury, it is an effective method of abuse and control.

In contrast, jurors expect to see visible injuries. Our juries and judges will have difficulty

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[27] Gael B. Strack, George E. McClane, Dean Hawley, *"A Review of 300 Attempted Strangulation Cases Part I: Criminal Legal Issues,"* (2001) 21 J. Emergency Med. 3:303, 305-306.

[28] *Id.*

[29] Dean A. Hawley, *Forensic Medical Findings in Fatal and Non-Fatal Intimate Partner Strangulation Assaults* 6 (2012), available at https://dfcs.alaska.gov/ocs/Documents/childrensjustice/strangulation/16.%20Forensic%20Medical%20Findings%20in%20Fatal%20and%20Non-Fatal%20Intimate%20Partner%20Strangulation%20Assaults%20-%20Hawley%20-%202012.pdf (accessed July 8, 2024).

[30] *Id.* At 1.

[31] Glass et al., *supra*, note 5, at 329.

[32] *Id.* At 3.

[33] See Gael B. Strack, *How to Improve Your Investigation and Prosecution of Strangulation Cases* (2007). See generally Kathryn Laughon et al., "Revision of the Abuse Assessment Screen to Address Nonlethal Strangulation," 37 J. OGNN 4:502-507 (2008); Jacquelyn C. Campbell et al., "The Danger Assessment: Validation of a Lethality Risk Assessment Instrument for Intimate Partner Femicide," (2009) 24 *J. Interpersonal Violence* 653.

understanding the serious nature of the crime without clear guidance from expert witnesses and competent investigations and prosecutions from professionals with specialized training.

Effective intervention in non-homicide strangulation cases will increase victim safety, hold offenders accountable for the crimes they commit, and prevent future homicides.

Kentucky Law

Kentucky's Strangulation statutes can be found in Kentucky Revised Code Chapter 508, Assault and Related Offenses.[34] Strangulation in the First Degree is a Class C felony, while Strangulation in the Second Degree is a Class D felony. They share common elements and are differentiated by the *mens rea*. The elements for each crime are as follows:

Strangulation in the First Degree: Class C felony KRS 508.170

A. Without consent.
B. Intentionally.
C. Impedes the normal breathing OR circulation of the blood of another by:
    a. Applying pressure on the throat OR neck of the other person; *OR*
    b. Blocking the nose OR mouth of the other person.
D. Venue.

Strangulation in the Second Degree: Class D felony KRS 508.175

A. Without consent.
B. Wantonly.
C. Impedes the normal breathing OR circulation of the blood of another person by:
    a. Applying pressure on the throat OR neck of the other person; OR
    b. Blocking the nose OR mouth of the other person.
D. Venue.

Strangulation in the First Degree requires evidence that the perpetrator acted intentionally, meaning, his conscious objective is to cause that result or to engage in that conduct.[35] Strangulation in the Second Degree requires evidence that the perpetrator acted wantonly, meaning, he is aware of and consciously disregards a substantial and unjustifiable risk that the result will occur or that the circumstance exists.[36]

While the two statutes are differentiated by the *mens rea*, they both focus on the act of impeding breathing or blood flow to the brain. This impediment to breathing or blood flow can occur in a variety of ways. Some common presentations involve the perpetrator's hand or hands on the victim's neck, the perpetrator's arm around the victim's neck, the use of a ligature, the use of a pillow or other object, or even the use of a substance such as water.

[34] KRS 508.
[35] KRS 501.020(1).
[36] KRS 501.020(3).

It is important to remember that regardless of the method by which the strangulation occurs, injury or loss of consciousness are not elements that need to be proven to obtain a conviction.

The Multi-Disciplinary Response in Kentucky

Kentucky was the 48th state to pass a felony strangulation law. Implementation requires we expand our understanding of the seriousness of strangulation and work together to develop a plan to address these cases. Approaching strangulation from a multi-disciplinary angle is imperative to devising an effective community response. This includes training across a wide range of professionals who will encounter strangulation victims. Primary goals should be:

- Developing strangulation protocols.
- Offering resource materials.
- Identifying experts.
- Developing collaborative, multi-disciplinary teams.
- Improving advocacy and safety for victims; and
- Increasing accountability for offenders.

Different communities have unique strengths and areas of needed improvement. Rely on your community's strengths to tailor an implementation plan. Start by recognizing the agencies and/or professionals who are willing to learn, collaborate, and see the bigger picture. From there, willing professionals can identify gaps in services and need for training the region.

It is critical that the victim receives a multi-disciplinary response to ensure safety as well as further the goals of justice. To accomplish these goals, it is important to consider the following:

- 911 recording preservation.
- Medical documentation at every step in every case.
- Dispatchers trained on questions to ask to properly assess for strangulation.
- Emergency care services at the scene and transportation of victims to the hospital.
- Police and paramedics encouraging victims to be medically evaluated, as there can be non-visible acute and long-term health consequences.
- Paramedics and medical professionals should be trained to understand the lethality of strangulation including how to screen and diagnose it, document it, and most importantly, how to medically treat it.
- Forensic nurses should be trained to conduct forensic strangulation exams.
- Experts should be identified and used to present medical testimony regarding the physiology and lethality of strangulation during court proceedings.

Multi-disciplinary collaboration and training is vital to hold perpetrators accountable and address victim needs. Communication is imperative with the objective that vertical prosecution is accomplished.

Chapter 3: Investigation

This chapter discusses the essential components of a strangulation investigation as well as the tools and tactics necessary to enhance law enforcement's response. Cases of domestic violence require a thorough investigation beginning with the initial / 911 call and continuing through trauma-informed interviews, evidence collection, forensic medical examinations, follow-up interviews and progressive photograph documentation to build a case based upon evidence.

Law enforcement's response must be informed and strategic since strangulation can cause loss of consciousness in seconds and death within minutes. However, since there may not be significant visible injury, or any visible injury at all, strangulation may unfortunately be treated as an assault fourth degree by law enforcement. Ultimately, victims of strangulation are not only affected physically, but also impacted socially, emotionally, and psychologically, which is why a comprehensive victim-centered, trauma-informed investigation is imperative.

Victim advocacy and support services aid rapport and victim participation throughout the criminal process. It is also imperative that law enforcement understand, appropriately identify, and document signs and symptoms of strangulation. The efforts made on the scene by the initial responding officer will directly impact the life of the victim and any future prosecution of the perpetrator.

The Investigation

The 911 Call

The 911 call is pivotal. It contains vital information about the crime, often while it is still occurring. As former San Diego prosecutor Casey Gwinn says, "911 is the microphone into the domestic violence home and contains important evidence in almost every case." Whether the victim or a child is the one calling for help, or other witnesses or neighbors are calling, the 911 call must be thoroughly evaluated by both the investigator and the prosecutor. Depending upon the facts and circumstances of the case, the prosecutor may be able to use statements contained in the 911 call at trial if they fit within a hearsay exception. This beginning of the criminal investigation will often support an evidence-based prosecution even if the victim later declines to participate in the prosecution of the offender.

The 911 call often provides:

- The identities of the victim and any witnesses, including children
- Whether a weapon is involved
- Whether the threat/assault is ongoing or still occurring
- The identity of the perpetrator by name and/or physical description
- Perpetrator's location: whether the suspect is still on scene, left the scene, whereabouts and whether likely to return.
- Critical facts and/or statements by the victim
- Critical statements of witnesses
- Valuable insight into the demeanor of the victim, witnesses, and the perpetrator

- A sample of the victim's voice immediately following the act of strangulation
- Valuable time stamps
- Geographical locations
- Computer Aided dispatch (CAD

The elements of the 911 call are recorded and maintained in an incident report, commonly referred to as the Computer Aided Dispatch or CAD report. The CAD report may be used by investigators and prosecutors to establish timelines of events, obtain victim and witness contact information, and gain an understanding of the assault as the information came to the 911 call center from the caller. This report not only documents the above listed information, but the CAD report also documents important response information such the names of the responding officers, the dispatched and arrival times, emergency medical services (EMS) information, run updates, and officer notes.

Recorded Statements and Body-Worn Cameras

Victim and witness statements should be recorded, and Body-Worn Camera (BWC) used when available. BWC is a vital tool for documentation, preservation of evidence, officer credibility, and protection. BWC provides investigators, prosecutors, judges, and juries a priceless look into the crime scene, the parties involved, and the immediate aftermath of the criminal conduct. This footage is the closest the decision makers in the case will ever get to the reality of the crime and the surrounding scene.

BWC should be activated (both video and audio) prior to the officer's arrival on the scene and not discontinued until after the officer has cleared the run. By ensuring the BWC is recording at first entry to the scene, the investigator may capture nontestimonial statements from victims and witnesses who are still experiencing the emergency. It is essential that prosecutors watch and evaluate BWC footage to determine if hearsay exceptions are applicable; these exceptions to allow the use of nontestimonial statements by parties who may subsequently be unable to participate in the prosecution. As with 911 calls, BWC footage lays the foundation for an evidence-based investigation and prosecution.

Safety Considerations

Domestic violence cases are notoriously volatile. It is critical for officer safety purposes that dispatch relays all pertinent information. Additionally, it is best practice for at least two officers to respond to domestic violence calls. Once on the scene, officers must locate and secure any weapons. Officers should confirm the existence of any protective orders and quickly assess the criminal history of the offender. If the perpetrator is still on the scene, law enforcement should separate the perpetrator and the victim, interview the parties separately, and provide direct quotes in the police report. If the suspect has fled the scene, officers should inquire about possible locations and make all attempts to locate and arrest when there is probably cause to do so.

Medical Attention

The lethality of strangulation can be underestimated by both the victim and law enforcement due to the fact injury is not always visible. The reporting officer should immediately call paramedics to the scene to medically evaluate the victim and encourage the victim to go to the hospital for medical treatment and examination. In addition to life-saving intervention, medical examinations can provide forensic evidence and critical documentation when physical injuries are not visible. Ideally, victims of strangulation would receive a forensic nurse examination by a Sexual Assault Nurse Examiner (SANE). SANEs are trained and credentialed by the Kentucky Board of Nursing in forensic examinations and are specifically trained to conduct exams on victims of strangulation. In addition to collecting, preserving, and documenting evidence, these professionals can also interpret medical records and testify in legal proceedings. Forensic examiners can also explain the seriousness of strangulation to the jury which makes their testimony indispensable.

Victim Interview

Law enforcement should engage in trauma-informed interviewing practices. The International Association of Chiefs of Police (IACP) has created an excellent short document on trauma-informed interviewing that all law enforcement officers should review.[37] While the IACP guidance is focused on sexual assault cases, it applies to strangulation assaults as well. There is also a certification for trauma-informed interviewing expertise known as the forensic experiential trauma interview (FETI).[38] A FETI certification is an excellent tool for successful investigators; however, even in the absence of FETI certification, investigators can be trained in the basics of trauma-informed interviewing techniques. The Training Institute on Strangulation Prevention focuses on four key concepts for investigators to practice and apply when working with trauma victims of all kinds:

- **N**on-Judgmental
- **I**nterested
- **C**oncerned
- **E**mpathetic

First and foremost, officers should strive to approach the victim as empathetically as possible; it is important to treat the interviewee as a victim of a crime and not as a witness to a crime. Officers should ask open-ended questions, refrain from interrupting the victim's narrative, and respond with follow up questions when clarification is needed. Investigators should not insist that victims "start at the beginning" understanding that the cognitive response to trauma often makes a chronological recitation of facts difficult. It is important to ask memory-eliciting,

[37] "Successful Trauma Informed Interviewing," (2017). https://www.theiacp.org/sites/default/files/2020-06/Final%20Design%20Successful%20Trauma%20Informed%20Victim%20Interviewing.pdf (accessed July 8, 2024).
[38] The Official Forensic Experiential Trauma Interview. https://www.certifiedfeti.com/resources/an-introduction-to-the-certified-feti-methodology/

sensory questions such as what the victim saw, heard, felt, thought, smelled, or tasted, and refrain from asking why questions. The BWC, or other recording devices when BWCs are not available, should be used to document the victim interview. The first responding officer at the scene is in the position to obtain the most critical, nontestimonial statements for an evidence-based prosecution. Once the scene is secure and the victim is medically cleared, the officer's priority should be to obtain a full statement from the victim.

Photographs

A. Photographing the Victim and The Suspect

Comprehensive photographs of the victim, perpetrator, and crime scene should always be taken. Photographs document visible injury, or lack thereof, and help corroborate statements made to reporting officers. When a victim is strangled, the only crime scene available to officers may be the victim's body. Additionally, if there are any visible injuries, they more than likely are not going to be permanent. The victim's injuries will eventually heal, and photographs are key to preserving this evidence.

Every area where a victim describes a complaint of pain should be photographed even if there is no visible injury. This is especially important because injuries heal differently for different people. As visible injuries appear or heal, follow-up photos should be taken to show the progression or regression.

Officers should have an in-depth discussion about injuries with the victim. It should be determined if injuries were sustained from previous incidents or from this victimization. The documentation of these injuries should be maintained through a series of (at least) three photograph successions:

1. *Full body photographs* of the victim should be taken to help identify the victim.
    - These should be taken at a distance, and they should capture the victim's entire body from head to toe.
2. *Visible injury photographs* should be taken of the injured body part to document the location of the injury.
    - This aids investigators and prosecutors in identifying a specific injury.
3. *Scaled photographs* should also be taken of each injury.
    - These photographs should be taken at a 90-degree angle utilizing a scale for the most accurate perspective.

Due to the nature of strangulation, the following areas of the body should be specifically examined for possible injury and/or evidence:

1. The victim's neck, chin, and chest.
2. The whites of the victim's eyes and eyelids.
3. Inside the cheeks, lips, and back of the victim's throat.
4. Behind the victim's ears.

5. The victim's hands and fingernails.
6. The perpetrator's chest, arms, and hands.

Multiple photographs of these critical areas are needed and follow up photography is also necessary. Even if no injuries are visible, officers should note in their report, "No visible injuries present at this time." This reminds everyone that injuries can appear later, and the lack of injuries does not mean a crime has not occurred. Many fatally strangled victims had no visible, external injuries at the time of their death. If you can strangle someone to death with no visible injuries, you can strangle them *almost to death* with no visible injuries.

Photos of the suspect in strangulation cases are equally important. In many near-fatal strangulation assaults the offender may have more injuries than the victim. The offender's injuries may include scratch marks, bite marks, or other types of wounds inflicted by the victim while fighting to survive the assault. In strangulation assaults, the victim experiencing deadly violence has the right of self-defense and officers should not be fooled into thinking that the injuries on a potential suspect suddenly transform the suspect into a victim.

B. Photographing the Crime Scene

Perspective is important when photographing the crime scene. The room should be four-corner photographed. This is accomplished by taking photographs standing in each corner of the room, taking the picture toward the middle of the room. This ensures the entire state of the scene is captured. If evidence needs to be collected, that evidence should be photographed prior to collection so that the item's position prior to disruption is documented.

Remember that each relevant item observed corroborates a detail of the crime story. Years after this investigation, you may be in trial defending every action taken throughout the investigation. Be thorough and comprehensive because truth and justice demand meticulous detail. Examples of comprehensive documentation:

1. If the victim tells you the perpetrator threw a specifically identifiable item against the wall:
    - Photograph the item where it is found.
    - Take the item into evidence; and
    - Photograph the wall where the item hit.
2. If the witness tells you the perpetrator kicked the front door in:
    - Photograph the door.
    - Photograph damaged parts of the door if they were scattered throughout the room; and
    - If the damage is substantial, consider taking the door into evidence.

Law enforcement's meticulous investigation and documentation equips prosecutors with the ability to *show*, not just *tell*, the jury what happened. Corroborating evidence is powerful, compelling, and essential in crimes of domestic violence. The more law enforcement can confirm facts and evidence that corroborate the statement of the victim, the more likely the offender will be held accountable.

C. Body Worn Camera Does Not Replace Photographs or the Collection of Evidence

BWC does not replace the best evidence, still photographs and media recordings BWCs can be affected by several factors and may not accurately depict the injuries sustained or the conditions of the scene. BWCs do not have the same capabilities as flash photography, and these limitations could hinder documentation efforts. Still photographs or any media recordings, such as security footage or phone recordings, should be collected and downloaded. This will be the best evidence for prosecutors and is not replaced by a BWC video. Additionally, if there is probable cause that the suspect's phone contains evidence of the crime, it should be seized, booked into evidence, and forensically examined with the authorization of a signed search warrant or court order.

Investigative Aids

Investigative aids may also be used to help document strangulations. Investigative aids may include documents such as worksheets, questionnaires, and checklists which law enforcement complete on the scene with the victim and help law enforcement conduct more detailed interviews. For example, the Investigation Wheel (below), first created by Detective Mike Agnew from Fresno, California and then made available to law enforcement across the country, is a tool the Training Institute on Strangulation Prevention recommends to law enforcement officers, both first responders and follow-up investigators, to help build an evidence-based case instead of relying only on the victim's statements. The Investigation Wheel highlights the types of evidence available in strangulation cases.

The Investigation Wheel

Additionally, victims of strangulation may have difficulty showing officers how exactly they were strangled without the ability to demonstrate the manner on a person. Victims can use items such as a doll, wig head, stuffed animal or even a pillow to demonstrate the manner of strangulation. Photographs may then document the victim's demonstration.

Report Writing

Strangulation reports need to be thorough and contain up-to-date contact information for the victim, all witnesses, and even the suspect. Secondary contact information for the victim should be documented. Acquiring the contact information of a trusted family member or friend will help to ensure follow-up communication with the victim is successful, and obtaining suspect contact information may assist with future apprehension efforts.

Your report should provide a detailed explanation of how the strangulation occurred. The word "choking" is frequently used to describe strangulation. However, this description is medically and legally inaccurate. Choking defines an internal blockage of the individual's trachea. The elements of the offense of strangulation should be articulated detailing how the perpetrator "impeded the normal breathing or circulation of the blood of another by applying pressure to the throat or neck or by blocking the nose or mouth of another." Each element must be met and be well documented in the police report.

Victims may also report that they were "choked" but only describe the perpetrator grabbing them by the throat. To meet the elements of the Kentucky strangulation statute, a victim's breathing or blood flow must be impeded. It is the job of law enforcement to differentiate whether the victim was simply grabbed by the throat or if they truly experienced strangulation; this investigative determination will be the difference between a felony charge and misdemeanor assault. Because this is such a critical distinction for the victim's interview, law enforcement reports should include quotations from the victim's exact verbiage. Through the use of strangulation checklists/questionnaires during victim interviews, law enforcement may obtain a more accurate description of the event for their report.

Dominant Aggressor

Incidents of domestic violence are particularly volatile because of the relationship between the parties. There is typically a history of abuse between the victim and perpetrator, and at times, both parties may display visible injury as discussed above in near-fatal strangulation assaults. This can make it difficult for law enforcement to determine which party is the dominant aggressor.

Prosecutors must also recognize that lack of visible injuries should not minimize the severity of the incident. Likewise, the existence of injury does not necessarily identify the perpetrator or victim. Identifying the dominant aggressor is an important aspect of strangulation-case evaluation. The International Association of Chiefs of Police (IACP) defines ***"predominant aggressor" as "the individual who poses the most serious, ongoing threat, which may not necessarily be the initial aggressor in a specific incident."***[39]

It is important to note that in strangulation cases, victims may use self-defense methods such as biting, scratching, kicking, and punching to protect themselves. Victim's self-defense efforts must be considered when both parties display visible injury or a complaint of pain. For example,

[39] International Association of Chiefs of Police, Intimate Partner Violence Response Policy and Training Content Guidelines, 6 (2017)

if a suspect is standing behind a victim and using their forearm to strangle the victim, the suspect may sustain a bite-mark to his arm which is indicative of self-defense. Suspect's may also have scratch marks to their arms and hands which are also often indicative of the victims' self-defense.

Factors that may be considered to assist in determining the dominant aggressor are:

1. The history of abuse between the parties.
    a. Evaluate current and former protection orders, police reports, calls for service, etc.
    b. Review the suspect's criminal history to understand the level of violence the suspect has exhibited and to determine the risk of future violence.
2. The degree of injury and manner of assault as well as the consistency of injury based on reported statements.
3. The statements of witnesses on the scene.
    a. If you believe there are child witnesses to acts of domestic violence, please conduct a limited, minimal facts interview to determine if the child saw the crime. If so, please contact your local Children's Advocacy Center to provide a forensic interview for child witnesses.
4. The presence and level of fear among the involved parties (i.e. Who is afraid of whom?).

To explain law enforcement's determination of the dominant aggressor, the report should note the totality of circumstances which lead to their conclusion. Law enforcement should articulate the signs and symptoms of strangulation, if the suspect has injuries, and describe how the injuries were determined to be defensive. ***Dual arrest is always discouraged***.

Visible injuries to the victim may not appear immediately after an incident of strangulation. If the reporting officer is unable to locate any visible injuries, symptoms supporting the presence of non-visible injuries should be described. These injuries could include loss of consciousness, difficulty breathing, and changes in vision. The correlation between the way the victim was strangled and the injuries to the suspect should be thoroughly explained in the narrative.

Manner of Strangulation

Often when people think of strangulation, the perpetrator's hands are assumed to be the weapon; however, strangulation can occur in several ways:

1. *Ligature strangulation* occurs when a suspect uses an object wrapped around the circumference of the neck to impede breathing or blood flow.
    a. Items such as cords, cables, clothes, belts, clothing, and purse straps are often used in this form of strangulation.
    b. Visible injury in the form of a linear pattern is often indicative of ligature strangulation.
    c. In cases of ligature strangulation, the ligature should be photographed, collected as evidence, and processed for additional evidence collection.
2. *Manual strangulation* occurs when the applied pressure is from the suspect's body part. Most strangulation assaults (97%) involve manual strangulation according to the research of Dr.

Dean Hawley, the Training Institute's first forensic pathologist. Dr. Hawley's research on this topic has even been retained on the resource site for the U.S. Supreme Court where the Training Institute's entire manual on the investigation and prosecution of strangulation cases is now available for judges to use when they take judicial notice of key facts about strangulation.[40]

Examples of manual strangulation can be:

- Suspect strangles the victim from behind using a forearm.
- Suspect stepping on a victim's throat while she/he is lying on the floor.
- Suspect strangling a victim by holding her by the neck against a wall.

3. *Aquatic strangulation* occurs where a perpetrator holds the victim's head underwater. In these cases, the victim would experience not only difficulty breathing, but their nose and mouth would also be blocked because of the water.
    a. Strangulation (or attempted murder) is an appropriate charge to consider where a perpetrator holds a victim's head in a bathtub of water or a toilet bowl.

Victim Safety Planning

Law enforcement should discuss safety planning with victims at the scene. This includes a discussion of safe housing locations such as domestic violence shelters, advocacy services, child safety considerations, and an explanation of Marsy's Law Rights pursuant to KRS 421.500. Officers should provide victims with Marsy's Law literature, such as a card or pamphlet to articulate the rights and points of contact for support and follow up services. Victim safety planning should also involve follow up conversations with the officer to explore if any acts of intimidation or threats have occurred.

Law enforcement assistance to the victim may also include the transportation of a victim to petition for a protective order or to obtain medical treatment, if needed. The Training Institute has an entire section of their website focused on resources for victims of strangulation assaults, and many of these resources are available in this manual.[41]

For additional information as to victim's rights and services please contact the Office of the Attorney General. The Attorney General's office can provide the tools you need to be equipped for safety planning and resources around Kentucky for victims of strangulation.

Arrest

Suspects should be interviewed as a part of the criminal investigation and arrested when there is probable cause to do so. If the suspect is not on the scene, all attempts must be made to locate, apprehend, interview, and arrest the suspect. Officers should inquire about any other past or

[40] Hawley, D. "Death by Strangulation or Suffocation," Chapter 6, The Investigation and Prosecution of Strangulation Cases, (2013), Training Institute on Strangulation Prevention & the California District Attorneys Association. https://www.supremecourt.gov/opinions/URLs_Cited/OT2021/21-783/21-783-1.pdf. (accessed July 8, 2024).

[41] https://www.strangulationtraininginstitute.com/survivor-resources/ (accessed July 9, 2024).

pending charges or court cases involving the suspect. No warrant is required to arrest on strangulation, a felony offense, and an officer may also arrest a suspect for the offense of assault fourth degree domestic or dating violence without a warrant when there is probable cause to do so. Additionally, if there are any crimes involving the violation of a protective order (e.g. violations of Kentucky EPOs, DVOs, TIPO's or IPOs) or violations of the suspect's conditions of release of which the suspect has notice, KRS 431 mandates the suspect "shall" be arrested for these crimes.

Follow-Up Investigation

Interviews

Follow-up interviews are critically important for law enforcement to understand the full extent of the abuse and to document any acts of intimidation or threats from the perpetrator. Officers should anticipate recantation or minimization by the victim. Both recantation and minimization are behaviors which result from the power and control dynamic of domestic violence. A victim's opinion about the prosecution should never dictate the investigation, the charging decision, or the prosecution. The investigation must always focus on the evidence and what can be proven through the evidence even if the victim does not want to participate in the criminal justice process.

Photographs

After the initial call for service and report has been completed, follow-up investigation is required. As stated previously, follow-up photographs of the victim's injuries are vital in strangulation cases. Follow-up photographs can help document the seriousness of physical injury or impairment. These follow-up photographs should be taken 24, 48, and 72 hours after the strangulation to document the full evolution of injury. **Many injuries, particularly bruising, may not develop right away after the assault. In the simplest of terms, if there is bleeding below the surface of the skin, it may take time for the blood to come to the surface and become visible to the naked eye. Therefore, it is necessary to discuss with the victim the importance of self-documentation throughout the process**. This can be accomplished simply by asking the victim to photograph the injured area daily and forward to photographs for documentation purposes.

Jail Phone Calls, Emailing, Messaging

When suspects are arrested, they may be provided the opportunity to make outgoing phone calls, email or utilize a messaging platform from the jail. These phone calls, emails, and messaging platforms can and should be monitored by law enforcement. They may contain discussion of the underlying case, which could include admissions by the defendant.

Additionally, these phone calls are often used by the suspect to contact the victim to coerce, threaten, or intimidate, and they may support new charges against the defendant. If law enforcement hears direct or implied threats, they should immediately notify the prosecutor so they may evaluate the communication for the following additional charges:

1. Violation of a Kentucky Emergency Protective Order/Domestic Violence Order (KRS 403.763)
2. Terroristic Threatening Third Degree (KRS 508.080)
3. Intimidating a Participant in a Legal Process (KRS 524.040)
4. Retaliating against a Participant in the Legal Process (KRS 524.055)

Caveat: Law enforcement must never intercept attorney/client privilege communications. If law enforcement officers discover that a recorded jail phone call, email, or message was between the defendant and their attorney, law enforcement must notify the prosecutor and the jail immediately to ensure corrective mechanisms are in place to prevent further disclosure of privileged communications. The prosecutor must also inform the defense attorney, and all jail calls, emails, or messaging documentation will be provided to the defense in discovery compliance.

Multi-disciplinary Collaboration

Investigators should contact the prosecutor's office early to determine if there is any additional information needed throughout the investigation. Remember, just because an arrest was made does not mean the case is closed; the pre-trial phase may be more labor-intensive than the initial investigation and arrest. It is vital that law enforcement communicate with their prosecutor to ensure they are exhausting their efforts to facilitate an evidence-based prosecution. When domestic violence cases receive a collaborative multi-disciplinary response, prosecutorial outcomes are improved, victims are safer, and offenders are held accountable.

Chapter 4: Prosecution

In some respects, prosecuting strangulation is like prosecuting other types of domestic violence – investigators and prosecutors must rely on the same two key concepts for a successful prosecution:

(1) Making the case more dependent on the evidence than it is upon the testimony of the victim and;
(2) Developing as much corroborating evidence as possible.

However, prosecuting strangulation requires the additional step of explaining the seriousness of the act. Communicating lethality effectively may require expert testimony. Specially trained, victim-centered prosecutors should remain a consistent presence throughout every stage of the prosecution. Best practice includes vertical prosecution where a single prosecutor, who is trauma-informed and victim-centered, handles the case at every stage. The success of felony prosecution begins with the work of county attorneys. Thorough case review and proper charging at the district court level is critical to ensuring swift prosecution and successful offender accountability.

Remember the tips and techniques described in this chapter are applicable to all cases involving domestic violence, not just strangulation.

Case Development

Prosecutors possess the ability and responsibility to collaborate with law enforcement to develop an effective response to strangulation. Because the initial investigation begins with law enforcement, prosecutors should collaborate with law enforcement to provide guidance on these cases. Evidence and documentation to consider should include:

- 911 calls (determine your agency retention period for calls)
- Recorded statements by the victim
- Recorded interviews of all witnesses (ensure you have all identifying information), including children[42]
- Computer-Aided Dispatch (CAD)/ Dispatch logs
- Record the Defendant's oral and written statement (after Miranda Warnings given and Miranda waiver signed, if applicable)
- Photographs of the crime scene and documentation of injuries/lack of visible injuries
- Follow-up photographs of victim injury
- Voice message left by the victim prior to strangulation for comparison to the post-strangulation voice
- Collection of any evidence not obtained initially by law enforcement
- Medical records
- Forensic exam records

[42] Child witness interviews should be conducted by trained forensic interviewers at the regional child advocacy center. A minimal fact interview, only when necessary, can be conducted by law enforcement or social workers at the scene, but the full interview should be done by a forensic interviewer.

- Emergency Medical Service records
- Evidence of prior acts
- Police reports (current and prior)
- Prior or pending EPO/DVO/TIPO/IPO documentation and hearings
- Electronic evidence
- Recorded jail calls.

Developing a Rapport and Building Trust with the Victim

Strangulation victims are often reluctant to participate in the criminal process. They frequently recant, minimize, and even avoid coming to court. Prosecutors should not be deterred by these behaviors, nor should they blame victims for their choices. While there are many reasons *why* this happens, a victim's reluctance is often caused by fear that participation could threaten their lives or their loved ones' safety. It is critical that prosecutors focus on the perpetrator's actions and not the victim's response. At every turn, the Training Institute for Strangulation Prevention recommends thinking of strangulation victims, not as "uncooperative" but as "terrified." If prosecutors replace the word "uncooperative" with "terrified", it will assist in better framing the complexity of victim recantation or victim minimization.

Building rapport and trust will often result in a more actively engaged victim. Similarly, providing support and services to victims can promote participation in the process. However, prosecutors should not assume the victim will be available and willing to participate in the prosecution of the case. Prosecutors should approach the case as if they are prosecuting a homicide, because homicide cases are always prosecuted without a victim's participation. This emphasis on evidence-based prosecution should not limit establishing a relationship with and attempting to obtain information from the victim. The best prosecutions are usually those where both solid evidence *and* victim participation exist.

While it is important that the prosecutor establish a trusting relationship with the victim, it is also vital to involve the victim advocate. Victim advocates can provide needed support, services, and resources. Victim Advocacy is discussed in Chapter 7.

Continued Case Preparation

The prosecutor or designee should make every effort to meet with the victim to explain the prosecution process and explore issues that may have been unknown in the initial police investigation.[43] Consider always having a third-party present to document any information obtained during the meeting.[44]

Having conversations with the victim "provides prosecutors with the opportunity to build rapport, rebuild the victim's confidence, and listen to the victim's concerns and desired outcome."[45]

[43] See KRS 421.500(5)(b) and National District Attorneys Association, *National Domestic Violence Prosecution Best Practices* Guide, 27 (2017)
[44] A third-party could also act as a witness should the need for impeachment arise.
[45] National District Attorneys Association, *National Domestic Violence Prosecution Best Practices* Guide, 15 (2017)

Additionally, it provides an opportunity for prosecutors to explain their role[46], which is to seek justice, hold the perpetrator accountable, and prevent future harm. "The prosecutor should be mindful that domestic violence often minimizes or eliminates the victim's control over her life and should be respectful of a victim's frustrations."[47]

Consistent communication creates an excellent opportunity to provide victims with information regarding their case and to dispel misinformation. The prosecutor can inquire about past incidents of domestic violence and any information that corroborates those incidents. If a victim is actively engaged in the conversation, it is important to seek as much detail as possible. The prosecutor or interviewer may not have another opportunity to gain this valuable information. Past incidents of domestic violence, may help establish a pattern of abuse and prove useful at many stages of the prosecution if the victim is later unavailable or if a forfeiture by wrongdoing issue arises at trial.[48]

Prosecutors should communicate with police to ensure they collect any additional evidence, including material records, evidence demonstrating the power and control dynamic,[49] and documentation of prior instances of domestic violence. Copies of these records (and any other records) should be obtained and provided to the prosecutor and provided in discovery compliance. After the initial trauma of the crime has subsided, the victim may be in a better position to recount what occurred. S/he may have already done so with a neighbor, a close friend, or a relative. It is important to collect information from individuals the victim has seen since the incident. Obtain follow-up interviews with those individuals, which may provide evidence that the victim was acting or speaking differently.

Medical Examination

One of the best methods of collecting evidence for the prosecution is through a medical examination of the victim, or when available, a forensic medical examination with a nurse or doctor who has been specially trained in strangulation assaults. Properly trained medical personnel can provide not only crucial emergency medical treatment, but they can also provide accurate diagnoses and documentation of physical signs and symptoms. Alternate light sources, laryngoscopy, CT scans, MRIs, and other medical tools not only document evidence of strangulation, but also provide life-saving diagnostics. Prosecutors should work closely with their medical providers to develop effective protocols to document and treat strangulation victims.[50]
Documents associated with the medical examination are required to be turned over in standard discovery compliance.[51] Additionally, it may yield evidence that is material to the perpetrator's

[46] Id.
[47] Id.
[48] See Pretrial Motions.
[49] For more information about the Power and Control Wheel, visit www.theduluthmodel.org. The Domestic Abuse Intervention Project (DAIP) is the home of the Duluth Model which developed what is commonly referred to as the Power and Control Wheel. The model is based upon the premise that battering is one form of domestic or intimate partner violence. It is characterized by the pattern of actions that an individual uses to intentionally control or dominate his intimate partner. That is why the words "power and control" are in the center of the wheel. A batterer systematically uses threats, intimidation, and coercion to instill fear in his partner. These behaviors are the spokes of the wheel. Physical and sexual violence holds it all together—this violence is the rim of the wheel.
[50] For more on medical examinations, see Chapter 5.
[51] Ky. Rules Criminal Procedure 7.24(1)(b).

defense. Part of the treatment and documentation process may reveal the victim used intoxicants either before or after the strangulation. The examination may also indicate the victim inflicted some of her own injuries which were actually sustained in a self-defense attempt to stop the abuser.

