

Responding to Strangulation in Alaska

Guidelines for Law Enforcement Health Care Providers Advocates and Prosecutors



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Training Institute on Strangulation Prevention (A Program of the National Family Justice Center Alliance)

www.strangulationtraininginstitute.com

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Chapter 1: Introduction and Overview of the Training Institute on Strangulation

By Casey Gwinn, J.D. and Gael Strack, J.D with additions by Randi Breager

"If Tamara's death has brought something to the community, saying 'hey we have to be more aware', then at least Tamara did not die in vain. We're grateful to all those professionals who are here today and willing to improve their response to this problem of strangulation cases."

Gloria Smith, mother of Tamara Smith

ABOUT THIS MANUAL

When we began our work addressing strangulation and domestic violence almost 20 years ago, we were compelled to advocate for this issue. We didn't want the deaths of two teenagers, 17-year old Casondra Stewart and 16-year old Tamara Smith, to be in vain. As a result of their tragic deaths, we realized our systems were failing victims in our response, treatment, and support. And, there was a lack of public acknowledgement of the seriousness of strangulation cases as well as the amount of violence our teens were experiencing.

Today, we not only have evidence on the prevalence and effects of strangulation, but we are taking action: **38 states have passed felony legislation, there is a federal statute for strangulation and suffocation cases, and recent federal sentencing guidelines recommend strangulation and suffocation cases be treated as specific serious conduct that deserves enhanced punishment regardless of injury.**

Today, the Training Institute on Strangulation Prevention (Institute) operated by the National Family Justice Center Alliance (Alliance) has **trained over 20,000 professionals across the globe either in-person, on webinars or through our on-line course; graduated four classes on Advanced Strangulation Prevention; and developed numerous tools** such as the "Document IT" i-Phone application to assist multi-disciplinary response teams to better support victims of strangulation assaults.

Today, national, state and local organizations and professionals such as the International Association of Chiefs of Police, the International Association of Forensic Nurses, the American College of Emergency Physicians, the National District Attorney's Association, state domestic violence and sexual assault coalitions, county District Attorneys Offices, state prosecutor's associations, and law enforcement organizations are **promoting awareness and educating the field on the effects and response to strangulation assaults.**

We are beginning to see strangulation assaults, so long minimized by ALL professionals, now being treated as serious felonies even when there is little or no visible injury.

But we can do more! We heard this important message from a survivor years ago – Why Didn't Someone Tell Me ... about the health consequences of strangulation assaults. We honor this message throughout the pages of this manual. The remainder of this introduction provides some historical context around the need and current work to help inspire your participation in building effective responses to address strangulation.

WHAT HAPPENS WHEN A VICTIM IS STRANGLED

When a victim is strangled, unconsciousness may occur within seconds and death within minutes. Victims may lose consciousness by any 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), or closing off the airway (making breathing impossible).

Very little pressure on both the carotid arteries and/or veins for 10 seconds is all that is necessary to cause unconsciousness. However, if the pressure is immediately released, consciousness will be regained within 10 seconds. To completely close off the trachea (windpipe), three times as much pressure (33 lbs.) is required. Brain death will occur in 4–5 minutes if strangulation persists.

It's important to remember that often in non-fatal strangulation cases there are no visible external injuries. The lack of external injuries on the victim and the lack of medical training among domestic violence professionals have led to the minimization of this type of violence, exposing victims to potential serious health consequences, further violence, and even death. Not only has strangulation been overlooked in the medical literature, but many states still do not adequately address this violence in their criminal statutes, policies, or responses.

Strangulation is, in fact, one of the most accurate predictors for the subsequent homicide of victims of domestic violence. One study showed that “the odds of becoming an attempted homicide increased by about seven-fold for women who had been strangled by their partner.”¹ Victims may have no visible injuries, yet—because of underlying brain damage due to the lack of oxygen during the strangulation assault—they may sustain serious internal injuries and may even die days or weeks after the attack.

Strangulation is also a form of power and control that can have a devastating psychological effect on victims in addition to the potentially fatal outcome, including suicide. Domestic violence perpetrators who use strangulation to silence their victims not only commit a felonious assault, but can be charged for an attempted homicide.

CREATING AWARENESS OF THE SERIOUSNESS OF STRANGULATION

For many years, medical training to identify domestic violence injuries—including strangulation—for police, prosecutors, and advocates was often overlooked and not included in core training. It wasn't until the deaths of 17-year old Casondra Stewart and 16-year old Tamara Smith in 1995 that the San Diego criminal justice system first began to understand the lethality and seriousness of “choking” cases. The deaths of these two teenagers were a sobering reminder of the reality of relationship violence, prompting the San Diego City Attorney's Office to study existing “choking” cases being prosecuted within the office. **The study revealed that on a regular basis victims had reported being “choked,” and, in many of those cases, there was very little visible injury or evidence to corroborate the “choking” incident.** The lack of physical evidence caused the criminal justice system to treat many “choking” cases as minor incidents, much like a slap on the face where only redness may appear. These two horrific deaths ultimately changed the course of history and launched an aggressive awareness and education campaign to recruit experts and improve the criminal justice system's response to the handling of “choking” cases, which are now referred to as “near-fatal strangulation” cases. The momentum for specialized training has spread around the country.

As a result of those early efforts, many strangulation cases are now being elevated to felony-level prosecution due to professionals understanding the lethality of strangulation. Police and prosecutors are using existing statutes or working with legislators to create new felony legislation. Doctors, forensic nurses, and domestic violence detectives are being utilized as experts and are testifying in court about strangulation. Strangulation training is also being provided at conferences and included at some regional police training academies, often aided by the strangulation training videos produced out of San Diego through partnerships with the Law Enforcement Television Network (1997) and IMO Productions (2000/2010). In addition, many articles on strangulation have been written by the Training Institute on Strangulation Prevention's Faculty and Advisory Team.

The Training Institute on Strangulation Prevention was launched in October 2011, as a program of the National Family Justice Center Alliance. It serves as the comprehensive training and technical assistance provider for the United States Department of Justice for Office on Violence Against Women (OVW) grantees. The Training Institute provides training, technical assistance, web-based [education programs](#), an online directory

1. Glass, Nancy, et al. “Non-Fatal Strangulation Is an Important Risk Factor for Homicide of Women.” (2008) 35 *J. Emergency Med.* 3: 329–335.

of national trainers and experts, and a clearinghouse of all research related to domestic violence and sexual assault strangulation crimes.

The goals of the Training Institute on Strangulation Prevention are to: (1) enhance the knowledge and understanding of professionals working with victims of domestic violence and sexual assault who are strangled; (2) improve policy and practice among the legal, medical, and advocacy communities; (3) maximize capacity and expertise; (4) increase offender accountability; and (5) ultimately enhance victim safety.

RAISING AWARENESS IN ALASKA

Alaska is the largest state in the union and is over twice the size of Texas. Though it covers one-fifth the size of the lower 48 states, encompassing 586,412 total square miles, there are only 6,500 miles of paved roads in the state. A large number of rural communities can only be reached by plane, boat, all-terrain vehicle and snow machine. The vastness of Alaska presents challenges in all service delivery and resource management that is seldom experienced in other states. A large number of Alaska's over 700,000 residents reside in smaller and geographically isolated communities; only about half of the state's residents reside in what is considered an urban area (United States Census Bureau, 2010). Additionally there are 228 federally recognized tribes in the state, most members of which reside in one of the hundreds of Alaskan Native Villages. Alaska's remoteness and vastness in addition to its environmental challenges play into regular conversations around providing services and ensuring victim safety that many states do not have to consider. For example, emergency police response that many citizens take for granted in urban areas with road systems can take many hours or even days in some parts of the state, weather dependent.

Alaska also has some of the highest rates of domestic violence, sexual assault, sexual abuse of minors, and of women killed by men in the country. The University of Alaska Anchorage Justice Center victimization survey found that nearly 60 percent of Alaskan women have been either physically or sexually assaulted in their lifetime.² Staggering on its own, this statistic also causes great concern for victims of strangulation. As discussed in subsequent chapters, strangulation is usually committed within the context of an intimate partner relationship- much more frequently than by a stranger. Considering high rates of violence against women in Alaska in addition to geographical isolation and limited victim resources, the potential for lethality is great. It is vital that providers and first responders around the state, beyond those who are typically provided training regarding strangulation, receive ongoing education on this topic. Often police officers and advanced medical providers do not receive the first report of this type of assault; training and buy-in must reach out to others who potentially come into contact with strangulation victims including Village Public Safety Officers, village health aids, child protection workers, advocates, and others.

The coalition of advocates and professionals featured here in Alaska's adaptation of this manual, "*Responding to Strangulation in Alaska: Guidelines for Law Enforcement, Health Care Providers, Advocates and Prosecutors*", have advanced the dialogue about strangulation. The work this team committed resulted in greater emphasis on the effects of strangulation not only in the context of domestic violence, but with a critical eye on how strangulation impacts victims of sexual assault, child abuse, elder abuse, and other vulnerable populations.

Special thanks and acknowledgment to the dedicated team that gave life to this manual:

Randi Breager, Alaska Department of Public Safety; **Gayle Garrigues** (Ret.), Alaska Children's Justice Act Task Force; **Cathy Baldwin-Johnson, MD**, Alaska CARES and The Children's Hospital at Providence; **Christine King**, University of Alaska, Center for Human Development; **Patricia Liss**, Alaska Department of Public Safety; **Lisa Mariotti**, Alaska Network on Domestic Violence and Sexual Assault; **Tracey Wiese, ANP, ANP**, Alaska CARES; **Barbara Jacobs**, Alaska Institute for Justice; and **Tim Despain**, Alaska Department of Public Safety.

2. Rosay, A. (2010). *Intimate Partner Violence and Sexual Violence in the State of Alaska: Key Results from the 2010 Alaska Victimization Survey*. University of Alaska Anchorage Justice Center.

As well as editing organizations for representing the voices of those they serve:

Council on Domestic Violence and Sexual Assault

Alaska Department of Law

Angie Ellis, Fairbanks Memorial Hospital

THE CONTINUING NEED FOR AWARENESS AND EDUCATION

There is still a need for consistent, basic, and advanced strangulation training nationwide. Family violence professionals rarely receive medical training concerning the identification and documentation of injuries or the signs and symptoms associated with strangulation. Providing these trainings on a regular basis will help institutionalize the best practice understanding of strangulation, increase the capacity of professionals to handle these cases adequately, and ultimately save lives.

There is a need to develop an implementation plan for the integration of strangulation training into core training programs for all professionals, especially after a state passes a new felony strangulation law.

Training, policy development, and the use of documentation instruments have not been universally instituted in all disciplines. There exists a need for a comprehensive approach and cross disciplinary training in the area of strangulation crimes.

Casondra Stewart and Tamara Smith and countless others did not die in vain. Their tragic deaths have clearly led to dramatic changes within the system. And the work continues. The Alliance is honored to be working with our friends in Alaska and looks forward to working with other states to develop similar statewide manuals for professionals on the investigation and prosecution of strangulation cases. We hope each manual improves on the last and together we can learn more and do more to increase offender accountability and victim safety. The most dangerous men in the world strangle their victims. We must recognize the seriousness of these assaults and do far more to properly investigate and prosecute them and provide the necessary advocacy and support that survivors of these nearly fatal assaults need and deserve from us.

Casey Gwinn is the president and co-founder of the Family Justice Center Alliance. He is also the visionary behind the Family Justice Center Movement, first proposing the concept of the Family Justice Center model in 1989. He is a national expert on domestic violence, including prosecution, strangulation, and best practices. Prior to this position, he was the elected San Diego City Attorney.

Gael B. Strack is the chief executive officer and co-founder of the Family Justice Center Alliance. She is a national expert on domestic violence, including strangulation, prosecution, and best practices. Prior to this position, she served as the first director of the San Diego Family Justice Center, the first of its kind in the United States.

Randi Breager is the Domestic Violence Sexual Assault Coordinator for the Department of Public Safety, Division of Alaska State Troopers where she provides training and technical assistance in domestic violence, sexual assault, and stalking to state and municipal police officers. Prior to this position, she worked in the victim advocacy field both in direct service provision and in program management. She uses her experience working with adult and child victims along with her experience in the criminal justice field to help provide multiple perspectives throughout training and discussions around these issues. She has undergraduate degrees in Psychology and Sociology and a Master's Degree in Public Administration specializing in Criminal Justice and Criminology.

Chapter 2: Strangulation and the Law

By Casey Gwinn, J.D. and Gael Strack, J.D., with additions by Gayle Garrigues

“Actually, when I came out of that [strangulation incident], I was more submissive—more terrified that the next time I might not come out—I might not make it. So I think I gave him all my power from there because I could see how easy it was for him to just take my life like he had given it to me.”

Former San Diego Family Justice Center Client (2010)

Survivors of non-fatal strangulation have known for years what prosecutors and civil attorneys are only recently learning: Many domestic violence offenders and rapists do not strangle their partners to kill them; they strangle them to let them know they can kill them—any time they wish. Once victims know this truth, they live under the power and control of their abuser day in and day out. This complex reality creates challenges for prosecutors who have to decide whether to prosecute non-fatal strangulation cases as attempted murders or serious felony assaults.

This chapter lays the foundation for Chapter 3 on Investigation and Chapter 4 on Prosecution by explaining why non-fatal strangulation should be a felony and the need for specialized statutes to address non-fatal strangulation assaults. This chapter is designed to help prosecutors argue the seriousness of these cases in front of judges and juries, with a special emphasis on Alaska law.

For many years across the country, prosecutors have failed to treat non-fatal strangulation assaults as serious crimes, due to lack of physical evidence. Today, because of (1) involvement of the medical profession, (2) specialized training for police and prosecutors, and (3) ongoing research, strangulation has become a focus area for policymakers and professionals working to reduce intimate partner violence and sexual assault.

As of May 2014, 37 states and 1 territory (US Virgin Islands) have passed strangulation laws that provide clear legislative definitions of the violent, life threatening assault now properly referred to as “strangulation.”¹ One state, Utah, passed an “Intent of the Legislature” resolution, which made legislative findings to help guide prosecutors apply existing assault statutes with a special emphasis on non-fatal strangulation assaults.² And, the newly re-authorized Violence Against Women Act added strangulation and suffocation language to federal law for the first time.³

Prior to the enactment of felony strangulation laws, prosecutors and police officers were sometimes prevented from charging non-fatal strangulation cases with minimal or no visible injury even with loss of consciousness as felonies.⁴ In some jurisdictions, strangulation cases are prosecuted as misdemeanors, reduced to lesser charges or simply dismissed altogether.⁵

1. The following 37 states have statutes, whether stand-alone strangulation statutes or under an existing assault or battery statute that specifically identifies strangulation as a crime: Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New York, North Carolina, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin, and Wyoming. To review the language of most statutes, see Winn S. Collins & Jacqueline Callari Robinson, *Strangulation Statutes: A New Tool in the Criminal Justice Toolbox* (2012).

2. Strangulation and Domestic Violence Joint Resolution, H.R.J. Res. 6, 2010 Gen. Sess. (Utah 2010).

3. Violence Against Women Reauthorization Act of 2013, Pub. L. 113–114, § 906, 127 Stat. 54 (2013) (amending the federal assault statute, 18 U.S.C. § 113).

4. http://www.criminaljustice.ny.gov/pio/press_releases/2011-04-07_pressrelease.html

5. Watch. Why Strangulation Should Not be Minimized by Marna Anderson

Bea Hanson, Acting Director of the Office on the Violence Against Women recently pointed out, “When states get new laws about strangulation, it shines a light on it, shows the severity of the crime.”⁶ Michigan’s new law focused on the severity of the offense and made strangulation or suffocation a felony punishable by imprisonment for up to 10 years and/or a fine of up to \$5,000. After New York passed their strangulation law, advocates, policy makers, police and prosecutors found the new law holds individuals criminally liable for their abusive and deadly conduct and serves as a valuable tool for the intervention and victim protection process.⁷

Most recently, the United States Sentencing Commission issued recommendations for strangulation and suffocation cases. After seeking public comment and holding hearings, they found not only that strangulation/suffocation cases should be a separate felony offense but they also deserve enhanced punishment regardless of injury. Defendants in the federal criminal system will likely face 10-year minimum sentences for strangulation/suffocation offenses.

WHY SHOULD NON-FATAL STRANGULATION CASES BE TREATED AS FELONIES?

There are clear reasons why strangulation assaults in domestic violence cases should have a separate felony statute, and, if there is a misdemeanor element to the statute, it should be only used after it is determined that a felony cannot be filed. Many of these reasons have been articulated during legislative hearings across the country as statutes have been passed over the last 10 years, but all prosecutors and law enforcement professionals should be familiar with these arguments. They can help in advocating for legal changes and they are good arguments to use in current cases being prosecuted at the misdemeanor or felony level.

- 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).⁸
- 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.”⁹
- 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.¹⁰
- Even given the lethal and predictive nature of these assaults, the largest non-fatal 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.¹¹
- The San Diego Study found major signs and symptoms of strangulation that corroborated the assaults, but little visible injury.¹²
- Strangulation is more serious than professionals have realized. Loss of consciousness can occur within

6. <http://usatoday30.usatoday.com/news/nation/story/2012-05-13/strangulation-crackdown-law/54935268/1>

7. http://www.criminaljustice.ny.gov/pio/press_releases/2011-04-07_pressrelease.html

8. 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” <<http://www.justice.gov/opa/pr/2013/February/13-opa-148.html>> (accessed May 7, 2013).

9. 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: 323, 325–326.

10. Nancy Glass et al., “Non-Fatal Strangulation Is an Important Risk Factor for Homicide of Women,” (2008) 35 *J. Emergency Med.* 3: 329, 329.

11. 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.

12. *Id.*

5–10 seconds, and death within 4–5 minutes.¹³ 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.¹⁴

- Because most strangulation victims do not have visible external injuries, strangulation cases are minimized or trivialized 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).¹⁵
- 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.¹⁶
- 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.¹⁷
- 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.¹⁸

Strangulation is a unique crime. It has more in common with sexual assault crimes than basic assault or battery crimes.

- The inability to get oxygen is one of the most terrifying events a person can endure.
- The body has an automatic reaction to being deprived of oxygen and blood to the brain. It knows it is about to die if it does not change the situation immediately, which leads to escalation of the violence by the victim.
- Domestic violence strangulation is usually about asserting control over the victim, i.e., showing that the offender has the power of life and death over the victim; it's *not* about doing serious bodily injury (as is required by many statutes). Strangulation is far more cruel, inhumane, and dangerous than merely punching a person (battery).

Jurors expect to see visible injuries. But the fact that strangulation often leaves no marks, combined with its terror value, makes it a favorite tactic of experienced batterers.¹⁹

Non-fatal strangulation assaults may not fit the elements of other serious assaults due to the lack of visible injury. Studies are confirming that an offender can strangle someone nearly to death with no visible injury, resulting in professionals viewing such an offense as a minor misdemeanor or no provable crime at all.²⁰

- Due to the research on the lethal and predictive nature of strangulation assaults, the International Association of Chiefs of Police (IACP) National Law Policy Center has incorporated strangulation training into its policy and model police protocols on domestic violence.²¹

13. Dean A. Hawley, *Forensic Medical Findings in Fatal and Non-Fatal Intimate Partner Strangulation Assaults* 6 (2012), available at <<http://www.strangulationtraininginstitute.com/library/finish/843-scholarly-works-and-reports/3690-forensic-medical-findings-in-fatal-and-non-fatal-intimate-partner-strangulation-assaults-hawley-2012.html>> (accessed Apr. 4, 2013).

14. *Id.* at 4.

15. *Id.* at 1.

16. Glass et al., *supra*, note 5, at 329.

17. *Id.* at 3.

18. 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.

19. Brett Johnson, Sweetwater County Attorney, from testimony at a House and Senate Judiciary Committee of the Wyoming Legislature regarding SF 132: Strangulation of a Household Member (2011).

20. Hawley, *supra*, note 8.

21. IACP *National Law Enforcement Policy Center, Domestic Violence* (2006).

- In 2008, the Abuse Assessment Screen was revised to address non-lethal strangulation due to the body of research on seriousness of the assault.²²
- In 2009, a review and analysis of laws related to non-fatal strangulation in all 50 states found that strangulation assaults have substantial direct health effects and are associated with increased risk of lethal violence in the future.²³
- Research confirms that the act of placing hands or a ligature around a victim’s neck introduces a different level of lethality, rage, and brain injuries than simple assaults such as pushing, punching, kicking, or slapping.²⁴
- Juries and judges have difficulty understanding the serious nature of the crime without clear guidance from expert witnesses, professionals with specialized training, and clear guidance in the law.
- Effective intervention in non-homicide strangulation cases will increase victim safety, hold offenders accountable for the crimes they commit, and prevent future homicides.

THE CRIME IS NOT “ATTEMPTED STRANGULATION”

As we gain a deeper understanding of existing strangulation laws and the need for new ones, a special point should be made here. For many years, medical experts and researchers referred to strangulation assaults as “attempted strangulation.” This represented inadequate understanding of the nature of the assault. Indeed, even the seminal San Diego Study referred to these assaults as “Attempted Strangulation” cases. The belief, though unstated in most research, was that strangulation meant death. And it is no coincidence that the best medical evidence of strangulation is derived from post mortem examination (autopsy) of the body²⁵. An autopsy affords the ability to examine all of the tissues of the neck, superficial and deep and track the force vector that produced the injuries. In living survivors of strangulation, the assessment of the victim/patient is usually limited to superficial examination of the skin. In rare circumstances, if the victim/patient seeks medical attention, the assessment may include two-dimensional shadows by radiography. So, the thinking went, if a victim survived, it must not have been strangulation; it must have only been “attempted strangulation.” Sadly, this language is still used by some courts, professionals, and even media outlets.²⁶ The use of “Attempted” should be viewed as incorrect and eliminated from the discussion.

Based on the current state of the law and the current research, any intentional effort to apply pressure to the neck in order to impede airflow or blood flow should be viewed as a felony strangulation assault. The perpetrator did not “attempt” the assault. He completed it. If an offender said to a victim that he was going to “choke her,” and he lunged for her but was unable to get a strong hold with one or both hands, that this might be an “attempted strangulation.” But the vast majority of strangulation or suffocation assaults are not “attempts.” They are completed criminal acts and should be prosecuted based on this understanding. The preferred terminology by

our national faculty and experts is strangulation or non-fatal strangulation. When unconsciousness, urination, defecation and/or petechiae is/are present, then near-fatal or near-lethal strangulation would be the appropriate terminology as the victim suffered a severe, life-threatening injury.

22. Laughon et al., *supra*, note 13.

23. Kathryn Laughon et al., “Review and Analysis of Laws Related to Strangulation in 50 States,” (2009) 33 *Evaluation Rev.* 358. The authors concluded that all states should pass felony strangulation laws. Based on their research, they found non-lethal strangulation of intimate partners has substantial direct health effects and is associated with an increased risk of later lethal violence by a partner or ex-intimate partner but can be difficult to prosecute under existing (non-strangulation) felony laws. They recommend that all states develop policies to improve prosecution of strangulation (implementation), include strangulation in their criminal codes (bail, enhancements) and use language that includes all potential victims (child abuse, sexual assault, and elder abuse).

24. See Ellen Taliaferro et al., “Strangulation in Intimate Partner Violence,” *Intimate Partner Violence: A Health-Based Perspective*, 217 (Connie Mitchell ed., 2009). See also Glass et al., *supra*, note 5, at 333–334; Hawley, *supra*, note 8, at 7–8. See generally Lee Wilbur et al., “Survey Results of Women Who Have Been Strangled While in an Abusive Relationship,” (2001) 21 *J. Emergency Med.* 297.

25. Hawley – JEM - 2001

26. See, for example, “Maryland Should Crack down on Strangulations,” *Wash. Post* (April 2, 2012), <http://www.washingtonpost.com/opinions/maryland-should-crack-down-on-strangulations/2012/04/02/gIQA9sxfR_S_story.html?tid=wp_ipad> (accessed Apr. 3, 2013).

ALASKA LAW

The Alaska Statute specific to strangulation is found within the definition of “dangerous instrument”. Subsection (B) of AS 11.81.900(a)(15) defines, *inter alia*, dangerous instrument as the “use of hands or other objects when used to impede normal breathing or circulation of blood by applying pressure to the throat or neck or obstructing the nose or mouth”. Thus, any offense which contains the use of a dangerous instrument as an element of the offense may be considered for use to prosecute an offender for a strangulation assault. It passed in 2005. Alaska was one of the first states to pass a felony strangulation/suffocation assault as a felony and being the journey to handle strangulation cases as a serious felony assault. Alaska was also one of the first states to utilize the training and experience of law enforcement in handling strangulation cases at trial. See *Carter v. State of Alaska*, 235 P.3d 221 (2010).

LESSONS LEARNED FROM STRANGULATION LAWS ACROSS THE COUNTRY

It is also helpful to understand what is happening across the country as many states implement stand-alone strangulation statutes. Three lessons have already emerged. First, the wording of the statute is very important. Second, implementation plans should be in place (or put in place) to train judges, police officers, prosecutors, advocates, and medical professionals after such statutes are passed. Third, as discussed above, cases should be presumptively handled as felonies or system bias may quickly relegate them to misdemeanors.

THE WORDING OF THE STATUTE

The statutory themes generally focus on impeding breathing and blood flow to the brain.²⁷ Whether pressure is applied to the jugular vein(s) or the carotid artery(ies), the life threatening nature of the assault is about the flow of oxygen contained in the blood, and blood trying to get out of the brain and return to the heart. Most statutes understand this truth, although a few fail to properly address the offense. The Texas statute is an excellent model for three reasons. First, it includes a “reckless” mental state, which relieves the state from proving that the defendant specifically intended to cause bodily injury to the victim. As discussed, many batterers use strangulation as a violent tool to gain power and control over their victims; most batterers do not intend to injure their victims. Second, the statute makes strangulation an automatic felony rather than wobbling between a misdemeanor and a felony. The statute emphasizes the gravity of the crime and sends a strong message to law enforcement agencies and the community that such an offense is taken seriously. Finally, the statute enables the state to increase the penalty for repeat offenders. The Texas legislation embraces the dynamics of domestic violence by holding high-risk and repeat offenders accountable via sentences commensurate with their criminal behavior.

IMPLEMENTATION PLANS

As states have moved forward to pass felony or felony/misdemeanor (wobbler) strangulation statutes, it has become very clear that most states have not developed implementation plans to guide the proper training and handling of these cases by all professionals. The lessons learned from this national trend should challenge all states to: include a directive from the state for prosecutors to treat these cases as presumptive felonies; create an implementation plan; provide ample resources; make prosecutor training immediately available, and enact a concerted effort to create a team of experts to testify in court in all cases. After the California strangulation law was passed in 2011, our Training Institute on Strangulation Prevention and the California District Attorneys Association partnered to develop an implementation plan. The plan included conducting multi-disciplinary trainings in 15 Family Justice Centers across the state, hosting four online video webinars for prosecutors and advocates, sending out a series of statewide *Constant Contact* newsletters to educate professionals about the online resources available through the Training Institute, developing a 30-minute online course for police officers, and publishing this manual.²⁸ But even those efforts are still not be enough. More can be done. We recommend and challenge each county in every state to develop their own “implementation team” made of a team of multi-disciplinary professionals who will make it their mission to ensure training and awareness

27. Laughon et al., *supra*, note 18.

28. The video webinars are accessible at www.cdaa.org for members of the California District Attorneys Association. The online resources of the Training Institute on Strangulation Prevention are available at www.strangulationtraininginstitute.com.

is provided throughout their entire community each and every year. The implementation team would be responsible for providing strangulation training, developing strangulation protocols and new resource materials, identifying experts, improving advocacy for victims of strangulation assaults and increasing accountability for offenders.