Regardless of the evidentiary benefit of the examination, the primary concern should always be that the victim receives proper treatment for her injuries, and the secondary purpose is that the injuries and other evidence are properly documented. Whether an item of evidence is favorable to the prosecution or to the defense turns on the argument of the lawyers and not the evidence itself.

Prosecution Review of Criminal Charges

Prosecutorial review of criminal charges should occur as quickly as possible. A swift decision can protect the victim and help break the perpetrator's control over the victim. Additionally, evidence in strangulation cases can be lost quickly. Because of the evidence, strangulation cases deserve the highest priority attention of prosecutors. As noted in Chapter 1, strangulation is one of the most accurate predictors for the subsequent homicide of victims of domestic violence. Therefore, delays in the review and prosecution of a strangulation case may be lethal.

While reviewing the evidence, prosecutors must consider the dynamics of domestic violence. If a victim is perceived as disinterested in prosecution or minimizes the abuse, this is not a reason to decline holding the perpetrator accountable for criminal conduct. The focus of the case evaluation should always be on the criminal conduct of the perpetrator and not on the response of the victim.

At initial contact with the prosecution, some victims may be experiencing the final phase of the abuse cycle often referred to as the "honeymoon" phase.[52] This phase is often characterized by apology, promises, and attempts at reconciliation. Prosecutors who understand the cycle of abuse are not discouraged when the victim is reluctant to participate:

> Recognizing the ploys of manipulation, the prosecutor should not be discouraged if the victim attempts to minimize the perpetrator's accountability for the criminal offense. By allowing the victim to make those prosecutorial decisions, the Commonwealth rewards perpetrators who are successful in the manipulation of their victim. The effect of disposing of a case according to the victim's wishes reinforces the perpetrator's conduct, giving him ultimate control over the disposition of his case.[53]

Prosecutors must also recognize that lack of visible injuries should not minimize the severity of the incident. Likewise, the existence of injury does not necessarily identify the perpetrator or victim. Identifying the dominant aggressor is an important aspect of strangulation-case evaluation. The International Association of Chiefs of Police (IACP) defines "predominant

[52] https://www.peaceoverviolence.org/iii-the-cycle-of-violence-and-power-and-control (accessed July 9, 2024).
[53] 2024 KYOAG Domestic & Interpersonal Violence Prosecution Policy and Procedure Manual

aggressor" as "the individual who poses the most serious, ongoing threat, which man not necessarily be the initial aggressor in a specific incident."[54]

The perpetrator may have numerous cuts, scratches, bite marks, or other injuries that were inflicted by the victim as a direct response to being strangled. This creates a misperception that the party with the visible injury must be the victim. This oversimplification should not lead to charges against actual victims, leaving them unprotected against the perpetrator. Careful investigation should be conducted to prevent dual arrests.

A thorough review of the facts will ensure accurate charging – it may be necessary to change existing or add new charges. The facts may support greater or lesser offenses, or removal of existing charges that may not fit the facts.

When the prosecution utilizes an evidence-based approach to prosecution, with or without the testimony of the victim, the victim's attitude toward the prosecution of the case should not dictate the charging decision.

Proving the Case without Victim Participation

Can you prove the case without the victim? It is important for the prosecution to remember the Training Institute's admonition: "Treat the case like a homicide so it doesn't become a homicide." Obviously, if the perpetrator was successful in his efforts to strangle the victim to death, there would be no victim in court and no issue of "victim participation." The fact the perpetrator failed to kill his victim should not change the approach to prosecution simply because the living victim is reluctant to participate.

Prosecutors should always initiate a prosecution with the assumption that the victim does not want to participate. Assume the victim will be pressured by the perpetrator and others to not testify. The victim may go into hiding, become uncooperative, or come to court and even face a judge attempting to hold the victim in contempt for refusing to testify.[55] If any of these things occur, consider how to establish the case without victim testimony and always advocate for the victim's right to choose whether to participate in the prosecution of her partner.

A solid investigation increases the likelihood prosecutors can proceed without the victim's testimony. Examine the physical evidence for statements made by the victim or perpetrator. Look for statements that might be admissible as an exception to the hearsay prohibition like an excited utterance, a statement made for the purposes of medical treatment or diagnosis, or otherwise admissible under the Kentucky Rules of Evidence. Remember that the confrontation right is a trial right that can be overcome if the statement is non-testimonial and otherwise admissible. It can also be overcome if there is evidence of witness intimidation by the defendant

[54] International Association of Chiefs of Police, Intimate Partner Violence Response Policy and Training Content Guidelines, 6 (2017)

[55] Prosecutors should not request material witness warrants absent extraordinary circumstances. Trauma-informed prosecution requires consideration of victims' safety. Allowing the victim to choose whether to participate in the criminal justice process is a form of victim autonomy and a way to honor the victim's personal choices in her life.

in which case the defendant, under federal law and most state laws, forfeits his right to cross-examine the victim under the United States Supreme Court Case of *Crawford v. Washington*.[56] Remember, the *Crawford* rule does not apply to non-hearsay statements, that is, those statements not being offered for the truth of the matter.[57]

Both the decisions of *Crawford* and *Davis v. Washington*[58] acknowledge the doctrine of forfeiture by wrongdoing and Kentucky Rule of Evidence 804(5) codifies this doctrine and provides an exception to the rule against hearsay wherein *"A statement [is] offered against a party that has engaged or acquiesced in wrongdoing that was intended to, and did, procure the unavailability of the declarant as a witness."* The analysis of whether the defendant intentionally caused the witness to be absent is heavily fact specific. Any claims of forfeiture by wrongdoing should be resolved by pre-trial evidentiary hearing.

If the case cannot be established without the victim's testimony, before dismissing a charge or an indictment, the prosecutor must determine the basis for the victim's reluctance to prosecute the case. If the victim's objection or reservation is the result of coercion or threats, the prosecutor should consider other charges that might be proven without the victim's participation. Additional or alternate charges to be considered are in the next section of this chapter.

Witness intimidation is common in cases of domestic violence. Stranglers are the most power and control-oriented abusers. Prosecutors, along with the victim's advocate should make victims aware of efforts by the defendant, and even family members, to manipulate and intimidate. Victims should be educated that their abuser's wrongful acts are not limited to criminal acts but may also include promises to change, declarations of love, and marriage proposals when intended to prevent victims from testifying.[59] When this intimidation occurs, prosecutor should consider additional charges.[60]

Choice of Charges

When a person, without consent, intentionally or wantonly impedes the normal breathing or circulation of the blood of another by applying pressure to the throat or neck, or by blocking the nose or mouth of another person, the crime of strangulation is committed.[61]

As previously discussed in Chapter 2, Kentucky has two felony strangulation charges. The distinction between the two charges is the *mens rea*, or the intent of the offender. A person who acts intentionally is charged in the first degree, a Class C Felony. A person who acts wantonly is charged in the second degree, a Class D Felony. All other elements are the same.
KRS 501.020 defines mental states:

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[56] *See* Witness Intimidation: Meeting the Challenge, *Aequitas*, https://aequitasresource.org/wp-content/uploads/2018/09/Witness-Intimidation-Meeting-the-Challenge.pdf (accessed July 9, 2024).
[57] *Crawford v. Washington*, 541 U.S. 36, 52 (2004).
[58] *Davis v. Washington*, 126 S. Ct. 2266 (2006)
[59] Bonomi, A., and Martin, D., Recantation and Domestic Violence: The Untold Story (2023). https://www.amazon.com/Recantation-Domestic-Violence-Untold-Story/dp/1032391685 (accessed July 9, 2024).
[60] See Section Charging Decisions
[61] KRS 508.170 and 508.175.

- KRS 501.020(2) "Intentionally – A person acts intentionally with respect to a result or to conduct described by a statute defining an offense when his conscious objective is to cause that result or to engage in that conduct."
- KRS 501.020(3) "Wantonly – A person acts wantonly with respect to a result or to a circumstance described by a statute defining an offense when he is aware of and consciously disregards a substantial and unjustifiable risk that the result will occur or that the circumstances exists. The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation. A person who creates such a risk but is unaware thereof solely by reason of voluntary intoxication also acts wantonly with respect thereto."

The crime of strangulation most commonly occurs within a factual scenario reflecting an intentional act which would support the charge of strangulation in the first degree. It is less common to see a factual scenario reflecting wanton conduct. Regardless, prosecutors are equipped with both Class C and D felonies to respond to this life-threatening crime and to hold perpetrators accountable.

Strangulation is often just one act of domestic violence occurring within the context of other criminal offenses. During case review, prosecutors must evaluate the facts and evidence to determine if other charges are appropriate[62]. It is important that the indictment reflect every distinct, independent criminal act that occurred within the factual scenario.

If the defendant has other charges pending which involve the same victim, when possible, prosecutors should join cases, which can help establish the severity of the relationship and abuse between the victim and their abuser.[63]

Although each case is unique, it is common to see the following criminal charges associated with acts of domestic violence:

Strangulation, Assault, and crimes threatening physical injury or use of force include:

- Strangulation in the First Degree – KRS 508.170
- Strangulation in the Second Degree – KRS 508.175
- Assault in the Fourth Degree – KRS 508.030
- Assault in the Fourth Degree (Enhancement of Penalty: Assault of family member of member of an unmarried couple)– KRS 508.032
- Assault in the Second Degree – KRS 508.020
- Wanton Endangerment in the First Degree – KRS 508.060
- Wanton Endangerment in the Second Degree – KRS 508.070
- Unlawful Imprisonment in the First Degree – KRS 509.020
- Unlawful Imprisonment in the Second Degree – KRS 509.030
- Kidnapping – KRS 509.040
- Stalking in the First Degree – KRS 508.140

[62] See Choice of Charges section above.
[63] National District Attorneys Association, *National Domestic Violence Prosecution Best Practices Guide*, 25 (2017)

- Stalking in the Second Degree – KRS 508.150
- Intimidating a Witness in the Legal Process – KRS 524.040
- Retaliating Against a Participant in the Legal Process – KRS 524.055
- Terroristic Threatening in the Third Degree – KRS 508.080
- Robbery in the First Degree – KRS 515.020
- Robbery in the Second Degree – KRS 515.030
- Burglary in the First Degree – KRS 511.020
- Burglary in the Second Degree – KRS 511.30
- Criminal Trespass in the First Degree – KRS

Protective Orders, Conditions of Release, Tampering & property damage:

- Violation of Order of Protection – KRS 403.763
- Violation of Conditions of Release – KRS 431.064
- Tampering with Physical Evidence – KRS 524.100
- Interference with Communications – KRS 438.210
- Criminal Mischief in the First Degree – KRS 512.020
- Criminal Mischief in the Second Degree – KRS 512.030
- Criminal Mischief in the Third Degree – KRS 512.040

Charges related to Sexual Violence:

- KRS Chapter 510

Child Victims:

In addition to the charges described above when children are victims of violence the following offenses may be considered.

- Assault charges in KRS Chapter 508 (seek medical attention)
- Criminal Abuse in the First Degree – KRS 508.100
- Criminal Abuse in the Second Degree – KRS 508.110
- Criminal Abuse in the Third Degree – KRS 508.120

Setting Bond and Other Safety Measures

Bond hearings and pre-trial detention hearings play a critical role in strangulation and domestic violence cases for three key reasons:

1. Victims are at highest risk of danger when they attempt to leave their abuser,[64] thus conditions set at bond hearings are pivotal to the victim's protection early in the case.
2. They offer an opportunity for a victim to assert their right to be heard.
3. They educate the court about the defendant and the case.

It is a good practice for the prosecution to file, prior to arraignment, an objection to all bond reductions and request that all bond motions be made in writing.[65] During motion practice, the

[64] Kentucky Office of the Attorney General, *Domestic Violence Prosecution Manual*.
[65] RCr 4.40 requires a "written motion" to apply for a change of conditions of release.

prosecution can take the opportunity to provide a summary of the case describing the evidence and arguments. This demonstrates the risks associated with strangulation and the underlying need for protective measures on behalf of the victim. Often, the pretrial detainment of the defendant allows the victim to engage available resources and options s/he may not otherwise be able to explore when under the defendant's influence and pressure.
In making this argument, the prosecutor may rely upon:

1. The seriousness of the offense
2. Use of weapons
3. Lethality of the defendant
4. The defendant's criminal record and history of violence
5. The defendant's history of noncompliance with court orders and outstanding warrants
6. The defendant's threats of harm directed toward the victim or to his or her own person. [66]

Lethality assessments serve to assess danger but can also help inform professionals of the risks most significant to the individual case. Judges can then use this information to support their decision on pretrial release and accompanying conditions.[67] Because domestic violence and strangulation cases demonstrate a high risk for lethality, the safest condition may be for the defendant to stay in custody. However, if the court releases a defendant pretrial, conditions should be imposed on the defendant to minimize the risk to the victim. These conditions may include:

- No further acts of abuse.
- Electronic monitoring.
- Prohibition against use of alcohol or controlled substances.
- Defendants may also be prohibited from possession of a firearm.
    - KRS 431.064(d) specifically allows an order prohibiting the person from using or possession a firearm or other weapon specified by the court. Firearm Removal reduces the risk of further violence and homicide and should be addressed as a condition of release.
    - When the defendant is moderate or high risk, KRS 431.067 also allows the court to order global positional monitoring (GPS) as a condition of release.
- No contact with victim or family, including electronic contact or third-party contact.
- Stay away from the victim (this is different than having no contact).
- KRS 431.064 further gives the court the authority for "any other order required to protect the safety of the alleged victim and to ensure the appearance of the person in court".[68]

Mutual "no-contact" orders should always be opposed. These ill-advised orders imply both parties are responsible for the defendant's criminal conduct. Permitting the defendant to dictate terms and conditions further subjects the victim to the defendant's power, control, and manipulation, not to mention orders of the court. While victims have a constitutional right, pursuant to Marsy's Law, to be heard in proceedings involving the defendant's release, it should not be forgotten that prosecutors are tasked with protecting the victim. This does not mean that the prosecutor's role

[66] National District Attorneys Association, *National Domestic Violence Prosecution Best Practices Guide*, 26 (2017)
[67] *Pettingill v. Pettingill,* 480 S.W.3d 920 (Ky.2015).
[68] See KRS 431.064(f).

and legal positions will always align with the victim's wishes. Giving the victim an opportunity to have a voice in court can foster a sense of empowerment. While prosecutors should give due consideration to the victim's perspective, their primary responsibility is to ensure justice and hold the defendant responsible for violating the law.

If the bond conditions are violated, swift action should be taken to revoke bond. Pursuant to RCr 4.40 and 4.42, when a defendant has willfully violated a condition of release, an adversary hearing may be requested by written motion to establish the violation by clear and convincing evidence.

Violation of any condition of release is a Class A Misdemeanor. Kentucky Revised Statute 431.005 requires that upon verification that the Defendant has notice of the conditions of release in accordance with KRS 431.064, he ***shall*** be arrested without a warrant if there is probable cause that a pre-trial condition of release has been violated.

Preliminary Hearing and Grand Jury

Both preliminary hearings and grand jury proceedings provide an opportunity to break the power and control of the abuser. Each proceeding makes it clear that the Commonwealth is the charging party, not the victim. Prosecutors should try to complete the preliminary hearing without the victim's testimony. Probable cause can be established by the investigator's synopsis, and hearsay is admissible at the hearing.[69]

While a common practice is to take a minimalist approach to grand jury and simply present the evidence and witnesses as quickly and as expeditiously as possible- a more thorough practice should be considered in domestic violence cases for the following reasons:

1. This is the time to thoroughly evaluate the case and to subpoena additional information. Grand jury proceedings can be utilized to secure the victim and witness testimony, often when they are more likely to still be cooperative.

2. Eliciting victim testimony before the grand jury should be carefully considered. Some prosecutors prefer to present victim testimony, especially in cases where recantation is likely.

   a. By choosing to have the victim testify, even if the victim recants, the grant jury can consider the victim's testimony along with all of the additional evidence. If the grand jury chooses to indict despite the victim's position, it sends an even stronger message that the Commonwealth is the charging party and not being influenced by the victim's attempt to dismiss the charges on his behalf. This also encourages guilty pleas.

3. Presenting evidence regarding the dynamics of strangulation allows the prosecutor to educate the grand jury and the public about the seriousness of strangulation. His testimony could come from a forensic nurse, paramedic, or a law enforcement officer with specialized training and experience.

[69] Kentucky Rule of Evidence 1101 exempts preliminary hearings and grand jury proceedings from evidentiary rules.

4. Prosecutors should consider presenting all information about the relationship of the individuals involved and any prior or current abuse including medical records, previous domestic violence petitions and applications, prior criminal charges involving the same victim, and any other relevant information.

As the case is developed at grand jury, it may be discovered that other criminal charges are appropriate.[70]Strangulation is often one component in a series of other criminal offenses. If the defendant has other charges with the same victim, prosecutors should also consider joining cases, which can help establish the severity of the relationship and abuse between the victim and their abuser.[71]

Combating Common Defense Theories

Strangulation cases have a series of potential defenses that typically arise. Adequate case preparation involves being able to address these defenses:

1. The victim self-inflicted her injuries:
    - If the victim has readily apparent visible injuries, the defense can claim the victim self-inflicted the injuries.
    - The defense may play this off as a victim who is vindictive who inflicts her own injuries then contacts law enforcement to punish the defendant.
        - It is important to explain how the victim's injuries are the result of the defendant inflicting them or the victim defending against the defendant's attack.
        - It is common for the victim to self-inflict scratches on her neck, for example, when she is trying to remove the ligature or stop the manual strangulation assault.
2. The victim likes to be strangled:
    - Another claim that may arise is that the victim and defendant engage in strangulation as a consensual activity, likely intertwined with some type of sexual behavior.
3. The injury was an accident:
    - This defense involves the defendant claiming the strangulation occurred through some mistaken action. The defendant was trying to calm the victim and his hands—that were meant to be placed on her shoulders—accidentally slipped to the neck, the defendant/victim fell into the grasp of the hands, or some other form of seemingly innocent explanation.
        - The defense can be defeated with a detailed account during either the initial or follow-up investigation. Is the conduct described by the defendant consistent with the injuries received by the victim? When there is an accident, there is usually an apology after the accident. Was there any indication of this?
4. The defendant acted in self-defense/mutual combat/dominant aggressor:
    - This defense may be combined in some form with the other defenses. Under this

[70] See Choice of Charges section above.
[71] National District Attorneys Association, *National Domestic Violence Prosecution Best Practices* Guide, 25 (2017)

theory, the defendant was using force to combat or defend against attack by the victim. It is important to evaluate which party is the dominant aggressor. Determining the dominant aggressor is particularly complicated in strangulation cases because the victim may exhibit a lack memory or become combative due to oxygen deprivation from his or her strangulation.[72] Additionally, injuries may be difficult to assess as they may be non-visible, internal, or caused by the victim's self-defense.[73]

- Prosecutors sometimes mistakenly believe that the only way to introduce this type of defense is through the defendant's testimony. This is incorrect. The victim may recant and give this as an explanation for what occurred, that is, "Everything I told the officer was correct, except it all occurred after I attacked the defendant." Countering this defense requires a detailed investigation by law enforcement.

Victim Participation in Court

Victims of domestic violence may be reluctant to testify against the defendant for a variety of complicated reasons including love, intimidation, threats, fear of loss of financial support, and issues involving children. Most defendants assume that if a victim refuses to testify, the criminal case becomes harder for the Commonwealth to pursue. However, if criminal justice professionals are focused on evidence-based prosecution, the victim's lack of prosecutorial engagement has less of an impact. Regardless of the victim's feelings towards prosecuting her offender, prosecutors must work to establish rapport and build trust with victims early on and then focus on the evidence in the case rather than the complexity of the victim's emotional, and often fear-driven, responses.

As discussed throughout this manual, determining the barriers to victim participation early, and referring the victim to support and services, may assist the victim in actively participating in the prosecution. When preparing for trial, prosecutors should consider basic needs like transportation to and from court, the needs of the victim's children, and the necessities of life which the victim may have lost because of the prosecution of her partner. Victims may need housing or food assistance. They may need ongoing medical assistance or counseling for their children. Working closely with the victim, the victim's advocate, and community-based advocates to assess the victim's needs and safety concerns can make a difference in avoiding more complex issues at trial and reduce the chances of the victim recant.

As with all witnesses, the victim should be subpoenaed to appear in court if her testimony is needed. If a victim does not comply with the subpoena, great consideration should be given to appropriate next steps. Given the complex nature of domestic violence victimization, incarceration of the victim is not the preferred response. Remember, it is the defendant's actions that have put the victim in this situation. Arresting or incarcerating the victim will not only

[72] Traditionally, prosecutors have viewed a lack of memory as a weakness in a case. The Training Institute argues that a lack of memory is EVIDENCE in a case. Lack of memory is evidence of oxygen deprivation to the brain and the compromise of the hippocampus, the memory center of the brain. The first part of the brain to suffer damage from strangulation is the hippocampus and, once unconscious, the victim of strangulation loses memory from the event. See https://www.frontiersin.org/journals/cellular-neuroscience/articles/10.3389/fncel.2023.1277375/full. (accessed July 9, 2024).

[73] https://evawintl.org/wp-content/uploads/DVReport1906.pdf (accessed July 9, 2024).

provoke a sense of injustice but may also further jeopardize her safety and the safety of her children.

All efforts should be made to avoid issues of re-victimization and re-traumatization. If a victim is brought before the court for failure to comply with the court order, it should be done in the most victim-centered, trauma-informed manner. A multi-disciplinary approach should be utilized to create the proper response, while enlisting a safety plan tailored to the victim's needs.

If the victim has an attorney to protect her interests, it is important to respect and comply with her rights pursuant to KRS 421.500 and section 26A of the Kentucky Constitution (Marsy's Law).[74] The prosecutor should be in immediate contact with the victim's attorney. While prosecutors have a great deal of discretion in deciding whether to use compulsive measures beyond the issuance of a subpoena, the decision to do so should be made with great care and with an awareness of the potential consequences.

Pre-Trial Motions

Prosecutors should practice the use of pre-trial motions in limine to control the quantity and quality of information sought to be introduced at trial.[75] Intimate partner violence evidence should be integrated in pre-trial motions to educate the court and support the Commonwealth's case.

The diagram known as the Power and Control Wheel[76] may be useful in pre-trial motion practice to provide a complete picture of the abuse. Understanding the violent dynamic of the relationship supports the admission of relevant evidence and exclusion of irrelevant evidence.

The following list of potential pre-trial motions in a strangulation case should be considered as the case advances towards trial:

- Rape Shield Law KRE 412
- Bond Motions KRS 431.064; RCr 4.40; RCr 4.42
- Motion to Join Offenses RCr 6.18
- Forfeiture by Wrongdoing
    - Hearsay exception for unavailable victim, KRS 804(b)(5)
- Motion to Limit Discovery of Victim
- Mental Health and Confidential Records (*Commonwealth v. Barroso*, 122 S.W.3d 554 (Ky.2003))
- Notice of Intent to Admit Other Acts of Defendant KRE 404(b)(c)
- Motion to Limit or Restrict Cross Examination of Victim
- Character Evidence (prior drug use, specific acts of conduct, or improper character evidence) KRE 404(a)(2), KRE 405

[74] If the victim is represented by counsel, prosecutors must also adhere to Kentucky's Rules of Professional Conduct. Supreme Court Rule 3.130 prohibits any lawyer from communicating regarding the subject of representation with a person known to be represented by counsel.
[75] National District Attorneys Association, *National Domestic Violence Prosecution Best Practices Guide*, 27 (2017)
[76] See Appendix.

- Motion to Enforce Marsy's Law: Presence / participation upon request of Victim – KRS 196.280
- Notice Expert Testimony[77]
- *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993)
- Motion for Testimonial Accommodations in cases of child strangulation during sexual activity KRS 421.350.
- Competency of Witness KRE 601
- Appointment of a Guardian Ad Litem for Child Victims KRS 26A.140.

Voir Dire

Jury selection in a strangulation case involves the same subject matter commonly addressed in domestic or intimate partner violence offenses. Prosecutors must understand how potential jurors will react to these issues. Additionally, prosecutors should have awareness of juror biases to ask the right and most meaningful questions. Good prosecutors plant seeds in jury selection that will last through closing arguments.

The following is a compilation of possible topics to address in voir dire depending upon the facts and circumstances:

- Dynamics of domestic violence, including fear.
- Victim's potential minimization of the abuse.
- Victim's lack of participation or recantation is irrelevant to whether the crime was committed.
- Juror bias in domestic violence, strangulation, and gender-based violence crimes.
- Inconsistent statements/credibility.
- Bad judgment does not mean the victim lacks credibility.
- Victim may still love the perpetrator or has chosen to remain with him.
- Memory and trauma.
- Elements of strangulation.
- Recantation.
- Visible physical injury versus non-visible physical injury.
- Different recollections from the victim not being indicative of reasonable doubt.
- Acceptance of expert testimony on strangulation.
- Understanding of the importance of oxygen to the brain (through blood) for the brain to stay alive and healthy.
- Absence of recordings or witnesses of the strangulation – losing memory when you pass out or lose oxygen to your brain.
- Dying when you lose oxygen to your brain.

When educating jurors in voir dire, remember that it should be an education that the jury gives themselves and that your evidence then becomes consistent with. The Training Institute strongly recommends finding jurors who may have experienced episodes of fainting, that have ever fainted, suffered from low oxygen to the brain, or those who have training in the martial arts or from military service (where they may have learned about strangulation).

[77] See Chapter 6, Use of Experts

Be mindful that jurors with backgrounds that frequently expose them to minor injuries (*e.g.* laborers, emergency room medical professionals, or athletes) may tend to regard scratches and redness as "non-injuries." Spend extra time with these potential jurors to determine if they can be appropriate jurors on a strangulation case. If they cannot, the discussions with them might serve as good examples for other potential jurors about the seriousness of the offense.

Prosecutors should use voir dire as an opportunity to shift the focus of the case towards the perpetrator and away from victim. Another goal of voir dire should be seen as an opportunity to lower the jury's expectations regarding the level of violence required to violate the law.

Shifting the Focus from the Victim to the Perpetrator

Remind jurors that the defendant has no burden in a criminal trial, and that the Commonwealth accepts its burden to prove each element of the crime beyond a reasonable doubt. The defendant only has rights. He has a right to a jury trial regardless of the evidence against him, he has a right to testify or not to testify and if he doesn't testify you cannot hold that against him. Most importantly if the defendant does testify, he is presumed innocent, he is not presumed to be truthful. Whether or not the defendant is being truthful is for the jury to judge. The jury needs to evaluate his credibility and any biases or motives he may have to tell the truth or to lie.

Opening Statement

The importance of the opening statement cannot be overstated. The first words spoken are crucial and will set the tone for the rest of the opening, if not the entire trial. The jurors are eager and ready to learn about the case, so make those first words compelling and allow them the opportunity to judge the defendant's actions – not the victim's.

The jurors' first impression of the case is often consistent with their ultimate verdict. In fact, in most cases, 85%, the jury's view at the end of opening statement impacts their ultimate decision in a case.[78] During opening statements, jurors are deciding which point of view, theme, and story they identify with as they learn about the case. When the prosecution has a theme, the jurors begin to connect with the Commonwealth's case. Finding true emotion in the narrative of the case and describing ways to create empathy for the witnesses is key. This can build rapport with jurors.

The structure of the opening statement should be delivered in a story-telling style versus the witness testimony sequence. Human beings are accustomed to listening to information given through story. The goal is to provide a compelling narrative that moves the jury to convict. The opening statement is an opportunity to educate the jurors about strangulation by telling them what your expert will testify about regarding the seriousness of the crime.

Do not be afraid to touch upon the weaknesses of the case. Do this in a manner that makes the weakness irrelevant. Unveiling weaknesses in the opening helps diminish them, rather than allowing the defense to point them out. At the close of your opening, explicitly tell the jurors

[78] See https://www.ojp.gov/ncjrs/virtual-library/abstracts/art-not-science-prosecutors-perspective-opening-statements.

what the Commonwealth will be asking them to do at the end of the case.

Structuring the Presentation of the Case

The manner of case presentation can impact credibility. It can be disturbing for a jury to listen to the opening statement of the prosecutor and a description of the facts of the case, only to have the victim testify and give a different version. For that reason, unless the prosecutor has absolute confidence the victim's testimony is consistent with the initial statement to law enforcement, another piece of evidence should be introduced first. Consider the following methods of presentation:

- 911 call introduced through the dispatcher/custodian of records.
- The neighbor who heard the spontaneous statements of the victim.
- The officer who observed the victim's demeanor and/or any injuries.
- Something that corresponds to the prosecutor's opening statement.

This has the impact of assuring the jury of the prosecutor's credibility. If later during the trial, the victim does testify and recants or testifies inconsistently, the jury will have already heard evidence that validates the prosecutor's opening statement. This tactic enhances the credibility of the prosecution's case. No jury should hear a strangulation case with a recanting victim without knowing the victim is likely to recant from the beginning of the case.

When considering case structure and presentation, it is critical that prosecutors review the 2023 Kentucky Supreme Court opinion Robertson v. Commonwealth, 2021-SC-0485-MR (not final). In this opinion, the Court opined:

Both the defense and the Commonwealth should consider in their trial preparations whether a conflict may arise between Marsy's Law and KRE 615. If there is an anticipated conflict, the parties should bring it before the court pretrial. At that time, the trial court should conduct a hearing at which the parties can discuss the potential conflict, and the Commonwealth can put forth its proposed order of witnesses and the basic substance of the victim's testimony. With that information, the trial court should, to the best of its ability, determine the impact of the conflict on the proposed testimony of the victim. Then the court should determine if, in the interest of maintaining the integrity of the trial, a different order of Commonwealth witness presentation is mandated. We trust trial courts to use their discretion in making these determinations to help ensure as fair a trial process as possible, within the parameters of Marsy's Law.

Additional Expert Testimony

See Chapter 6.

Victim Testimony

If the victim is going to testify, be prepared for that testimony to be inconsistent. The nature of these cases is that the victim might not feel safe to tell the truth. Moreover, trauma and brain injury in a strangulation case can impact memory and recitation of an event. Refrain from

criticizing a victim who testifies inconsistently with previous statements. The statements can almost always be confronted in a manner that is more reserved, professional, and demonstrates the terrified victim's recantation is a natural part of victimization. Prosecutors must be aware of tone and body language while in front of the jury and particularly if they must cross-examine a recanting victim.

Cross-examination of the Defendant

The defendant's testimony will come after hearing from the prosecution witnesses, including the strangulation expert. Anticipate that the defendant's testimony will attempt to incorporate some aspects of your expert's testimony into his version of what occurred. If the expert mentions that some persons engage in strangulation as part of their sexual practices, for example, the defendant may adopt that as a part of his testimony. Always question whether the defendant raised this defense at the scene of the crime or only after consulting with a defense attorney.

Defendants who claim self-defense should be questioned about their fear of imminent harm and their prior statements to law enforcement evaluated for those claims at the scene.[79] Defendants who claim that they placed their hands on the victim to "calm them down" should be questioned in detail regarding how this action turned into strangulation.

Closing Argument

The factual theory must support the legal theory.

Closing arguments tend to be the favorite part of trial for prosecutors. It is the last opportunity for the prosecutor to advance the case to support the theory, theme, and legal argument. For the closing argument to be effective, it is not the "argument" that will get the conviction, but the facts that support it. No matter how skilled an attorney, if the argument is not supported by the facts and evidence, the jury will not convict.

Closing arguments are where the prosecutor can explain to the jury how significant the evidence is and how it supports the case. "Arguments" require helping the jury connect the dots and draw inferences from them. Consider the following organization and structure for an effective closing argument.

<u>Structure of the Closing Argument:</u>

1. The Attention Step:
    a. Get the attention of the jury right away, just as in opening statement. This can be done by conveying the case theme or perhaps with the 911 recording.
2. The Facts of the Case:

[79] Strangulation offenders are well-known for not being willing to express fear of their victim. Why? Because they are not afraid of their partner. It is hard to even fake their fear. Prosecutors can often capitalize on this struggle for offenders. See https://www.contracostaalliance.org/calendar/understanding-the-rage-and-lethality-of-men-who-strangle. (accessed July 9, 2024).

a. Do not just repeat the facts of the case the jury has already heard. Now is the time to discuss the evidence that supports and proves the factual theory of the case.

3. The Law that Supports the Facts:
    a. Show how the legal theory is supported by the factual theory. Apply the facts to the law. Using the jury instructions during this phase is helpful.
        i. The prosecutor is the teacher or facilitator. No matter how simple the prosecutor believes the jury instructions are, that is never the case for the lay person on the jury.
        ii. Go through the instructions. Confusion can lead to reasonable doubt. Confusion is welcomed by the defense. Clearly explain to the jurors how to read, understand, and apply the facts of the case to the instructions.
        iii. Consider using visuals, courtroom technology, a Power Point slideshow, or at minimum, a white board to aid in the explanation.
4. Closing Line:
    a. Plan and develop this final part of closing. This should be strong, forceful, and definite. The prosecutor should let the jurors know it is their time to act and tell them what you expect from them: to return a verdict of guilty.
    b. Reference the content of the attention step again.
    c. Do not be afraid to pick-up your evidence.

Tip: Do not forget to explain in lay terms why the expert witness's opinion is important to the case. Reiterate to the jury that this testimony is evidence and emphasize how this evidence supports the Commonwealth's case.

For the closing argument to be most effective, the prosecutor must utilize the argument throughout the entire case and have a clear understanding of what she/he is trying to accomplish. Applying the facts to the law, while emphasizing the lethality of the crime, is the most persuasive closing argument.[80] At the end of the day, prosecutors must help the jury feel the terror that the victim felt when she realized he was capable of and willing to kill her. Then, the jury will be able to convict him of strangulation even without significant, or even any, visible injuries.

[80] National District Attorneys Association Trial Advocacy Manual (2019).

Chapter 5: Medical Evaluation

Strangulation is a very dangerous and potentially lethal form of interpersonal violence. Unfortunately, it is common in the context of sexual assault and domestic violence. Minimal pressure on the neck can cause serious injury and, even in fatal cases of strangulation, it is possible there may be no external visible signs of injury at all. Not only is the strangulation act itself a threat to life, but it is a significant risk factor for future homicide (by any method) for that strangulation victim. A history of a single act of non-fatal strangulation increases a victim's odds of subsequently being killed by that perpetrator by 7.5 times.

Health care providers working in the field of clinical forensic medicine commonly examine victims who were assaulted by strangulation. The strangled patient presents multiple challenges and questions. Are they medically stable or might they deteriorate? What evaluation is appropriate? What documentation is necessary, both medically and forensically? What was the intensity and duration of the assault? How does the assault translate into the level of threat posed to the victim's life?

A clarification of terms is important for the purposes of this discussion. The term "**forensic**," refers to the interface between the law and medicine. "**Forensic pathology**" is the medical discipline that deals with the evaluation of *dead* victims. This differs from "**clinical forensic medicine**," which is the medical discipline that deals with the evaluation and care (both medical and forensic) of *living* victims. Clinical forensic medicine includes attention to patient care needs, while forensic pathology does not.

Strangulation 101: Understanding the Basics

Whether evaluating a strangled patient, investigating a strangulation case, or prosecuting a strangulation assault, everyone involved, including the jury, needs to understand the fundamental nature of strangulation. This starts with normal basic anatomy (structure of the body) and physiology (bodily functioning).

The brain needs a continuous supply of oxygen. The brain is the most sensitive organ in the body when deprived of oxygen. Without oxygen, brain cells quickly malfunction and die. When brain cells die, they do not regenerate, and the function they once supported is permanently gone. To ensure continuous oxygen supply, two vital bodily systems must work perfectly and in unison—the respiratory (breathing) system and the cardiovascular (blood flow) system. Multiple areas of vulnerability exist in both systems, and the compromise of a single area can rapidly produce a very bad outcome.

Terms and Definitions to Understand

- **Respiration** describes the delivery of oxygen into the body via inhaled air, producing oxygen-rich or **oxygenated** blood. Air must pass through the mouth and nose into the upper air passages, the voice box (larynx), the windpipe (trachea), and finally into the lungs. The chest and the diaphragm muscle work together to create the "bellows" that

moves the air (breathing). Once oxygen is transferred to the cells throughout the body (including the brain), the blood becomes devoid of oxygen or **deoxygenated** and rich in carbon dioxide**.** Air must be able to pass freely out of the lungs, which allows carbon dioxide gas to shift from the blood into air in the lungs and then be exhaled into the atmosphere. Normal respiration is the unobstructed in and out of airflow.

- **Cardiovascular** refers to the system that includes the heart and blood vessels (arteries and veins). The heart provides the pumping action that moves the blood through the lungs (for oxygenation and carbon dioxide removal) and to and from the bodily tissues and organs. Arteries move oxygenated blood away from the heart and veins move deoxygenated blood back toward the heart.

- **Carotid arteries** (right and left) are the two main blood vessels in the neck that transport about 85 percent of the oxygenated blood to most of the brain cells. At the angle of the jaw, each common carotid artery divides into an **internal carotid** and an **external carotid** branch.

- **Vertebral arteries** (right and left) travel through the bony passages in the bones of the neck (cervical vertebrae) to supply about 15 percent of the oxygenated blood to the brain cells, mainly to the posterior parts of the brain.

- **Jugular veins** (right and left; also, with internal and external branches) are the blood vessels in the neck that transport oxygen-depleted, carbon dioxide-rich blood from the brain back to the heart.

- **Hypoxia** is an oxygen deficiency in body tissues.

- **Hypoxemia** is an oxygen deficiency in the blood.

- **Anoxia** is the absence or lack of oxygen in body tissues.

- **Asphyxia** is when the body does not receive or utilize adequate amounts of oxygen. In the context of strangulation, asphyxia occurs when brain cells do not receive adequate oxygen for normal functioning. This may result from compromise of respiration—the lungs being deprived of oxygen—or cardiovascular compromise—the brain being deprived of blood flow. Asphyxia may result from a combination of problems in both systems.

- **Under KRS 508.170 and 508.175, Strangulation** occurs when, without consent, a person intentionally or wantonly impedes the normal breathing or circulation of the blood of another by applying pressure on the throat or neck of the other person or by blocking the nose or mouth of the other person. There are two types of strangulation—manual and ligature. **Manual strangulation** can be accomplished with one hand, both hands, or another body part (e.g. a forearm or knee). **Ligature strangulation** is accomplished when an object is used to apply pressure to the neck (e.g. a cord, item of clothing, or necklace).

- **Suffocation** is a broad term encompassing various causes of asphyxia associated with oxygen deprivation. Suffocation can include choking, smothering, drowning, and compressive asphyxia.

    - **Choking** is what happens when an object mechanically blocks the upper airway, stopping airflow *internally*. Choking can occur when food or some other object gets stuck in the airway. *Caution*: This term is often used inappropriately. Patients may use it to describe what happened when they were strangled; however, these terms should not be used interchangeably.

    - **Smothering** is a mechanical obstruction of airflow into the nose and mouth (e.g. blocking the victim's nose and mouth or putting a pillow or other object over the victim's nose and mouth).

    - **Drowning** is a form of asphyxia caused by a liquid entering the lungs and preventing the absorption of oxygen, leading to cerebral hypoxia.

    - **Compressive asphyxia can occur with either compression to the chest or to the airway. The chest compression can** occur when an assailant puts his body weight on the victim (e.g. sitting on their chest), limiting the expansion of the lungs, which interferes with breathing. Airway compression compromises airflow by compressive force applied to the airway (typically at the level of the voice boxy [larynx] or windpipe [trachea]) that squeezes the airway closed. Examples of this include the external force of strangulation (manual or ligature) and the mass effect of an enlarging area of post-traumatic swelling and bleeding inside the neck that pinches the airway closed.

- **Symptoms** are a patient's subjective description of what they feel or experience. Symptoms may be current or past (resolved).

- **Signs** are objective medical observations. These may include physical findings from the examination, laboratory testing results, and imaging studies (e.g. x-rays, CT scans, MRI scans, etc.).

Pathophysiology

Pathophysiology is the study of the functional changes associated with disease or injury. Because two complex systems (respiratory and cardiovascular) are involved in oxygenating the brain, functional vulnerabilities exist in many areas—alone or in combination. Functional changes may be temporary and resolve when the compromising force is removed. Examples include compression of the airway, the chest, a blood vessel, or a nerve. Restoration of normal functioning may be immediate, complete, and without serious consequence. The injuring force may cause mild structural damage that temporarily impairs function but will heal spontaneously. Other injuries may create significant damage. Examples include fractures, tears, ruptures, or crushing of airway or blood vessel structures. These injuries may pose an immediate threat to life. In the context of strangulation, there are two situations in which the initial presentation of the injury may appear trivial, with minimal or even no symptoms, yet a life-threatening problem

is beginning to evolve—bleeding and swelling. Even minimal force may cause bleeding and/or swelling in the injured tissue. Initially, both symptoms and signs may be mild or unrecognized. The great risk is that both bleeding and swelling can progress, often slowly, and not cause obvious problems until the airway is blocked or a vascular disaster occurs. A stroke resulting from vascular damage may occur hours, days, months, or even years after the strangulation event.

Specific Functional Changes in Strangulation

In discussing the details of strangulation injuries and alteration of normal functioning, the question of how much force (or pressure) was applied is frequently posed. Only in experimental research situations where the forces are measured and monitored will there be accurate data on the issue. There is significant variability from one individual to the next in the thresholds of vulnerability for injury with a given force. The details of the exact quantity of force applied, the duration and direction of the force application, the surface area of the force distribution, and the exact anatomic location to which the force was applied, all influence the resultant findings. The reality is that—outside of a research experiment— the exact force cannot be known. With these caveats in mind, these "force numbers" should not be relied upon as exact values and only used as general guidelines for relative amounts of force. It is generally surprising how little force is required to cause significant alterations in function or a severe injury. For example, the following "forces of daily activities" provide a general knowledge context:

- An adult's average maximum grip = 100-120 pounds
- A firm handshake = 60-80 pounds
- Opening a soda can or "pop top" = 20 pounds
- A handgun trigger pull = 6 pounds

Airway compromise may occur as a result of the compressive forces of strangulation, by squeezing the airway closed, with or without causing damage to the structures. Occlusion of the trachea requires about 33 pounds of pressure. Functional changes in a strangulation case may include injury to the larynx, such as bleeding, bruising, and swelling (edema), only requiring 22 pounds of pressure. Swelling is something that should be of grave concern given that it may not be apparent until hours after the strangulation occurs. Most of the structural components of the larynx and trachea are made of cartilage, which can sustain fractures at about 35 to 46 pounds of pressure. Fracture of the hyoid bone, which aids in tongue movement and swallowing, is rare but may occur in cases of non-fatal or fatal strangulation. Various combinations of functional changes may occur, leading to severe trauma to the upper airway. For example, the airflow can be compromised, the larynx fractured, and facial and neck swelling can be evident. Air can escape from the air passages and leak into the soft tissues (subcutaneous emphysema). These injuries can be very dangerous to a patient and may lead to death.

The forces of strangulation can compress blood vessels in the neck, which can diminish or stop blood flow in the arteries and/or veins. The impact of altered blood flow involves many variables: the specific vessel(s) involved, the duration of compression, and the nature of the

compressive force. **Arterial compromise** may occur, which alters the blood flow to the brain. Occlusion of the carotid arteries requires about 11 pounds of pressure. When a single carotid artery is compressed or blocked, there may be neurologic findings on the opposite side of the body. These findings include weakness, numbness, and tingling. When both carotid arteries are compressed or blocked, the result is neurologic dysfunction that may cause an alteration in consciousness (light-headedness or dizziness) or a loss of consciousness. As a result of more anatomic protection, more force (about 66 pounds of pressure) is required to compress the vertebral arteries. As with compression of the airway structures, there is a spectrum of dysfunction and injury that results from pressure on the arteries. Temporary closure may cause mild hypoxia in the brain, leading to brief dysfunction (without significant tissue damage) that resolves completely when the force is removed. If the compression is maintained for a longer period, brain cells may pass through hypoxia to anoxia and die, never to regenerate or be replaced. The potential outcomes are permanent brain damage or death.

Another very serious potential problem stemming from direct arterial pressure is damage to the artery itself. This is a subtle diagnosis. Trauma may tear a small flap of tissue in the lining of the artery and as the body tries to heal it, a blood clot (thrombus) inside the artery may form and grow. Eventually, blood flow through the artery may decrease or even stop. These developing blood clots can break off and travel to the brain (embolization) and block a distant artery. Neurologic findings may develop from the areas deprived of blood flow. This resembles both the mechanism and clinical findings of a stroke. Another possibility with a tear/dissection is that it may "balloon out" into the weaker outer layers of the arterial wall to form a pocket (false aneurysm or pseudoaneurysm). This creates an unstable situation where the abnormal pouch can continue to grow and press on adjacent structures. The blood flow in the wall may break back into the lumen or rupture through the remaining arterial wall allowing arterial blood to uncontrollably escape. This cascade of dangerous events is overwhelmingly asymptomatic at the onset, and the majority of patients have no obvious neurologic manifestations at presentation. The time course between injury, symptom development, and neurologic compromise is unpredictable and may be minutes, hours, days, weeks, or even years.

Venous compromise may occur if the return of blood from the brain is altered (venous outflow obstruction), causing deoxygenated blood coming back to the heart to back up. This creates a situation called *stagnant hypoxia*, which if prolonged, can cause unconsciousness, depressed respiration, and death. If bilateral jugular vein blockage occurs, an increase in pressure in the venous system will occur above the point of applied pressure. Occlusion of the jugular veins requires about 4.4 pounds of pressure. Common clinical findings in this situation are tiny surface blood vessels that rupture from increased internal pressure. Those found on the skin or mucous membranes are known as *petechiae*. Others may be found in the white part of the eye (sclera) and are called *subconjunctival hemorrhages*. Further, ruptured blood vessels may occur internally, so they are not visible.

The fact that relatively small amounts of force can create a spectrum of injury reinforces the reality of multiple variables in any given case.

Clinical Symptoms Reported by Strangled Patients

Strangulation-related symptoms may result from the effects of traumatic compression on the various tissues and structures within the neck, causing injury; or related to a decreased oxygen supply to the brain cells because the neck compression has compromised blood flow, air flow, or both. Traumatic injuries may initially be asymptomatic and only begin producing symptoms later, after progression of the injury with swelling and bleeding.

Neck and throat pain is very common in victims of strangulation and is usually related to direct trauma (blunt force) to the neck structures. This physical trauma may be mild, and the symptoms resolve without treatment; however, these same symptoms may also be associated with more severe damage to internal neck structures, especially those related to the airway. Changes in breathing or difficulty breathing are also commonly reported. It is important to determine the onset, duration, nature, and severity of the breathing problem. During the compression, many patients report they "couldn't get enough air" or had a complete inability to breathe. The majority of these breathing issues resolve after the compression stops. Hyperventilation may occur post-strangulation, with patients reporting they felt they could not "catch" their breath and may have experienced subsequent dizziness or light-headedness. Hyperventilation usually resolves spontaneously as the acute anxiety subsides. Pulmonary edema (fluid in the lungs), breathing problems, and worsening of other conditions such as asthma, may not be evident until hours or days after strangulation; therefore, patients should be given strict return precautions, should breathing issues occur after the initial medical evaluation.

Some patients report not being able to speak (aphonia) during the strangulation event, likely due to complete airway compression, which prevents air from passing through the larynx, thus preventing any sound generation. Aphonia usually resolves when compression is lifted. Voice changes (e.g. hoarse or raspy voice) and coughing may be observed after strangulation. Most voice changes resolve in hours to days after strangulation. Coughing is non-specific but may be due to airway irritation or injury, and usually clears spontaneously.

> ***Practice Tip for First Responders and Healthcare Personnel:*** It is helpful to ask a patient if they are speaking in their normal voice or if they notice a change, as this may not be obvious to personnel who have never otherwise heard the patient's normal voice.

Patients often report difficulty swallowing (dysphagia) or painful swallowing (odynophagia) after strangulation. This may be due to injury or swelling (edema) of the larynx or esophagus. These symptoms may be immediate or delayed. Although uncommon in non-fatal strangulation, fracture of the hyoid bone also causes painful swallowing.

Mental status and consciousness changes may include lightheadedness and dizziness, loss of memory, and loss of consciousness. It may be difficult to establish loss of consciousness in the history because victims frequently cannot recall losing consciousness. Patients often report symptoms related to an altered state of consciousness (often preceding a loss of consciousness), including vision changes (blurry vision, blind spots, "seeing stars" or "seeing black") and

hearing changes (ringing or loss of hearing in one or both ears). In these cases, some helpful follow-up questions to ask include:

- Do you remember everything clearly, or are there gaps in your memory?
- Regarding any gap, what is the last thing you remember before the gap and the next thing you recall after the gap?
- Did you start in one place and end up in another and can't recall how you got to the second place?
- Did you lose either urine or feces and not know when or why?

Behavioral changes that may appear during or immediately after the assault include agitation, restlessness, and combativeness. Victims may be fearful (or frantic) because they do not have enough oxygen. Weeks to months after an assault, a victim may display impairment in memory and concentration, and may have problems sleeping. Mental health problems can include anxiety, depression, and post-traumatic stress disorder. The mental health and behavioral changes are most commonly due to the brain cells being deprived of oxygen. If the interruption is brief, the symptoms and signs are temporary and generally resolve. However, if the interruption of oxygen to the brain is longer, the findings may be permanent and will not resolve. When brain cells die, resulting in a traumatic brain injury, the damage can be permanent and devastating.

Other neurologic signs and symptoms related to decreased oxygen supply to the brain may include facial or eyelid droop (palsy), one-sided body weakness (hemiparesis), incontinence (bladder or bowel), and seizure-like activity (anoxic convulsions or myoclonic jerks). Incontinence and seizure activity related to neck compression are preceded by a loss of consciousness.

> ***Practice Tip for First Responders and Healthcare Personnel:*** You may have to ask questions about incontinence because victims may not readily share this information.

It is important to remember that symptoms are subjective; they are described by the patient. Over time, symptoms will change or even resolve. Documentation is essential, and it must be thorough and detailed. Some symptoms may be non-specific and/or have multiple causes—these must be thoroughly explored and recorded.

> ***Practice Tip for First Responders and Healthcare Personnel:*** While many post-strangulation symptoms are self-limiting and resolve without treatment, persistent or worsening complaints should receive prompt medical evaluation.

The focus of this section has been the variety and frequency of symptoms experienced by victims of strangulation. The converse is also noteworthy; that is, the frequency of patients who report strangulation, but do not acknowledge any symptoms. Do not overinterpret or extrapolate the lack of documented symptoms to conclude that nothing happened, or that the patient is safe and healthy.

Physical Findings Documented After Strangulation

The point just made, that lack of documented symptoms does not refute the history of a strangulation event nor assure the health and safety of the patient, buttresses the same point regarding visible injuries after strangulation. Patients who have experienced a non-fatal strangulation often do not have visible neck or head findings. In these situations, it is very dangerous to speculate about the seriousness of the event or try to predict the clinical outcome. Despite the lack of visible injury, the patient may experience pain (subjective discomfort described by the patient) or tenderness (discomfort with palpation). The common visible physical findings in strangled patients can include redness, abrasions, bruising, petechiae, and subconjunctival hemorrhages.

> ***Practice Tip for First Responders and Healthcare Personnel:*** The lack of visible findings or minimal injuries does not exclude a potentially life-threatening condition.

*Redness (erythem*a) is usually not indicative of a structural injury and resolves rapidly. The redness is the result of pressure to the skin, which causes temporary dilation of the local blood vessels, so more blood is flowing close to the skin's surface. Note than redness can have other etiologies, including but not limited to infection, inflammation, allergic reaction, skin disease, sun burn, and emotional or drug-related flushing. Redness can also be the first finding of a bruise and represent blood that has leaked into the superficial skin tissue after structural injury. In this situation, the red area may be tender and will not blanch on palpation; the follow-up exam will likely reveal the development of a bruise.

Abrasions are caused by an abrading force damaging superficial skin tissue, which may remove layers of skin. The edges of abrasions are irregular, and the depth is variable. Depending on the age of the injury, there may be active bleeding or scabbing from healing. In strangulation, abrasions are often caused by the scratching of fingernails; these may be from the perpetrator's nails, or defensive wounds from the victim's nails in an attempt to remove the strangling force. Abrasions may also be caused by a ligature creating impact abrasions by the crushing of tissue; this type of abrasion may pattern the injuring object.

> ***Practice Tip for First Responders and Healthcare Personnel:*** If abrasions are noted to the neck, you may ask the patient if they know what caused them. The patient may additionally be able to detail garments of clothing they were wearing during the assault that acted as a ligature, such as a necklace or hooded top.

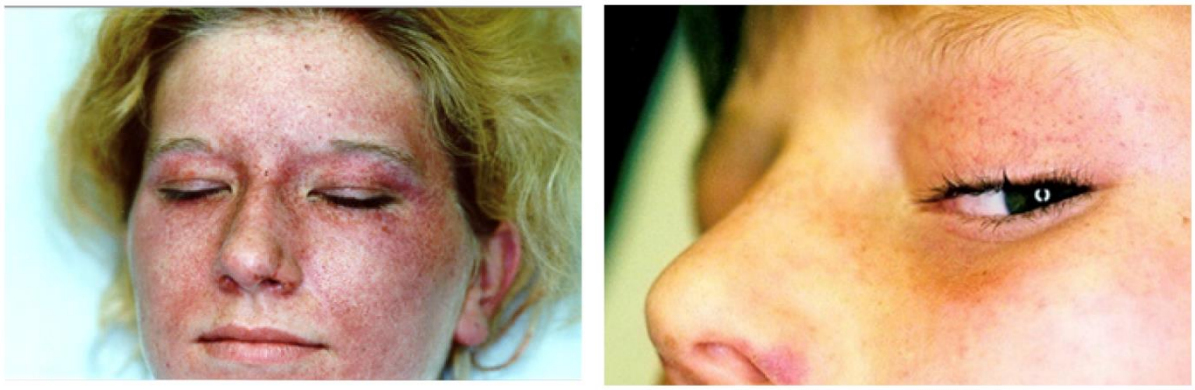
A *bruise* occurs when blunt force trauma ruptures blood vessels under the surface of the skin and blood escapes into the surrounding tissue. A bruise may also be referred to as a contusion. The area will not blanch with pressure and will usually be tender. Pattern bruises may give some information about the injuring object; in strangulation, the firm, focal pressure from finger and thumb tips may create fingertip bruises. Healthcare personnel should not speculate as to what has caused the bruise but may document objective findings and remarks made by the patient. A unique injury, sometimes seen in strangulation, is a bruise or abrasion underneath the victim's chin from chin drop. This can occur reflexively as the victim lowers their chin against the assailant's hands (or ligature) and moves their chin back and forth in an attempt to remove the

strangling force. There is no evidence to support aging or staging a bruise.

Petechiae are small (1-2mm), flat, oval, or round red spots of blood that are caused by rupture of tiny blood vessels because of increased pressure inside the veins (due to compression impeding venous blood flow). Petechia have four helpful distinguishing characteristics:

- They are non-palpable and "flat" and cannot be felt on palpation.
- They are non-tender and do not hurt when touched.
- They do not blanch and do not change color when pressed.
- They appear in crops with multiple petechiae in the same area above the point of applied pressure/compression.

1. Geographic Petechiae
   The physical and anatomic factors that cause geographic petechiae (those that occur above the point of compression) are specific. All four jugular veins must be simultaneously and completely blocked, while some degree of cerebral arterial blood flow must be maintained. This causes the veins within the brain (and above the constriction) to dilate to accommodate the influx of blood. If the total jugular obstruction is maintained for at least 10-30 seconds, the pressure in the venous system will increase to a point that the smallest and weakest venous structures (capillaries and venules) will rupture, creating petechiae. Petechiae will be visible when the ruptures are close to the surface of the skin or mucous membranes.



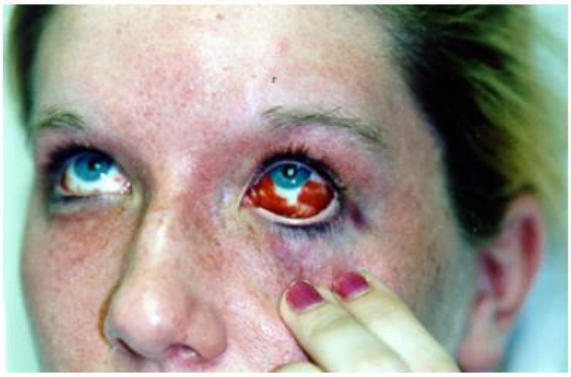
Petechiae

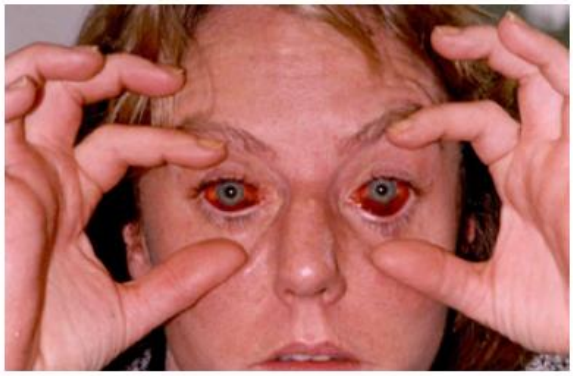
2. Generalized Petechiae
   Generalized petechiae are found bodywide and may occur as a result of suffocation. In suffocation, the incoming air is blocked from entering the body and as the victim struggles, unsuccessful attempts at inhalation create significant negative pressure in the chest, which can stop the general inflow of venous blood from the body back to the heart. This impeded venous return from the body can create the same scenario as seen in the neck and venous pressure will increase and cause ruptures and petechiae anywhere in or on the body. It is not uncommon for the perpetrator to both sit on the victim's chest and abdomen and simultaneously strangle the victim manually, thus creating petechiae from two mechanisms with a potentially confusing petechial pattern. Petechiae usually resolve

spontaneously in a few days. Of note, many non-assaultive, non-asphyxial activities can also cause petechiae, including the Valsalva maneuver; straining; vigorous coughing, sneezing, and vomiting; disease conditions; and infection. A thorough history of physical examination or a careful review of the medical records should be sufficient to exclude these less common causes of petechiae.

Practice Tip for First Responders and Healthcare Personnel: The term "petechiae" is used inappropriately to describe direct blunt trauma findings, which should correctly be described as "micro hemorrhages."

3. Subconjunctival hemorrhage
   Another post-strangulation finding closely related to petechiae are subconjunctival hemorrhages (or hematomas). The same strangulation forces that increase venous pressure and cause geographic petechiae also increase venous pressure in the tiny veins in the lining of the eyeball (conjunctiva) and rupture vessels under the conjunctiva (subconjunctiva) to form a hemorrhage or hematoma. The reason this bleeding is not petechial is because the conjunctival tissue is so lax that bleeding is not contained into petechiae but continues to form much larger pools. They are not painful, and they do not impair vision. No treatment is required, and they resolve within days or weeks. These injuries can be very disturbing to the patient and those around them.





Subconjunctival Hematomas. While distributing for the patient, this injury is not dangerous, painless, and does not affect vision. Subconjunctival hematomas resolve spontaneously within a few days to a week.

It is important to understand the mechanism of injury. It allows the healthcare provider to compare and correlate the history of what happened to the physical findings. The follow-up exam should include forensic photography that can document emerging or evolving injuries. Further, it provides for a comparison and clarification of non-specific injuries (e.g. redness).

Practice Tip for First Responders and Healthcare Personnel: A mannequin head can be a useful visual tool on which the patient can demonstrate the mechanism of strangulation and describe what happened.

See Appendix for infographic: Strangulation Signs and Symptoms from The Training Institute on Strangulation Prevention.

The Rossen Study

What is experienced by the victim (and potentially seen by witnesses) will vary depending on the severity and duration of the neck compression. Physiologically, this corresponds to the temporal path from mild hypoxia in the brain to anoxia. The extreme situation occurs when all blood flow (and oxygen supply) to the brain is abruptly and completely cut off. There is some experimental work in humans that illustrates what happens. In 1944, Rossen studied the effects of sudden cessation of all cerebral blood flow (i.e. strangulation) using an experimental neck device on volunteers. For safety and ethical reasons, this study could never be done today, but the findings are instructive, providing us with several important physiologic benchmarks in estimating the duration of strangulation compression.

A specially designed vest was inflated to 600 mmHg within 1/8 of a second. This pressure immediately stopped all cerebral blood flow to the brain. The researchers made a number of observations and measurements during and after vest inflation. Fixation of the eyes occurred in about 5–6 seconds. Most subjects had fixation looking straight ahead while some fixated with their eyes in an upward gaze. About one second after eye fixation, the subjects lost consciousness; all lost consciousness within 10 seconds. Shortly after vest release, many subjects exhibited "anoxic convulsions" (or myoclonic jerks), which are brief periods (6–8 seconds) of rhythmic jerking of the extremities. All subjects returned to full consciousness within 3–12 seconds. None had any memory of the jerking. When questioned about the experience, some subjects recalled brief sensations of tingling in the extremities and some narrowing of vision or "spots" just before they went out. Awareness of these observations is important because even though the victim may have no memory of events (including no recollection of being unconscious), a witness may be able to confirm loss of consciousness by describing eye fixation or jerking.

In 1982, Reay and Holloway addressed the same issue by using "five muscular, athletic law enforcement volunteers" to undergo a "carotid sleeper" hold while being medically monitored to assess the physiologic effects of this law enforcement technique. This procedure reduced carotid blood flow to about 10 percent of normal and did so within about 6 seconds from the onset of compression while leaving vertebral blood flow intact. The range from onset of neck compression to loss of consciousness was 6.4–9.7 seconds with an average of 7.7 seconds. This is very consistent with Rossen's data. After release, blood flow returned to normal in 7–23 seconds with an average of 13.7 seconds. This study also affirms that the 15 percent of cerebral blood flow in the vertebral arteries (and the distribution of that flow to the posterior brain structures) is not sufficient to maintain consciousness. The study also shows that in order to quickly lose consciousness, carotid flow does not have to be stopped completely, just significantly reduced.

The scientifically validated information about how quickly obstruction to blood flow in both carotid arteries can produce unconsciousness is a very important forensic benchmark in addressing the issue of duration of compression. Other temporal markers of compression

duration are urinary incontinence (15 seconds) and fecal incontinence (30 seconds). In the Rossen Study, not all subjects lost bodily fluids and the time from cessation of cerebral blood flow to incontinence varied, but no urine was lost before 15 seconds and no feces lost before 30 seconds.

In many real-life strangulation situations, time from onset of compression to sufficiently compromised carotid flow to produce unconsciousness may be longer than a few seconds because the victim is struggling and/or the compressive force is not consistent, strong enough, or properly placed. As the victim transitions more slowly from cerebral hypoxia to anoxia, brain asphyxia develops more gradually allowing more behaviors to manifest. The victim may also be able to describe more symptoms. Progressive hypoxia also occurs with many lung problems and has a fairly consistent clinical presentation. Initially, patients complain of shortness of breath or "air hunger"; the respiratory rate increases as does the pulse rate. A headache may develop. As more of the circulating blood contains less and less oxygen, the color of the blood gets less red and more bluish. This is known as cyanosis and is most visible in blood vessels closest to the skin's surface (e.g., face, lips, and fingernails). From a behavioral perspective, early hypoxia creates anxiety, which, as it worsens, gives way to restlessness and agitation, and then desperation and panic. As the behavioral response escalates, mental status and functioning decrease from difficulty communicating, to confusion and disorientation, then weakness and lethargy, and finally unconsciousness. As strangulation victims slide further down this slope during compression, just before losing consciousness, many report the fear of death giving way to resignation and thoughts of their family.

Was the Neck Compression Brief or Prolonged?

Forensic science has provided some reliable benchmarks based on physical findings:

- If geographic petechiae (above the level of constriction) are present, enough sustained, uninterrupted, bilateral compression of the neck occurred for at least 10–30 seconds in order to occlude all four jugular veins.
- If loss of consciousness occurred during the neck compression, then bilateral, simultaneous pressure occluded both carotid arteries for at least 5–10 seconds.
- If the victim was incontinent of urine during neck compression, then bilateral, simultaneous pressure occluded both carotids for at least 15 seconds. Note: Given this mechanism and length, the victim would have been unconscious and unresponsive for at least five seconds before urine was lost.
- If the victim was incontinent of stool during neck compression, both carotids were simultaneously compressed without interruption for at least 30 seconds. The victim would have been obviously unconscious for at least 20 seconds before stool was released.

See Appendix for Physiological Consequences of Strangulation Timeline from The Training Institute on Strangulation Prevention.

Was This a Life-Threatening Event?

This is usually the most important question for the criminal justice system and the jury even if it is not an element of the crime. The victim has survived a strangulation assault. The fundamental issues are:

- Was there a mechanism of injury present that could create a lethal outcome?
- Were there symptoms or findings present that confirm the patient was on the path to death?

There are two basic lines of inquiry. First is the presence of geographic petechiae. Petechiae confirm that bilateral, simultaneous occlusion pressure was present for at least 10–30 seconds. This is the requisite mechanism for the path to stagnant hypoxia and, if sustained, to death.

The next avenue is more complicated with wider possibilities. The final common pathway is asphyxia of the brain. Sustained asphyxia will lead to death. There are two mechanisms that lead from normal to cerebral hypoxia to fatal asphyxia. First is impairment of arterial blood flow to the brain. Without adequate arterial blood flow, there will be inadequate oxygen for normal brain cell activity and cells will begin to malfunction.

Manifestations of brain cell malfunction include:

- Altered mental status (light-headedness, dizziness, confusion, hallucinatory phenomena). loss of consciousness;
- Incontinence (bladder or bowel); and
- Visual loss or disturbance.

These findings, individually or in combination, indicate the path toward death has begun. If the arterial blood flow interruption continues, death will follow.

The second mechanism to brain asphyxia is airway compromise that interrupts arterial oxygenation. Impaired oxygenation will eventually lead to the final common pathway of brain asphyxia with same findings just described. But before that point, airway compromise has unique symptoms that indicate the mechanism is in place:

- Inability to breathe;
- Inability to speak;
- Hoarseness or change in voice; and
- Shortness of breath or difficulty breathing.

If airway compromise is sustained, oxygenation will fail, brain asphyxia will progress, and death will ensue. There are fundamentally only two kinds of strangulation victims: dead ones and near misses. The line between survival and death rests on the degree of force applied and the duration of that force.

Medical Forensic Evaluation of the Strangled Patient

In clinical forensic medicine, there are two sets of needs the medical professional must address. The first is the patient's needs. This includes evaluating and stabilizing any acute medical issues, emotional support, and crisis intervention. It may also include health issues and prevention strategies for sexually transmitted infections and pregnancy in the sexually assaulted patient.

Safety and social issues must also be addressed, including risk and lethality assessment, safety planning, and follow-up care. The second area that must be addressed is the criminal justice needs. The proper collection of evidence and documentation of physical findings are necessary precursors to developing an expert medical opinion and later, expert testimony.

There are a number of medical and forensic issues that prove to be challenging in these types of cases. Historically, both inadequate research and limited medical training have allowed a casual clinical response to prevail. It is not unusual for personnel involved in the case to under-appreciate and minimize the medical risk of strangulation. Patients may initially present with seemingly minimal or subtle injuries and symptoms. Consequently, this can result in limited medical evaluation and treatment, which may lead to clinical deterioration and a poor outcome for the victim. Forensic issues, related to lack of understanding and subsequent minimization, may include limited or poor documentation and little or no medical testing, which compromises objective proof of injury.

Strangulation is a potentially life-threatening event. A benign initial presentation (patient looks well, normal vital signs, minimal symptoms, absent or minimal visible injury) does not exclude a serious medical condition or predict a good outcome. All strangled patients need a thorough evaluation by a trained healthcare professional. A medical forensic evaluation requires specialized training, typically outside the scope of standard medical education.

A medical forensic evaluation should only be performed with patient consent or assent. A detailed history of the assault is the first step in the medical forensic evaluation, to determine the mechanism(s) of injury and subsequently guide the physical examination. The narrative history should be in the patient's own words, using quotation marks. Clinicians should document patient symptoms at the time of the assault, after the assault, and at the time of the medical encounter. Clinicians should record both the words used to describe the event as well as actions demonstrated by the patient regarding the event. It is important to note that it can be difficult to obtain a complete linear history due to a variety of factors that impair the patient's ability to recall the events, including the use of drugs/alcohol; the effects of a traumatic experience on memory creation; head trauma; and the act of strangulation itself limiting oxygenation, which affects the area of the brain (hippocampus) that is responsible for memory formation. The history will direct the physical exam, which should consist of a comprehensive head-to-toe assessment, focusing on illness and injury identification. Injuries should be described using size, shape, color, and type of injury. Photographic documentation of injuries should be part of the medical forensic evaluation. Documentation of these encounters must be detailed, thorough, and complete.