CHALLENGE EVERYONE TO VIEW STRANGULATION FIRST AS A FELONY

Research confirms that the act of placing hands or ligature around a victim's neck introduces a different level of lethality, rage, and brain injuries than simple assaults such as pushing, punching, kicking, or slapping.²⁹ The level of violence and potential for serious bodily injury or death warrants felony arrest and prosecution. Two articles in particular, *Why Strangulation Should Not be Minimized* by Marna Anderson in 2009³⁰, and *Why Strangulation Should Be a Felony: Background Information for a California Strangulation Statute in 2011* by Casey Gwinn and Gael Strack³¹, articulate additional reasons why strangulation should be treated as a felony and can serve as a resource tool for professionals seeking to bring awareness, advocating for legal changes and encouraging felony prosecution.

Bottom line: Strangulation is a unique crime. It has more in common with sexual assault crimes than basic assault or battery crimes. The inability to get oxygen is one of the most terrifying assaults a person can endure. The body has an automatic reaction to being deprived of oxygen and blood to the brain. It knows it is about to die if it does not change the situation immediately, which leads to escalation of the violence by the victim. Domestic violence strangulation is usually about asserting control over the victim, i.e., showing that the offender has the power of life and death over the victim; it's *not* about doing serious bodily injury (as is required by many statutes). Strangulation is far more cruel, inhumane, and dangerous than merely punching a person (battery). Jurors expect to see visible injuries. But the fact that strangulation often leaves no marks, combined with the terror it causes, makes it a favorite tactic of experienced batterers.³² Studies are confirming that an offender can strangle someone to death or nearly to death with no visible external injury, resulting in professionals viewing such an offense as a minor misdemeanor or no provable crime at all.³³ When an abuser strangles his intimate partner, he is committing a serious criminal offense, often causing permanent brain damage to his victim. He must be held accountable for his conduct through the criminal justice system.

One of the greatest lessons learned, as strangulation statutes have been passed across the country, is that strangulation assaults should be a presumptive felony. But getting there is difficult and requires every professional to treat strangulation cases seriously from the time the first 911 call is made all the way through the sentencing hearing. Every professional plays a key role in this effort. Implementation of recent strangulation statutes will take time, planning, training and perseverance. Without these efforts, most strangulation cases will continue to be filed as misdemeanors. If we continue to treat strangulation as misdemeanors or fail to prosecute, victims will die. San Diego learned that painful lesson in 1995 when two teenagers were murdered after being "choked" and neither case resulted in prosecution. Sadly that painful lesson is being repeated throughout the country as the Training Institute on Strangulation Prevention continues to monitor news story after news story.

29. See Ellen Taliaferro et al., "Strangulation in Intimate Partner Violence," *Intimate Partner Violence: A Health-Based Perspective*, 217 Connie Mitchell ed., (2009). See also Glass et al., *supra*, note 5, at 333–334; Hawley, *supra*, note 8, at 7–8. See generally Lee Wilbur et al., "Survey Results of Women Who Have Been Strangled While in an Abusive Relationship," (2001) 21 *J. Emergency Med.* 297.

30. Watch, Volume 17, Issue 2, Spring 2009

31. <http://www.strangulationtraininginstitute.com/index.php/library/viewcategory/838-legislation.html>

32. Brett Johnson, Sweetwater County Attorney, from testimony at a House and Senate Judiciary Committee of the Wyoming Legislature regarding SF 132: Strangulation of a Household Member (2011).

33. Hawley, *supra*, note 8.

CONCLUSION

Non-fatal strangulation cases are the edge of a homicide. Abusers who strangle are among the most dangerous. Prosecutors in Alaska and across the country can benefit from understanding the strengths and weaknesses of various strangulation statutes in the United States. It's also time for time for states to revisit their existing strangulation laws and seek improvement. Suffocation should also be included in strangulation statutes. Strangulation and suffocation should be considered at the time of bail, issuance of criminal and civil protection orders, and sentencing hearings. Prosecutors must lead the way for the criminal justice system in treating non-fatal strangulation offenses as serious crimes. This leadership will help hold dangerous offenders accountable and, ultimately, save the lives of victims of this vicious crime.

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The authors give special thanks to Melissa Mack, California Western School of Law (J.D. Candidate, December 2014) for contributing her excellent research and writing skills.

Chapter 3: Investigation of Strangulation Cases

By Gael Strack, J.D. and Michael Agnew with additions by Gayle Garrigues, J.D. and Christine King

“Police Officer investigations should allow a victim to start from the beginning and tell her story; Our job then is to ask who can have the victim talk with that will help, keep them connected, and provide resources.”

Mike Agnew, 2014 Advanced Strangulation Prevention Course

Every day police departments across the country receive a constant stream of 911 domestic violence calls where victims report being threatened, pushed, slapped, kicked, punched, choked, stabbed, or even shot. Some agencies report that as many as 40 percent of all 911 calls are domestic-violence related. By the time officers respond, victims may already be recanting, minimizing, or simply unaware of the seriousness of their assault, especially if strangulation is involved, in which case the victim may be suffering from anoxic brain injury. Victims may be traumatized by the incident, embarrassed, or afraid of the abuser or the police.

This chapter focuses on the challenges of investigating a strangulation case, discusses the core components for improving a strangulation investigation, reviews new tools, and provides practical tips for handling a strangulation case for dispatchers, first responders, detectives, and investigators working with prosecutors.

THE INVESTIGATION

The mind set of all domestic violence responders should mirror the philosophy of the prosecutor: How can we prove this case without the participation of the victim? Successful prosecution of domestic violence cases hinges on the responder’s collection of evidence. The entire investigation will vary greatly depending on the focus of the case—is the focus on the victim or is it on proving the abuser’s conduct? Generally, if the victim is the crux of the case, her or his testimony will be the primary evidence obtained. Little effort will be made to identify and collect corroborating evidence. This traditional approach will not lead to aggressive prosecution and effective intervention in domestic violence cases. On the other hand, if the entire case focuses on proving the offender’s conduct, the investigation will move beyond the victim’s testimony and lead to a stronger case that is supported by independent corroboration.

Legislation in many states has forced police agencies to define guidelines for arrest practices and protocols for the investigation of domestic violence cases. Many state laws include mandatory arrest, collection of evidence, report writing, referrals to victims, emergency protective orders, notice of the defendant’s release from custody, and much more.¹ Mandatory or pro-arrest policies play a critical role in relation to victim safety and thorough case investigation. Arrest not only acknowledges the criminal behavior, but provides immediate safety to the victim and heightens the likelihood of a provable case.

Most law enforcement protocols today have developed specialized domestic violence reporting forms or checklists. In those jurisdictions utilizing a law enforcement protocol for the investigation of domestic violence cases,² officers arriving at the scene conduct a thorough investigation and prepare written reports describing all incidents of domestic violence involving the victim and perpetrator, as well as documenting all domestic violence crimes committed by the perpetrator. Some jurisdictions across the country are also including lethality assessments within their domestic violence reports.³

1. Larry L. Tift, *Battering of Women: The Failure of Intervention and the Case for Prevention* 131 (1993).

2. See *Domestic Violence and Children Exposed to Domestic Violence Law Enforcement Protocol*, San Diego County. (2008). See also Robert T. Jarvis, “Symposium on Integrating Responses to Domestic Violence: A Proposal for a Model Domestic Violence Protocol,” (Spring 2001) 47 *Loy. L. Rev.* 513.

3. The Lethality Assessment Program-Maryland Model (LAP), created by the Maryland Network Against Domestic Violence (MNADV) in 2005, is an innovative prevention strategy to reduce domestic violence homicides and serious injuries. It provides an easy and effective method for law enforcement and other community professionals to identify victims of domestic violence who are at the highest potential for being seriously injured or killed by their intimate partners and immediately connect them to the domestic violence service provider in their area.

One of the obstacles for officers is that this type of crime is happening between people who are (or were) in an intimate relationship. Because of that emotional bond, the fact that they have children together, or because they live in the same house, officers may have a tendency to downplay what is happening. They probably have been to the house before. They probably have talked to these people before. They may have had this victim recant and minimize prior investigations that they conducted. Officers become very frustrated with this behavior. In addition, without medical training, police don't necessarily view strangulation as one person trying to end another person's life; they view it simply as a non-consequential "disturbance" between a couple or a simple assault.

When someone is lying on the floor with an open bleeding wound, or has been shot, or is deceased, it is easy to gauge the seriousness of the crime. It is much more difficult to grasp the significance of the victim's statements that she was "choked," especially when the victim is standing without difficulty, talking freely to police or investigators, and has no visible injuries. To many law enforcement professionals, it's just another family disturbance.⁴ However, it is critical that police and prosecutors have more than just a basic understanding of strangulation; they need to understand the internal and external signs and symptoms of a victim who has been strangled as described in Chapter 5, "Medical Evidence in Non-Fatal Strangulation Cases."

Special attention should also be paid to our vocabulary. While most victims will continue to report they were "choked" or grabbed by the neck—and it is important to use words the victim is most comfortable using—responders need to acknowledge the seriousness of the abuse that is actually occurring. "Choking" is accidental. Strangulation is intentional. Choking means having the windpipe blocked entirely or partly by some foreign object, like food. Strangulation means to obstruct the normal breathing of a person. For report writing, the proper term is "strangulation." Officers should use words such as "strangled," "near-fatal strangulation," and "non-fatal strangulation" to describe what happened to the victim. By using the correct terminology, more awareness is brought to the seriousness of the crime that has been committed, and we can slowly begin to change how the criminal justice system treats strangulation cases. Use of the proper terminology will also produce more felony prosecutions. In a recent study conducted in Minnesota, when officers used the word "strangulation" as opposed to "choked," and described how the victim was strangled, more cases were prosecuted as felonies.⁵

Once a victim reports being strangled, treat the case as a felony first and a misdemeanor second. If there is evidence to suggest the victim was strangled and her life was threatened, the case should be considered and investigated as if it were an attempted homicide or aggravated assault case. If the case is treated seriously from the time the 911 call is made, everyone involved, including the victim will treat it seriously, as well. A non-fatal strangulation case can be charged as an attempted homicide, felony assault with intent to commit great bodily injury, spousal abuse, and/or false imprisonment.

When a victim is strangled, that is when the "hands or other objects are used to impede normal breathing or circulation of blood by applying pressure on throat or neck or obstructing nose or mouth", Alaska law provides "the hands or other objects" are considered a dangerous instrument⁶. Thus, any offense which contains the use of dangerous instrument as an element of the offense may be considered for charging when a person is strangled. This includes Assault in the First Degree,⁷ Assault in the Second Degree,⁸ and Assault in the Third Degree.⁹ However, as discussed in chapter four these are not the only theories which may be charged when a victim is strangled.

4 DVD: *Strangulation: What We Have Learned* (Inez Odom Prod. 2010), available at <<http://strangulationtraininginstitute.com/index.php/training-dvd.html>>.

5. Marna L. Anderson, Report Part II: *The Impact of Minnesota's Felony Strangulation Law*, WATCH 3 (2009).

6 AS 11.81.900(b)(15).

7 AS 11.41.200(a)(1) – recklessly causing serious physical injury with a dangerous instrument.

8 AS 11.41.210(a)(1) – with intent to cause physical injury, causes physical injury with a dangerous instrument.

9. AS 11.41.220(a)(1) – recklessly (A) places another person in fear of serious physical injury by means of a dangerous instrument or (B) causes physical injury with a dangerous instrument.

When officers respond to a domestic violence scene and the incident includes strangulation, the victim's subtle signs and symptoms become very important. Learning how to identify, document, and understand these signs and symptoms requires special training and a special investigation. A typical domestic violence investigation begins with the 911 call and includes statements from the victim, the suspect, witnesses, evidence at the scene, photos, medical documentation, prior history of abuse, follow up interviews, and a search for any new evidence. The investigation wheel developed by Detective Mike Agnew from the Fresno Police Department illustrates how to build a strong domestic violence case for prosecution.

Each component of a domestic violence investigation is covered below, with a special emphasis on the investigation of a strangulation case.

The Emergency 911 Call

Emergency 911 tapes should be reviewed on every case prior to disposition. They accurately capture the victim's emotional state and often include (1) statements about the incident; (2) the domestic violence history in the relationship; (3) the victim's physical condition; (4) the suspect's level of intoxication and/or use of drugs; (5) the presence of witnesses; (6) the presence of weapons; and (7) the existence of protective orders. The 911 call is a microphone into the violent incident and often records statements from children, witnesses, and/or the abuser.

Absent a video tape of the crime occurring, the 911 emergency call is often the most graphic and powerful piece of evidence introduced to the jury at trial. The recording of the 911 call often contains "excited utterances" from the victim. Excited utterances generally refer to the spontaneous statements a victim makes just seconds and minutes after the assault. Courts view spontaneous statements or excited utterances under Rule 803(2) of the Alaska Rules of Evidence as trustworthy, reliable, and admissible as an exception to the hearsay rule.¹⁰ The 911 recording and associated logs will also show when the call was made, who made the call, where the call was made from, when and how many officers were dispatched, when officers arrived at the scene, whether or not paramedics were also dispatched, and if the situation escalated to the point where hostage negotiators and/or the SWAT team were called to the scene.

At least 50 percent of strangulation victims experience voice changes, which is another reason to obtain a copy of the 911 tape. If the victim called 911 to report the incident, there may be evidence of her voice changes and evidence concerning the victim's signs and symptoms.

The Victim Interview

Before contacting a victim of domestic violence, anticipate that she may have been strangled. Victims of strangulation, especially those who are repeatedly strangled by their perpetrator, may also acquire Traumatic Brain Injury (TBI) caused by blows to the head, shaking of the brain or Anoxic Brain Injury (AnBI) caused by loss of oxygen to the brain, resulting in irreversible psychological and physical damage.¹¹ Evidence of unconsciousness includes loss of memory, lapse in time or location, an unexplained bump on the head, and bowel or bladder incontinence. The victim may also report that she was standing up one minute, then simply woke up on the floor and didn't know why. Symptoms of hypoxia or asphyxia (a lack of oxygen to the brain) will likely cause the victim to be restless or hostile at the scene. The victim may appear to be under the influence of drugs or alcohol, or appear to have stroke-like symptoms. Evidence of temporary or permanent brain injury may include problems with memory, inability to concentrate, headaches, anxiety, depression, and/or sleep disorders.

¹⁰ An *excited utterance* is one which the circumstances of the event "stills the capacity of reflection and produces utterances free of conscious fabrication"; Rule 803 Commentary to Alaska Rules of Evidence; *Davis v. State*, 133 P.3d 719, 727 (Alaska App. 2006). The statement is presumed trustworthy as it is made while the speaker is laboring under the emotional stress engendered by the event. The declarant's condition at the time the statement was made was such that the statement was spontaneous, excited or impulsive rather than the product of reflection and deliberation; *Lipscomb v. State*, 700 P.2d 1298, 1307 (Alaska App.1985) citing *United States v. Iron Shell*, 633 F.2d 77, 86 (8th Cir.1980). There is no bright line with regard to the interval between the event and the statement, the key is the duration of the speaker's statement of excitement. ; *Davis v. State*, 133 P.3d 719, 727 (Alaska App. 2006).

¹¹. Traumatic Brain Injury and Domestic Violence. Empire Justice Center, Building Bridges: A Cross-Systems Training Manual for Domestic Violence Programs and Disability Service Providers in New York, 2006

These symptoms of a TBI or AnBI may impair their cognitive, behavioral, neurological, and physical functioning and can mask itself as a mental health disability. The victim may be embarrassed or minimize the incident, and she will likely be traumatized from the attack. These factors can dramatically impact how the victim tells her story. It is common in such situations for the victim's story to be jumbled or confused. Early detection and appropriate medical treatment is crucial. If either injury is suspected in communicating with a victim increased sensitivity, patience, and understanding of what services or accommodations can be provided will make the investigative process go more smoothly. For more tips on how to best communicate with a victim with a TBI or AnBI please see the appendix titled Traumatic Brain Injury and Domestic Violence.

The level of injuries and symptoms depends on many different factors including the method of strangulation, the age and health of the victim, whether the victim struggled to break free, whether the victim was under the influence of alcohol and/or drugs, the size and weight of the perpetrator, and the amount of force used. Therefore, it is important to ask the victim a series of questions designed to elicit specific information about her symptoms and internal injuries that are consistent with someone being strangled. Even when victims exhibit injuries from strangulation, the injuries will likely appear minor and limited to the point at which pressure was applied. It is important for investigators to look for other signs of injury such as subtle injuries around the eyes, under the eyelids, nose, ears, mouth, neck, shoulders, and upper chest area. If injuries are present, look for redness, scratches, red marks, swelling, bruising, or tiny red spots (petechiae) that arise from increased venous pressure.¹²

In the last 15 years, specialized tools have been developed to assist law enforcement with the investigation of strangulation cases. These tools include law enforcement brochures, lists of questions that are helpful in identifying and documenting strangulation cases, and specialized documentation and checklists. These tools have been designed to improve the ability of officers to identify and document a strangulation case. When properly used, they increase prosecutorial success and perpetrator accountability. For samples, see the Appendix of this manual. There is also an electronic strangulation/choking application¹³ available to assist in documenting strangulation cases, called "Document It."

Method

Simply reporting that a victim was "grabbed by her neck and forced into the wall" does not provide sufficient detail for a prosecutor to walk into a courtroom and prove the case. The prosecutor needs to paint a picture of what took place so jurors can create in their minds an image of exactly what happened. Jurors should feel like they are watching the actual event. To achieve this, investigators need to detail for prosecutors what took place without offering "suggestions" of what happened to the victim. If an investigator asks, "Did he grab you with one hand, or two hands, or his arm?" the victim—who is likely traumatized—may simply select one of the choices offered rather than express in her own words the details of the assault. Start with open-ended questions, followed with phrases such as "and then what happened?" or "what happened next?" Specific questions are helpful in ascertaining the details of the method of assault. Investigators should:

- Ask the victim to describe how she was assaulted.
- Document the victim's description of the assault, including the location and positions of each individual involved.
- Using a wig head or mannequin, doll, or stuffed animal, ask the victim to physically demonstrate how she was strangled. Video record the demonstration.
- Determine if the victim was simultaneously shaken while being strangled. (Possible whiplash.)
- Was the victim thrown against the wall, floor, or ground? (Possible concussion.)

12. Petechiae is defined as a "minute reddish or purplish spot containing blood that appears in skin or mucous membrane as a result of localized hemorrhage." *Merriam-Webster* <<http://www.merriam-webster.com/dictionary/petechiae>> (accessed Mar. 24, 2013).

13 Visit www.strangulationtraininginstitute.com for more information.

- Ask the victim where she was strangled and look for corroborating evidence in those areas. If something was broken in the struggle, photograph it.
- How long did the suspect strangle the victim? Ask the victim to close her eyes and go through the assault with you while you look at your watch to determine the approximate length of time. In one case a victim was actually strangled in front of a wall clock. She saw the time as she was being strangled to unconsciousness, and, when she came to, she saw the new time.
- How many times was the victim strangled during the incident? Were different methods used to strangle the victim during the incident? (Shows intent)
- Determine the amount of pressure that was used. Ask the victim, on a scale from 1 to 10, 10 being the most pressure, how hard was the perpetrator's grip?
- Ask (one at a time) if the victim could (1) breathe? (2) talk? (3) scream? (These questions will help in determining pressure applied to the victim.)

Identifying Visible Injuries

The reference guide below provides a summary of what to look for on a victim who has reported being strangled or who is believed to have been strangled.

Face	Eyes & Eyelids	Nose	Ear	Mouth
<input type="checkbox"/> Red or flushed <input type="checkbox"/> Pinpoint red spots (petechiae) <input type="checkbox"/> Scratch marks	<input type="checkbox"/> Petechiae to R and/or L eyeball (circle one) <input type="checkbox"/> Petechiae to R and/or L eyelid (circle one) <input type="checkbox"/> Bloody red eyeball(s)	<input type="checkbox"/> Bloody nose <input type="checkbox"/> Broken nose (ancillary finding) <input type="checkbox"/> Petechiae	<input type="checkbox"/> Petechiae (external and/or ear canal) <input type="checkbox"/> Bleeding from ear canal	<input type="checkbox"/> Bruising <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cuts/abrasions (ancillary finding)
Under Chin	Chest	Shoulders	Neck	Head
<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Abrasions	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Abrasions	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Abrasions	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Fingernail impressions <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature mark	<input type="checkbox"/> Petechiae (on scalp) Ancillary findings: <input type="checkbox"/> Hair pulled <input type="checkbox"/> Bump <input type="checkbox"/> Skull fracture <input type="checkbox"/> Concussion

- Look for injuries behind the ears, around the face, neck, scalp, chin, inside the mouth, jaw, on the eyelids, shoulders, and chest area.
- Look for redness, abrasions, bruises, scratch marks, scrapes, fingernail marks, thumb-print bruising, ligature marks, petechiae, blood in the white of the eye, swelling, and/or lumps on the neck.

- If the victim is wearing makeup, ask her to remove it before leaving the scene. Take photographs before and after the makeup was removed. The first photo will show exactly what the investigator saw, and the second may capture additional injuries.
- Look for neck swelling (it may not be easy to detect). Ask the victim to look in the mirror to assess any swelling. Take photos of the neck even if you do not see injuries or swelling as they may appear later. ER nurses have reported using a tape measure to determine neck swelling.
- Injuries may be easily concealed with makeup, long hair, and/or clothing.
- Having a victim also look in a mirror when no injuries are apparent may be helpful to get her perspective. It is important to tell the victim to notify detectives working on her case if injuries appear or if she seeks additional medical care.

Leaving your business card with encouragement to call will be more effective than if you give the victim a general phone number at your agency.

Identifying Symptoms of Injury

The reference guide below provides a summary of what to look for when seeking to identify any symptoms of internal injury on a victim who has reported being strangled or who is believed to have been strangled.

Breathing Changes	Voice Changes	Swallowing Changes	Behavioral Changes	Other
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Raspy voice	<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Agitation	<input type="checkbox"/> Dizzy
<input type="checkbox"/> Hyperventilation	<input type="checkbox"/> Hoarse voice	<input type="checkbox"/> Painful to swallow	<input type="checkbox"/> Amnesia	<input type="checkbox"/> Headaches
<input type="checkbox"/> Unable to breathe	<input type="checkbox"/> Coughing	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> PTSD	<input type="checkbox"/> Fainted
Other:	<input type="checkbox"/> Unable to speak	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Urination
		<input type="checkbox"/> Drooling	<input type="checkbox"/> Combativeness	<input type="checkbox"/> Defecation

Here is the challenge: The first sign of a traumatic injury to the victim may begin with symptoms that the victim does not realize are significant, and therefore she may not volunteer the information. If the right questions are asked, investigators may be able to identify a traumatic injury that is not readily apparent. Identifying these symptoms may also be an indicator that the victim needs medical attention even though she is declining it. This is the type of assault where victims need to be educated about what happened. To identify internal injuries, consider asking the following questions:

- How does your neck feel? Do you feel any pain on movement or touch? Describe it.
- Do you have pain anywhere else? Describe the pain.
- Are you having any trouble breathing now? Is your breathing any different than before the incident?

- Do you have asthma or a history of breathing troubles?
- Did you experience any visual changes? What did you see? (Indicators of a lack of oxygenated blood to the brain)
- How does your throat feel? (Have the victim describe it in her own words.)
- How does it feel to swallow? (Have the victim describe it in her own words.)
- Are you having any drooling problems?
- Does your voice sound any different since the assault? (Have the victim describe the difference in her own words and record her voice.)
- Was there any coughing after the assault? Is the coughing still occurring? (Describe.)
- How did you feel during and after the assault? Did you feel any dizziness?
- Did you faint or lose consciousness? (Describe.)
- (If the victim lost consciousness) Explain why you believe you were unconscious? (Gap in time, waking up on the floor, bump on head from unknown cause, etc.)
- Did you lose control of any bodily functions? (e.g. urination or defecation)
- Is it possible you are pregnant? (How far along? Any problems since the assault?)
- Did you feel nauseated or vomit? (Describe.)

Evidence Gathering

Prosecutors need to re-create the scene for the judge or jury. It is important for the judge and jury to understand the evidence gathered by officers at the scene, and in order to understand it, they must see and feel it. Prosecutors must make the case come back to life. Everyone who reviews the case should feel as if he or she were present when the incident took place. Prosecutors need evidence that will corroborate the truth of what happened to the victim. Victims of domestic violence may recant, minimize, or even completely change their story by the time the case goes to trial. If that happens, it will be the evidence gathered by investigators that tells the truth.

Take the example of a victim reporting that she was “choked” in the bedroom. She ran out of the room, and the defendant tackled her at the top of the stairs where he “choked” her again. He then pushed her down the stairs to the landing. What visual images would the prosecutor want the court to see? The investigator’s diagrams and photographs will become evidence that will be marked as exhibits and introduced into court.

- Photograph and sketch the scene. A sketch can provide a visual of the scene layout, especially the locations of people at the scene, distances, and areas of significance.
- Imagine a victim is strangled on the bed and manages to roll off the bed into a small space between the bed and wall where the strangling continues. A visual showing the confined space would provide the court with a gripping sense of how vulnerable the victim felt.
- Was an object used to strangle the victim? Locate, photograph, and collect the object. Ask the victim where the object came from. (This may go towards intent.)
- Was there blood on the victim, on the walls, or along or at the bottom of the stairs?
- Clothing that has blood on it may help indicate the amount of bleeding.

- Clothing that is torn or ripped during the incident would support pulling, dragging, and/or a struggle.
- Photograph the stairs looking up and down. Were the stairs covered with carpet, wood, or tile? How many steps did the victim fall down?
- Collect writings or journals by the victim of past similar events.
- Collect any lists of “household rules” created by the suspect.
- Was any property damaged during the incident? (Photograph and collect if there is anything significant)
- Was any medical treatment recommended or obtained? (Obtain medical/dental release. Consider obtaining a copy of the emergency medical services response report.)

In cases where the suspect has fled the scene, a critical piece of evidence will be a photograph of the suspect. Ask the victim for a recent photo of the suspect and to identify the perpetrator who assaulted her. This photo should then be booked as evidence. When the victim is not present at the preliminary hearing, this photo can be used for suspect identification by the officer who collected it.

Photographs

As the saying goes, “A picture is worth a thousand words.” A responding officer cannot take too many photographs in domestic violence cases.

Every visible injury should be documented with a photograph. Even areas where there is a complaint of pain but no visible injury should be documented. Later, when the injury does appear, the initial photograph can corroborate that there was not a pre-existing condition.