Currently, there is no standard protocol or recommendation for obtaining touch DNA in the context of strangulation, therefore healthcare personnel should follow their facility and jurisdictional guidelines. Neck swabs may be collected from a strangled patient, with their informed consent or assent, for the purpose of forensic evidence collection. Touch DNA samples may be indicated if the strangulation occurred within 24 hours of hospital presentation, and the patient has not bathed or showered. One neck swab (sterile cotton-tipped swab) should be lightly moistened (with sterile water) and gently rolled over the neck with specific attention to the site the patient reported contact. This motion should be repeated with one dry swab. Areas of injury may have a higher concentration of touch DNA. Buccal swabs should be collected as a patient

reference DNA sample, to distinguish their DNA from that of the perpetrator. Personnel should follow their jurisdictional policies for packaging, labeling, and sealing evidence. Chain of custody must be maintained by all parties handling, transferring, and storing evidence.

The next branch in the medical decision tree is imaging. In the context of strangulation, the two most common imaging modalities are basic (non-enhanced) magnetic resonance imaging (MRI) and computed tomographic angiography (CTA). CTA is the gold standard for evaluation of vessels and bony/cartilaginous structures, while MRI is the best study for detection of soft tissue trauma.

See Appendix for Recommendations for the Medical/Radiographic Evaluation from The Training Institute on Strangulation Prevention.

Many experts recommend admission/observation for all strangulation patients for at least 24 hours after the assault. Most recent guidelines indicate that the period of observation should be between 12 and 24 hours. Red flags that should be taken very seriously (and many experts agree necessitate imaging studies and/or observation) include a history of loss of consciousness, facial and/or conjunctival petechiae, neck soft-tissue injury(either on physical exam or imaging), incontinence (urinary or fecal), intoxication, and/or the potential for poor home observation (such as in those with transient housing or who live alone).

The fundamental pitfall is that medical science cannot reliably predict which strangled patient is at risk for deterioration and which is not. Until better data is available, the only prudent course of action is an abundance of caution. Clinically, this translates into doing more for each strangled patient and accepting (and for the patient's benefit, embracing) a high percentage of negative imaging studies and inconsequential observations.

Healthcare personnel should address the following issues with patients prior to discharge:

- Make sure patients' medical and mental health needs related to the assault have been addressed.
- Provide patients with verbal and written medical discharge instructions, including return precautions.
- Arrange follow-up appointments and discuss follow-up medical contact procedures.
- Address patients' physical comfort needs.
- Help patients plan for their safety and well-being *(ideally, a community advocate should be involved in this process.*

See Appendix for Strangulation Assessment Sheet & Strangulation and/or Suffocation Discharge Information from the Training Institute on Strangulation Prevention.

Injuries sustained in a non-fatal strangulation evolve, so a follow-up medical visit, ideally within 72 hours, is helpful. A follow-up exam may include neck remeasurement (for comparison to the neck circumference at the time of the initial exam), the continued documentation (including photography) of evolving symptoms and physical findings for the medical forensic evaluation, and further safety assessment including psychological risk assessment.

Pediatric Considerations

As highlighted previously, strangulation is very dangerous and potentially lethal. Minimal pressure on the neck can cause serious injury, but even in fatal cases of strangulation, up to 40 percent may have no visible external injuries of the neck which can complicate the investigation and medical care of patients who have experienced strangulation[81]. These same difficulties are encountered when pediatric patients are victims of strangulation. Furthermore, strangulation also occurs in very young children, or in children who are developmentally unable to provide histories for their assaults. These situations present even more challenges for law enforcement and health care professionals when working with this unique population as the strangulation event is unknown. This section will discuss considerations which are intended to guide one's evaluation in cases where strangulation of the pediatric patient is suspected or witnessed.

Age and Development factors: Pediatric non-fatal strangulation protocols are typically divided into "14 years old and under" and "Ages 15-17", however development is also a large factor in the assessment.

Challenges in evaluating pediatric strangulation cases.

A number of unique challenges are present when evaluating pediatric patients who have suspected, witnessed or confirmed histories of a strangulation assault. In general, these hurdles mostly affect the child's ability to provide an accurate history of their assault.

Typically, children under the age of 3 will be unable to participate in a forensic interview. While many children have astounding capacities for vocabulary prior to the age of three, their brain development may not allow them to put together an accurate timeline which could be used in a legal investigation, or for the purposes of collecting a medical history. In addition, many children over the age of three years have limited speech development for a variety of reasons and still may not be able to provide an accurate history. As a child ages, their cognitive ability to provide an accurate historical account and timeline will improve, assuming their development is typical. Children who are affected by cognitive, behavioral, or physical disabilities may be slower to develop this capacity, and for some children, this ability may never come, depending on the extent of their disabilities or developmental delays. Given the increased rates of abuse in children with disabilities, these limitations can be quite frustrating for professionals.

In addition, children are most often abused by people that they know and trust. As a result, children might be hesitant to disclose details of their assault if they feel they might cause trouble for a caregiver or loved one, especially when being questioned by law enforcement. It would be appropriate to consult with the closest Child Advocacy Center to inquire about the possibility of gathering histories from pediatric strangulation victims in a child friendly, non-leading, non-traumatic fashion. Also, it is possible that a caregiver who has perpetrated strangulation on a child may have told the child not to be honest about the assault. They may have threatened the

[81] Gill JR, Cavalli DP, Ely SF, Stahl-Herz J. Homicidal neck compression of females: autopsy and sexual assault findings. *Acad Forensic Pathol*. 2013;3(4):454-457

child with emotional or physical harm should they disclose what happened to them. Finally, children who grow up in environments of chronic domestic violence have often been told by caregivers to not provide information to law enforcement or medical personnel that could affect the family. The child might also not understand that this type of assault is out of the norm, especially if strangulation is something that occurs often in the home when people are in trouble, angry or upset.

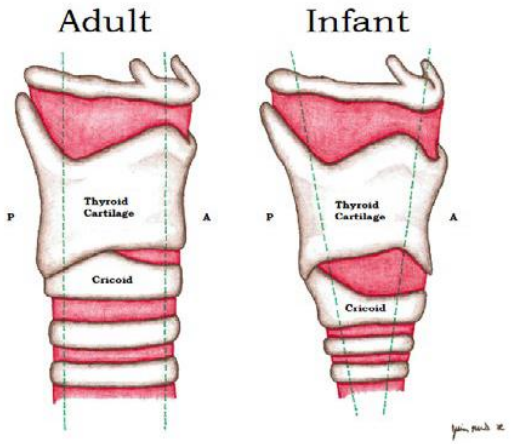
In conclusion, the emotional, behavioral, cognitive, and developmental status of a child will have a significant impact on their ability to provide an accurate account of their strangulation assault, further complicating the job of medical professionals and law enforcement personnel.

Pediatric Anatomy of the head and neck

Pediatric patients have distinct differences in their anatomical structures when compared to adults. It cannot be assumed that children are "little adults" and that their bodies are simply smaller. The differences in the pediatric anatomy of the head and neck have significant implications when considering potential findings and sequela after a strangulation assault. It is outside the scope of this chapter to completely review all anatomical structures of the head and neck. Rather, the differences in pediatric anatomy when compared to adult anatomy will be discussed. While there is an absence of literature that has specifically studied the exact implications of these anatomical differences during the course of a strangulation assault, health care providers can glean educated inferences supported by literature from other disciplines such as anesthesia, biomechanics and infant and child car seat safety studies.

Airway

As the pediatric patient ages, the difference in the structures of the airway when compared to adults becomes much less marked. The most notable differences are found when comparing the infant airway with the adult airway (below image). The infant as well as the pediatric airway are higher in the neck when compared to that of an adult. Also, rather than being a linear structure, the airway in an infant and the young pediatric patient is actually funnel shaped, with the cricoid cartilage as the narrowest component. More specifically, at birth, the lower border of the cricoid cartilage lies opposite the lower border of the fourth cervical vertebra. At 6 years of age, the cricoid cartilage is at the level of the fifth cervical vertebra and in the adult, it lies at the level of the sixth cervical vertebra. An important factor to consider after a strangulation assault in the pediatric patient is that because the cricoid cartilage is smaller and forms a complete ring around the trachea, mucosal edema at this site will severely compromise the airway.



Adult and Infant differences in the airway

Another difference in the pediatric airway is the shape of the epiglottis. This structure is typically broad leaf shaped in the adult and its axis lies parallel to that of the trachea. Conversely, in the infant patient, the epiglottis is narrower, softer and more horizontally positioned than in the adult. By the time the pediatric patient reaches the age of 4 or 5 years, the epiglottis is more consistent with the adult form.[82] It is unknown what implications these differences may have during a strangulation assault. The medical provider may infer however, that given the position and softer form of the epiglottis in the younger pediatric patient, there may be an increased risk of aspiration.

Many other anatomical differences create an increased vulnerability in the pediatric patient for an obstructed or compromised airway. For instance, given their proportionally larger head and occiput relative to body size, pediatric patients are more susceptible to flexion of the neck, potentially obstructing the airway when lying in a supine position. In addition, pediatric patients have smaller nasal apertures which can become easily obstructed by secretions, edema, or blood. [83] It is known that infants are obligate nasal breathers and the above differences can create a situation in which the infant will need to work much harder to breath. Also, given the relatively large tongue size and decreased muscle tone of the pediatric patient, there is a decrease in the size of the oral cavity allowing obstruction to occur more easily.[84] While there is no literature

[82] Adewale, L (2009) Anatomy and assessment of the pediatric airway. Pediatric Anesthesia, 19 Suppl 1 1-8 doi: 10.1111/j.1460-9592.2009.03012.
[83] Ommaya, A.K., Goldsmith, W., Thibault, L. (2002). Biomechanics and neuropathology of adult and pediatric head injury. *British Journal of Neurosurgery, 16(2)*: 220-242.
[84] Burdi, A.R., Huelke, D.F., Snyder, R.G., Lowrey, G.H. (1969). Infants and children in the adult world of automobile safety design: Pediatric and anatomical considerations for design of child restraints. *Journal of Biomechanics, 2*: 267-280

which discusses the implications of these anatomical differences during a strangulation assault, in general, the medical provider can infer that the pediatric airway is simply more susceptible to compromise.

Head and Neck

One major difference of the infant head when compared to the adult head is that the skull in the adult patient is a rigid structure. In an infant and also in the pediatric patient, there is a compliant nature to the skull. It is made up of curved plates of bone that are loosely associated. The curved plates are brittle and nearly elastic and they can resist compression and shear forces. This means that the infant skull is not capable of supporting bending loads, especially across suture lines or fontanels. This remains true through early pediatric developmental. The skull becomes more rigid as the child ages. Clinical data collected from impact injury studies shows that the unique properties of infant skulls result in a lower level of injury threshold for the infant brain. In addition, the adult skull is better equipped to withstand forces that may cause a fracture. In fact, the adult skull's resistance to fracture is eleven times greater than for a neonate and over twice that for a young child. Given the relative proportional differences of the pediatric head size, differential motion of the brain and skull is amplified because of the weak neck in infants and young children.[85] Finally, the vascular system in infants is also thought to be more fragile and much more susceptible to abrupt pressure changes when compared to adults.[865] Given these differences, it is clear that the medical provider can logically infer that infants and young children can be more susceptible to serious injury from a strangulation assault, especially if that strangulation includes differential motion (or shaking) of the head and neck structures.

In conclusion there is a lack of literature which supports exact implications of pediatric and infant anatomy in susceptibility to injury from a strangulation assault. However, available knowledge and research (from basic anatomy and physiology as well as literature which examines injuries from shaking assault of infants, as well as biomechanical and infant injury literature) allows the medical provider to infer that infants and children, especially young children, are significantly more susceptible to serious injury from a strangulation assault.

Clinical Presentation of Pediatric Patients

It is common for strangulation injuries to be missed or underestimated in children, where the clinical spectrum may range from mild self-limiting symptoms to severe neurologic sequelae or death. Children are most commonly abused by someone they know, often a parent or parent figure, so that the incident may be reported late or not at all. The child may be preverbal or unable to articulate exactly what they experienced or their current symptoms. Some symptoms in adults may not be as helpful in assessing young children, such as incontinence. And just as in adults, up to 50% of children will not have clinically apparent signs of strangulation.

[85] Jain et al. Strangulation Injury, A Fatal Form of Child Abuse. Indian Journal of Pediatrics 2001,86:571-572
[86] Dayapala et al. An Uncommon Delayed Sequela After Pressure on the Neck. Am J Forensic Med Pathol 2012, 33(1):80-82.

Typical symptoms reported by children include voice changes, sore throat or neck pain, difficulty breathing, and problems swallowing. Older children may report urinary and/or fecal incontinence. Children may report dizziness or a loss or near-loss of consciousness. First responders and health care providers should be alert that a child may describe their symptoms in ways that are very different than an adult but are developmentally appropriate, such as "I talked like a duck," "I saw sparkles in my eyes" or "I fell asleep." Some children may be able to articulate that they thought they were going to die.

Children may present due to physical findings that are noted by neighbors, teachers, daycare providers or family members who then report to child protection or law enforcement. Findings may include:

- Petechiae of neck, face, conjunctivae
- Bruising of neck, potentially patterned, from fingers or thumbs, ligatures, or clothing
- Swelling in the neck and face Defensive scratch marks on neck
- Abrasions or patterned injury from jewelry worn by child or assailant
- Bruising and injuries elsewhere on the child's body.

Children may also present initially with:

- Seizures or altered level of consciousness due to hypoxic brain injury.
- Altered mental status including agitation or confusion likely due to hypoxic brain injury Respiratory distress due to acute lung injury, aspiration, or hypoxic brain injury.

Some case reviews that included imaging studies have found fractures of the bony and cartilaginous structures of the neck in up to 25% of pediatric strangulation deaths, including the thyroid cartilage and the hyoid bone.[876] Others have found these injuries to occur much less frequently in children than adults, while sequelae from soft tissue edema in the neck was more common in children.

Severe delayed effects of strangulation have been reported in children, including vocal cord paralysis, hypoxic- ischemic encephalopathy, cerebral edema, cerebral infarction, aspiration pneumonia, fractures of the hyoid bone or thyroid cartilage, behavioral changes, cognitive deficits, injury to the carotid artery, and death.[88],[89] ,[90],[911] Thyroid storm induced by strangulation has been reported as an uncommon but potentially life-threatening complication in adults.[92] Poor

[87] Verma, S. K. Pediatric and adolescent strangulation deaths. *J Forensic and Legal Medicine* 2007, 14:61-64

[88] Bird et al. Strangulation in child abuse: CT Diagnosis. *Radiology* 1987, 163(2):373-5.
[89] Jain et al. Strangulation Injury, A Fatal Form of Child Abuse. *Indian Journal of Pediatrics* 2001,86:571-572.
[90] Dayapala et al. An Uncommon Delayed Sequela After Pressure on the Neck. *Am J Forensic Med Pathol* 2012, 33(1):80-82.
[91] Yadav et al. Carotid sheath haematoma: A case report. *Journal of Forensic and Legal Medicine* 2008, 16:411-13.
[92] Ramirez et al. Thyroid Storm Induced by Strangulation. *Southern Medical Journal* 2004, 97(6):608-610.

prognostic signs include prolonged coma, seizures, need for ventilatory support, elevated intracranial pressure, diabetes insipidus, or blood sugar >300 on admission.[93]

Most reported deaths in strangled children have been due to cerebral asphyxia from obstruction of carotid artery flow to the brain and jugular venous return, however early and delayed deaths due to carotid hematomas and cerebral infarction have been reported and it is possible cardiac dysrhythmias play a role.

Consideration should always be given to concurrent additional types of child abuse including sexual abuse/ assault, abusive head trauma, and other forms of physical abuse.

Other Considerations in pediatric patients

Choking game

Known by a number of different names, including choke out, pass out game, rush, and flat lining, the "choking game" is an activity in which persons strangulate themselves or others to achieve euphoria through brief hypoxia. The CDC identified the earliest choking game death as occurring in 1995, with very few deaths annually until 2005 when rates increased. The majority of deaths (86.6%) were boys with a mean age of 13.3 years and the youngest being 6. The age distribution for choking game deaths in children and teens differed from suicides by hanging or suffocation: choking game deaths tend to occur in younger children, peaking at age 13, whereas suicides by hanging or suffocation became more prevalent with age.[94]A survey conducted in Oregon found that 36.2% of 8th grade respondents had heard of the "choking game," 30.4% had heard of someone participating, and 5.7 had participated themselves. Hispanic and American Indian/Alaska Native youth as well as youth living in rural areas had the highest rates of participation. In addition, participants were significantly more likely to report substance use and mental health problems.[9514] Primary care and emergency medicine medical providers should be alert to symptoms that can include blood shot eyes, marks on the neck, altered mental status, severe headache, vision loss, seizures, and syncopal episodes. A thorough medical history should include questions about the choking game as part of routine assessment of other risk-taking behaviors.[9615,9716]

Accidental

Infants and young children are especially vulnerable to accidental strangulation injuries from cribs, other furniture, ropes and cords, and entanglement in clothing, highchairs, and playground equipment.[9817] A careful history that includes child's developmental status along with a scene

[93] Sabo et al. Strangulation Injuries in Children. Part 1. Clinical Analysis. *The Journal of Trauma: Injury, Infection, and Critical Care* 1996, 40(1):68-72.
[94] Unintentional Strangulation Deaths from "The Choking Game" Among Youths Aged 6-19 Years – United States, 1995-2007. *MMWR* 2008; 57(6).
[95] "Choking Game" Awareness and Participation Among 8th Graders – Oregon, 2008. *MMWR* 2010; 59(1).
[96] Egge et al. The Choking Game: A Cause of Unintentional Strangulation. *Pediatric Emergency Care* 2010; 26(3):206-208.
[97] Andrew et al. Update on "The Choking Game". *The Journal of Pediatrics* 2009; 155(6):777-780.
[98] Feldman, K. and Simms, R. Strangulation in Childhood: Epidemiology and Clinical Course. *Pediatrics* 1980; 65(6):1079-1085.

investigation and re-enactment by law enforcement partners in the multidisciplinary team will help distinguish accidental from inflicted strangulation.

Suicide

It may be challenging to distinguish strangulation by suicide from the "choking game" or auto-erotic asphyxiation. Studies have indicated teen-aged males are at higher risk for suicide by strangulation, and that the age distribution is somewhat different for suicide attempts or completions vs injuries related to the "choking game" or accidental strangulation. Again, a careful history that includes prior behavioral health concerns as well as scene investigation from law enforcement will help determine the cause of the injuries found.

Medical

Some children and adolescents (as well as adults) may develop facial and conjunctival petechiae from prolonged vomiting, coughing, or other significant Valsalva maneuvers, even in the absence of a bleeding diathesis. A thorough medical history and exam should usually distinguish medical causes of petechiae from strangulation injuries.

Recommendations for first responders and healthcare personnel

It is critical to remember that a lack of visible external neck injuries does not mean that strangulation did not occur, and that strangulation victims may die without visible external injuries.[99] A medical history should include:

- The situation in which the strangulation occurred.
- The method of strangulation.
- Symptoms the child may have experienced during and after the strangulation episode as well as current symptoms at the time of presentation to medical care, remembering that children may describe their symptoms differently than adults.
    - Ask specifically about loss of urine or stool during the incident, as this information may not be spontaneously volunteered.
- Time elapsed between the strangulation episode and presentation to medical care.
- Presence or absence of witnesses.
- Presence of any medical conditions that might predispose the child to facial and conjunctival petechiae.
- Child's developmental level.
- History of prior or concurrent additional forms of child abuse.

See Appendix for Pediatric Strangulation Evaluation and Documentation from the Training Institute on Strangulation Prevention.

[99] Shields et al. Living Victims of Strangulation. *Am J Forensic Med Pathol* 2010; 31(4):320-325.

Physical exam

A child presenting with a potential strangulation injury should have a thorough medical evaluation that includes:[100]

- Vital signs including pulse oximetry.
- Complete survey of all skin surfaces, particularly looking for petechiae, bruising, bites, redness, tenderness, patterned marks (such as from ligatures, fingers, etc.), and areas of tenderness.
- Assessment for intraoral injury, including frenular tears, petechiae, bruising, tongue injuries.
- Initial and serial measurements of the neck circumference every 10-12 hours (in the same marked spot each time) if admitted for observation; the admitting physician should be notified promptly if neck swelling increases.
- Assessment for respiratory distress, stridor, difficulty swallowing or speaking, voice changes, cough, hemoptysis, voice changes.
- Eye exam for petechiae and redness with consideration of a dilated retinal exam by an ophthalmologist.
- Otoscopic exam if any ear complaints.
- External examination of anal-genital area.
- Neurologic exam including age-appropriate mental status assessment, presence of irritability, somnolence, behavioral changes, seizures, or localizing findings.

Forensic Evaluation

Depending on how long ago the strangulation incident occurred and interim hygiene activities, it may be possible to find forensic evidence on the child's body. If applicable and according to state guidelines for touch DNA:

- Collect debris or foreign material. Label, seal, and maintain chain of evidence until transferred to law enforcement.
- Swab the child's neck for possible assailant epithelial cells left on the skin. Follow local crime laboratory directions for the technique to use for swabbing.

Additional forensic evidence collection may be indicated, such as situations where strangulation occurs during sexual abuse or sexual assault.

Please refer to Children's Advocacy Centers of Kentucky Medical resources at https://cackentucky.org/medical-resources/ for state protocol for evidence collection.

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[100] Faugno et al. Strangulation Forensic Examination – Best Practice for Health Care Providers. *Advanced Emergency Nursing Journal* 2013, 35(4):314-327.

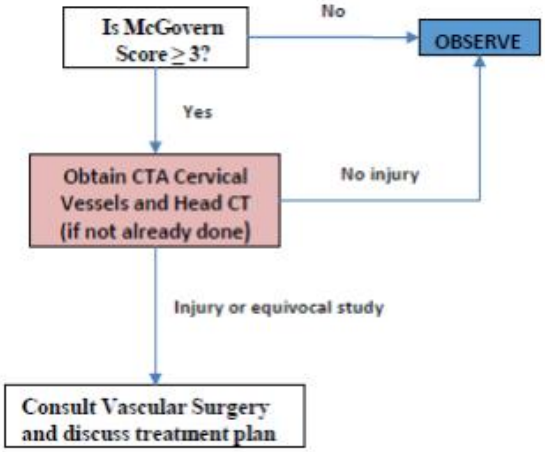
Diagnostic Testing

Depending on the clinical presentation of the child and time elapsed since strangulation incident (recommend low threshold for transfer for acute events), consideration should be given to transfer to a pediatric treatment center where the following will be considered:

- CT angiogram remains gold standard for evaluation of vessels and bony/cartilaginous structures, less sensitive for soft tissue trauma or MRA of carotid/vertebral arteries. [101,102]
    - Blunt cerebrovascular injuries (BCVI) are rare. Most patients are symptomatic. According to Herbert, et al., the McGovern score is the first BCVI screening tool to incorporate the mechanism of injury in screening criteria. This can allow physicians to minimize the use of radiation and determine which patient are high risk and which actually need angiographic imaging[103]. Please refer to pediatric trauma center's protocols for up-to-date information.

McGovern Score	
Criteria	**Points**
GCS score ≤ 8	1
Focal Neuro Deficit	2
Carotid Canal Fracture	2
Mechanism (MVC, HBC)	2
Petrous temporal bone fracture	3
Cerebral infarction on CT	3
Score ≥ 3 points signifies high risk for BCVI. The patient should undergo angiography.	

NOTE: If neuro decline, ACTIVATE STROKE ALERT



- Imaging studies of the neck, including:
    - Neck x-rays to identify fractures of bony structures of neck
    - Neck CT to identify injuries to bony, cartilaginous, and soft tissues in the neck
    - Neck MRI to identify intramuscular hemorrhage, hematomas and swelling in other soft tissues, and hemorrhage into lymph nodes (all associated with more severe, life-threatening strangulation)[104,105]
- Pharyngoscopy or laryngoscopy if stridor or voice changes

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[101] Brommeland T, Helseth E, Aarhus M, et al. Best practice guidelines for blunt cerebrovascular injury (BCVI). Scan J Trauma Resusc Emerg Med. 2018; 26 (1):90.
[102] Bruguier C, Genet P, Zerlauth JB, et al. Neck-MRI experience for investigation of survived strangulation victims. Forensic Sci Res. 2019;5(2): 113-118.
[103] Herbert JP; Venkataraman SS, et al. Pediatric blunt cerebrovascular injury: the McGovern screening score. J Neurosurg Pediatr. 2018; 21:639-49. DOI: 10.3171/2017.12.PEDS17498.
[104] Christe et al. Life-threatening versus non-life-threatening manual strangulation: are there appropriate criteria for MR imaging of the neck? *Eur Radiol* 2009, 19(8):1883-1889.
[105] life for survivors of manual strangulation? A statistical analysis. *Legal Medicine* 2010, 12:228-232.

- Chest x-ray if any respiratory symptoms
- EEG if concerns for hypoxic-ischemic encephalopathy
- Head CT or MRI if concerns for intracranial injury or hypoxic-ischemic encephalopathy
- Age appropriate child abuse work-up including:
    - Skeletal survey for occult fractures in children <2years of age, with consideration for children up to 5 depending on development
    - Trauma labs for children <5 years of age and within 72 hours of the reported assault including CBC, CMP, PT, PTT, amylase, lipase, urinalysis.

Diagnostic testing may not be indicated in children presenting days after the strangulation incident with no current symptoms. Consideration should still be given to obtaining a skeletal survey in very young children, as studies have indicated a significant yield of occult fractures in young children with other physical abuse findings.

Documentation

Comprehensive documentation improves patient care and increases the likelihood of achieving both justice and future safety for child victims. Documentation should include:

- Child or adolescent's verbatim description of the strangulation incident(s), demeanor and mental and emotional status including clearing identifying the source of information.
- Any disclosure of prior or concurrent other abuse.
- History provided by caregiver accompanying the child (if present.)
- Any subjective complaints such as pain, sore throat, difficulty swallowing, loss of memory – using the child's own words.
- Shape, size, color, and location of any observed injuries, both described with words as well as drawn on traumagrams.
- Photographs of any observed injuries
    - Photos of each injury should include a distance orientation image, a close up, and a close up with scale.
    - Photos should also be taken of areas where pain or tenderness are present even if no current visible injury, as bruises may surface later.
    - Follow up photos should be obtained until near or complete resolution of visible injuries.

See Appendix for a specific pediatric strangulation assessments and documentation tools from the Training Institute on Strangulation Prevention.

Follow-up

Discharge instructions should include specific warning signs that would indicate a child should be brought back for urgent re-evaluation. These include:

- Difficulty breathing or shortness of breath
- Loss of consciousness
- Changes in voice or difficulty speaking
- Difficulty swallowing, lump in throat, or muscle spasms in throat or neck

- Swelling of tongue, neck, or throat Prolonged nose bleed
- Persistent cough or coughing up blood Persistent vomiting or vomiting up blood
- Left or right sided weakness, numbness or tingling
- Headache not relieved by over the counter pain medication taken as directed on bottle
- Seizures
- Behavior changes or memory loss
- Thoughts of harming self or others

A scheduled follow up exam with the Child Abuse Team, clinic, emergency department or child's primary care provider should occur preferably 72 hours-2 weeks after reported injury.

Strangulation may cause both acute and long-term psychological consequences therefore counseling is recommended.

Long-term neurologic sequelae have been reported in some children who have sustained either inflicted or accidental strangulation injuries, ranging from mild learning problems to severe cognitive and motor impairment[106]. It is therefore important that these children have appropriate long-term medical follow up for monitoring and treatment of any identified adverse outcomes.

Reporting

Kentucky law requires a report to the Department for Community Based Services if there is reasonable cause to suspect that child abuse or neglect has occurred. Since strangulation is a criminal act, a concurrent report to the appropriate local law enforcement agency is also indicated.

Summary

The significance and potential lethality of strangulation injuries in children is often underestimated due to delayed presentation and barriers to communicating details about the event as well as their symptoms. Recognition of potential strangulation signs and symptoms, a thorough medical evaluation, detailed documentation, and prompt involvement of child protection workers and law enforcement officers will help provide current and future safety for the affected child. Medical providers with specialized child abuse and forensic training can provide invaluable assistance with forensic evidence collection and photo-documentation, as well as recommendations and referrals.

Kentucky has two child abuse programs that are available for consultation:

1. Kentucky Children's Kosair for Kids Center for Safe and Healthy Children at families at (859)218-6727 or 24/7 through UKMD at (859)257-5522
2. Norton Children's Pediatric Protection Specialists Services at (502)629-6000.

[106] Sabo et al; Strangulation Injuries in Children. Part 1. Clinical Analysis. J of Trauma, Infection and Critical Care 1996; Vol. 40, No. 1.

Chapter 6: Use of Experts

Expert testimony can overcome a jury's belief in myths about sexual assault or domestic violence, particularly in the case of strangulation. It can explain the lack of injury, minor injury, or the victim's reaction to the assault. An expert is a person qualified to testify because of special knowledge, skill, experience, training, or education sufficient to qualify him or her as an expert on the subject to which his or her testimony relates.

Expert testimony is important to educate the jury on subjects not typically known to a lay person. It also works to dispel commonly held myths and misconceptions about sexual assault and domestic violence, particularly in strangulation cases. It explains the lack of visible injury, minor injury, or the victim's reaction to the assault.

Experts are persons qualified to testify because of their specialized knowledge, skill, experience, training, or education.[107] Expert witness can be used for various reasons, including educating judges and jurors about medical, technical, or scientific principles. Experts may also be able to express opinions after evaluating the significance of the facts of the case.

Lack of physical evidence and injury may lead jurors to handle strangulation cases as minor incidents rather than serious and life-threatening. Even when the victim has not received medical treatment, it is critical to use an expert to educate the judge and jurors about the seriousness of strangulation.

Developing, Selecting, and Using Experts

Prosecutors may be able to use an expert at different stages of the proceedings. Do not overlook the possibility of using an expert at a bond hearing, trial, or sentencing hearing. Also, determine what kind of expert the case requires. If there are significant injuries, the expert may be the treating physician who can provide detailed descriptions of injuries. For a general discussion of medical issues, the case may warrant the use of medical experts such as medical examiners, emergency room physicians, forensic nurses, paramedics, or even a coroner who has been trained and has experience handling strangulation cases.[108]

Preparing for the use of experts is instrumental in a successful presentation of expert witnesses. When using experts, prosecutors should check references and the background of any expert with whom they are not familiar. Verify credentials, conduct internet searches, review transcripts, and talk to others who have hired the expert or had the expert testify against them in the past. For those who are handling strangulation the Institute's four-day Advanced Course on Strangulation Prevention is a must. The course is taught virtually and in-person multiple times per year.[109]

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[107] Kentucky Rule of Evidence 702.
[108] NDAA, Introducing Expert Testimony to Explain Victim Behavior in Sexual and Domestic Violence Prosecutions, p. 35.
[109] Go to www.strangulationtraininginstitute.com to find Advanced Courses available for all professionals.

Motions

Expert testimony can be admitted when:

(1) The testimony is relevant to the case;
(2) The testimony is related to a matter sufficiently beyond common experience; and
(3) The opinion of the expert would assist the trier of fact.[110]

Remember, a written pretrial notice of expert testimony is required for admissibility and provides an opportunity to educate the court and defense on the offense and its lethality.

Preparation of the Expert

Pretrial preparation of even the most seasoned expert is essential. No prosecutor should ever put on an expert without meeting with the expert and preparing for a *Daubert* hearing and trial together.

Qualifications:

- Experts should review their curriculum vitae (CV) both independently and with the prosecutor to ensure that it is current.
- Prosecutors must file their Notice of Intent to Use Expert Testimony.
- Prosecutors should prepare the expert for any challenges to his or her qualifications.

The prosecution should never stipulate to the qualifications of the expert. It is imperative that the jury hear about all the education, training, and experience that qualify the expert to testify. After questioning the witness on their qualifications, approach the bench and move to qualify them as an expert witness.

Subject Matter/Case Specific

Pretrial preparation should also include a discussion about the subject matter on which the prosecutor seeks to offer the witness as an expert. Prosecutors should meet with the expert to go over the purpose and focus of the expert's direct testimony. Caution should be taken when working with a credentialed expert to make sure that unless the expert has been hired to testify about a particular victim, a diagnosis or evaluation of the victim is not the focus of the testimony.

Questions for the Expert

This is not an exhaustive list of questions—it is merely a starting point for prosecutors.

1. Name.
2. Title.
3. Education.
4. Licenses.

[110] Kentucky Rule of Evidence 702; *See e.g. Stringer v. Commonwealth*, 956 (S.W.2d 883 (Ky. 1997).

5. Certificates.
6. Professional organizations teaching experience (if applicable)
7. Any experience in local policy development regarding the evaluation or care of strangled patients.
8. Published writings (if applicable).
9. Pertinent presentations at professional meetings.
10. Previously qualified as an expert witness and how many times.
11. Testified for the prosecution.
12. Testified for the defense.
13. Current employer.
14. Current duties.
15. Years employed in current position.
16. Prior work experience.
17. Medical training (if applicable) including board or sub-specialty board certification(s).
18. Law enforcement training (If applicable).
19. Strangulation training.
20. Examine patients who have reported being strangled (if applicable).
21. How many patients have they examined as a treating physician (If applicable). For academic physicians (medical schools or teaching hospitals) ask additional questions about experience and responsibilities for teaching doctors in training about the evaluation and management of the strangled patient.

Questions Related to a Non-Fatal Strangulation Case

1. Define "choking".
2. Define "strangulation" [Strangulation is external pressure to the neck, by any means, that blocks airflow or blood flow, or both.]
3. Difference between choking and strangulation?
4. Describe the methods of strangulation. In this case, is the strangulation manual or ligature. If manual, was it one hand, both hands, or the use of some body part.
5. Define asphyxia. [Asphyxia is specific to lack of oxygen for brain cells; hypoxia is a generic lack of oxygen in the blood. So, asphyxia is brain hypoxia.]
6. Define hypoxia.
7. In strangulation, what causes hypoxia? [Impaired respiration, impaired blood flow to the brain or both.]
8. What happens to the brain when there is a lack of oxygen after 10 seconds, 20 seconds,30 seconds, 1 minute, 2 minutes, 3 minutes, 4 minutes.
9. What is hypoxic encephalopathy.
10. What is the difference between hypoxia and asphyxia.
11. What happens to the brain when there is asphyxia or an interruption of oxygenation.
12. Can lack of oxygen to the brain result in either temporary or permanent brain injury.
13. Other than unconsciousness, are there other signs of temporary hypoxia or asphyxia.
14. What are behavioral changes? Difference between "acute" changes while oxygen starvation of the brain is occurring, and "delayed" changes, which may surface later.
15. How much external pressure and time does it take to cause unconsciousness.
16. Discuss the spectrum of "altered" consciousness beginning with light-headedness and dizziness to the other extreme of death. What are some of the variables.