If the victim is wearing makeup, ask the victim to remove her makeup before leaving the scene. Take photographs before and after the makeup was removed. The first photo will show exactly what the investigator saw and the second may capture additional injuries such as flurid.¹⁴ Generally speaking, the following photographs should be taken:

- **Distance photo**—one full-body photograph of the victim from a distance will help identify the victim and the location of the injury.
- **Close-up photos**—multiple close-up photographs of the face and neck area (front, back, and sides) at different angles will make it easier to see the injuries clearly. Specific areas to photograph include: both surfaces of both ears, under the chin, the inner surface of the upper and lower lips, the soft palate, the inside of the cheeks, under the eyelids, and the eyes (looking up, down, medial, and lateral).
- **Follow-up photos**—taking follow-up photographs of the injury 24, 48, and 72 hours later will document the injuries as they evolve over time and maximize your documentation. It is also helpful to place a non-glare ruler in the same plane of the injury to accurately measure the size of the injury or injuries.

Consider having a female officer take photos of the victim, especially if there are injuries to the breast area. The victim may need to change or remove clothing in order to accurately document her injuries. Victims will likely be embarrassed and there could be cultural considerations.

For strangulation cases, especially where there is flurid petecheiae (multiple red spots that may look like a rash), it is recommended that officers also take photos of the victim when the injuries have cleared.

Photographs of children in the home at the time of the incident are often particularly powerful—they put a face to a voice on a 911 tape. Photographs of children often assist the testimony of an officer regarding an admissible hearsay statement from a child. And photographs of children crystalize the destructive reality of domestic

14 · See note 11, *supra*.

violence for everyone in the courtroom.

Photographs of pets present at the scene also bring the reality of domestic violence to the courtroom, especially where there are threats against the pet or a history of animal abuse.

Medical Examination and Documentation

As discussed above, the victim may have internal injuries that later cause complete airway obstruction, even 36 hours after an injury.¹⁵ As such, when victims report they were “choked,” dispatchers, patrol officers, investigators, and prosecutors should strongly encourage victims to seek medical attention. If a victim report symptoms such as difficulty breathing or swallowing, paramedics should be immediately dispatched to scene in order to screen the victim for possible internal injuries. Even if the paramedics determine a lack of objective symptoms to support internal injury, their medical examination will prove very helpful to assess the victim’s health and document any visible injuries and/or symptoms. Without question, medical documentation is persuasive evidence.

In urban areas after speaking with the victim and making an assessment of the victim’s physical condition, determine whether emergency medical services (EMS) should be summoned to the scene. Officers should always summon EMS if: (1) the victim requests medical attention (whether the officer believes EMS should be summoned or not) or (2) if it appears that strangulation has occurred.¹⁶ It is also important for officers to take this opportunity to educate the victim about the seriousness of strangulation.

In remote villages that do not have access to traditional EMS, the victim’s physical condition can be assessed by a Community Health Aide/Practitioner (CHA/P). CHA/Ps can triage victims of strangulation and help make the assessment regarding the necessity of more aggressive treatment that may require transporting the victim to a larger medical facility. Some villages can link to the Alaska Federal Health Care Access Network (AFHCAN). This network is a telemedicine system that links hospitals and clinics across the state. If available, this network allows CHA/Ps to link with medical providers who can assist in the immediate diagnosis and care of the victim.

Reports from CHA/Ps, responding paramedics and emergency room records should be reviewed for statements by the victim describing the infliction of her injuries. Emergency medical service transporters (paramedics, emergency medical technicians, firefighters) generally must complete a “run-sheet” when they transport someone for treatment. These sheets may contain valuable hearsay statements or other material evidence. These reports or run sheets should be attached to and provided with the investigative reports to the District Attorney so they may be properly discovered the medical staff can be subpoenaed.

The treating CHA/Ps, paramedics and emergency room personnel can also testify about the extent and treatment of the victim’s injuries. Most juries are fascinated by physicians’ medical testimony, and it drives home the seriousness of the case.

In one case prosecuted by the San Diego City Attorney’s Office, the police officer indicated in his report that the victim had “red abrasions to the neck.” He encouraged the victim to seek medical attention, which she did. In reviewing the medical records, the treating physician indicated the patient had “multiple linear contusions to both sides of her neck with overlying redness, mild edema, and tenderness.” The medical corroboration tremendously enhanced the case, allowing the prosecutor to obtain a quick guilty plea in court. None of the witnesses or the victim had to come to court to testify.

More importantly, by calling the paramedics, you may even save a life by providing the victim with immediate medical attention. Medical records are generally viewed as exceptions to hearsay and can be very useful to

15 . 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: 323–329, 327 (2001).

16 . IACP Nat’l L. Enforcement Pol’y Ctr., *Domestic Violence* (2006).

prosecutors in overcoming objections by the defense and state and federal laws.

Prior History of Abuse

A victim of a prior strangulation is 700 percent more likely to be a victim of attempted homicide by the same partner, and she is 800 percent more likely of becoming a homicide victim at the hands of the same partner. Prior history of abuse is important for many reasons. It helps professionals assess risk of future violence, establish the pattern of abuse, explain whether there is a credible threat, and document the level of fear. It also helps the prosecutor in charging, sentencing, bail hearings, probation revocation hearings, and for impeachment purposes at trial.

Identification of the Principal Physical Aggressor

When officers arrive at the scene of a domestic violence call, they may find both parties without visible injuries, both parties with visible injuries, or one party with injuries and the other with no visible injuries. The challenge is determining which party is the principal physical aggressor or the true victim. In non-fatal strangulation cases, it is more likely that victims will use self-defense to stay alive. Because victims fear for their lives, they may protect themselves by pushing, biting, scratching, or pulling the suspect's hair. Depending on the method of strangulation being used, the suspect may be the only individual with visible injuries.

For example, if the suspect is strangling the victim from behind and using a chokehold, the victim may protect herself by biting the suspect in the arm. If the suspect is manually strangling the victim from the front (face to face), she may push him away, scratch him, or pull his hair.

To identify the principal physical aggressor, officers and prosecutors should consider the following factors:

- Height/weight of the parties;
- Who is fearful of whom;
- Details of statement and corroboration;
- History of domestic violence, assaults, or criminal history;
- Use of alcohol or drugs;
- Whether either party is subject to a restraining order or on domestic violence probation;
- pattern evidence;
- Injuries consistent with reported statement;
- Hair, blood, or fiber on the hands, or evidence of epithelia cells after strangulation (fingernail scrapings);
- Signs of symptoms of strangulation; and
- Signs of offensive/defensive injuries.

Under Alaska law, Section 18.65.530 **(b)** If a peace officer receives complaints of domestic violence from more than one person arising from the same incident, the officer shall evaluate the conduct of each person to determine who was the principal physical aggressor. If the officer determines that one person was the principal physical aggressor, the other person or persons need not be arrested. In determining whether a person is a principal physical aggressor, the officer shall consider: **(1)** prior complaints of domestic violence; **(2)** the relative severity of the injuries inflicted on each person; **(3)** the likelihood of future injury from domestic violence to each person; and **(4)** whether one of the persons acted in defense of self or others.

Under Section 18.65.530 (c): A peace officer is not required to make an arrest under (a) of this section if the officer has received authorization not to arrest from a prosecuting attorney in the jurisdiction in which the offense under investigation arose.

It is also important to consider defense of self, others, and/or property. Also consider self-inflicted injury caused by victims trying to defend themselves, or the defense argument that the victims likes to be strangled as discussed in both Chapter 4 and Chapter 6.

Suspect Interview

While remaining mindful of *Miranda* and its progeny, investigators **should always** attempt to interview the suspect. **Any story is better than NO story!** Any statement from an offender is better than no statement. Even exculpatory statements are helpful as they provide the investigator an opportunity to conduct further investigation and find support for, or discredit the story. The suspect interview will provide prosecutors clues regarding the probable defense which will assist them in presenting their case at trial. In the event the offender changes his story or defense at trial he will be forced to explain the discrepancies. While conducting the suspect interview investigators should keep the possible defenses in mind (as discussed in Chapters 4 & 6) and inquire in a manner that will eliminate the defense or, at the very least, narrow the defense down.

Writing Strangulation Investigation Reports

As in other criminal cases, such as driving under the influence or being under the influence of a controlled substance, patrol officers should note their experience and training concerning domestic violence and strangulation in their police reports. For example:

I have been a patrol officer for five years. During that time, I have investigated 500 domestic violence cases. In many of those cases, victims have reported being strangled. I have also received training in domestic violence and in particular the medical signs and symptoms of strangulation. Based on my experience and training, I know strangulation can cause serious injury. Unconsciousness can occur within seconds. Death can occur within minutes. The symptoms and injuries as reflected in this investigation are consistent with someone being strangled. The elements of a felony (list crime) are present. I further encouraged the victim to seek medical attention and to carefully log her symptoms and injuries.

Follow-Up Investigations

The follow-up investigation by a detective or investigator is critical in domestic violence cases. Such investigations should be geared to the requirements of the prosecutor's office with the focus on how to prove the case even without the participation of the victim.

At a minimum, the follow-up investigation should verify the inclusion of all investigative steps described above for on-scene investigation. In addition, the most important pieces of evidence at trial are often follow-up photographs taken 2–3 days after the incident. Follow-up photographs can provide far more powerful evidence of the true violence than initial on-scene photographs. Since most bruises are not visible for days after a violent assault, follow-up photographs must be central to every investigation.

Re-interviewing the victim and witnesses is as important as taking follow-up photos. Victims often give more detailed statements after they have had a chance to calm down and reflect on what occurred. On the other hand, it will be very clear in the follow-up investigation if the victim is still with, or reluctant to testify against, her abuser. The prosecutor must know the relationship status of the victim when deciding how to proceed at trial.

In addition to follow-up photos and interviews, the following evidence is very useful in prosecuting batterers and should be collected in a thorough follow-up investigation:

- The name, address, and phone number of two close friends or relatives of the victim who will know her whereabouts 6–12 months from the time of the investigation;
- Statements of family members, including any children in visual or auditory presence of the assault for corroboration of the assault and/or history of the relationship;
- A records check for documented domestic violence history;
- An interview with the victim regarding all prior domestic violence incidents including dates, locations, witnesses, injury, and corroborating evidence;
- A statement by the victim regarding prior admissions and apologies from the defendant, especially those documented in any texts, e-mail, social media, letters, notes, or cards;
- An interview with the suspect if he was not interviewed by responding officers;
- The defendant’s phone records to show his contact with the victim, including copies of the recordings of calls from jail;
- Notes, cards, emails, faxes, and letters (including those sent from jail);
- A statement by the victim regarding any “house rules” for the victim to follow that the abuser may have written and displayed in the house; and
- A diary or a log of history of abuse by the defendant.

Remember, victims experience voice changes in 45–80 percent of non-fatal strangulation cases.¹⁷ Based on this anecdotal evidence and the medical literature, it is important to tape record or video tape your follow-up investigation to document voice changes for later evaluation by medical experts and to corroborate the victim’s allegations. Many digital cameras today also have a video feature; use this feature to capture a raspy voice, difficulty swallowing, coughing, pain exhibited by the victim, and/or drooling.

NEW EVIDENCE

After the defendant is arrested, there will be new evidence to collect. Defendants will call victims from the jail. They will apologize, harass, threaten, intimidate, and violate protection orders in order to get their victims to drop charges. Therefore, it is important to obtain audio copies of phone calls made from suspects who are in jail. By collecting this valuable evidence, investigators can assist prosecutors in building their case.

USE FORENSIC INVESTIGATORS AND/OR NURSES

Forensic investigators and nurses are specially trained to gather evidence using various techniques and photographic equipment. They are proficient in follow-up examinations, taking photographs, and interpreting medical records. Since 1997, the San Diego City Attorney’s Office has worked closely with forensic nurses to interpret medical records; understand offensive, defensive, accidental, and/or intentional injuries; document follow up injuries; and/or testify in court as experts. These experts can be very useful to investigators. Jurisdictions such as Maricopa, Arizona and Louisville, Kentucky have developed Strangulation Response Teams and have documented tremendous results: higher filing rates; higher convictions; improved sentences; and enhanced victim safety.

DEVELOPING THE EXPERTISE OF POLICE OFFICERS AND INVESTIGATORS

Chapter 7 discusses the need for and use of experts in court to help jurors understand the seriousness of strangulation cases. Expert testimony is routinely admissible where the “scientific, technical or other specialized

¹⁷ . Lee Wilbur et al., “Survey Results of Women Who Have Been Strangled While in an Abusive Relationship,” (2001) 21 *J. Emergency Med.* 3: 297–302, 301); Interviews with detectives from the San Diego Police Department.

knowledge will assist the trier of fact to understand the evidence or determine the fact in issue”.¹⁸ Expert witnesses can be used for various reasons, including teaching the jurors about medical, technical, or scientific principles or expressing an opinion after evaluating the significance of the facts of the case. For decades, police officers have been used as experts in drug cases, driving under the influence cases, and for explaining accident reconstruction.

Within the last 15 years, police officers, mental health professionals, domestic violence shelter staff and advocates have been routinely used as experts in domestic violence cases to explain why victims recant, why victims stay, power and control dynamics, the identification of the principle physical aggressor, and the impact on children witnessing domestic violence. Officers regularly receive specialized training on domestic violence as a matter of law and as part of their training at the police academy, advanced officer training, specialized investigator courses, and much more. The use of the carotid restraint is often part of core self-defense training. Specialized training in the investigation of strangulation cases started being offered to law enforcement in California in late 1995. Since 1996, P.O.S.T. has been incorporating strangulation training into all of its courses.

Police officers may be allowed to testify regarding his/her observations of the victim with are consistent with the officer’s training and experience in the investigation of domestic violence and strangulation cases.¹⁹ A thorough foundation should be laid regarding extent of the officer’s training, experience, and number of cases investigated. If the inquiry is along the lines of what has the officer experienced in the past, what the officer is trained to look for, and what the officer observed in the present case, and does not seek an opinion from the officer as to whether the victim was strangled, the officer will be considered an Evidence Rule 701 lay witness and should be allowed to testify.

Many police officers may be qualified as experts under Evidence Rule 702 when they have “specialized knowledge which may assist the trier of fact”.²⁰ If it is anticipated the officer will be offered as an expert, Rule 16(b)(1)(B) of the Alaska Rules of Criminal Procedure, must be met.²¹

Given the extent to which strangulation training is being incorporated at all levels of law enforcement, prosecutors should not be shy about asking police officers or investigators if they have been trained in strangulation and are using that training and experience as part of their testimony in strangulation cases. And if prosecutors don’t ask law enforcement about that training and experience, officers are encouraged to speak up and let the prosecutor know that they can provide more information about strangulation as part of the foundation of their testimony and investigation.

CONCLUSION

Tragic deaths by strangulation have led to dramatic changes in California and across the United States. Partnerships have been developing between the legal and medical community. Specialized training has been available since 1995. The training is now helping thousands of domestic violence professionals improve their investigation, documentation, and prosecution of non-fatal strangulation cases. As a result, many strangulation cases are being elevated to felony-level prosecution due to improved investigations. Cases once thought non-prosecutable are being routinely submitted for either felony or misdemeanor prosecution. Law enforcement and prosecution protocols are being updated. Individual police officers, prosecutors, advocates, doctors, nurses, probation officers, and elected officials have been champions of change. Training videos on strangulation have been developed by the Law Enforcement Television Network, the San Jose Police Department, the California Commission on Police Officers Standards and Training, and the National Family Justice Center Alliance, and are being used to educate domestic violence professionals and even grand juries. By working together, police and prosecutors can make a difference by holding batterers accountable for the crimes they are committing. Lives will be saved through thorough investigations that fully document the evidence and assist prosecutors in successfully prosecuting these cases in court.

¹⁸ Rule 702 of the Alaska Rules of Evidence.

¹⁹ *Carter v. State*, 235 P.3d 221, 226 (Alaska App. 2010).

²⁰ *Carter v. State*, 235 P.3d 221, 226 (Alaska App. 2010) and ER 702.

²¹ Rule 16(b)(1)(B) requires a notice of the expert be filed at least 45 days before the trial. The notice must include a written description of the substance of the proposed testimony of the expert, the expert’s opinion, the basis of the opinion, as well as the expert’s CV

Michael Agnew was the lead domestic violence detective with the Fresno Police Department until his retirement in July 2011. He created the Domestic Violence Unit in 1996, which grew from two detectives and one victim advocate, to 10 detectives and two advocates. The unit currently reviews approximately 7,000 DV police reports each year. In addition to serving as part of the Advisory Team for the Training Institute on Strangulation Prevention, he has developed several domestic violence courses for P.O.S.T, which he teaches, and he participates as a trainer throughout California teaching on domestic-violence related topics to law enforcement, probation, prosecutors, and victim advocates.

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Chapter 4: Prosecuting Strangulation Cases

By Gerald W. Fineman, J.D. with contributions from Casey Gwinn, J.D., Gael Strack, J.D., Gayle Garrigues, J.D., and Alaska Department of Law

“Anytime we are able to file a felony charge and convict on one, we are enhancing victim safety.”
WATCH Report, 2007

In some respects, prosecuting strangulation cases is similar to prosecuting other types of domestic violence. These cases rely on two key elements for successful prosecution: (1) make the case more dependent on the evidence than it is upon the testimony of the victim, and (2) develop as much corroborating evidence as possible. Strangulation prosecution requires the additional need to explain and emphasize the seriousness of the act. Accomplishing this requires using expert testimony. Vertical prosecution by specially trained prosecutors can greatly improve the probability for a successful prosecution.

INITIAL INVESTIGATION

The initial investigation of strangulation cases falls outside the prosecutor’s direct control, but that does not prohibit prosecutors from influencing the way law enforcement conducts the initial case investigation. Prosecutors possess both the ability and responsibility to collaborate with law enforcement in developing an effective response. Chapter 3 of this manual provides clear guidelines for conducting the investigation. Depending upon the resources available in a particular jurisdiction, protocols may need to be modified to include:

- Taped statements by the victim
- Interviews of all witnesses
- Defendant’s statement
- Photographs of the crime scene and documentation of injuries/lack of visible injuries
- Collection of any evidence left by law enforcement
- 911 or other calls to law enforcement
- Medical records
- Evidence of prior acts
- Police reports
- Restraining orders or other family law paperwork

PRE-FILING CONTACT WITH THE VICTIM

Victims can recant, minimize, and avoid coming to court. Early victim contact can limit this behavior. Still, prosecutors should not assume the victim will be available and willing to cooperate with the prosecution of the case. In situations with living victims, prosecutors should approach the case as if they are prosecuting a homicide, because homicide cases are always prosecuted without a victim. If you can prove your case independent of the victim coming to court to testify about what occurred, then you have a very solid case. However, this emphasis on evidence-based prosecution should not limit your desire to obtain information from the victim.

FOLLOW-UP INVESTIGATION

Because the initial investigation may fail to uncover clear, visible evidence of injury, successful strangulation prosecution demands follow-up investigation with the victim. In some jurisdictions, this investigation can be conducted by law enforcement, but in many jurisdictions the existence of any follow-up investigation will fall upon the prosecutor's office¹. If your jurisdiction cannot allow for pre-filing interviews, the investigation conducted by law enforcement becomes even more critical in the filing determination.

Most state laws entitle the victim to have an advocate and a support person present at the follow-up interview. While Alaska law does not specifically entitle a victim to an advocate or support person this is a best practice and consistent with the spirit of the rights of crime victims found in Article 1, Section 24 of the Alaska Constitution² and AS 12.61.010. Early contact informs victims about their rights and the court process.³ The interview creates an excellent opportunity to provide victims with information regarding their case and to dispel misinformation. The follow-up interview also provides an opportunity for providing and collecting information as well photographing bruises or other injuries as they progress, develop or heal. The follow-up interview provides law enforcement the chance to collect evidence that might have been missed during the initial investigation, and it can provide a glimpse into the power and control involved in the relationship. The interview may help to better document prior instances of domestic violence. It can alert the prosecutor to issues involving the victim's ability to cooperate with prosecution efforts. Even where law enforcement conducts a thorough investigation, evidence that initially seemed irrelevant gains meaning. If the victim has not adequately described the incident, this is a good time to get that description. Prosecutors and law enforcement are cautioned against demonstrating the strangulation on the victim. To avoid re-traumatization, use a mannequin or wig head, doll or stuffed animal. As demonstrations can be quite compelling consider video recording them as they may be admissible at trial.

MEDICAL EXAMINATIONS

One of the best methods of collecting evidence for the prosecution is through a medical examination of the victim. Properly trained medical personnel can provide not only emergency medical treatment, but careful diagnosis of the victim and documentation of physical signs and symptoms. Alternate light sources, laryngoscopy, CAT scans, MRIs, and other medical tools not only document evidence of the 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.⁴ The medical examination may yield some potentially exculpatory evidence. Part of the treatment and documentation process may reveal the victim has used intoxicants. It may also indicate the victim inflicted some of her own injuries in an effort to stop the abuser. **The importance of the victim receiving proper treatment and documentation of injuries outweighs any concern of obtaining potentially exculpatory evidence.**⁵ 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.

PHOTO-DOCUMENTATION AND VOICE RECORDINGS

1. While not prohibited, the general Alaska practice is for officers from the investigating agency to conduct any follow-up interview. Should an interview of a victim or witness be conducted by the prosecutor, a law enforcement officer, or a staff member from the prosecutors office should be present to record and document the interview. The documentation can then be discovered through the usual discovery process, thus preventing any allegations of a discovery violation and avoids the potential situation where the prosecutor becoming a witness.

2. "Crime victims have the right . . . to be treated with dignity, respect, and fairness"

3. AS 18.65.515(a) directs peace officers investigating domestic violence offenses to provide notice to the victim of their rights as provided in 18.65.520 which includes notice of how to obtain a domestic violence protective order as well what protections such an order can provide, where the closest shelter is, what services the police officer can provide to obtain safety for the victim, and how to contact the local prosecuting authority. AS 12.61.015 directs the prosecuting attorney to keep the victim informed of various matters, including the date and time of any bail hearing, of trial and of sentencing.

4. Most emergency rooms in Alaska use a strangulation specific set of forms to assess strangulation reports.

5. *Brady v. Maryland* (1963) 373 U.S. 83.

ecause the injuries caused during a strangulation attack may prove difficult to recognize, a good practice is to take follow-up photographs over a period of time. This can help differentiate petechiae from other red spots on the face, and it can also show changes in skin hue and document swelling and reduction of swelling. Voice recording of the victim may also demonstrate changes in voice and speech patterns. It may be helpful to obtain a copy of any voice message left by the victim prior to the strangulation for comparison to the post-strangulation voice.

VICTIM ADVOCACY

Advocacy is an important part of the victim follow-up process. This is the opportunity to inform the victim about safety options and to assess the danger to the victim. Victim advocacy is discussed in detail in Chapter 10 of this manual.

IDENTIFICATION OF OTHER WITNESSES

After the initial chaos 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, or she may have reported the incident as a justification for missing employment. The initial statement may not completely reflect the incident. The victim may still be experiencing trauma from the assault or experience stroke-like symptoms that inhibit speech function called dysexecutive syndrome. Reviewing the report of the incident with the victim may be helpful. Document persons the victim has seen since the incident. Follow-up interviews with those individuals may provide evidence that the victim was acting or speaking differently after the incident than s/he normally behaves. If a victim has sought a civil domestic violence protective order, the statements made by the victim in the petition as well as those on the record at the hearing(s) are often useful.⁶ Copies of these records should be obtained and provided to the prosecutor and discovered.

If emergency personnel transported the victim to a medical facility, obtain the records of paramedics and interview the involved personnel. The victim may make statements in the course of the emergency that are later admissible at trial even over the defendant's right of confrontation.⁷

THE FILING DECISION

Most state Constitutions guarantee victims the right to a prompt decision regarding the filing of cases and the right to be informed of that decision. While Alaska does not have a specific provision however, it is the policy of the Department of Law to promptly screen domestic violence cases and notify the victim of the screening decision. Speed can protect the victim and help break the abuser's control over the victim. The evidence in strangulation cases can be lost quickly. Because of their lethality and the evanescent nature of the evidence, strangulation cases should have priority review.

PROTOCOLS/POLICIES

A case should not be filed unless there is a reasonable likelihood of conviction based upon the state of the evidence.⁸ Nothing in this section should override that guideline. Prosecutors also need to be aware of any filing protocols within their own office. There are a number of factors to consider in making the determination of filing. Recognize that the lack of injuries may cause prosecutors to minimize the severity of the incident. Also recognize that the existence of injury does not necessarily identify the abuser or victim. Identifying the dominant aggressor is an important aspect of strangulation-case evaluation. The batterer may have numerous cuts, scratches, bite marks, or other injuries that were inflicted by the victim as a direct response to being

6. Additionally, the filings the civil domestic violence protection hearings or recordings of protection hearing may contain either inculpatory or exculpatory statements by the offender.

7. Pursuant to Rule 803(4) (the medical records exception) of the Alaska Rules of Evidence. Be aware of the limitations imposed on this exception by *Davison v. State*, 282 P.3d 1262, 1269 (Alaska 2012) and lay a proper foundation by having the medical care provider explain or testify that the examination of the victim was necessary for medical purposes. Officers, advocates and medical care providers should be certain to leave the impression with the victim that the strangulation examination is necessary to ensure the victim is medically safe.

8. Rule 3.8 of the Alaska Rules of Professional Responsibility and Department of Law policy.

strangled by the abuser. This creates a misperception that the party with the visible injury must be the victim. This oversimplification can lead to the filing of charges against actual victims, leaving them unprotected against their abuser.

VICTIM COOPERATION

Can you prove the case without the victim? Utilize the theme of “treat the case like a homicide so it doesn’t become a homicide.” If the defendant was successful in efforts to strangle the victim to death, there would be no victim in court. Assume you do not have a victim. Assume the victim will be pressured by the defendant and others to not testify. The victim may go into hiding, become uncooperative, or come to court and be held in contempt for refusing to testify. If any of these things occur, consider how you will establish the case. A solid investigation may allow you to proceed without the victim. Examine the physical evidence and any statements made by the batterer. Look for pieces of non-testimonial hearsay evidence that might be admissible as a spontaneous statement or otherwise admissible hearsay. Remember that the confrontation right is a trial right that can be overcome if the statement is non-testimonial and otherwise admissible.⁹ It can also be overcome if there is evidence of witness intimidation by the defendant 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. See Witness Intimidation: Meeting the Challenge at www.aequitasresource.org.

THE VICTIM’S ATTITUDE TOWARDS THE PROSECUTION

As long as the case can be proven without the testimony of the victim, the victim’s attitude toward the prosecution of the case has no bearing on the charging decision. If the case cannot be established without the victim’s testimony, what is the victim’s attitude towards the prosecution of the case and, more importantly, why is the attitude the way it is? Perhaps victim advocacy can address the reason for the victim’s refusal to cooperate. If the victim is being coerced into not cooperating, this may give rise to a claim of forfeiture by wrongdoing.¹⁰ While no such enabling legislation exists in Alaska law, prosecutors may still argue forfeiture by wrongdoing under federal law or pursue witness intimidation charges against the defendant.¹¹ If the victim is being coerced into not cooperating, this may give rise to other charges as well.

CHOICE OF CHARGES

Offenders who strangle a victim may be charged with the following offenses: The distinction between the three offenses is the mental element and the severity of the injuries.