17. What are the signs or symptoms of unconsciousness.
18. How long does it take a strangled victim to regain consciousness after unconsciousness. What are the variables?
19. How much external pressure must be applied before death occurs. What are some of the variables.
20. Aside from unconsciousness or behavioral disorders, are there other signs and symptoms of strangulation.
21. Would a chart help you explain those signs and symptoms. Did you bring a chart with you today.
22. Describe the external signs of strangulation.
23. Where would you find visible findings such as redness or scratch marks.
24. Impression marks, or claw marks.
25. What is petechia.
26. What does it look.
27. Where can it be seen on victims after strangulation has occurred.
28. How long does it last.
29. Are there other causes for it.
30. Why could there be swelling to the neck from strangulation.
31. Are there other internal injuries associated with strangulation.
32. Are there internal injuries associated with hypoxia.
33. What would cause the tongue to swell.
34. What are some of the symptoms of strangulation.
35. Can strangulation cause voice changes.
36. Can strangulation cause changes in swallowing.
37. Do some victims of strangulation vomit or feel like vomiting.
38. Do some victims of strangulation urinate and defecate.
39. Is there a way to tell how close a strangulation victim has come to death.
40. What information and/or documents did you review in this case prior to testifying (if applicable). [Remember, it is not necessary for your expert to review any documents in your case.]
41. From your review, what are the signs and symptoms the victim exhibited.
42. In your opinion are those signs and symptoms consistent with someone who has been strangled.

Exhibits for the Expert

Exhibits should be utilized to help the jury understand complex medical structure and function in cases of strangulation. A diagram or a model of the internal workings of the neck may be a valuable tool in court to use while the expert is explaining the anatomy of the neck area.

When available, a photograph of the victim where signs of strangulation appear should be used as the expert testifies. The expert can point out these signs and/or injuries and indicate they are consistent with strangulation. If medical record exists from a post-strangulation exam, it should be reviewed by the expert for any symptoms or findings consistent with strangulation.

Audio recordings, including the 911 dispatch recording, should be reviewed by the expert to detect and explain voice change, hoarseness, and shortness of breath. If there are other

recordings of the victim's voice, they may demonstrate changes and resolution of injuries after the assault.

Anticipated Cross-Examination Questions

There are four areas that are typically attacked during the cross-examination of an expert witness:

- Qualifications
- Basis of opinion
- Substance of opinion
- Bias, and motive or prejudice

Qualifications

Less experienced experts can expect that the defense will attempt to challenge their background education and experience. Experts should never over inflate or exaggerate their experience. Experts should know their CV inside and out. Remember that experience obtained though practice with strangled patients—especially following or managing them over time—is the most germane and significant qualification of an expert, and this may not be adequately captured on the CV.

Basis of Opinion

The defense may question prosecution experts about reports, studies, or evidence they have not reviewed. They may ask questions that insinuate that the experts' opinion is only as good as the assumptions and facts they are accepting. Defense counsel may also ask questions that ask experts to admit they are relying only on the victim's version of events versus the defendant's version of the events. This supports the importance of the history—including ALL versions of what the victim said happened and what they experienced—from police officer(s), paramedics, nursing personnel, the family, and the ER doctor.

Substance of Opinion

This is the area where defense counsel may attempt to gain concessions from the expert. Defense counsel may attempt to get experts to concede facts that are consistent with the defense theory. (Note: It is always helpful for the expert to have some understanding ahead of time about where the defense theory is going.) Experts should not try to anticipate the motive behind the questions; they should simply answer them truthfully. Good experts always concede the limitations of their opinions.

Bias/Motive/Prejudice

Questions may include how the expert is being compensated for his or her testimony, whether the expert has ever testified for the defense, and what percentage of the expert's income, if any, is derived from courtroom testimony. The Training Institute teaches a course on expert testimony and recommends that expert witnesses attend this course.

If the question posed contains incorrect information about the expert's testimony (or incorrect assumptions that become agreement if the expert answers without clarification), the expert needs to correct that information before answering the question. Experts may be asked the same questions in different ways, and they will want to make every effort to be consistent in their answers.

Experts should be alert for compound questions, and they should be sure to clarify what part of the question they are answering. If there are other possible conclusions, experts need to be willing to acknowledge they exist.

Tips for the Testifying Experts
Pretrial

Quality courtroom testimony starts with pretrial preparation.
Beyond the pretrial preparation referred to above, a potential expert should:

1. Be familiar with relevant strangulation publications.
2. Know pertinent membership qualifications for professional organizations.
3. Know the ethical obligations or protocols that govern profession practice.
4. If possible, observe other expert testimony.
5. Anticipate and discuss potential questions for direct- and cross-examination.
6. Review any available transcripts of respected transcripts.

In Court

1. Always demonstrate professionalism. Jurors make observations both inside and outside of the courtroom.
2. Consider Power Point presentations or visual aids to assist the jury's understanding if it is technologically available (The Training Institute offers free visual aids for experts).
3. Look at the jury and make eye contact while testifying.
4. Listen to the question asked and answer only that question.
5. When an objection is made, pause, and let the attorneys communicate and receive a ruling from the judge.
6. Listen carefully to objections and follow the court's rulings.
7. Ask for clarification if a question is not understood.
8. During cross-examination remain poised and respectful—do not spar or argue with the defense.
9. Rely on the prosecutor to make objections to improper questions and poor treatment by the defense.
10. Never overstate the facts or opinions.
11. Do not exceed the scope of experience or expertise.
12. Always be accurate and precise.

For additional assistance with questions for an expert witness contact the Office of the Attorney General for resources.

Chapter 7: Victim Advocacy

Editor's Note: Throughout this manual we use the example of a female victim and a male perpetrator for illustrative purposes only. It is critical to remember that victims of strangulation can and do represent every gender.

Victim Advocacy in Strangulation Cases

Guiding advocacy principles should be grounded in an understanding of trauma and victimology. Services and interactions should speak to the unique challenges confronting women in violent relationships. Advocates who understand trauma and victimology issues will be better equipped to meet the needs of strangulation victims.

Guiding principles

- Victims should be treated with dignity, fairness, and respect, even when choosing not to participate with law enforcement or prosecution.
- Victims are not responsible for the violent behavior of the perpetrator.
- Victims are deserving of respect with regard to their cultural background and belief systems.
- Victims are best positioned to assist professionals in assessing the danger posed by the perpetrator.
- Victims have the right to make their own decisions, and have those decisions supported with dignity and respect.

Advocacy Goals

- Victim safety.
- Decreasing trauma-related symptoms.
- Preventing secondary victimization. Supporting the victim during the investigation and prosecution.
- Validating the victim's feelings.

Advocacy Roles and Services

- Clearly informing victims of their rights throughout the criminal justice system, pursuant to Marsy's Law, KRS 421.500 and Section 26A of the Kentucky Constitution. Providing information on the criminal justice process.
- Helping victims with safety planning.
- Empowering, non-judgmental emotional support.
- Accompaniment/advocacy during the investigation and court proceedings.
- Assistance with filing a police report or with reporting the violation of a protective order.
- Assistance in filing for crime victims' compensation, preparing victim impact statements for sentencing, and preparing applications for protective orders.
- Facilitating communication with law enforcement and prosecution.

Victim Engagement

The initial victim contact is critical in building trust between the advocate and the victim and should be initiated at the earliest possible time. The primary purposes of the initial contact are to respond to the needs of the victim; assess the level of risk; assist with safety planning for the victim and any children residing with the victim; and informing the victim of their rights and options. To effectively serve victims of strangulation, advocates should be familiar with the dangers associated with strangulation and be able to explain the dangers to the victim. It is important to ensure victims understand as much as possible about the dangers of strangulation. A language interpreter should be used when appropriate. If your office would like information on interpreter services or if other advocacy resources are needed, contact the Office of the Attorney General's Office of Victim Advocacy for assistance.

The advocate should understand the importance of certain behaviors as risk factors for homicide. Risk factors associated with higher levels of violence include the following:

- Whether the perpetrator has threatened to kill the victim.
- Whether the perpetrator threatens suicide if the victim leaves.
- Whether the perpetrator threatens to harm the children if the victim leaves.
- Whether the perpetrator has brandished a knife or gun.
- Whether the perpetrator has been abusive to animals or pets.
- Whether the perpetrator has strangled the victim.

Strangulation epitomizes the power and control dynamic and is a predictor for a perpetrator's escalation to more lethal behavior. Strangulation generally occurs as part of an on-going pattern of escalating abuse and is strongly correlated with an increased risk of lethality. It is one of the ultimate forms of power and control because the perpetrator can demonstrate control over the victim's next breath.

Victims will feel terror and severe pain and, if the strangulation persists, unconsciousness will occur. Before lapsing into unconsciousness, victims will usually resist violently, often producing injuries to their own neck in an effort to fight off the perpetrator. In this effort, they also frequently inflict injury on the face or hands of their assailant. (These defensive injuries may not be present if the victim is physically or chemically restrained.)

Victims often refer to strangulation as "choking" and minimize the incident. It is important for advocates to refer to the act as "strangulation" and for victims to understand that strangulation is correlated with an increased risk of lethality and that strangulation can easily become homicide. The use of the term "strangulation" helps convey the seriousness of the offense. If the victim states that they have been "choked" it is important to involve the prosecutor and law enforcement to facilitate a follow-up interview. Advocates can help victims by discussing with them the increased risks of serious injury or even death if strangulation has occurred.

Trauma-Informed Service Delivery

The fundamental principle underlying trauma-informed services is an understanding of the impact of domestic violence on victims, including cultural context and common coping and adapting strategies used by victims. Per KRS 521.570(2), victim advocates should complete training on the appropriate intervention when working with victims of domestic violence. Trauma-informed services emphasize safety and personal choice. Trauma-informed services are not meant to treat the specific symptoms of trauma, but rather to support resilience and self-care.

The victim advocate should strive for a collaborative relationship with the victim, establishing goals together. The advocate should be clear about their own role and what confidentiality they can or cannot provide. The experiences and choices of the victim should be validated. Advocate approaches must be perceived by the victim as being supportive, safe, and predictable.

Victims' Rights

Section 26A of the Constitution of Kentucky ensures crime victims' rights are "respected and protected by law in a manner no less vigorous than the protections afforded to the accused." Marsy's Law does not give crime victims the same rights as the accused. However, the rights given to crime victims have equal protection under the law.

Under Marsy's Law, crime victims have the constitutional right to:

- Timely notice of all proceedings.
- Be heard in any proceeding involving release, plea, sentencing, or consideration of pardon, commutation, granting of reprieve, or other matter involving the right of a victim.
- Be present at all proceedings, other than grand jury proceedings.
- Proceedings free from unreasonable delay.
- Consult with the attorney for the Commonwealth or County or the attorney's designee.
- Reasonable protection from the accused.
- Timely notice of release or escape of the accused.
- Have their safety and their family's safety considered in setting bond, the defendant's release and conditions of release.
- In certain situations, full restitution to be paid by the convicted defendant.
- Fairness and consideration of the victims' safety, dignity, and privacy.
- Be informed of these rights and standing to assert these right.

These constitutional rights are not all provided by the prosecutor's office but should be given to the victim at the appropriate stage of the proceeding.

Victim Impact Statements

Victims have the right to provide written victim impact statements. The victim should express how the crime has impacted her life. KRS 532.055(2)(7).

Some questions you might want to discuss with the victim:

- How has your life changed since the crime occurred?
- How has the crime affected you emotionally or psychologically?
- How has the crime affected you financially?
- What do you want to happen to the defendant? (jail/prison/treatment, etc.)
- How do you think it will affect you, your family, or the community if the defendant is released?

It is important for advocates to remember that victim impact statements are about how the victim's life has been impacted as a result of the crime. This is not a recitation of the facts, the facts have already been established.

Victim advocates play a critical role in ensuring victim safety and engagement throughout the criminal justice process. Systems-based advocates have a particularly complex role. Advocates based in the offices of prosecutors or law enforcement must support the victim while remaining constantly vigilant as to the defendant's constitutional rights. Systems-based advocates cannot promise confidentiality to victims. If a victim discloses information to an advocate that mitigates the defendant's conduct or exculpates the defendant, the advocate must inform the prosecutor immediately and the prosecutor will make the appropriate disclosures to the defense. Likewise, victim advocates are not investigators. If the advocate is in a discussion where the victim is disclosing new or different information, inform the prosecutor and involve law enforcement for all follow-up interview needs.

Chapter 8: Conclusion

“It is our collective hope that this manual inspires others to develop comprehensive response protocols to strangulation crimes in every state in the nation…we must now all become passionate allies in this work.” Gael Strack J.D.

The Kentucky Office of the Attorney General is proud to have partnered with local and nationally recognized experts to create Kentucky’s first manual on Responding to Strangulation in KY. In all our endeavors, our office strives to support YOU, the front-line responders to Kentucky’s most heinous and violent criminal offenses. It is because of your courage and dedication to justice that victims of strangulation can hope for a safer tomorrow. It will take a state-wide, comprehensive, and multi-disciplinary response to end the prevalence of strangulation and save victims’ lives. The Kentucky Attorney General’s office is grateful to be your ally in the fight. Together, we can create a safer and more peaceful Commonwealth of Kentucky.

When assisting someone who has suffered domestic violence or sexual assault

ALWAYS ASK

IF ANY PRESSURE HAS BEEN APPLIED TO THE NECK

AND . . .

D Help **DOCUMENT** the abuse

O Take the time to **OBSERVE** the victim for subtle signs and symptoms of strangulation and suffocation

M Encourage the victim to seek **MEDICAL ATTENTION**

O **OFFER HOPE** by educating victims about their rights, local resources, and the science of Hope

R Make sure to conduct a **RISK ASSESSMENT**

E **EDUCATE** the victim and others about the seriousness, lethality and long-term consequences of non-fatal strangulation assault

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v 4.5.2023

STRANGULATION
IN INTIMATE PARTNER VIOLENCE

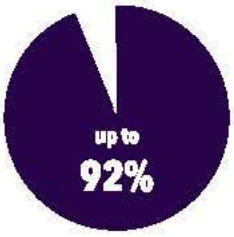
STRANGULATION is the obstruction of blood vessels and/or airflow in the neck resulting in asphyxia.

1 in 4 women will experience **INTIMATE PARTNER VIOLENCE** (IPV) in their lifetime[1]

Of women at high risk, between **68-80%** will experience **NEAR-FATAL STRANGULATION BY THEIR PARTNER**[2]

Strangulation survivors have the LOWEST HOPE scores of all victims of domestic violence, with a 31% increase in suicidal ideation[3]

Strangulation is among the most lethal forms of Domestic Violence. Loss of consciousness can occurr within 5 - 10 seconds. Death within minutes[4]



of women who have experienced IPV, including strangulation, are estimated to have suffered some type of a TBI[5]

are strangled along with sexual assault/ abuse[6]

9% are also pregnant[7]

of children witnessed their mothers being strangled[8]

of strangled women believed they were going to die[9]

are strangled manually (with hands)[10]

report losing consciousness[11]

And odds for homicide increase 750%
for victims who have been previously strangled, compared to victims who have never been strangled[12]

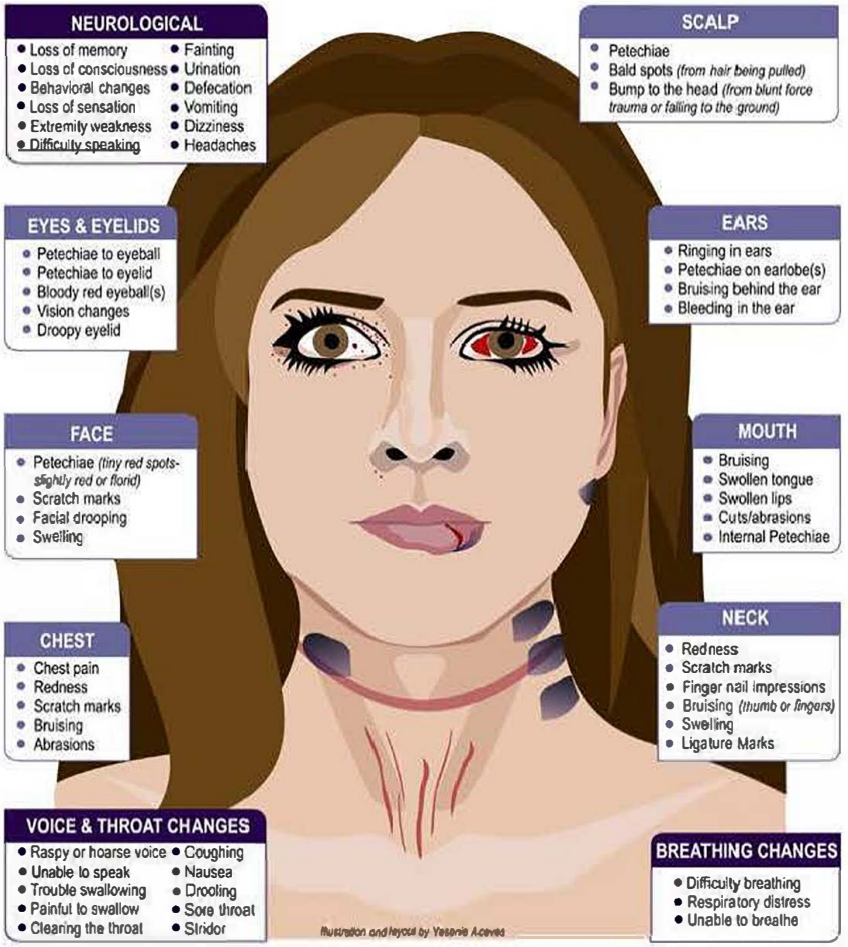
The majority of all POLICE OFFICERS KILLED IN THE LINE OF DUTY are killed by men who have strangled women[13]

Today, **50 States, 22 Tribes** and **2 US Territories** have passed felony strangulation laws[14]

Strangulation and **suffocation** are included in **Federal (2013)** and **Military (2019) Codes**[14]

STRANGULATION

SIGNS AND SYMPTOMS [2]



CONSEQUENCES [15]

PSYCHOLOGICAL NEUROLOGICAL INJURY and TBI

PTSD, depression, suicidal ideation, memory problems, nightmares, anxiety, severe stress reaction, amnesia, and psychosis.

DELAYED FATALITY

Death can occur days or weeks after the attack due to cartoid artery dissection and respiratory complications such as pneumonia, acute respiratory distress syndrome, stroke due to the risk of blood clots traveling to the brain (embolization).

HOWEVER...Oftentimes, even in fatal *cases*, there are NO EXTERNAL SIGNS of injury [16]

Only half of victims have visible injuries [10]

Of these, only 15% could be photographed [10]

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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.

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DOMESTIC ABUSE INTERVENTION PROGRAMS
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.theduluthmodel.org

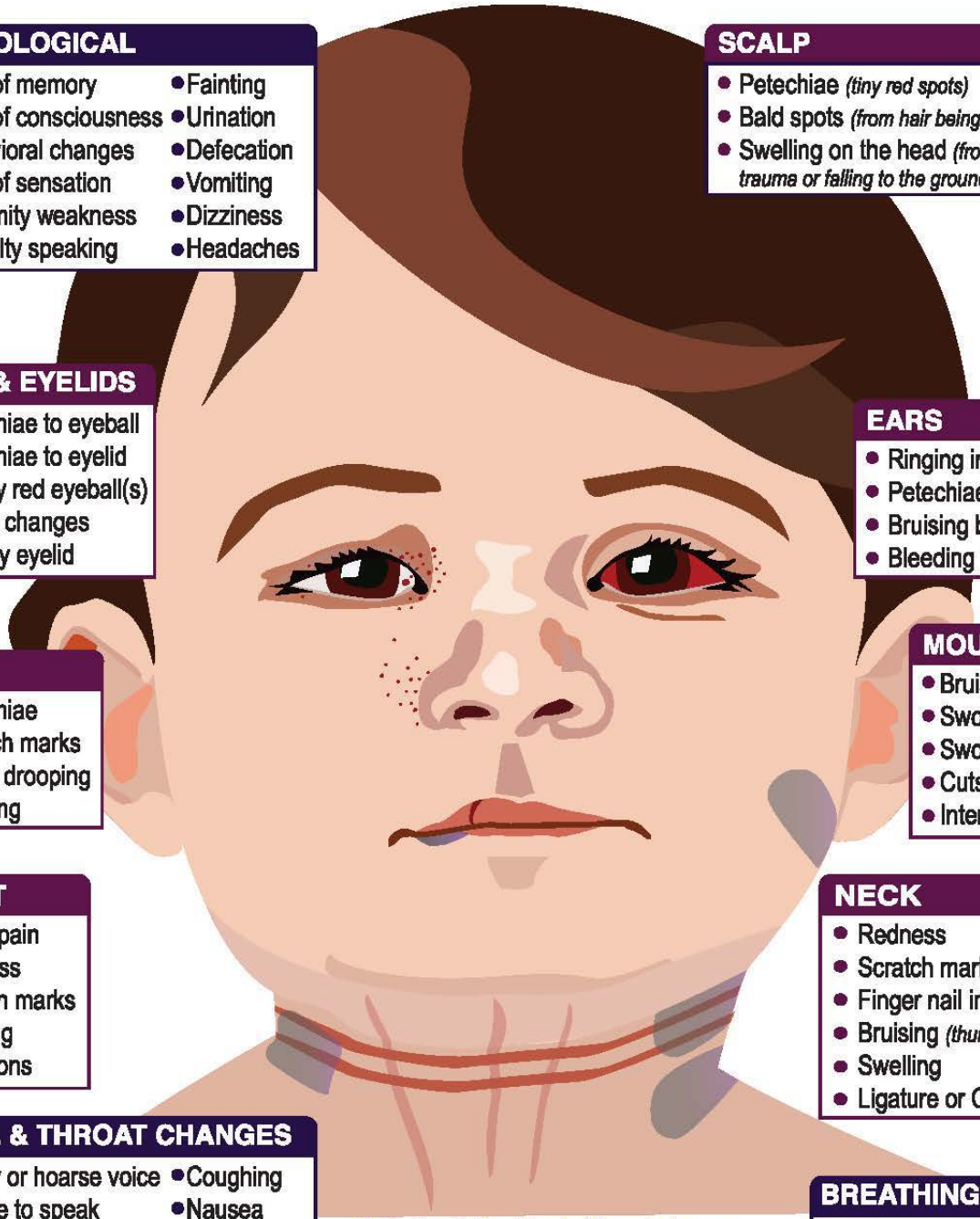
STRANGULATION

SOURCE: Strangulation in Intimate Partner Violence, Chapter 16

SIGNS & SYMPTOMS

Visible injuries.

Injuries not visible to the naked eye; may be obervable only to the victim.



NEUROLOGICAL

- Loss of memory
- Loss of consciousness
- Behavioral changes
- Loss of sensation
- Extremity weakness
- Difficulty speaking
- Fainting
- Urination
- Defecation
- Vomiting
- Dizziness
- Headaches

SCALP

- Petechiae *(tiny red spots)*
- Bald spots *(from hair being pulled)*
- Swelling on the head *(from blunt force trauma or falling to the ground)*

EYES & EYELIDS

- Petechiae to eyeball
- Petechiae to eyelid
- Bloody red eyeball(s)
- Vision changes
- Droopy eyelid

EARS

- Ringing in ears
- Petechiae on earlobe(s)
- Bruising behind the ear
- Bleeding in the ear

FACE

- Petechiae
- Scratch marks
- Facial drooping
- Swelling

MOUTH

- Bruising
- Swollen tongue
- Swollen lips
- Cuts/abrasions
- Internal Petechiae

CHEST

- Chest pain
- Redness
- Scratch marks
- Bruising
- Abrasions

NECK

- Redness
- Scratch marks
- Finger nail impressions
- Bruising *(thumb or fingers)*
- Swelling
- Ligature or Clothing Marks

VOICE & THROAT CHANGES

- Raspy or hoarse voice
- Unable to speak
- Trouble swallowing
- Painful to swallow
- Clearing the throat
- Coughing
- Nausea
- Drooling
- Sore throat
- Stridor

BREATHING CHANGES

- Difficulty breathing
- Respiratory distress
- Unable to breathe

Illustration & Graphics by Yesenia Aceves

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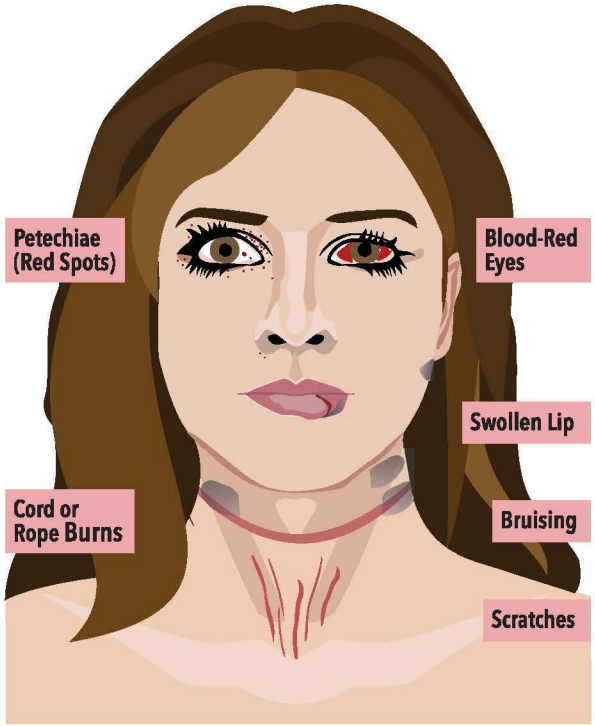
VISIBLE SIGNS (may not be present)



ADDITIONAL RESOURCES are available for download on our resource library at: allianceforhope.com/training/online-resource-library/ including a larger and more detailed version of the **SIGNS AND SYMPTOMS** graphic shown above. It is available in Adult English, Spanish, and Arabic versions. Pediatric versions in English and Spanish are also available.

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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.

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 is a common symptom in strangulation victims; it is caused 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.

ALLIANCE for HOPE INTERNATIONAL

TRAINING INSTITUTE on STRANGULATION PREVENTION

a program of HOPE INTERNATIONAL

strangulationtraininginstitute.com

Illustrations and Graphic Design by Yesenia Aceves

Agency's Contact Information
Anything they want to appear here is fine, we recommend general phone number and physical address whenever possible.

Vital FACTS for Victims of STRANGULATION

Monitor Your **SYMPTOMS**

DATE/TIME	DESCRIBE SYMPTOMS

Monitor Your **SIGNS**

DATE/TIME	DESCRIBE SIGNS

DATE/TIME	DESCRIBE ANY OTHER SENSATIONS

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.

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.

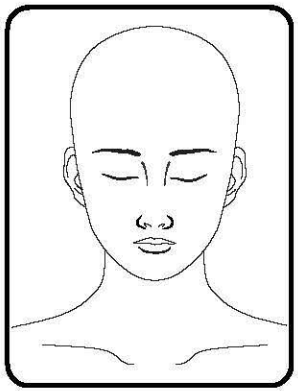
NECK Redness, scratch marks, fingernail impressions, bruise(s), abrasions, swelling, ligature marks.

CHEST AND SHOULDERS Redness, scratch marks, bruise(s), abrasions.

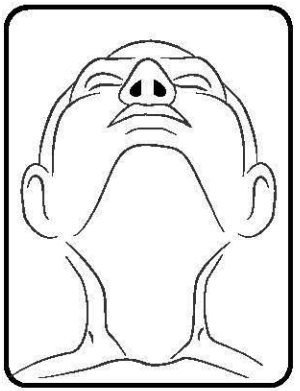
Mark Visible Injuries

Use a pen or marker to indicate any visible signs of strangulation in the diagrams below:

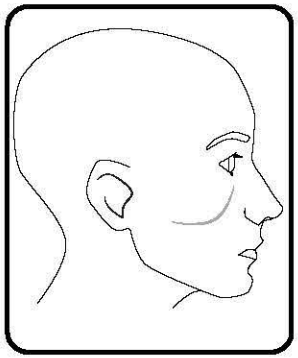
FRONT



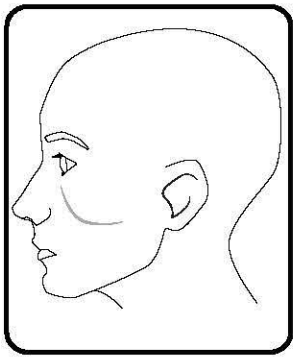
UNDER CHIN



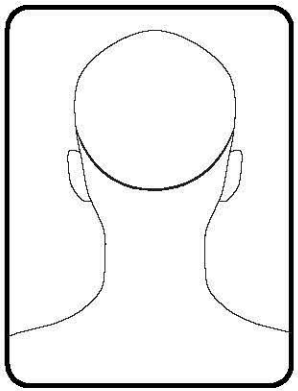
RIGHT SIDE



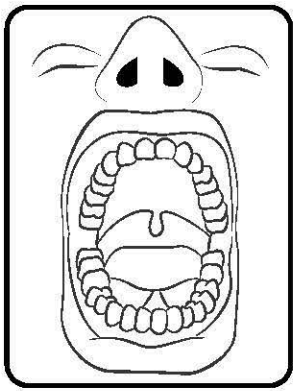
LEFT SIDE



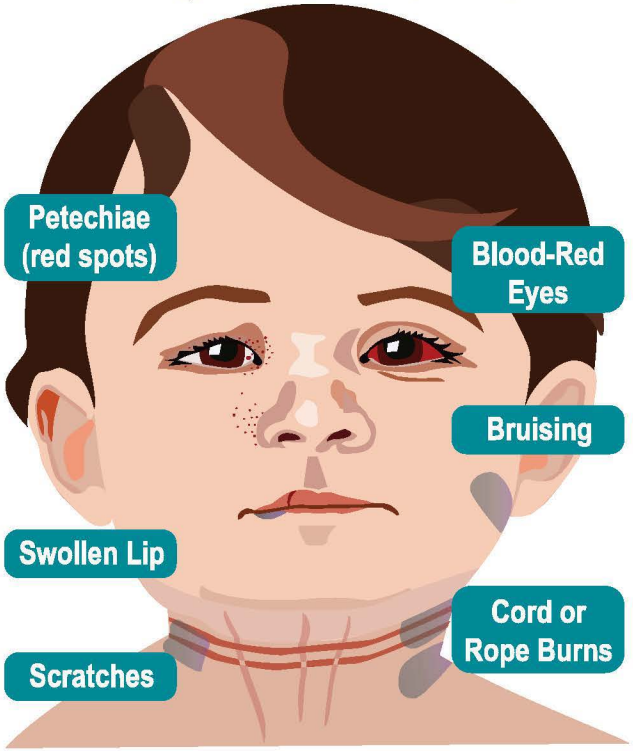
BACK



INSIDE MOUTH



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/resources/library/pediatric/

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TRAINING INSTITUTE ON STRANGULATION PREVENTION

A program of ALLIANCE for HOPE INTERNATIONAL

Illustrations and graphic design by Yesenia Aceves

STRANGULATION

Strangulation is often under-recognized in children but no less serious than in adults. Unconsciousness may happen within seconds and death within minutes. Children may be strangled when caregivers lose control, as part of physical and/or sexual assault, or as a way of demonstrating ultimate power and control over the child. Regardless, strangulation of a child can have long-lasting physical and mental health effects and can result in death even months later.

Child victims of strangulation may feel terror and extreme pain. If strangulation continues, unconsciousness will follow. Before sliding into unconsciousness, a child victim may resist violently, producing injuries to their own neck or to the face or hands of their attacker. These defensive injuries may not be present in young or developmentally disabled children, or if the victim is physically or chemically restrained.

Observing Changes

Documentation by photographs organized in order, for a period of days after the attack is very helpful in beginning and building a journal of proof. Victims should be given medical attention if they experience difficulty breathing, speaking, swallowing or experience nausea, vomiting, lightheadedness, headache or holding head, accidental urination and/or bowel movement in children not diapered. A medical evaluation may be extremely important in detecting internal injuries and saving a life.

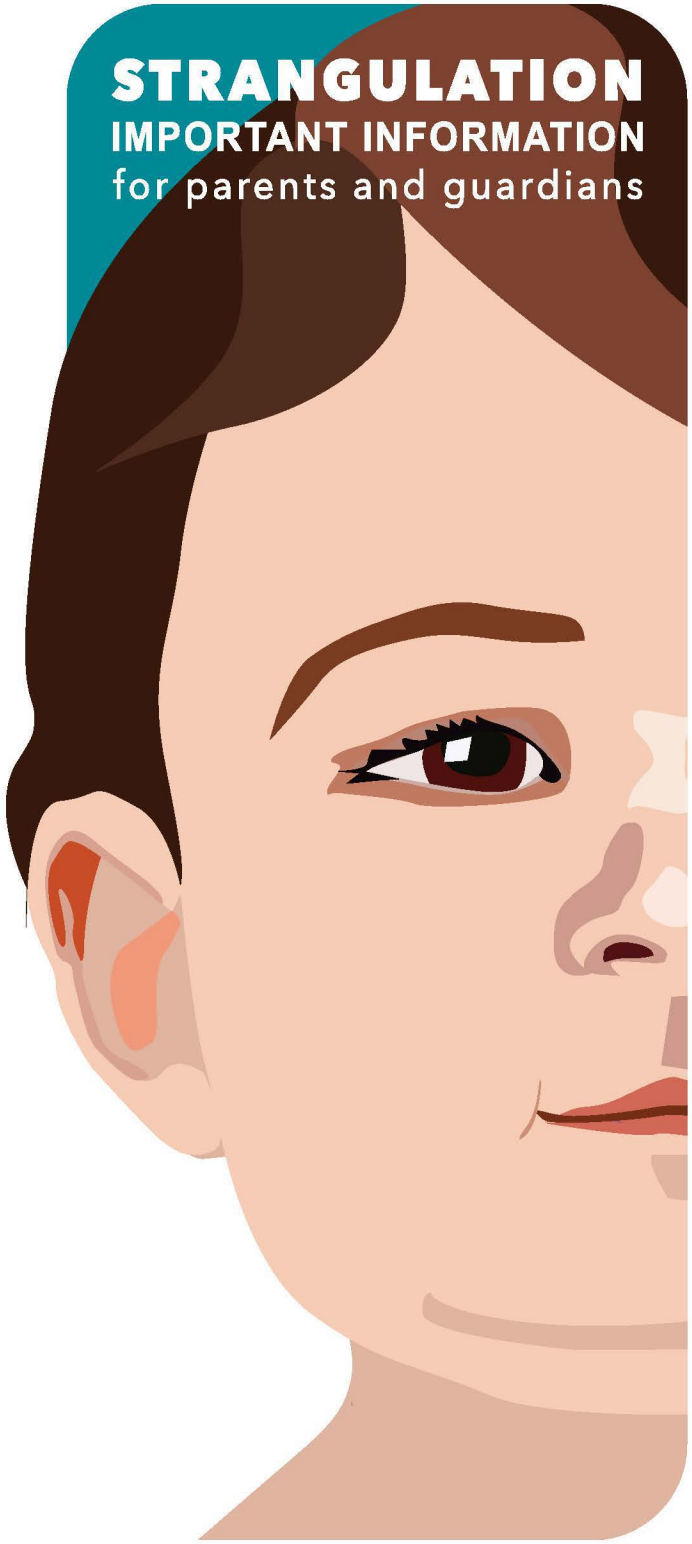
Loss of Conciousness

Victims may lose awareness or faint by any one or all of the following methods: blocking of the blood vessels from the heart in the neck (taking away oxygen from the brain), blocking of the large veins in the neck (preventing deoxygenated blood from exiting the brain), and closing off the tube from the mouth to the lungs, making breathing impossible.