- AS 11,41,200(a)(1) – Assault in the First Degree – with *intent* causes *serious physical injury* by means of a dangerous instrument;
- AS 11,41,210(a)(1) – Assault in the Second Degree – with *intent* to cause *physical injury* causes serious physical injury to another by means of a dangerous instrument;
- AS 11.41.220(a)(1)(B) – Assault in the Third Degree – *recklessly* causes *physical injury* by means of a dangerous instrument.¹²
- AS 11.41.220(a)(4) – Assault in the Third Degree – with *criminal negligence* causes *serious physical injury* to another by a dangerous instrument.¹³

MULTIPLE CHARGES

Multiple charges may be considered and brought for each distinct criminal act which occurs during the assault episode. For example, should the offender first use his/her hands to apply pressure to the victim’s throat and

9. See *Crawford v. Washington* (2004) 541 U.S. 36 and *Davis v. Washington* (2006) 547 U.S. 813.

10. Evid. Code § 1390.

11. Federal Rules of Evidence 804(b)(6)

13. The serious physical injury must be of the type defined in AS 11.81.900(b)(56)(B), that is, serious and protracted disfigurement, serious and protracted impairment of health, protracted loss or function of a body member or organ, or that unlawfully terminates a pregnancy.

impede breathing or circulation, followed later by using an object to cover the victim's mouth to interfere with breathing two counts should be charged.

While not specific to the use of a dangerous instrument, and thereby strangulation, depending on the facts and circumstances a number of other charges may be appropriate such as:

- AS 11.41.100 – Murder in the First Degree
- AS 11.41.110 – Murder in the Second Degree
- AS 11.31.100 and AS 11.41.100 – Attempted Murder in the First Degree
- AS 11.31.100 and AS 11.41.110 – Attempted Murder in the Second Degree
- AS 11.41.200(a)(2) – Assault in the First Degree – with intent to cause serious physical injury, causes serious physical injury
- AS 11.41.200(a)(3) – Assault in the First Degree – knowingly engages in conduct which results in serious physical injury under circumstances manifesting extreme indifference to life.
- AS 11,41,210(a)(2) – Assault in the Second Degree – recklessly causes serious physical injury
- AS 11,41,210((a)3) – Assault in the Second Degree – recklessly causes serious physical injury through repeated assaults
- AS 11.41.220(a)(2) – Assault in the Third Degree – intentionally places a person in fear of death or serious physical injury through threats to cause death or serious physical injury to another person.
- AS 11.41.220(a)(2) – Assault in the Third Degree – history of conviction of two or more misdemeanor domestic violence offenses within the previous 10 years.
- AS 11.41.230 – Assault in the Fourth Degree

Additionally, the prosecutor should consider whether he defendant's conduct supports the filing of any other charges such as:

- AS 11.41.410-.425 – Sexual Assault in the First, Second or Third Degree
- AS 11.500 & .510 – Robbery in the First or Second Degree
- AS 11.520 -- Coercion
- AS 11.46.300 -- Burglary in the First Degree
- AS 11.46.320 – Criminal Trespass in the First Degree
- AS 11.46.480-.486 – Criminal Mischief in the Second through Fifth Degree,
- AS 11.56.540 & .545 – Tampering with a Witness in the First or Second Degree
- AS 11.56.610 – Tampering with Physical Evidence
- AS 11.56.740 – Violating a Protective Order
- AS 11.56.745 – Interference with a Report of a Crime of Domestic Violence
- AS 11.56.750 & .755 – Unlawful Contact
- AS 11.56.757 – Violation of Conditions of Release

The list could continue almost indefinitely. The point is that strangulation is often one component of a series of domestic violence and other criminal offenses.

CHILD VICTIMS

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

- AS 11.41.220 – Assault in the Third Degree (a)(1)(C)(i) – recklessly causes physical injury to a child under 12 years of age and the injury would cause a reasonable caregiver to seek medical attention in the form of diagnosis or treatment.
- AS 11.41.220 – Assault in the Third Degree (a)(1)(C)(ii) – recklessly causes physical injury to a child under 12 year of age on more than one occasion.
- AS 11.41.220 – Assault in the Third Degree (a)(3) – knowingly causes physical injury to a child under the age of 16 and over the age of 12 and the injury reasonably requires medical treatment.

Also when the victim is a child consider asking the jury to find aggravating factors so the court may impose a harsher sentence beyond the typical range the pertinent sentencing statute provide. See below for a discussion of possible aggravating factors.

ELDERLY OR VULNERABLE ADULTS¹⁴

While there are no specific assault statutes which apply when a victim is elderly or a vulnerable adult, as with child victims the perpetrator may be sentenced more harshly due to application of aggravator factors. See discussion below.

MANDATORY REPORTING

AS 47.17.020 requires persons of specific occupations, who in the performance of their occupational duties “have reasonable cause to suspect child abuse” to report these suspicions to the nearest Office of Child Services (OCS). Law enforcement officers and paid employees of domestic violence shelters are listed as one of the occupations who are mandatory reporters. If OCS cannot be contacted the nearest law enforcement officer should be contacted. Child abuse and neglect are defined in AS 47.17.290 and includes “maltreatment” and “mental injury”. Exposure of a child to domestic violence may be considered maltreatment and/or mental injury.¹⁵ Thus, when children are victims or present in the home when strangulation occurs that is child maltreatment, and a report must be made to OCS. Note subsection (g) of AS 47.17.020 provides that a reporter is not relieved of his/her reporting responsibility by reporting the suspicions to a supervisor and relying on the supervisor to make the required report. Failure to comply with these reporting requirements may result in prosecution of the non-reporter for a class B misdemeanor.

AS 47.24.010 requires persons of specific occupations, who in the performance of their occupational duties, “have reasonable cause to believe a vulnerable adult is abandoned, exploited, abused, or neglected” are to report their concerns to the Department of Health and Social Services. Law enforcement officers are mandatory reporters under this statute. AS 47.24.900 defines abuse to include the non-accidental and non-therapeutic infliction of pain. Failure to comply with these reporting requirements may result in prosecution or the non-reporter for a class B misdemeanor.

CASE LAW AROUND THE COUNTRY: STRANGULATION AND RAPE DEEMED SEPARATE CONDUCT TO SUPPORT MULTIPLE CONVICTIONS

Defendant was convicted of assault and rape. The victim woke to Defendant strangling her after the rape occurred. When the police arrived, they observed the victim’s neck displayed “severe redness” and bruising, and there were “red spots” on her face. The victim had blood on her shirt, her panties were torn, and the police observed urine and feces on the victim’s bed linens and pillow. The defendant argued that the assault and rape

14. “vulnerable adult” means a person 18 years of age or older who, because of incapacity, mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, fraud, confinement, or disappearance, is unable to meet the person’s own needs or to seek help without assistance; AS 11.51.220 & AS 47.24.900(16).

15. AS 47.10.011(8)

convictions were of similar import and should be merged into a single conviction. After considering the merger issue, the trial court merged violation of a protection order and domestic violence into the other convictions, but rejected the Defendant's argument that the rape and felonious assault (strangulation) convictions were allied offenses. Defendant appealed the decision not to merge the rape and felonious assault convictions. The appellate court affirmed Defendant's separate convictions, concluding that Defendant "failed to establish that he committed both crimes with the same conduct and animus." **State v. Tannreuther, No. CA2013-04-062, 2014 WL 10785, *1 (Ohio Ct. App. 2014).**

Editor's Note: The judge and the appellate court clearly understood that the felonious assault of strangulation and rape were two separate and distinct crimes and understood the significance and seriousness of each crime.

FELONY OR MISDEMEANOR CHARGES

Strangulation, when it can be proved, should always be filed as a felony. In a continuum of violence, strangulation falls just short of homicide. The seriousness of the offense cannot be overemphasized.

ENHANCEMENTS

Shortly after the grand jury returns the indictment prosecutors should consider filing, pursuant to AS 12.55.155(f),¹⁶ notice of any applicable aggravating factors which must be found by the jury. This is particularly important in those cases where the victim is a child, vulnerable adult or a member of the same social unit as the perpetrator. It should be noted, however, that facts which duplicate an element of the underlying conviction may not be used to support an aggravating factor.¹⁷ For example, if an offender is convicted of an offense which contained the element "by a dangerous instrument", that particular aggravator would not be applicable to that specific offense. Aggravating factors which may be considered are:

- AS 12.55.155(c)(2)- the defendant's conduct manifested deliberate cruelty
- AS 12.55.155(c)(4)- the defendant employed a dangerous instrument.
- AS 12.55.155(c)(5) – the victim was vulnerable or incapable of resistance due to advanced age, extreme youth, disability, ill health, homelessness, consumption of drugs or alcohol, or substantially incapable of exercising normal physical or mental powers of resistance.
- AS 12.55.155(c)(9) – offense involved more than one victim
- AS 12.55.155(c)(10) – offense is most serious in its class.
- AS 12.55.155(c)(18)(A) – the offense was a chapter 41 (violence) offense and committed against a member of the same social unit living with the defendant,
- AS 12.55.155(c)(18)(C) – the offense was a chapter 41 offense and committed in the physical or aural presence of a child under the age of 16.
- AS 12.55.155(c)(18)(D) – the offense was a chapter 41 offense and committed against person the offender had a dating or sexual relationship with.
- AS 12.55.155(c)(22) – the offense was directed at the victim due to the victim's race, sex, creed, disability, ancestry, or national origin

Most recently, the United States Sentencing Commission issued recommendations for strangulation and suffocation cases. After seeking public comment and holding hearings, they found strangulation/suffocation cases should be a separate felony offense and taken seriously at sentencing. They recommended "strangulation and suffocation, or an attempt of either, is specific serious conduct that deserves enhanced punishment

16. AS 12.55.155(f) provides the jury deliberate and find all aggravators with the exception of those involving the offender's prior record or probation or parole status. The prosecution must file notice that it intends to pursue jury aggravators at least 20 days before the trial. To avoid any unnecessary delays best practice is to find the proposed aggravators during the pretrial work up and discovery phase of the case.

17. Only "one bite at the apple" is permitted. *Juneby v. State*; 641 P.2d 823, 842 (Alaska App. 1982); *Ritter v. State*, 97 P.3d 73, 81-82 (Alaska App. 2004).

regardless of injury.” Defendants in the federal criminal system will most likely face 10-year minimum sentences for strangulation/suffocation offenses. Prosecutors should make good use of these recommendations at the time of sentencing in state court.

SETTING BAIL AND OTHER SAFETY MEASURES

Bail provides several opportunities for the prosecution to impact the batterer. First, setting bail may help keep the abuser from exerting power and control over the victim. Second, establishing a bail that keeps the victim safe from the abuser empowers the victim to seek a resolution of the relationship. In setting bail, remember that the safety of the public and the victim is paramount. The general presumption in Alaska is in favor of bail. However, when an offender is charged with unclassified, class A, a sexual felony, has a prior conviction for a violent felony, or is charged with a crime involving domestic violence, and has a prior conviction for a crime involving domestic violence in the past 5 years (12.30.011(d)(D)) this presumption is reversed. That is there is a presumption, rebuttable by the offender that no bail will secure the safety of the community.¹⁸ Should an Alaska offender be charged with a domestic violence offense the court may not permit the offender to return to the victim’s home or place of employment for at least 20 days after the date of arrest and with consent of the victim after making a finding by clear and convincing evidence that the return to the home or place of employment does not place the victim in danger.¹⁹ The bail hearing provides an excellent opportunity to educate the bench regarding the lethality of this type of violence. Consider calling a strangulation expert at this stage of the proceedings. If your office is in the process of developing experts in strangulation, the bail hearing can serve as a testing ground for assessing the strength of your expert. In *Carter v. State of Alaska* (235 P. 3d 221 (2010)), the court permitted the responding officer to testify as an expert at trial and provide testimony as to petechiae and delayed bruising in strangulation victims. Prosecutors should also consider other protective measures such as Criminal Protective Orders.

PRELIMINARY HEARING & GRAND JURY

Preliminary hearings provide another opportunity to break the power and control of the abuser. However they are rarely used in Alaska as they are adversarial, the defendant is present with counsel, and resource and time consuming. A preliminary hearing is not required to hold an offender as long as a timely grand jury is convened. If an offender is in custody for the offense, the grand jury must be convened within 10 days; if an offender is out of custody the grand jury must hear the case within 20 days.²⁰ A grand jury presentation is preferable as neither the offender nor his/her attorney or the public are present. The standard of evidence for the grand jury to indict is: “if all the evidence taken together, if unexplained or uncontradicted would warrant a conviction”.²¹ Telephonic testimony may be presented at grand jury when the witness is more than 50 miles away or there is some other compelling reason.²² One police officer may summarize the work of all the investigating officers.²³ These grand jury rules and procedures make it relatively easy for the prosecution to present its case and obtain an indictment. This may be sufficient to demonstrate to the victim that the batterer is being held accountable. It can demonstrate to the abuser that there will be a consequence for the incident.

As grand jury occurs relatively quickly after the offense, the victim and associated family member witnesses are more likely to still be cooperative and talkative. While a common Alaska prosecution practice is to take a minimalist approach- present the evidence and witnesses to the grand jury as quickly and as expeditiously as possible- another practice should be considered in domestic violence cases. Careful and detailed questioning of the victim and witnesses before the grand jury is an excellent way to preserve evidence which, in the event the victim or witness recants or “forgets” at trial can be subsequently played for the trial jury.²⁴ Often subtle examination at grand jury can lay a foundation to counter the trial defense. Children, even young children, who were present at the scene are often excellent grand jury witnesses. While some find it distasteful to call

18. AS 12.30.011(d).

19. AS 12.30.027(b). In addition the court must find the offender does not have a prior chapter 41 domestic violence offense.