STRANGULATION

IMPORTANT INFORMATION

for parents and guardians



Monitor the Signs

Write down signs on the child, include time/date

Monitor the Symptoms

Write down symptoms in the child, include time/date

Additional notes:

Signs of Strangulation

HEAD–loss of hair, bruises, skull fracture, concussion, red spots (petechiae).

FACE–reddened marks, petechiae, scratches.

EYES AND EYELIDS–petechiae on one or both eyeballs, red and/or bloody 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(scrapes).

UNDER THE CHIN–redness, scratches, bruises, abrasions.

NECK–redness, scratch marks, fingernail marks, bruise(s), abrasions, swelling, ligature(tie) or clothing marks.

CHEST AND SHOULDERS–redness, scratch marks, bruise(s), abrasions.

Symptoms of Strangulation

VOICE CHANGES–raspy and/or hoarse voice, cough, inability to speak, complete loss of voice.

SWALLOWING CHANGES–difficulty swallowing, pain when swallowing, neck pain, nausea/vomiting, drooling.

RESPIRATORY CHANGES–difficulty breathing, hyperventilation, unable to breathe.

BEHAVIOR CHANGES–restlessness or combativeness, concentration problems, amnesia (memory loss), agitation, hallucinations, post-traumatic stress syndrome.

VISUAL CHANGES–complete loss, or black and white vision, seeing 'stars', blurry, dark, fuzzy around the eyes.

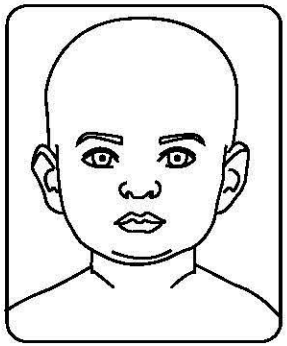
HEARING CHANGES–complete hearing loss, ringing, gurgling, buzzing, popping, pressure, tunnel-like hearing.

OTHER CHANGES–memory loss, loss of consciousness, dizziness, headaches, involuntary urination or bowel movement in potty-trained child, loss of strength, going limp.

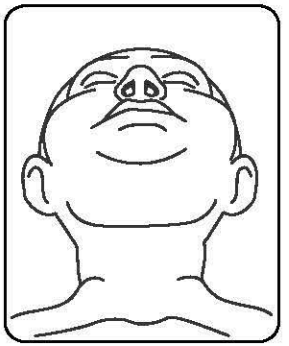
Diagrams to Mark VISIBLE LESIONS

Use a pencil or pen to mark any visible signs

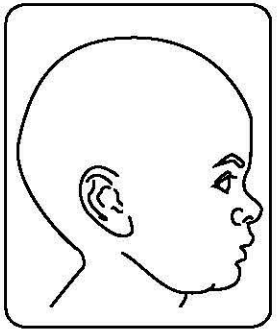
Front



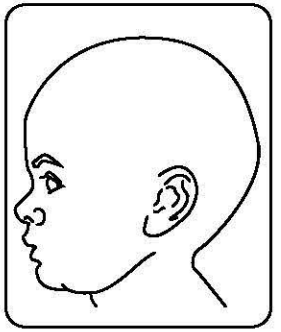
Under Chin



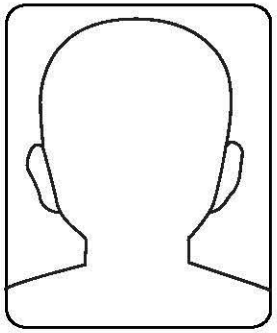
Right Side



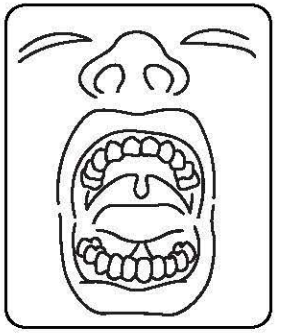
Left Side



Back



Inside Mouth



DANGER ASSESSMENT-5 (DA-5)
BRIEF RISK ASSESSMENT FOR CLINICIANS

The DA-5 is a brief risk assessment that identifies victims at high risk for homicide or severe injury by a current or former intimate partner.[1-3] It should be used when intimate partner violence has been identified in the Emergency Department or other health care settings, protective order or child custody hearings, or other brief-treatment/practice settings. Presence of these risk factors could mean the victim is in danger of serious injury and/or homicide. Evidence-based risk assessments should be used in combination with survivor self-determination and practitioner expertise to collaboratively develop the best way forward for each individual.

Mark **Yes** or **No** for each of the following questions.

_____ 1. Has the physical violence increased in severity or frequency over the past year?
_____ 2. Has your partner (or ex) ever used a weapon against you or threated you with a weapon?
_____ 3. Do you believe your parent (or ex) is capable of killing you?
_____ *4. Has your partner (or ex) ***ever tried*** to choke/strangle you or cut off your breathing?
4a. If yes, did your partner ever choke/strangle you or cut off your breathing? check here: ____
4b. About how long ago? ____
4c. Did it happen more than once? ____
4d. Did it make you pass out of black out or make you dizzy? ____
_____ 5. Is your partner (or ex) violently and constantly jealous of you?
_____ **Total "Yes" answers**

*can be asked instead of or in addition to: Have you ever been beaten by your partner (or ex) while you were pregnant?

Scoring Instructions

4 or 5 "yes" responses:
- Tell the victim they are in danger. Give them the choice of reporting to the police and/or a confidential hotline (800-799-7233). Make the call with the victim and/or complete an in-person hand-off to a knowledgeable advocate.

3 "yes" responses:
- If the victim is female and you are trained to use the DA:
  - Complete the full DA using the calendar and weighted scoring. Inform the victim of her level of danger. Do safety planning based on the full DA results.
- If the victim is female and you are NOT trained to use the DA:
  - Refer and hand-off the victim to someone certified to administer the full DA (in-person or voice-to-voice hand-off is preferable).

2 "yes" responses:
- Tell the victim there are 2 risk factors for serious injury/assault/homicide. If victim agrees, refer and hand-off to a knowledgeable advocate (in-person or voice-to-voice hand-off is preferable).

0-1 "yes" responses:
- Proceed with normal referral/procedural processes for domestic violence.

Brief Strangulation Protocol

If the victim answered **yes to 4a**, follow this strangulation protocol for further assessment and/or refer to someone who is trained to conduct the following assessment.

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 loss of consciousness or possible loss of consciousness (victims are commonly unsure about loss of consciousness) particularly if they became incontinent—ask if the victim "wet themselves".

If there were multiple strangulations:
- Conduct a neurological exam for brain injury or refer for examination. Inform the victim of increased risk for homicide.

If the victim wants, notify police and/or prosecutors
- Know state/local law on strangulation and mandatory reporting and inform the victim.

For more information, visit www.dangerassessment.org

[1] This is a brief adaptation of the Danger Assessment (2003). The full DA with weighted scoring provides the most accurate assessment of risk. The DA and its revisions are evidence-based risk assessments intended for use with survivors to educate them and their supports about their risk of lethality or reassault and to inform their decision-making. [2] Snider, C., Webster, D., O'Sullivan, S.C., & Campbell, J. (2009). Intimate partner violence: Development of a brief risk assessment for the emergency department. *Society for Academic Emergency Medicine, 16,* 1209-1216. [3] 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.

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DANGER ASSESSMENT

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex-partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage or choking* (use a © in the date to indicate choking/strangulation/cut off your breathing- example 4©)
5. Use of weapon; wounds from weapon
   (If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

_____ 1. Has the physical violence increased in severity or frequency over the past year?
_____ 2. Does he own a gun?
_____ 3. Have you left him after living together during the past year?
   3a. (If you have *never* lived with him, check here: __)
_____ 4. Is he unemployed?
_____ 5. Has he ever used a weapon against you or threatened you with a lethal weapon? (If yes, was the weapon a gun? check here: __)
_____ 6. Does he threaten to kill you?
_____ 7. Has he avoided being arrested for domestic violence?
_____ 8. Do you have a child that is not his?
_____ 9. Has he ever forced you to have sex when you did not wish to do so?
_____ 10. Does he ever try to choke/strangle you or cut off your breathing?
   10a. (If yes, has he done it more than once, or did it make you pass out or black out or make you dizzy? check here: __)
_____ 11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, "meth", speed, angel dust, cocaine, "crack", street drugs or mixtures.
_____ 12. Is he an alcoholic or problem drinker?
_____ 13. Does he control most or all of your daily activities? For instance, does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: __)
_____ 14. Is he violently and constantly jealous of you? (For instance, does he say: "If I can't have you, no one can.")
_____ 15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: __)
_____ 16. Has he ever threatened or tried to commit suicide?
_____ 17. Does he threaten to harm your children?
_____ 18. Do you believe he is capable of killing you?
_____ 19. Does he follow or spy on you, leave threatening notes or messages, destroy your property, or call you when you don't want him to?
_____ 20. Have you ever threatened or tried to commit suicide?

_____ Total "Yes" Answers

Thank you. Please talk to your nurse, advocate, or counselor about what the Danger Assessment means in your situation.

STRANGULATION QUESTIONNAIRE

If at any time during intake, the survivor discusses or discloses being choked/strangled during an incident, discuss questions. This is a guide to better understand the dangers of strangulation.

1. Has the abuser strangled/choked you morethan once?

☐ 1 time ☐ 2 to 3 times ☐ 4 or more times ☐ Unsure

NOTES:

2. When you were previously strangled/chokedwhat method was used?

☐ With hands, arm, other body part(manually)

☐ With rope, cord, or something placed around the neck

NOTES:

3. Did the strangulation occur while having sex? | Did you consent to the strangulation during sex?

☐ Yes ☐ No ☐ Yes ☐ No

4. Did you experience any of the following while being strangled/choked? *Check all that apply.*

☐ Changes in vision or hearing ☐ Difficulty breathing

☐ Feeling lightheaded/dizzy ☐ Pass out or black out

☐ Wake up not remembering what happened ☐ Unsure ☐ No

NOTES:

5. While being strangled/choked did you lose any bodily functions?

☐ Urination – losing control of bladder ☐ Defecation – losing control of bowels

☐ Unsure ☐ No

NOTES:

6. Was anyone else present while you were being strangled/choked?

- ☐ Child/Children
- ☐ Roommate or other family member in the house
- ☐ Unsure
- ☐ No one was present at the time

NOTES:

7. Did the abuser say anything before or during the strangulation/choking happened? What were you feeling or thinking while it was happening? What made the abuser stop?

DESCRIPTION:

8. Did you experience any of the following changes immediately after being strangled/choked?

- ☐ Breathing changes (difficulty breathing, hyperventilation (breathing very fast, unable to breathe)
- ☐ Voice changes (raspy or hoarse, whispering or soft voice, coughing or unable to speak)
- ☐ Swallowing changes (trouble or painful swallowing, nausea or vomiting, neck pain)
- ☐ Bruising, scrapes or scratches, redness or swelling, etc.
- ☐ None of the above ☐ Unsure ☐ Other

NOTES:

9. Was law enforcement involved? If so, did the police officer(s)ask or talk to you about the strangulation/choking?

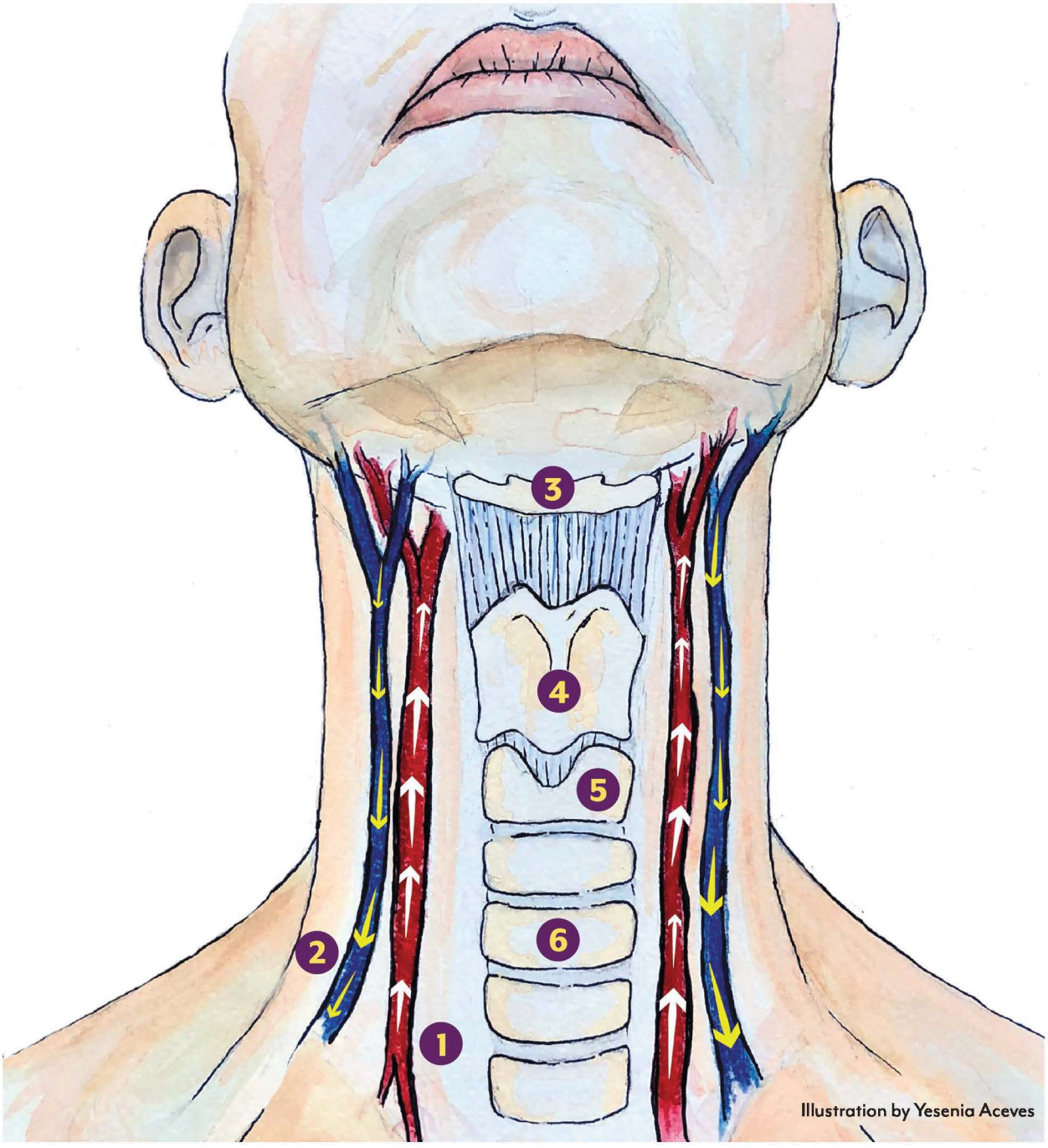
- ☐ Yes law enforcement was involved, yes they spoke about the strangulation/choking
- ☐ Yes law enforcement was involved, no they did not speak about the strangulation/choking
- ☐ No law enforcement was not involved

10. Did you seek medical attention? If yes, did the medical provider ask or talk to you about the strangulation/choking? What medical procedures were conducted?

DESCRIPTION:

VITAL NECK STRUCTURES

Arteries, Veins and Cartilage



1 Carotid Artery

2 Jugular Vein

3 Hyoid Bone

4 Thyroid Cartilage

5 Cricoid Cartilage

6 Tracheal Rings

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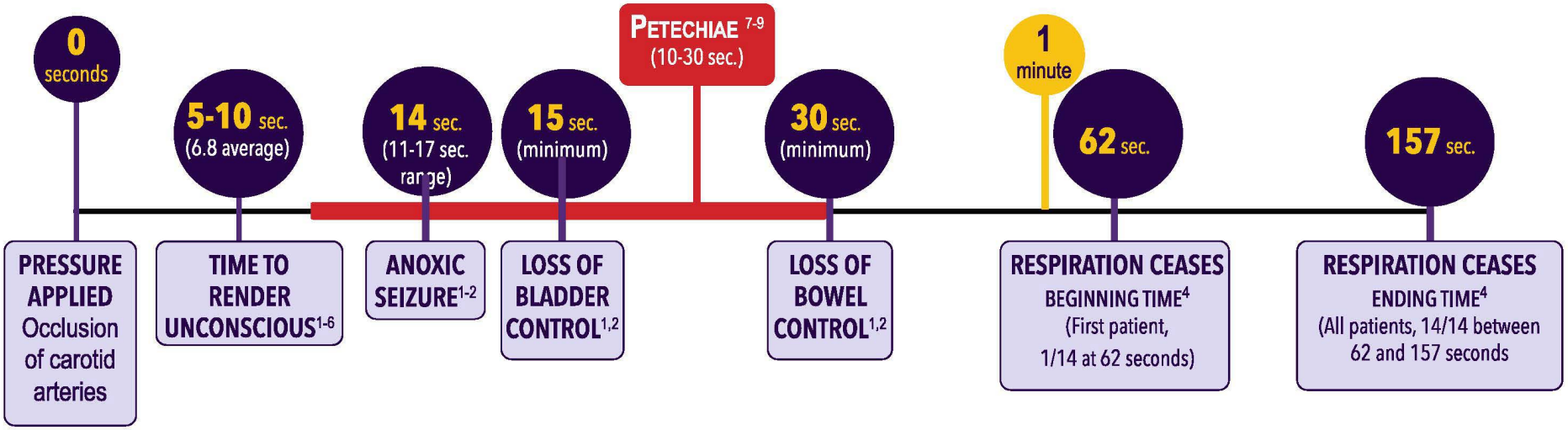
PHYSIOLOGICAL CONSEQUENCES OF STRANGULATION

Occlusion of Arterial Blood Flow: Seconds to Minutes Timeline

CREATED BY: Ruth Carter; Bill Smock, MD; Gael Strack, JD; Sean Dugan, MD; Marisol Martinez, MA ; Yesenia Aceves; and Ashley Peck

TRAINING INSTITUTE on STRANGULATION PREVENTION



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STRANGULATION ASSESSMENT SHEET

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 AND 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 AND 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.

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

- In patients with a history of a loss of consciousness, loss of bladder or bowel control, vision changes or petechial hemorrhage, medical providers should evaluate the carotid and vertebral arteries, bony/cartilaginous and soft tissue neck structures and the brain for injuries. A list of medical references is available at 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.

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RECOMMENDATIONS FOR THE **MEDICAL/RADIOGRAPHIC EVALUATION** OF **ACUTE ADULT NON/NEAR FATAL STRANGULATION**

Prepared by **Bill Smock, MD; Bill Green, MD;** and **Sally Sturgeon, DNP, SANE-A**

Endorsed by the **National Medical Advisory Committee**:
Cathy Baldwin, MD; Ralph Riviello, MD; Sean Dugan, MD; Steve Stapczynski, MD; Ellen Tailiaferro, MD; Michael Weaver, MD

GOALS:

1. Evaluate for acute medical conditions requiring immediate management/stabilization
2. Evaluate carotid and vertebral arteries for injuries (dissection/thrombosis)
3. Evaluate airway structures and other bony/cartilaginous/soft tissue neck structures

STRANGULATION PATIENT PRESENTS TO THE EMERGENCY DEPARTMENT

HISTORY (ANY of the following; current OR assault related and now resolved)

1. Loss of consciousness
2. Visual changes: "spots," "flashing lights," "tunnel vision"
3. History of altered mental status: "dizzy," "confused," "lightheaded," "loss of memory," "any loss of awareness"
4. Breathing changes: "I couldn't breathe," "difficulty breathing"
5. Incontinence (bladder or bowel)
6. Neurologic symptoms: seizure-like activity, stroke-like symptoms, headache, tinnitus, decreased hearing, focal numbness, amnesia
7. Ligature mark or neck contusion
8. Neck tenderness or pain/sore throat/pain with swallowing
9. Change in voice: unable to speak, hoarse or raspy voice

PHYSICAL EXAM (ANY Abnormality)

1. Functional assessment of breathing, swallowing, and voice
2. Thorough examination of neck, eyes, TMs, oral mucosa, nose, airway, upper torso for: tenderness, swelling, bruising, abrasions, crepitance, bruit
3. Venous congestion/petechial hemorrhages/ scleral hemorrhages
4. Ligature mark **= HIGH RISK**
5. Tenderness of airway structures/ carotid arteries **= HIGH RISK**
6. Mental status/complete neurologic exam

CONSIDER ADMINISTRATION OF ONE 325MG ASPIRIN IF THERE IS ANY DELAY IN OBTAINING A RADIOGRAPHIC STUDY

RECOMMENDED RADIOGRAPHIC STUDIES TO RULE OUT LIFE-THREATENING INJURIES* (including delayed presentations of up to 1 year)

1. CT Angio of carotid/vertebral arteries (GOLD STANDARD for evaluation of vessels and bony/cartilaginous structures, less sensitive for soft tissue trauma) or
2. MRA of carotid/vertebral arteries
3. Carotid Doppler Ultrasound (NOT RECOMMENDED - Unable to adequately evaluate vertebral arteries or proximal internal carotid arteries)
4. Plain Radiographs (NOT RECOMMENDED - Unable to evaluate vascular and soft-tissue structures)
5. Consider fiberoptic direct laryngoscopy to evaluate possible larygeal injury or airway compromise

POSITIVE RESULTS

1. Consult Neurology/Neurosurgery/Trauma Surgery for admission
2. Consider ENT consult for laryngeal trauma or dysphonia
3. Perform a lethality assessment per institutional policy

NEGATIVE RESULTS

Discharge home with detailed instructions, including a lethality assessment, and to return to ED if:
neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens

IF THE CTA IS NEGATIVE, CONSIDER OBSERVATION OF NEAR-FATAL STRANGULATION PATIENT IF THE AIRWAY IS OF CONCERN. OBSERVATION HAS NO ROLE IN RULING OUT A VASCULAR INJURY.

Graphic Design by Yesenia Aceves

*References on page 2

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Recommendations based upon case reports, case studies, and cited medical literature. Click below for hyperlinks, please note that some sources may require purchase or subscription.

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ATTACHMENT 5-1
Strangulation History and Exam

STRANGULATION HISTORY #1			
NATURE OF STRANGULATION			❒ Unknown
How many episodes of strangulation?			❒ Unknown
How long did the worst episode last?	____ seconds	____ minutes	❒ Unknown
During the strangulation, was the victim also:			
» Shaken?	❒ Yes	❒ No	❒ Unknown
» Straddled?	❒ Yes	❒ No	❒ Unknown
» Held against a wall or other object?	❒ Yes	❒ No	❒ Unknown
Was the victim's head pounded against a wall, floor, or other object?	❒ Yes	❒ No	❒ Unknown
Did the assailant intentionally cover the victim's			
» Mouth	❒ Yes	❒ No	❒ Unknown
» Nose	❒ Yes	❒ No	❒ Unknown
If yes, describe: _____			
METHOD OF STRANGULATION			❒ Unknown
Assailant position			❒ Unknown
» In front of the victim	❒ Yes	❒ No	❒ Unknown
» Behind the victim	❒ Yes	❒ No	❒ Unknown
» Sitting on the victim	❒ Yes	❒ No	❒ Unknown
Ligature	❒ None		❒ Unknown
» Rope	❒ Yes	❒ No	❒ Unknown
» Wire	❒ Yes	❒ No	❒ Unknown
» Cord	❒ Yes	❒ No	❒ Unknown
» Clothing	❒ Yes	❒ No	❒ Unknown
» Other: _____			
One hand	❒ Yes	❒ No	❒ Unknown
» Left	❒ Yes	❒ No	❒ Unknown
» Right	❒ Yes	❒ No	❒ Unknown
Both hands	❒ Yes	❒ No	❒ Unknown
Chokehold	❒ Yes	❒ No	❒ Unknown
If yes, describe: _____			
Pressure from other body part	❒ Yes	❒ No	❒ Unknown
» Forearm	❒ Yes	❒ No	❒ Unknown
» Knee, leg, or foot	❒ Yes	❒ No	❒ Unknown
» Other: _____			
Was the victim's neck stretched or twisted?	❒ Yes	❒ No	❒ Unknown
If yes, describe: _____			

STRANGULATION HISTORY #2

SYMPTOM	None	Onset During Strangulation	Onset After Strangulation	Now Resolved	Present Unchanged	Present Getting Better	Present Getting Worse*	Unknown
Neck Pain	❒	❒	❒	❒	❒	❒	❒	❒
Sore Throat	❒	❒	❒	❒	❒	❒	❒	❒
Breathing Changes	❒							
» Unable to breathe	❒	❒	❒	❒	❒	❒	❒	❒
» Painful breathing	❒	❒	❒	❒	❒	❒	❒	❒
» Short of breath	❒	❒	❒	❒	❒	❒	❒	❒
» Hyperventilation	❒	❒	❒	❒	❒	❒	❒	❒
Voice Changes	❒							
» Raspy voice	❒	❒	❒	❒	❒	❒	❒	❒
» Hoarse voice	❒	❒	❒	❒	❒	❒	❒	❒
» Coughing	❒	❒	❒	❒	❒	❒	❒	❒
» Unable to speak	❒	❒	❒	❒	❒	❒	❒	❒
Swallowing Changes	❒							
» Difficulty swallowing	❒	❒	❒	❒	❒	❒	❒	❒
» Painful swallowing	❒	❒	❒	❒	❒	❒	❒	❒
Nausea	❒	❒	❒	❒	❒	❒	❒	❒
Vomiting	❒	❒	❒	❒	❒	❒	❒	❒
Neurologic Changes	❒							
» Vision changes or difficulty	❒	❒	❒	❒	❒	❒	❒	❒
» Ringing in ears	❒	❒	❒	❒	❒	❒	❒	❒
» Facial or eyelid droop	❒	❒	❒	❒	❒	❒	❒	❒
» One-sided body weakness	❒	❒	❒	❒	❒	❒	❒	❒
» Headache	❒	❒	❒	❒	❒	❒	❒	❒
» Loss of bowel control	❒	❒	❒	❒	❒	❒	❒	❒
» Loss of urine control	❒	❒	❒	❒	❒	❒	❒	❒
Mental Status Changes	❒							
» Dizzy/lightheaded	❒	❒	❒	❒	❒	❒	❒	❒
» Confusion	❒	❒	❒	❒	❒	❒	❒	❒
» Hallucinations	❒	❒	❒	❒	❒	❒	❒	❒
» Loss or memory	❒	❒	❒	❒	❒	❒	❒	❒
» Loss of consciousness	❒	❒	❒	❒	❒	❒	❒	❒
Behavioral Changes	❒							
» Restlessness	❒	❒	❒	❒	❒	❒	❒	❒
» Agitation	❒	❒	❒	❒	❒	❒	❒	❒
» Combativeness	❒	❒	❒	❒	❒	❒	❒	❒
» Fear of death	❒	❒	❒	❒	❒	❒	❒	❒

Other Symptoms

Explain _____

_____

_____

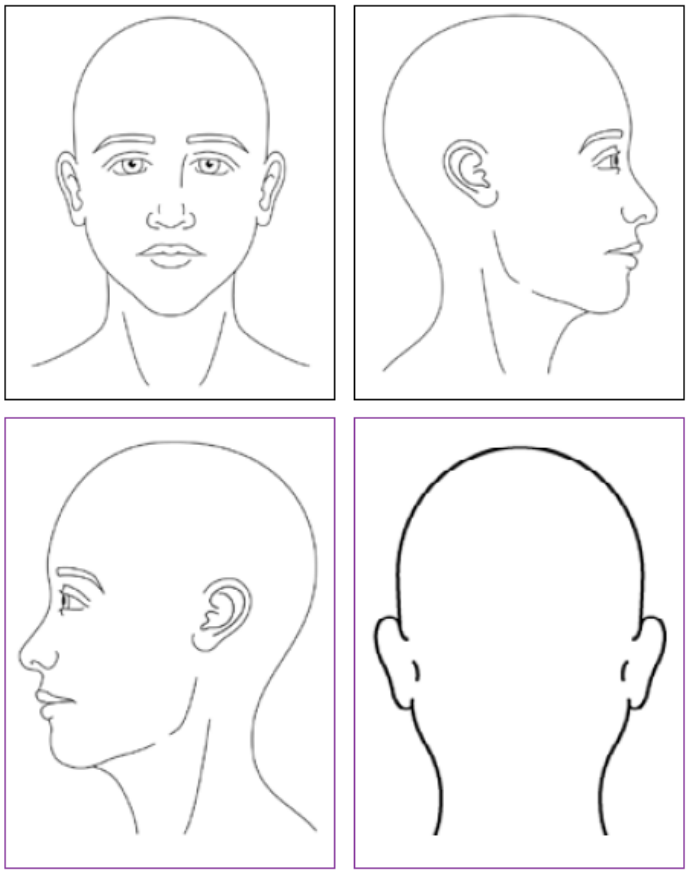
_____

* Needs immediate medical evaluation

STRANGULATION EXAM #1: CURRENT FINDINGS

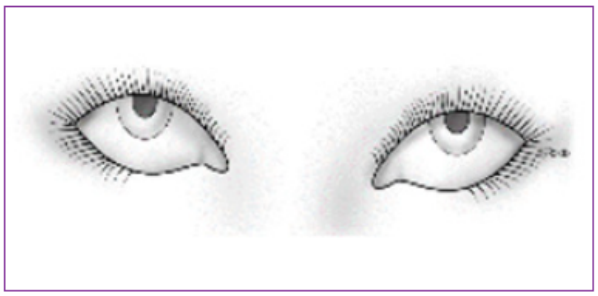
Date _____	**Time** _____				
VS	**T** ____	**P** ____	**R** ____	**BP** ____	**SAT** ____
Eyes	❒ Perrla	❒ Abnormal _____			
	❒ EOMi	❒ Abnormal _____			
	VA	OD ___/___	OS ___/___		
Voice	❒ Normal	❒ Abnormal _____			
Airway	❒ Normal	❒ Tender	❒ Crepitance	❒ Other _____	
Carotid Arteries	❒ Normal	❒ Tender R L	❒ Bruit R L	❒ None	
Swallowing	❒ Normal	❒ Abnormal _____			
Lungs	❒ Normal	❒ Abnormal _____			
Mental Status	❒ Normal	❒ Abnormal _____			
CN 2-12	❒ Normal	❒ Abnormal _____			
Motor	❒ Normal	❒ Abnormal _____			
Sensation	❒ Normal	❒ Abnormal _____			
Cerebellar/Gait	❒ Normal	❒ Abnormal _____			
Reflexes	❒ Normal	❒ Abnormal _____			

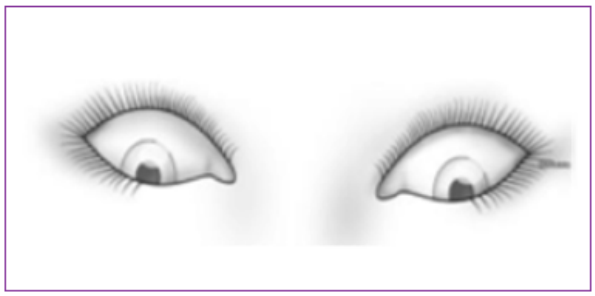
STRANGULATION EXAM #2

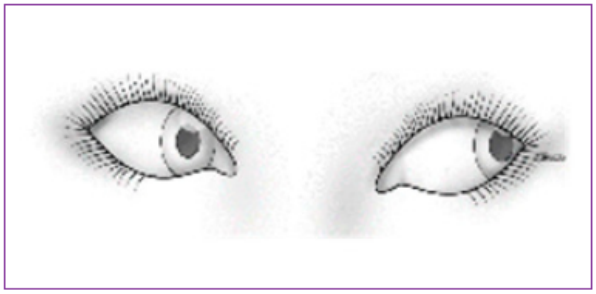


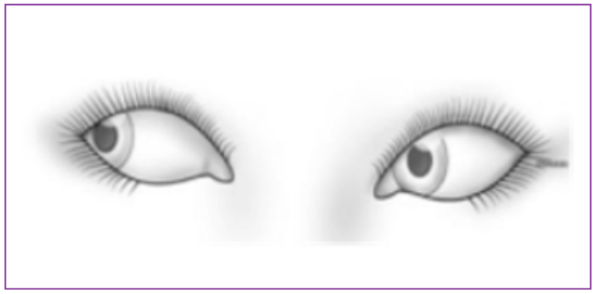
HEAD AND SCALP	FACE	EARS
❒ No Findings ❒ Redness (ER) ❒ Bruise (EC) ❒ Abrasion/Scratch (AB) ❒ Laceration (LA) ❒ Swelling (SW) ❒ Petechiae (PE) ❒ Tenderness (TE) ❒ Alopecia ❒ Other Finding _____ _____ _____	❒ No Findings ❒ Redness (ER) ❒ Bruise (EC) ❒ Abrasion/Scratch (AB) ❒ Laceration (LA) ❒ Swelling (SW) ❒ Petechiae (PE) ❒ Tenderness (TE) ❒ Facial Droop ❒ Eyelid Droop ❒ Other Finding _____ _____ _____	❒ No Findings ❒ Blood in Ear Canal ❒ R ❒ L ❒ TM Performation ❒ R ❒ L ❒ Hemotympanum ❒ R ❒ L ❒ External Petechiae (PE) ❒ R ❒ L ❒ Canal Petechiae (PE) ❒ R ❒ L ❒ Other Finding _____ _____ _____

STRANGULATION EXAM #3



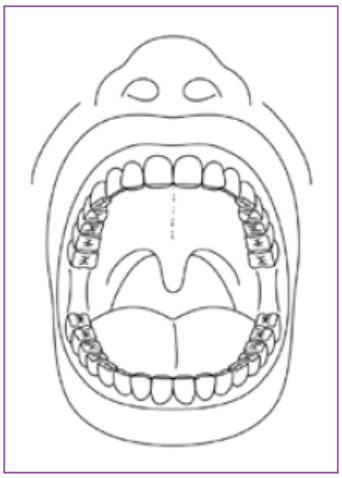






EYES

- ❒ Petechiae (PE)
- ❒ Subconjunctival hematoma (SCH)
- ❒ Other Finding _____



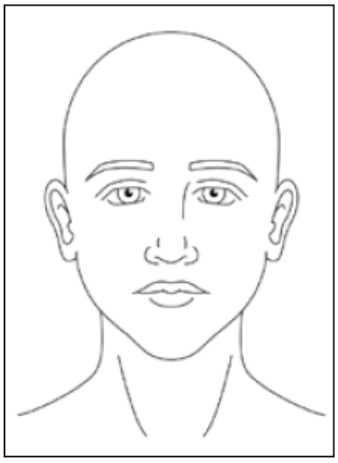
NOSE AND NARES

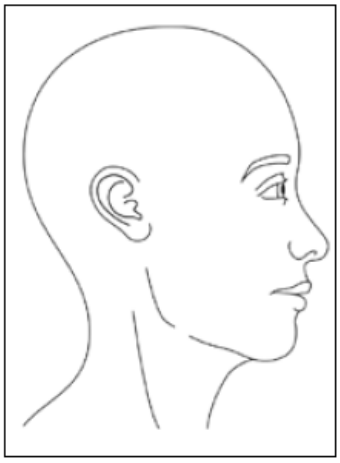
- ❒ No Findings
- ❒ Active Bleeding
- ❒ Dried Blood
- ❒ Bruise (EC)
- ❒ Abrasion (AB)
- ❒ Laceration (LA)
- ❒ Swelling (SW)
- ❒ Acute Deformity
- ❒ Petechiae (PE)
- ❒ Tenderness
- ❒ Other Finding _____

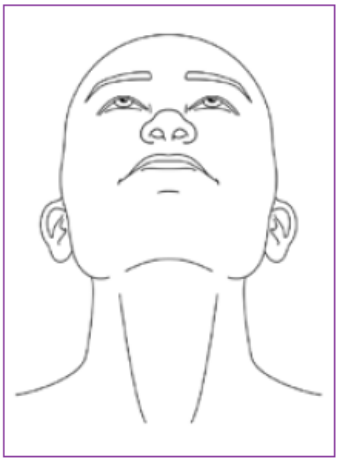
MOUTH

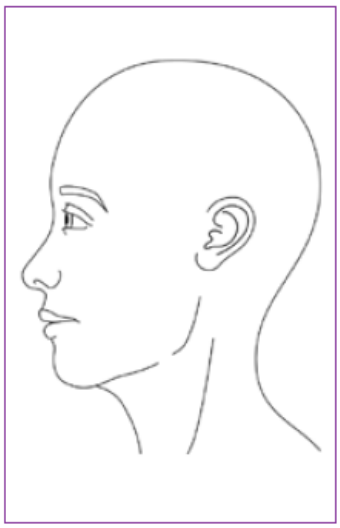
- ❒ No Findings
- ❒ Redness (ER)
- ❒ Bruise (EC)
- ❒ Abrasion (AB)
- ❒ Laceration (LA)
- ❒ Swelling (SW)
- ❒ Petechiae (PE)
- ❒ Tenderness (TE)
- ❒ Other Finding _____

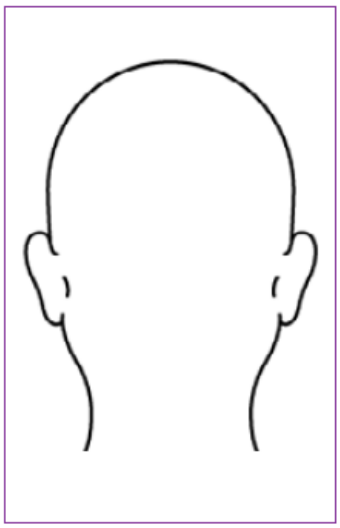
STRANGULATION EXAM #4









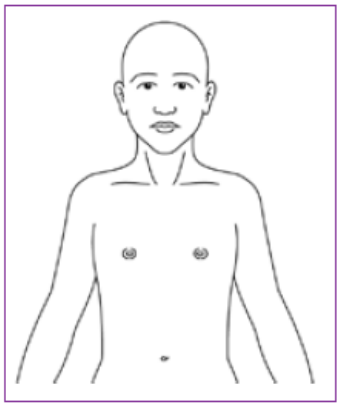


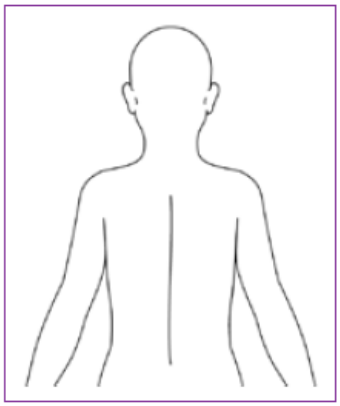
UNDER CHIN AND NECK

- ❒ No Findings
- ❒ Redness (ER)
- ❒ Bruise (EC)
- ❒ Abrasion/Scratch (AB)
- ❒ Laceration (LA)
- ❒ Swelling (SW)
- ❒ Petechiae (PE)
- ❒ Ligature Marks (LM)
- ❒ Arterial Tenderness (AT)
- ❒ Laryngeal or Trachael Tenderness (LT)
- ❒ Carotid Bruit (CB)
- ❒ Other Tenderness
- ❒ Other Finding _____

_____

_____





UPPER TORSO

- ❒ No Findings
- ❒ Redness (ER)
- ❒ Bruise (EC)
- ❒ Abrasion (AB)
- ❒ Laceration (LA)
- ❒ Swelling (SW)
- ❒ Petechiae (PE)
- ❒ Tenderness (TE)
- ❒ Other Finding _____

_____

_____

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Illustration and layout of this tool by Yesenia Aceves

PEDIATRIC-ADOLESCENT FOLLOW-UP EVALUATION

Name of Examining Agency:_____

Address: _____

Date of Initial Exam: _____ Date of Today's Exam:_____ Time: _____

Case Number(s): _____

Name of Patient: _____ Date of Birth: _____

Address: _____

Accompanied By: _____

Others Present: _____

PATIENT RELEASE STATEMENT

I, _____, hereby request and authorize the staff of (agency/agencies) _____to conduct a medical-forensic follow-up evaluation and clinical procedures, including collection and examination of specimens as are necessary for diagnosis and treatment as well as investigation. Furthermore, I hereby authorize and request the medical staff to supply all items of evidence (_____ initials) and copies of medical and laboratory reports (_____ initials) to the appropriate investigative agency for use in the investigation and any resulting legal proceedings.

Patient Examined: _____ Date: _____

Parent or Guardian: _____ Witness: _____

PHOTOGRAPHIC RELEASE

I, _____ , hereby request and authorize the staff of (agency/agencies) _____ _____to capture and produce photographs of body surface or colposcope images of injury, healing injury or normal anatomy. The release of these photographs is conditioned upon the images being viewed only by those persons officially involved in the investigation or legal proceedings. De-identified photos may be used and viewed for education/teaching purposes.

Patient Examined: _____ Date: _____

Parent or Guardian: _____ Witness: _____

Patient's Name: _____

1. Review of initial exam documentation ☐ Yes ☐ No ☐ N/A

2. Reason for follow-up examination ☐ Physical Abuse ☐ Strangulation ☐ Other _____

Summary of acute strangulation evaluation: _____

_____

_____

_____

_____

_____

_____

_____

Description of injury/abuse event(s) in patient's own words:_____

_____

_____

_____

_____

_____

_____

_____

Name of examiner: _____ Date: _____

Signature: _____

Patient Label

PHYSICAL ASSESSMENT

Patient's Name: _____

Vital Signs: T _____ P_____ R _____ B/P _____ Pulse Ox _____

Neck Circumference _____ (Anterior) _____ (Lateral)

Mental Status/Behavior/Appearance: _____

_____

_____

_____

REVIEW OF SYSTEMS

Neurological: _____

Cardiovascular: _____

Respiratory: _____

HEENT: _____

Gastrointestinal: _____

Genito-urinary: _____

OB/Gynecological: _____

Skin/Muscle/Bone: _____

Psych/Social: _____

Since the strangulation, has the patient noted any of the following symptoms:

☐ Coughing ☐ Drooling ☐ Dyspnea ☐ Dysphagia ☐ Odynophagia ☐ Headache

☐ Lightheadedness ☐ Neck pain ☐ Neck swelling ☐ Nose pain ☐ Nausea ☐ Vomiting

☐ Crepitus ☐ Uncontrolled shaking ☐ Combativeness ☐ Irritability ☐ Restlessness

☐ Otherwise altered mental status Describe:

☐ Voice changes Describe: _____

☐ Vision changes Describe: _____

☐ Bleeding Describe: _____

☐ Weakness/numbness of extremities Describe: _____

Name of examiner: _____ Date: _____

Signature: _____

Patient's Name: _____

Pain score: _____ ☐ Numbered scale used ☐ Wong Baker scale used (insert score) _____

On a scale of 0-10, with 0 being no pressure and 10 being the worst pressure you can imagine, how strong was the grip during your strangulation (Circle one): 0 1 2 3 4 5 6 7 8 9 10

Is the patient **pregnant**? ☐ Yes ; How many weeks? _____ ☐ N/A

☐ **Petechiae** Locations: ☐ Conjunctivae ☐ Face ☐ Palate ☐ Ears ☐ Scalp
☐ Tympanic Membrane(s) ☐ Neck ☐ Chest

☐ **Tongue or oral cavity injury** Describe: _____

☐ **Neurological findings**
- ☐ Ptosis ☐ Facial droop ☐ Paralysis ☐ Unilateral weakness
- ☐ Loss of sensation ☐ Other: _____
- ☐ Absence of normal crepitus when manipulating cricoid cartilage
- ☐ Visible injury (describe on body maps below)
- ☐ Digital photography complete

Method/Manner of Strangulation:
- ☐ One hand Estimated length of time: _____seconds _____minutes
- ☐ Two hands Estimated length of time: _____seconds _____minutes
- ☐ "Choke-hold" Estimated length of time: _____seconds _____minutes
- ☐ Approached from the front
- ☐ Approached from behind
- ☐ Multiple strangulation attempts during incident How many? _____
- ☐ Jewelry on patient's neck during strangulation
- ☐ Ligature used Describe if possible: _____
- ☐ Smothering attempt Describe: _____
- ☐ Other Describe: _____

During the strangulation did the patient note any of the following:
- ☐ Loss of consciousness/blacking out/passing out Number of times: _____
- ☐ Incontinence of urine Incontinence of stool
- ☐ Bleeding Describe: _____
- ☐ Patient's feet lifted off the ground
- ☐ Patient's shirt was tightened around their neck

During the follow up evaluation were symptoms noted by the examiner?

☐ Yes: _____ ☐ No

Name of examiner: _____

Signature: _____ Date: _____

GLASGOW COMA SCALE

Patient's Name: _____

Best eye response (E)	Spontaneous--open with blinking at baseline	4
	Opens to verbal command, speech, or shout	3
	Opens to pain, not applied to face	2
	None	1
Best verbal response (V)	Oriented	5
	Confused conversation, but able to answer questions	4
	In appropriate responses, words discernible	3
	Incomprehensible speech	2
	None	1
Best motor response (M)	Obeys commands for movement	6
	Purposeful movement to painful stimulus	5
	Withdraws from pain	4
	Abnormal (spastic) flexion, decorticate posture	3
	Extensor (rigid) response, decerebrate posture	2
	None	1

CRANIAL NERVE ASSESSMENT

Patient's Name: _____

NERVE	ASSESSMENT	NOTES	
CN I **Olfactory**	Identifies a familiar scent with eyes closed (coffee)	☐ WLN	☐ Unable to assess
CN II **Optic**	Read one eye at a time, visual fields tested by having patient cover one eye and identifying number of fingers in each visual field	☐ WLN	☐ Unable to assess
CN III **Oculomotor**	Check pupilary response with light, check accommodation by moving your finger towards the patient's nose, check for EOMs	☐ WLN	☐ Unable to assess
CN IV **Trochlear**	Have patient look down and in	☐ WLN	☐ Unable to assess
CN V **Trigeminal**	Ask patient to open mouth while you attempt to close it, have them attempt to move jaw laterally. Have patient close their eyes, touch their face with cotton and have patient identify where they were touched	☐ WLN	☐ Unable to assess
CN VI **Abducens**	Have patient move their eyes from side to side	☐ WLN	☐ Unable to assess
CN VII **Facial**	Ask patient to smile and raise eyebrows, ask them to keep eyes and lips closed while you try to open them	☐ WLN	☐ Unable to assess
CN VIII **Acoustic/Vestibular**	Test hearing with rubbing fingers or whispering	☐ WLN	☐ Unable to assess
CN IX **Glossopharyngeal**	Observe patient swallow and check gag reflex	☐ WLN	☐ Unable to assess
CN X **Vagus**	Assess gag and swallowing with IX, assess patient's voice characteristics	☐ WLN	☐ Unable to assess
CN XI **Spinal Accessory**	Have patient shrug shoulders with resistance, have patient move head from side to side	☐ WLN	☐ Unable to assess
CN XII **Hypoglossal**	Have patient stick out tongue and move it internally from right to left, assess articulation	☐ WLN	☐ Unable to assess

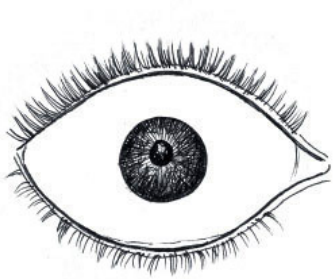
Describe abnormalities here: _____

_____

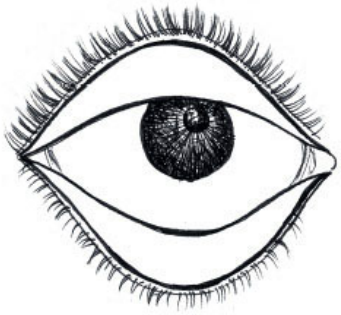
☐ **Cranial nerve assessment normal**

Patient's Name: _____

Right Conjunctiva

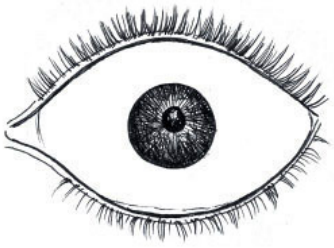


Right Inner Eye Lid

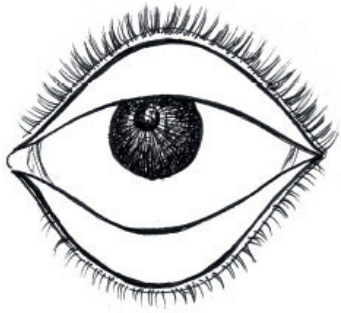


Right Outer Eye Lid

Left Conjunctiva



Left Inner Eye Lid

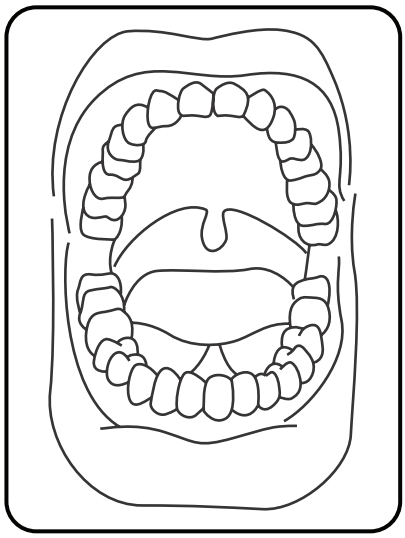


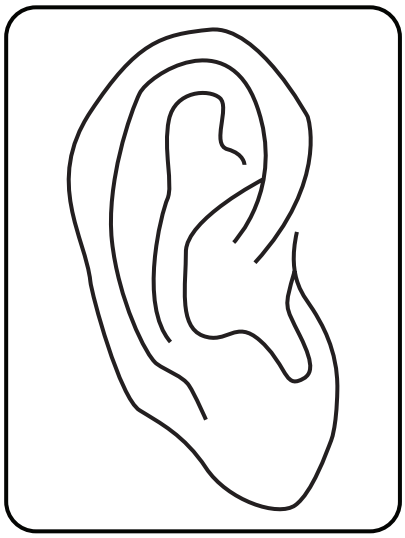
Left Outer Eye Lid

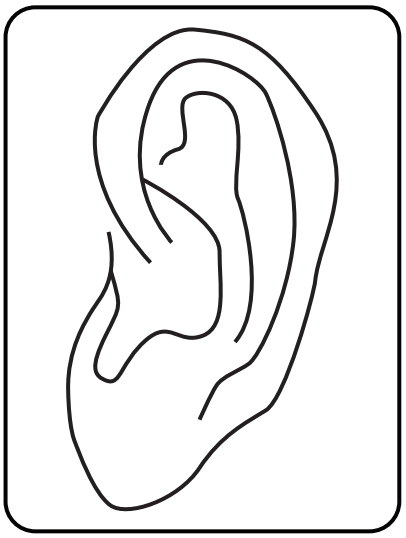
Name of examiner: _____

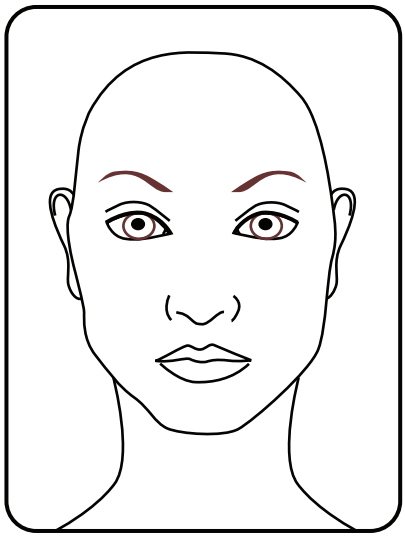
Signature: _____ Date: _____

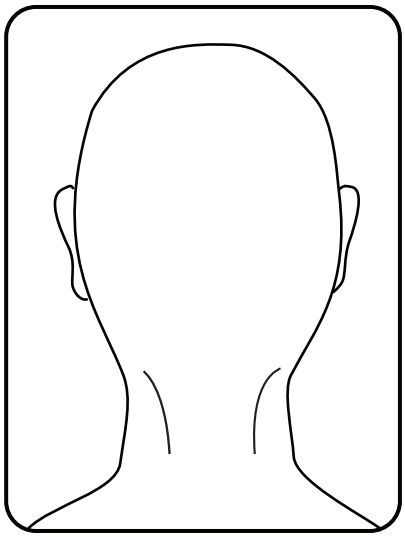
Patient's Name: _____

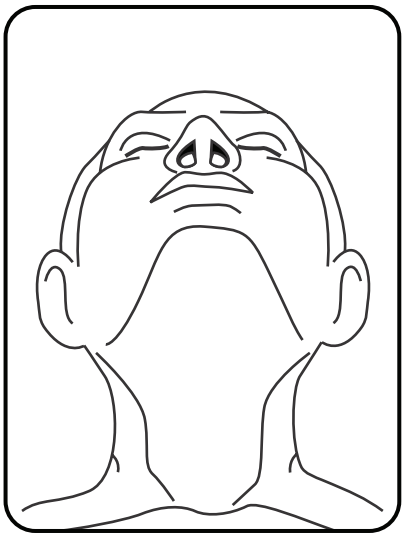


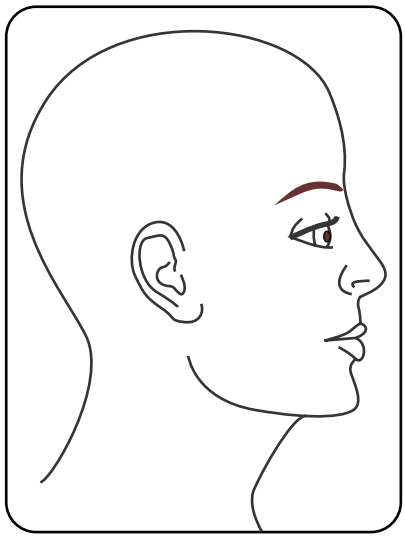


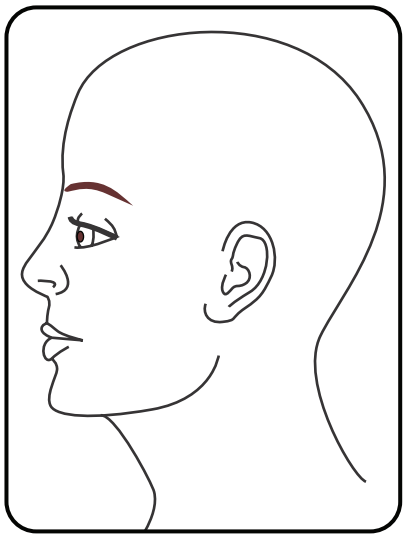












Name of examiner: _____

Signature: _____ Date: _____

Patient's Name: _____

SUMMARY ASSESSMENT

PLAN OF CARE & RECOMMENDATIONS

☐ Pediatric Strangulation Discharge Instructions

Name of examiner: _____ Date: _____

Signature: _____

DETAILED BODY SURFACE FINDINGS

Patient's Name: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____

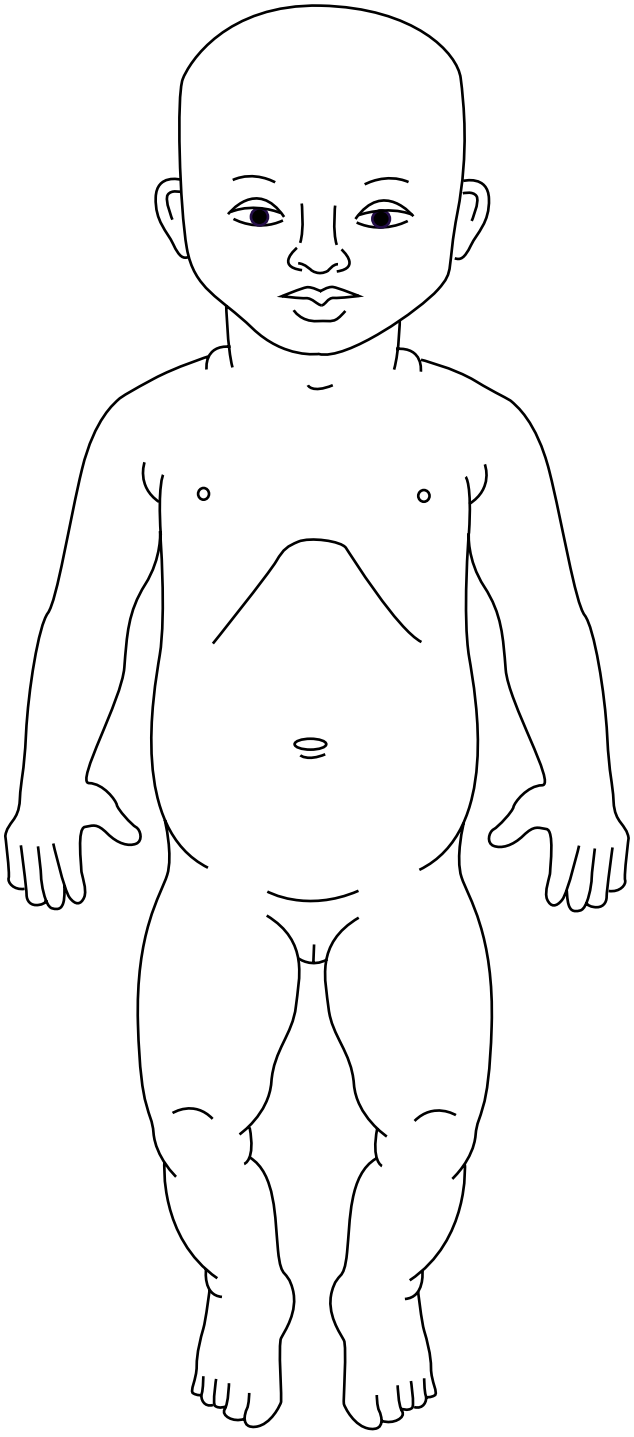
If more space is required, please use a progress note and check the box below.

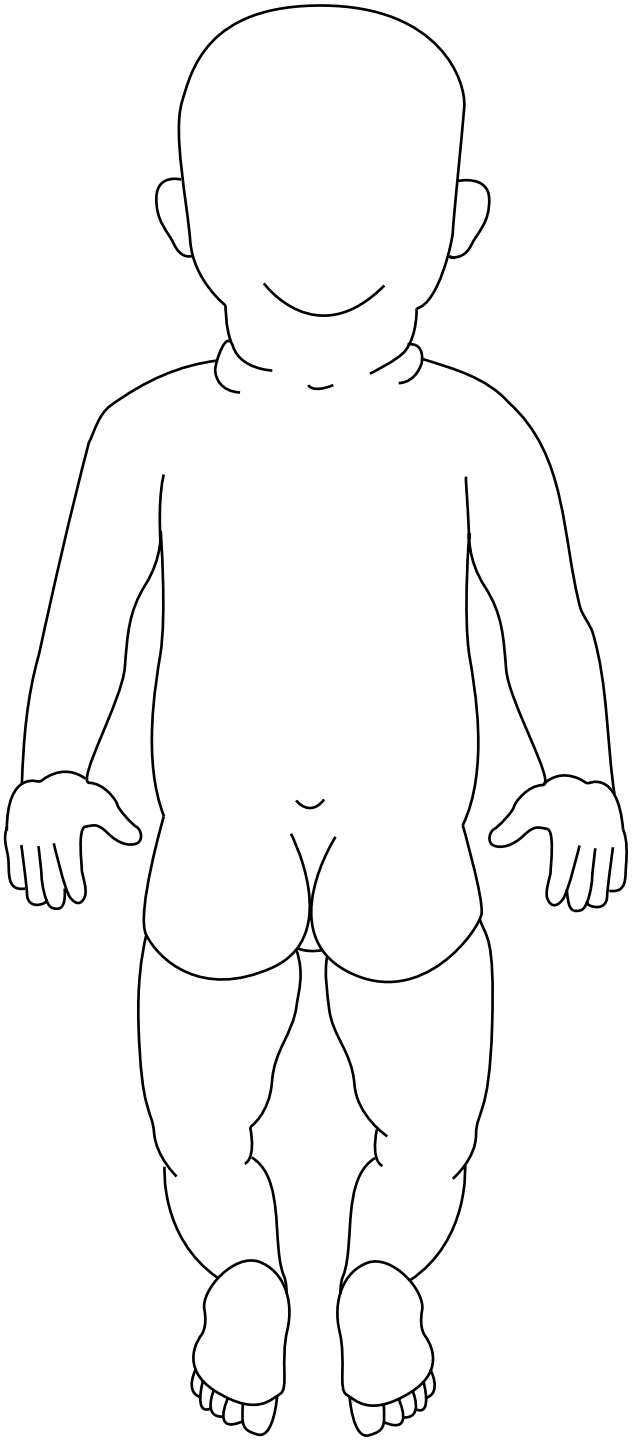
☐ Please see progress note for additional findings.

☐ Please see age appropriate diagrams (appendices) for additional findings

Patient's Name: _____

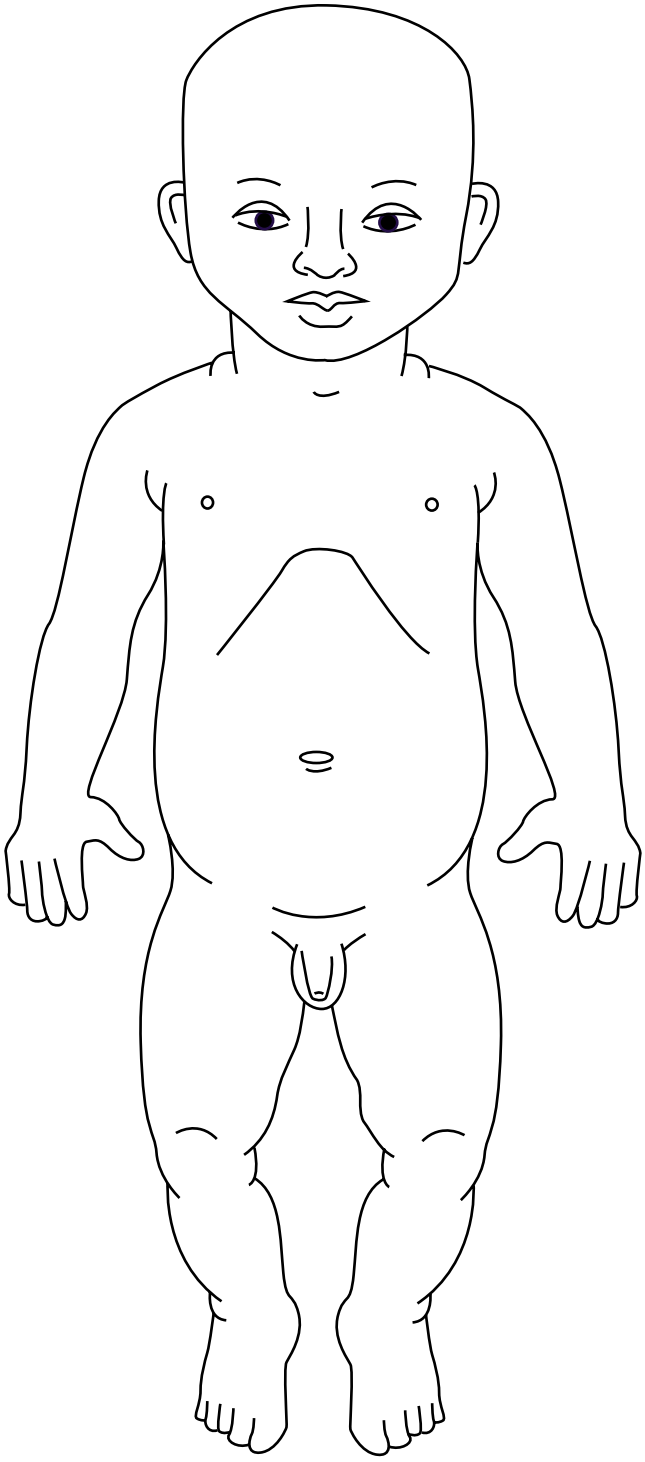
Numerically mark each finding (1, 2, 3…) and provide a detailed description.

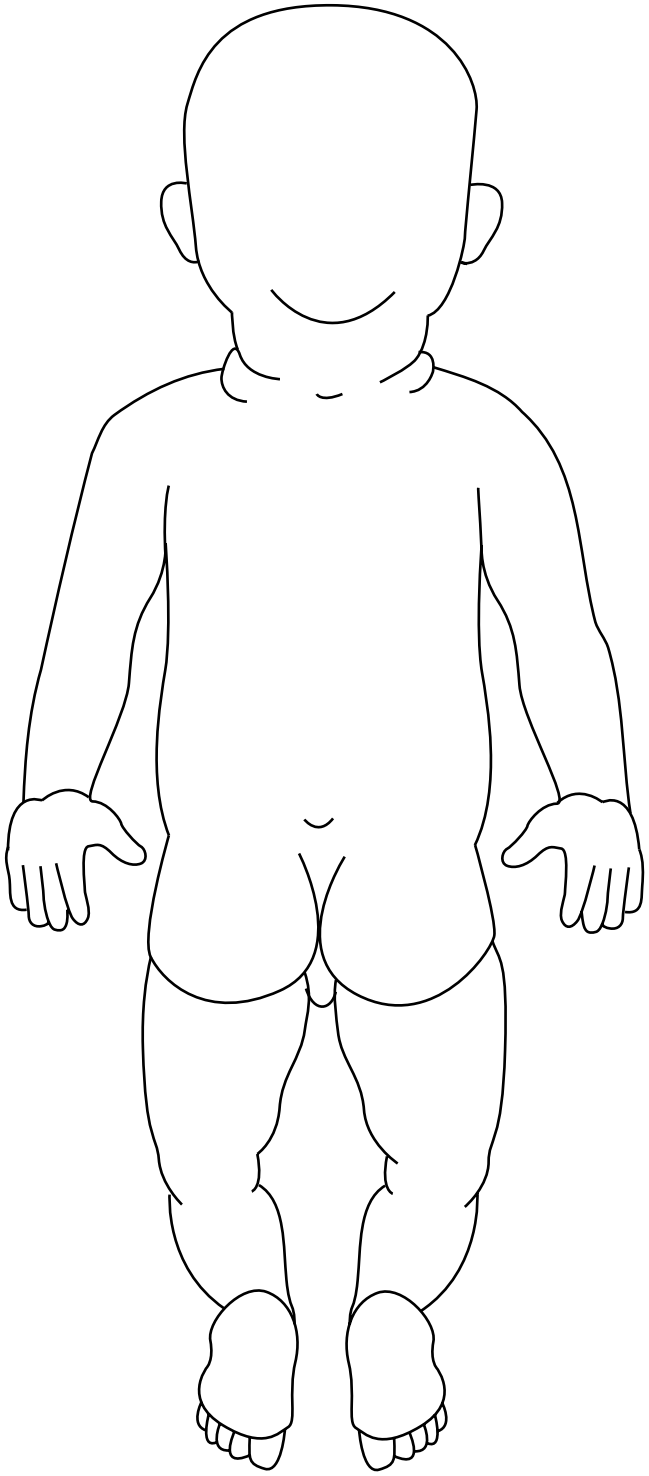




Patient's Name: _____

Numerically mark each finding (1, 2, 3…) and provide a detailed description.

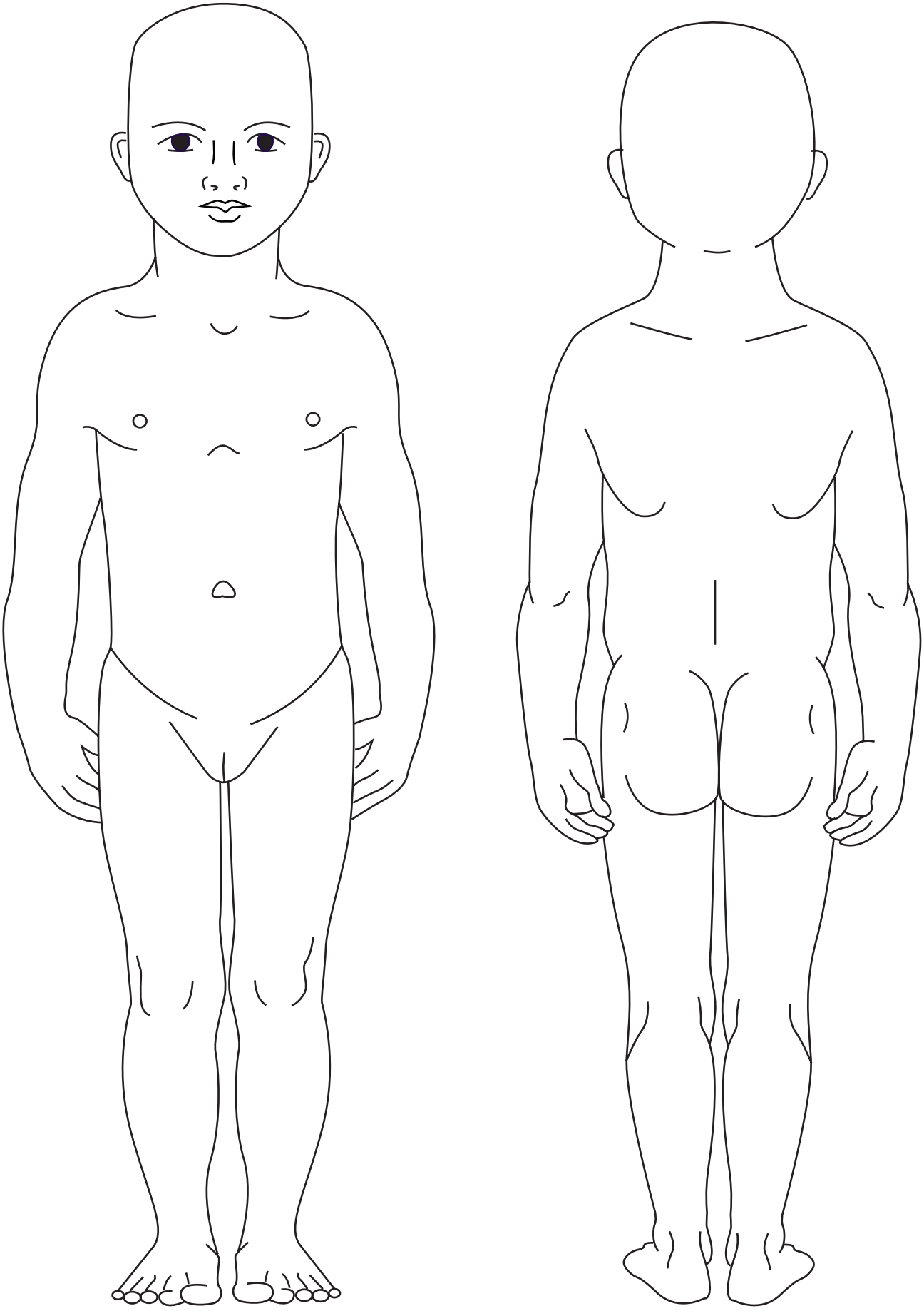




Patient's Name: _____

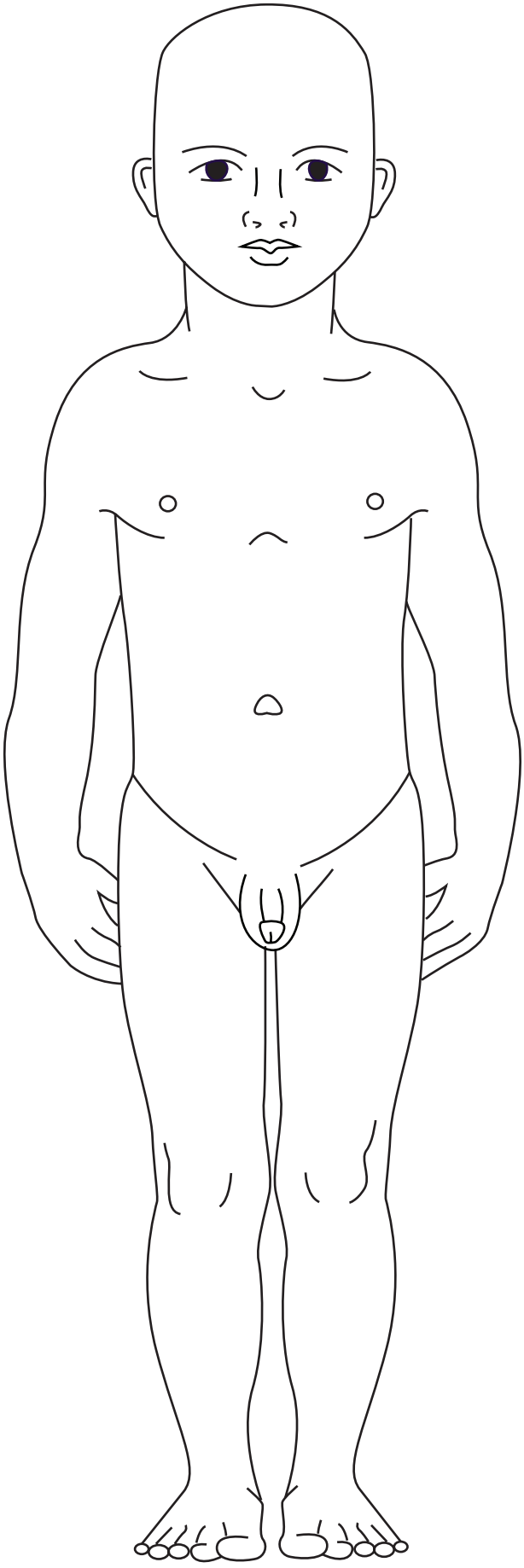
Patient's Name: _____

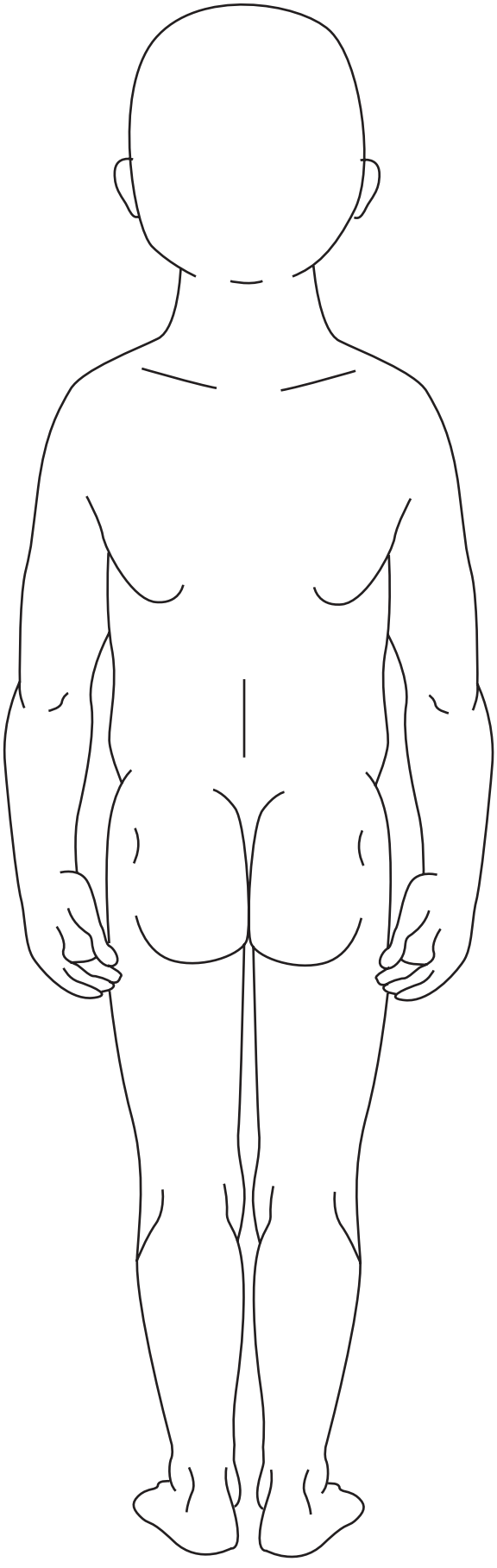
Numerically mark each finding (1, 2, 3…) and provide a detailed description.



Patient's Name: _____

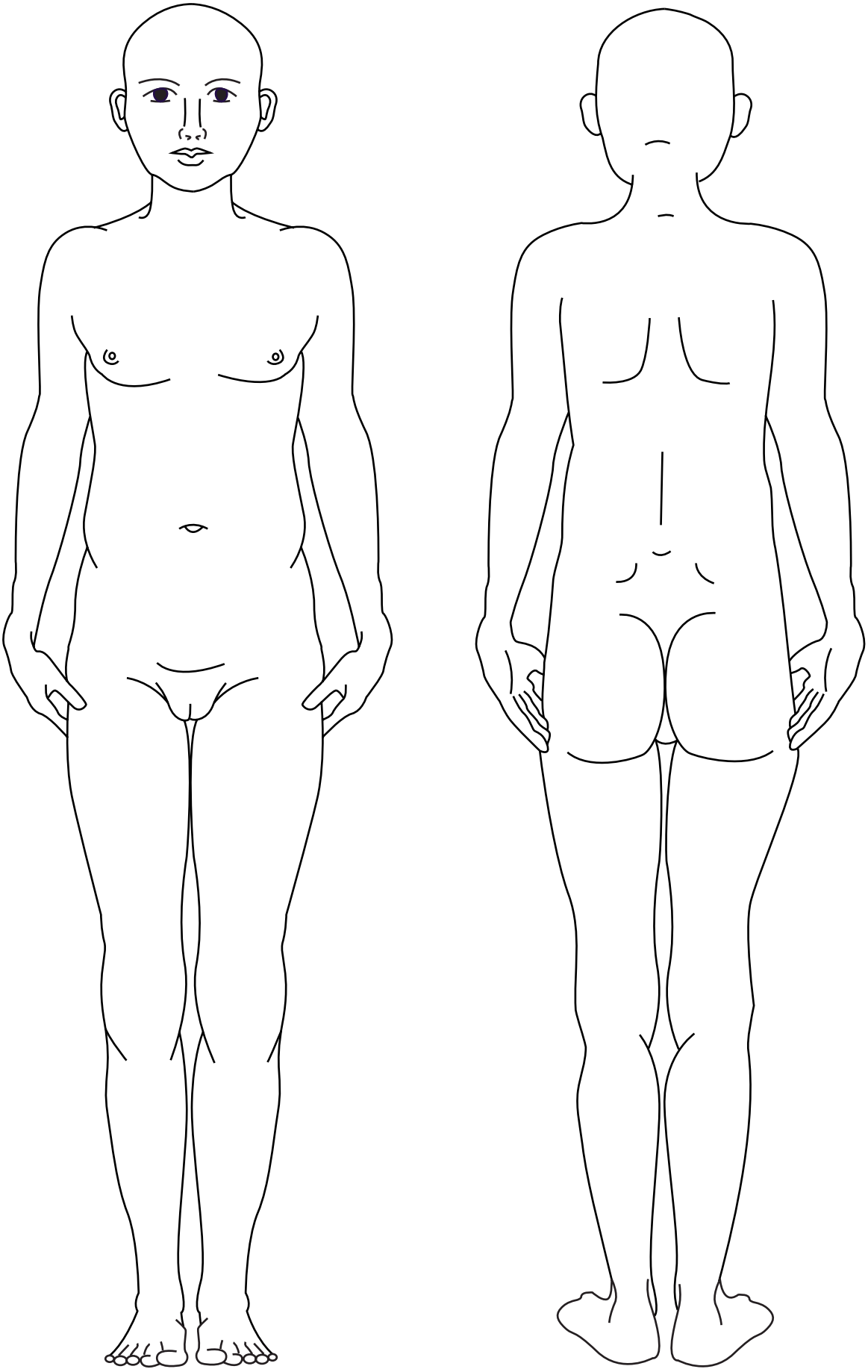
Numerically mark each finding (1, 2, 3…) and provide a detailed description.





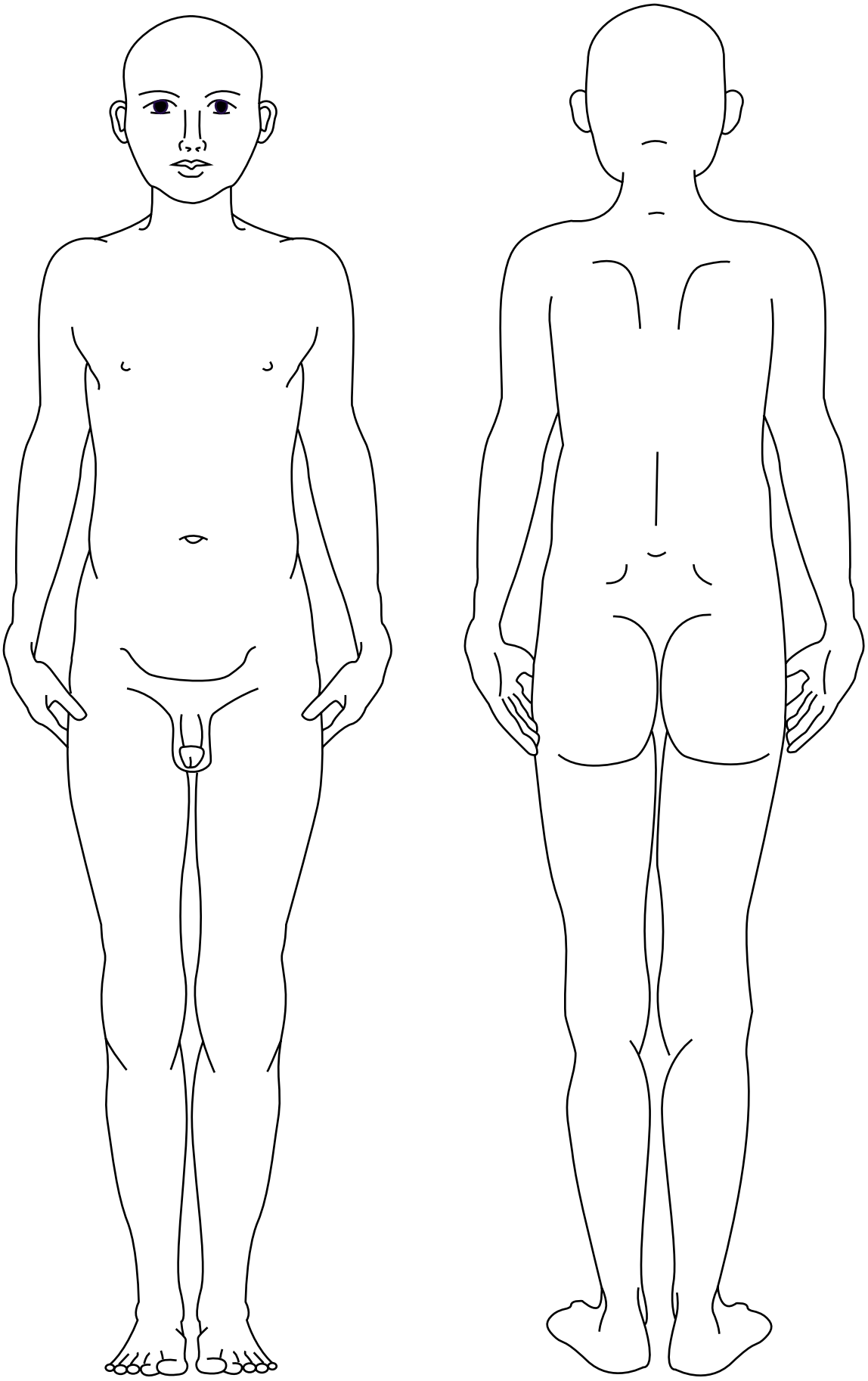
Patient's Name: _____

Numerically mark each finding (1, 2, 3…) and provide a detailed description.



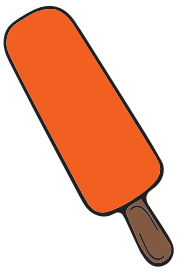
Patient's Name: _____

Numerically mark each finding (1, 2, 3…) and provide a detailed description.



PEDIATRIC STRANGULATION DISCHARGE INSTRUCTIONS

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
- 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.

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

Patient/Parent Signature	Provider Signature	Date
1 copy patient file	1 copy patient	

STRANGULATION and/or SUFFOCATION DISCHARGE INFORMATION

Because you have reported pressure applied to your neck and/or difficulty breathing, we are providing you with some important discharge information.

- After a choking, strangulation and/or suffocation assault, victims can experience **delayed symptoms** of internal injuries.
- Symptoms of internal injuries may appear quickly or develop over a few days after the event. **Internal injuries can be serious and even fatal.**
- It is important that someone you trust stays with you for **the next 24–72 hours** to help you monitor your signs and symptoms.
- We recommend you keep a **list of your symptoms** to share with your healthcare provider and advocate.

***(Internal)** The individual filling out the form should check off items discussed with the patient as part of their discharge. Written discharge instructions should be provided to all patients.*

Please check all the following actions that apply:

- ☐ Reviewed after-care instructions and strangulation warning signs
- ☐ Provided resource handouts and phone numbers
- ☐ Safety plan reviewed
- ☐ Referred to primary care in _____ days for follow up
- ☐ Other: _____

_____

The NATIONAL DOMESTIC VIOLENCE HOTLINE number is 1-800-799-SAFE (3722)
or get help without saying a word at https://www.thehotline.org/

Please follow up with the crisis/advocacy center to talk to a confidential victim advocate about your **options and safety planning** by calling:

_____

If you have questions about your **legal case**, please contact the police department, officer involved, prosecutor or victim witness advocate by calling:

_____

_____ _____

Name of Forensic Nurse **Office Phone**

TRAINING INSTITUTE on STRANGULATION PREVENTION
strangulationtraininginstitute.com

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.

Emergency Care Required

If you notice any of the following symptoms, you should **CALL 911** or go right away to the nearest **EMERGENCY ROOM:**

- Difficulty breathing
- Persistent cough or coughing up blood
- Loss of consciousness or "passing out"
- Changes in your voice, difficulty speaking, or understanding speech
- Difficulty swallowing, feelings of a lump in your throat or a muscle spasm in your throat or neck
- Swelling to your throat, neck, or tongue
- Increased neck pain
- Drooping eyelid
- Weakness, numbness or tingling on the left or right side of your body
- Difficulty walking
- Headache, not relieved by pain medication
- Dizziness, lightheadedness or changes in vision
- Seizures
- Behavioral changes, memory loss, or confusion
- If you are having thoughts of harming yourself or others

If you are **PREGNANT**, report any of the following symptoms to your doctor **IMMEDIATELY:**

- Decreased baby movement
- Vaginal spotting or bleeding
- Stomach pain
- Contractions

Normal Reaction

Sometimes the **PHYSICAL SYMPTOMS** of a traumatic event are:

- Trembling or shaking
- Pounding heart
- Rapid breathing
- Lump in throat; feeling choked up
- Stomach tightening or churning
- Feeling dizzy or faint
- Cold sweats
- Racing thoughts

Call the **CRISIS CENTER** or **A FRIEND** to talk about your emotions and feelings.

If you notice some **bruising or mild discomfort**, apply ice to the sore areas for **20 minutes** at a time, **4 times** per day, for the first **2 days**.

If you go to the **EMERGENCY ROOM**, **TAKE THIS PAPER WITH YOU** and refer personnel to:

https://www.familyjusticecenter.org/resources/recommendations-medicalradiographic-evaluation-acute-adult-non-fatal-strangulation/

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 ___Unsure 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 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

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: _____

Duration the victim was strangled/suffocated: ___Sec. ___ Min. ___Unsure Did it happen multiple times? ___Yes ___No ___Unsure

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 (1=Weak - 10=Very Strong): _____ Did you lose of consciousness? ___Yes ___No ___Unsure

Extent of pain experienced during strangulation/suffocation (1=Weak - 10=Very Strong): _____

Have there been prior incidents of strangulation/suffocation? ___Yes ___No If Yes, how many times? _____

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 (1=Normal-10=Unable to breathe): ___ Pain while breathing? ___Yes ___No Shallow breathing? ___Yes ___No

Any other changes to your breathing? ___Yes ___No Clearing of the throat? ___Yes ___No Rapid breathing? ___Yes ___No

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 __DV Pamphlets/Crisis/Referral Information given to the victim

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

__Detective notified or responded: _____ Victim Advocate notified: _____

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

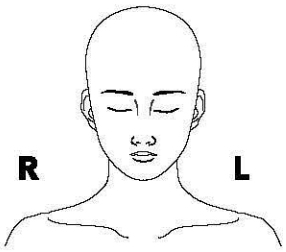
SYMPTOMS (mark/annotate all that apply)

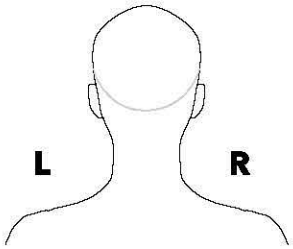
SYMPTOMS	DURING	AFTER	UNSURE	NO	DESCRIPTION
Headache					
Dizziness/Feel Faint					
Disoriented					
Loss or changes in vision					
Loss or changes in hearing					
Raspy/Hoarse Voice					
Difficulty Speaking					
Unable to Speak					
Painful to Swallow					
Trouble Swallowing					
Sore Throat					
Neck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

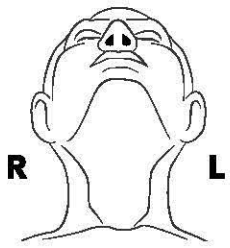
***Is the victim wearing the same clothes that they were wearing during the attack? Did they change clothes?**

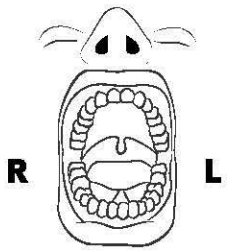
VISIBLE SIGNS (mark/annotate all that apply)

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:	

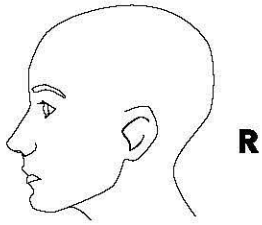


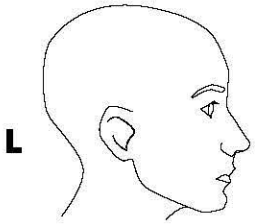


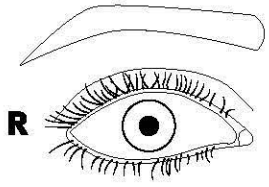


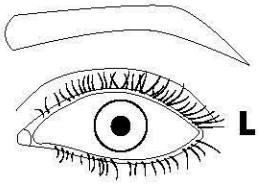


CHEST	SHOULDERS	UNDER CHIN	MOUTH
Redness or Bruising	Redness or Bruising	Redness or Bruising	Swollen Lip(s)
Scratches/Abrasions	Scratches/Abrasions	Scratches/Abrasions	Abrasions/Lacerations
Laceration(s)	Laceration(s)	Laceration(s)	Swollen tongue
Describe:	Describe:	Describe:	Petechiae (palate)









FACE	EARS			NOSE	EYES & EYELIDS		
Redness or Flushed	Swelling			Scratches/Abrasions	Petechiae in eye(s)	Right	Left
Scratches/Abrasions	Bruising			Swelling	Petechiae on 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

ALLIANCE for HOPE INTERNATIONAL

Being strangled (choked) could end your life within 4 minutes

LET'S CREATE YOUR SAFETY PLAN

"NOW IS THE TIME TO TELL WHAT HAPPENED"

SURVIVOR

This informational brochure was created by
The Institute on Strangulation Prevention, a program of Alliance for HOPE International
strangulationtraininginstitute.com

When domestic violence perpetrators strangle (choke) their victims, this is a crime. Strangulation can be charged as a felony assault and could be considered attempted homicide.

Strangulation is an ultimate form of power and control, where the batterer demonstrates control over the victim's next breath, having devastating psychological effects and a potentially fatal outcome.

A SMALL AMOUNT OF PRESSURE AROUND THE NECK CAN RESULT IN A LOST OF CONSCIOUSNESS IN 6.8 SECONDS. DEATH CAN OCCUR WITHIN 62 SECONDS ALL THE WAY TO 152 SECONDS. TO LEARN MORE VISIT youtube.com/watch?v=_i79_xdEgK8

Victims of non-fatal strangulation are at a higher risk of being re-assaulted by their abuser/perpetrator and **750%** more likely of being killed by their abuser. If the abuser/perpetrator has access to firearms the risk of being killed increases to **1100%**.

Safety **BEFORE** Strangulation

- Educate yourself on the seriousness of strangulation.
- If your abuser/perpetrator has threatened to strangle, choke or suffocate you in the past, take it seriously.
- If your abuser/perpetrator talks about using strangulation/choking during sex or as "play," take this seriously for the health reasons mentioned previously.
- If strangulation is imminent try to remove scarves, jewelry, loose strings or cords that could be easily used to strangle you.
- If possible, avoid rooms like the bedroom, and bathroom where the risk for suffocation by pillow or drowning may increase.
- If comfortable, learn self-defense strategies to try to stop your abuser/perpetrator from strangling, like pressing your chin to your chest to block hands/arms from tightening and kneeing the abuser/perpetrator in the groin.
- If you can sense abuse coming, then you can try to manage it by implementing your safety plan (i.e. leave the home, tell someone you trust, ask someone to check on you, leave the room etc.)
- Remain calm and trust your judgment.
- If you have more questions connect with a victim advocate for additional support and safety planning.
- Keep this document in a safe place away from the abuser/perpetrator.

Safety **DURING** Strangulation

- Comply with abuser/perpetrator if necessary to stay alive.
- Leave if possible. Your life is at risk.
- Keep pressure off at least one side of your neck in order to keep from losing consciousness.
- If the abuser/perpetrator relaxes their hold, try to escape if you can.
- Trust your instincts, whether fighting back or not is most effective.

Often survivors are reluctant to tell anyone about the abuse.

However, **IF SOMEONE HAS STRANGLED/CHOKED YOU, OR IF ANYONE HAS EVER CAUSED YOU TO BE UNABLE TO BREATHE, YOU MUST SHARE THIS PIECE OF YOUR STORY; IT IS MOST IMPORTANT TO TELL BECAUSE IT CAN SAVE YOUR LIFE.**

Safety **AFTER** Strangulation

- Get away immediately, call for help, and go to a safe place.
- Seek immediate medical attention.....**IT MAY SAVE YOUR LIFE!**
- Know that you are not alone and there is **HOPE FOR A BRIGHTER FUTURE**.
- If you go to the hospital, tell the doctor/nurse you were strangled and request a CTA scan.
- Give your medical provider the Medical Assessment Card in order to get a complete medical exam.
- Do not be left alone for at least 48 to 72 hours after a strangulation assault.
- Take photos of your injuries immediately and/or few days afterwards.
- Do not be embarrassed if there was involuntary urination or defecation, as this is a symptom of strangulation.
- Do not wash your clothes (which could be evidence).
- It is important to **FULLY** explain to your medical provider everything that happened to you, and to follow up after your initial appointment.
- Follow up with an Advocate for appropriate safety planning and additional resources and support.

USE THE CHART BELOW TO KEEP TRACK OF YOUR SIGNS, SYMPTOMS AND ANY OTHER SENSATIONS. IF YOU ARE UNABLE TO MONITOR ON YOUR OWN, ASK SOMEONE CLOSE TO YOU TO DO IT FOR YOU.

Please request the **Facts of Strangulation** brochure or download it at www.familyjusticecenter.org/wp-content/uploads/2017/11/Facts-Victims-of-Strangulation-Choking-Need-to-Know-Brochure-2017.pdf

MONITOR AND JOURNAL SIGNS, INCLUDE DATE/TIME

Date/Time	Sign(s)

MONITOR AND JOURNAL SYMPTOMS, INCLUDE DATE/TIME

Date/Time	Symptom(s)

MONITOR AND JOURNAL OTHER SENSATIONS, INCLUDE DATE/TIME

Date/Time	Other Sensations

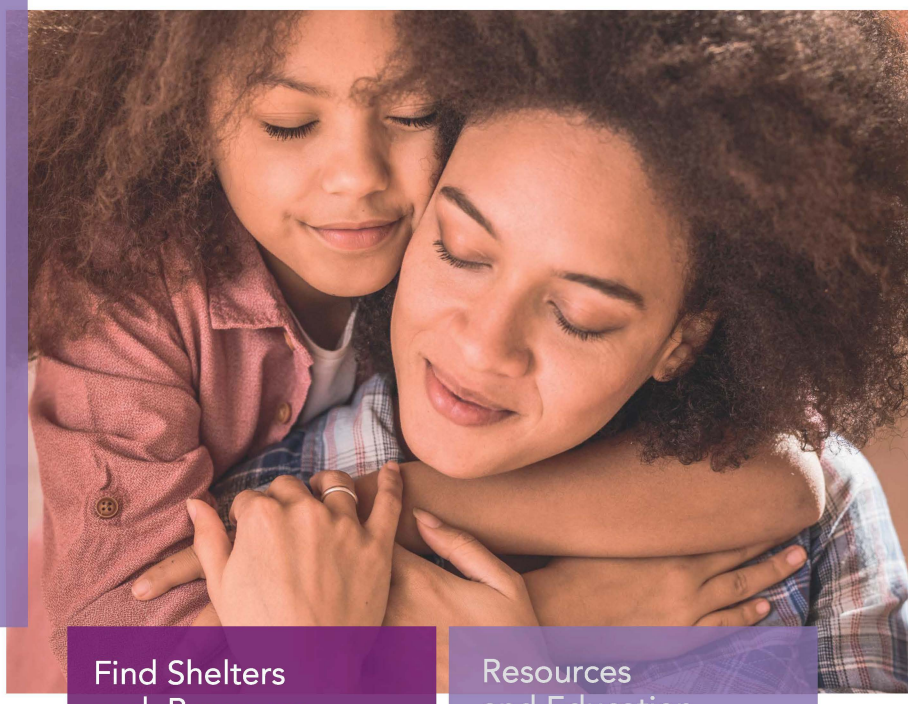
NAME AND PHONE NUMBERS OF WHO TO CALL FOR HELP/SUPPORT

Name	Phone/Email

The production of this document was supported in part with funding from the Office on Violence Against Women in the U.S. Department of Justice. This website and a portion of the documents in this Resource Library are supported 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.

domesticshelters.org

The leading online source
of domestic violence information and resources.



Over 2 million survivors and professionals served annually.

DomesticShelters.org talks about the important things we need to know.
- DV Advocate, Wyoming

Find Shelters and Programs

The first and largest searchable database of agencies, programs and shelters in the U.S. and Canada.

Resources and Education

The leading online library of domestic violence education, information, news and tools.

Free Professional Tools

Expert webinar training helps professionals serve their clients even better.

Automate donation purchasing and delivery via the Wishlist Platform.

Purple Ribbon Awards

The first comprehensive awards program honoring the countless heroes of the domestic violence movement.

DomesticShelters.org strives to be the catalyst that those experiencing abuse need for positive change.

ALLIANCE for HOPE INTERNATIONAL

DomesticShelters.org @DomesticShelters @DomesticShelters

DomesticShelters.org is a program of Alliance for HOPE International
allianceforhope.com

THE TRAINING INSTITUTE ON STRANGULATION PREVENTION

THE TRAINING INSTITUTE ON STRANGULATION PREVENTION (Institute) is a program of Alliance for HOPE International. The Institute was launched with support from the United States Department of Justice, Office on Violence Against Women. The Institute provides consulting, training, resources, and support services to professionals working in the fields of domestic violence and sexual assault.

OUTCOMES from past training sessions reflect an increased awareness in cases involving strangulation; improved documentation and investigation of strangulation cases; increased prosecution of strangulation cases; and increased offender accountability and victim safety.

The Institute trains over 48,000 professionals per year on Domestic Violence and Sexual Assault Strangulation Crimes.

NATIONAL ADVISORY BOARD AND COMMITTEES for the Institute include 93 experts, physicians, nurses, law enforcement officers, prosecutors, advocates, researchers and trainers from the United States.

WHAT PAST ATTENDEES ARE SAYING:

"This course was fantastic! I would attend again and will recommend to anyone in my field."

"I truly enjoyed the experience and I will take with me what I learned for a lifetime."

"Excellent information with engaging presenters - you can see/hear/"feel" the passion of the speakers, which always makes for a great day!"

"This is the most important and relevant information out there for our law enforcement, judges, children services, doctors, prosecutors, nurses, and social workers - we need to work as a team instead of against each other!"

"The most dangerous domestic violence offenders strangle their victims. They are more likely to kill police officers, kill children, and kill their partners."

Casey Gwinn, President, Alliance for HOPE International

STRANGULATION has been identified as one of the most lethal forms of domestic violence and sexual assault: unconsciousness may occur within seconds and death within minutes. When domestic violence perpetrators choke (strangle) their victims, not only is this 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: it may have devastating psychological effects or a potentially fatal outcome.

The Institute provides training, technical assistance, education programs, a directory of national trainers and experts, and a clearinghouse of all research related to domestic violence and sexual assault strangulation crimes.

"The lack of visible injuries and the lack of training caused the criminal justice system to minimize strangulation. But now we know it is lethal."

Gael Strack, CEO, Alliance for HOPE International

THE GOALS OF THE INSTITUTE ARE TO:

Enhance the knowledge and understanding of professionals working with victims of domestic violence and sexual assault who are strangled;

Improve policy and practice among the legal, medical, and advocacy communities;

Maximize capacity and expertise;

Increase offender accountability; and ultimately

Enhance victim safety.

survivor resources

strangulationtraininginstitute.com/survivor-resources/

institute@allianceforhope.com

strangulationtraininginstitute.com/training/

training