20. Rule 6, Alaska Rules of Criminal Procedure.

21. Rule 6(q) Alaska Rules of Criminal Procedure.

22. Rule 6(u), Alaska Rules of Criminal Procedure.

23. Rule 6(r), Alaska Rules of Criminal Procedure.

24. Admissible pursuant to Rule 801(d)(1)(A) of the Alaska Rules of Evidence as a prior inconsistent statement.

children to testify, doing so sends a clear message to the offender and his/her attorney that the prosecution is prepared and willing to do so. This encourages pleas. While it is not necessary, it is good practice to present evidence regarding strangulation to educate the grand jury and the public about the seriousness and effects of strangulation. This could be from a forensic nurse, or other medical care provider, or in some cases, a law enforcement officer with training and experience in the field. Presenting these ‘expert’ witnesses to the grand jury also gives them some experience as witnesses.

CASE PREPARATION

Electronic evidence is prevalent today. Investigators can gain valuable evidence through the collection of cell phone data, text messages, social media, and other forms of electronic data. If the defendant is in custody, jail calls and jail mail should be monitored and obtained. This process becomes especially critical as trial approaches and the batterer’s need to dissuade the victim increases.

ELIMINATING DEFENSES

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

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 will play this off as a victim who is vindictive for some reason. The victim inflicts her own injuries and then contacts law enforcement in an effort to make the defendant suffer. Two areas of preparation are required to counter this defense. First, research and then eliminate potential reasons for the victim to fabricate the claim. Second, utilize the strangulation expert to explain how the victim’s injuries are the result of the defendant inflicting them or the victim defending against the defendant’s attack.

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. Again, pre-trial investigation can eliminate this defense. The location of the occurrence and the absence of any sex toys, bondage tools, erotica, or other related instruments can be useful in defeating this defense. If this was consensual activity, the victim would not be reporting it.

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 apology after the accident. Was there any indication of this?

The defendant acted in self-defense/mutual combat/dominant aggressor. This defense may be combined in some form with the other defenses. Under this theory, the defendant was using force to combat or defend against attack by the victim. 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, i.e., “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.

GETTING THE VICTIM TO COURT

A key piece of preparation is preparing and getting the victim to court. This problem is eliminated if the case can be prosecuted without the victim’s courtroom testimony. If this is not the case, early efforts to subpoena the victim should be exerted. A material witness warrant may be necessary in order to obtain the victim’s attendance.²⁵ Prosecutors should strongly consider the implications of proceeding in this manner. Try to determine what the barriers are to victim cooperation. Enlist the shelter advocates for assistance in overcoming

25 · AS 12.30.050.

those barriers and securing victim cooperation. You are incarcerating a victim of a crime in order to make that victim available for courtroom testimony. There are issues of re-victimization and issues of affecting the cooperation of the victim, as well. This is not a preferred method of proceeding and should be discussed at a high level before undertaking this process.

While a victim may not be incarcerated as a sanction for refusing to testify, the victim may be incarcerated for failing to respond to a valid subpoena.²⁶

PRE-TRIAL MOTIONS

The prosecution should prepare for the admission of expert testimony by providing notice of the expert, the expert's curriculum vitae, and statements from the expert.²⁷ In jurisdictions where several expert witnesses may share duties of testifying on strangulation, it is prudent to provide this information from all the experts. That way, if one expert becomes unavailable on the date of trial, another expert may still be called without the defense claiming a lack of notice or discovery. Prosecutors should also prepare for a pre-trial hearing with the expert witness. Sample motion attached in the appendix.

Should the investigation or interview of the victim reveal the defendant has prior instances of domestic violence against the present or another victim the prosecution should discover this information to defense counsel and file an Evidence Rule 404(b) motion. While 404(b)(4) is the provision for admission of prior domestic violence offenses, depending on the facts and circumstances of the case, the evidence of prior offenses may be admissible under other subsections of 404(b).²⁸ While a 404 motion can be filed anytime, prudent practice is to file it pretrial.²⁹ This will allow the court time to make a reasoned decision and the prosecution time locate the necessary witnesses.

VOIR DIRE

Jury selection in a strangulation case involves many of the same issues as in other forms of domestic violence. You need to reflect on how potential jurors will react to issues in the case. Verbalize jury bias and attitude that may exist about domestic violence. These may include things such as:

- General domestic or family violence dynamics.
- Absence of the victim means there is no case.
- Absence of victim cooperation with prosecution means the crime did not occur.
- If the victim minimizes or recants, the crime did not occur.
- Two different versions from the victim means there is reasonable doubt.
- Victims who stay in a relationship deserve what they get.
- Same sex victims are not entitled to protection of “domestic violence” laws.

26. See *People v. Cogswell* (2010) 48 Cal.4th 467.

27. Rule 16(b)(1)(B) Alaska Rules of Criminal Procedure.

28. Evidence Rule 404(b)(1) provides for admission of other crimes, wrongs or acts for a nonpropensity purpose. Evidence Rule 404(b)(2) provides in a physical or sexual abuse of a child prosecution, for admission of similar acts to child. (Note the 10 year remoteness limit on this subsection was removed by the legislature in 2013). Evidence Rule 404(b)(3) provides in sexual assault prosecutions where a defendant relies on the consent defense, for admission of other sexual assaults.

29. See *Bingaman v. State*, 76 P.3d 398, 415 (Alaska App. 2003) for a list of factors which the trial court should consider in determining the admissibility of evidence pursuant to ER 404(b)(4).

When educating in voir dire, remember that it “should be an education that the jury give themselves...and that your evidence then becomes consistent with.”³⁰ Some questions to ask include:

- What are common dynamics of domestic violence?
- What should make an assault more serious (i.e. bodily injury, weapon, strangulation)?
- What are the ways strangulation is more serious than just bodily injury?
- How is strangulation used by the abuser?
- What in the anatomy of the neck makes strangulation dangerous?³¹

Also ask about any experiences being strangled: “Has anyone ever been “choked out” or strangled in a mixed martial arts, military, or law enforcement setting?” Ask any volunteer jurors to explain:

- Did you sustain any visible injury? If so, what?
- Describe how you felt, sensations, after effects, etc.³²

In addition to the more traditional topics of domestic violence jury selection, jurors in strangulation cases may have other misperceptions. These may include:

- Strangulation and choking are the same thing.
- Strangulation for a short period is not serious.
- Strangulation is only serious if the victim loses consciousness.
- Strangulation does not occur if the victim can still breathe.
- There will be ligature marks if there is any type of strangulation.
- Strangulation does not have any real long-term effects.

Prosecutors can also use voir dire as an opportunity to shift the focus of the case towards the batterer and away from victim. Another goal of voir dire is to lower the jury’s expectations regarding the level of violence required to violate the law. See sample Voir Dire Questions developed by the Maricopa County Prosecuting Attorney’s Office.³³

JUROR ACCEPTANCE OF EXPERTS

The necessity of expert testimony requires jurors who will accept such testimony. This issue becomes more critical if your expert lacks the traditional earmarks of expertise, such as a Ph.D. or M.D. However, an expert is anyone with special knowledge, skill, experience, training, and education.³⁴ There is no requirement that a witness possess a particular license or academic degree in order to qualify as an expert; the criterion in determining whether a person qualifies as an expert witness is whether the fact finder can receive appreciable help from that person.³⁵ Jurors must be willing to accept that your nurse practitioner or law enforcement officer may have sufficient knowledge, skill, experience, training, or education to testify as a competent expert, even without a degree in “strangulation.” This can be satisfied through foundational questions of the expert.

30. McKay, Kelsey. (Presentation on August 4, 2014). Advanced Strangulation Prevention Course. Training Institute on Strangulation Prevention.

31. *ibid*

32. *ibid*

33. See Training Institute on Strangulation Prevention Resource Library: <http://strangulationtraininginstitute.com/index.php/library/viewcategory/840-basic-course-materials.html>

34. Rule 702 Alaska Rules of Evidence.

35. *Dymenstein v. State*, 720 P.2d 42 (Alaska App. 1986).

JUROR TYPOGRAPHY

Much discussion occurs about who is a good juror and who is a bad juror in a domestic violence case. While those viewpoints are not discussed here, there are a few issues specific to strangulation cases that may prove thought provoking. For example, jurors with backgrounds that frequently expose them to minor injuries (for example laborers or athletes who engage in physically violent sports) may tend to regard scratches and redness as “non-injuries.” Spend extra time with these potential jurors to determine if they can be good jurors on your strangulation case. If they cannot, the discussions with them might serve as good examples for other potential jurors about the seriousness of the offense.

TRIAL STRATEGIES

Evidence-based prosecution strategies work. Prosecutors can minimize the impact of the abuser’s power and control over the victim by presenting a case that proves guilt independent of the victim’s testimony. A typical case might consist of the introduction of the 911 call, followed by the observations of a law enforcement officer, followed by an expert witness in strangulation, and concluding with the introduction of admissions from the defendant.

OPENING STATEMENT

The opening statement should be as long as necessary to explain the case and preemptively counter any perceived weakness in the case. Storytelling as a method of conveying the facts of the offense proves a highly successful approach. In telling the story, avoid overstating the case. At the same time, do not be so brief as to fail to highlight the strengths of the case. Your goal is to provide a compelling story that moves the jury to convict. The opening statement allows you to train the jurors about strangulation by telling them, in summary fashion, what your expert will testify about regarding the seriousness of the crime.

Do not be afraid to address jury bias and attitudes that may exist about strangulation or to touch upon the weaknesses of the case. Do this in a manner that makes the weakness irrelevant. Make it politically incorrect for the jury to consider a not-guilty verdict.

THE CONCEPT OF PUTTING THE TRUTH FIRST

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, and have that followed up by the prosecution’s first witness denying that these facts occurred or giving a different version of the events. For that reason, unless the prosecutor has absolute confidence the victim’s testimony concurs with the initial statement to law enforcement, another piece of evidence should be introduced. This could be the 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 with visible 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 recant, the jury will have already heard evidence that validates the prosecutor’s opening statement. This tactic enhances the credibility of the prosecution’s case.

After presenting the truthful portion of the case, the prosecutor should follow up with additional evidence in an organized fashion. Depending on the facts of the case, this may be in chronological order, or in some other fashion. Expert witness testimony needs to follow all evidence that would establish foundation for the expert opinion.

ADDITIONAL EXPERT TESTIMONY

While Chapter 9 discusses the need for an expert to explain strangulation signs and symptoms, it may be prudent to include other expert witnesses. There may be a need to call an expert witness related to certain types of electronic data (cell phone towers, text messaging, and so forth) or an expert witness on intimate partner battering.

VICTIM TESTIMONY

If the victim is going to testify, be prepared for that testimony to change. The nature of these cases is that the victim might not feel safe to tell the truth. Resist the natural instinct to launch into an attack of a victim who testifies inconsistently with previous statements. The statements can almost always be confronted in a manner that is more reserved and professional, and demonstrates that the victim's recanting is a natural part of the process of being abused. Try to remain aware of your tone and body language. The testimony of the recanting victim will serve to set the stage for testimony by an expert in intimate partner battering and its effects.³⁶

CROSS-EXAMINATION OF THE DEFENDANT

The defendant's testimony will come after hearing from the prosecution witnesses, including your 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 your 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. Defendants who claim self-defense should be examined with regard to the fact that they were not in fear of imminent harm, that any danger that might have existed had ceased, and the absence of any statements regarding self-defense being made to law enforcement.³⁷ 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.

CASE LAW FROM AROUND THE COUNTRY: DEFENDANT'S SELF DEFENSE ARGUMENT NOT WARRANTED

Defendant was convicted of first-degree domestic assault and felonious restraint. Defendant argued that he was entitled to a self-defense instruction; he only strangled the victim to the point of unconsciousness because she would not stop hitting him. The appellate court found that Defendant's argument was without merit. Defendant was not entitled to this defense because there was no evidence that Defendant was ever in fear of serious bodily injury or death. Defendant testified that he strangled her to get her to stop hitting him, not that he feared injury, even minor, from her. Therefore, the court found that applying deadly force by strangling her was not in self-defense and therefore not justified. **State v. Crudup, 415 S.W.3d 170 (Mo. Ct. App. 2013).**

Editor's Note: Both the trial court and the appellate court understood the lethality of strangulation and how strangulation can lead to death. Although the Defendant testified that the victim slapped him multiple times and bit him, he was not entitled to strangle the victim to unconsciousness (deadly force) and therefore not automatically entitled to a self-defense instruction. Victims will instinctively fight for their lives in a strangulation assault. In some situations, the predominant aggressor may even have more visible injuries than the victim who was strangled.

CLOSING ARGUMENT

The closing argument provides the final opportunity to address with the jury the violent and potentially fatal nature of this type of attack. Prosecutors should utilize all the evidence and all logical inferences of the evidence in formulating their closing argument. Utilizing the exhibits and other forms of demonstrative evidence can illustrate the near-fatal nature of this attack. The batterer who strangles his victim holds the life of the victim in his bare hands. It takes a particularly narcissistic and callous individual to commit this type of offense.

POST-CONVICTION PROTECTIONS

If the defendant pleads guilty or is otherwise convicted at trial without the use of expert testimony, consider calling an expert at sentencing. Use the strangulation expert to emphasize the dangerousness of the offense. See sample sentencing brief from Maricopa County Prosecuting Attorney's Office.

36. While the State may not initially present expert evidence regarding victim characteristics or behavior, in the event the defense raises the issue, or "opens the door", that is argues, or through cross examination, implies the victim's behavior is inconsistent with an abused or assaulted person, the State may present such evidence. Thus, good practice is to have an expert ready and available. *Hilburn v. State*, 765 P.2d 1382, 1386-87 (Alaska App. 1988); *Haakanson v. State*; 760 P.2d 1030 (Alaska App. 1988); *Rodriquez v. State*, 741 P.2d 1200 (Alaska App. 1987); *Handley v. State*, 615 P.2d 627 (Alaska 1980).

37. This type of examination assumes that the defendant did speak to law enforcement and does not take into account a discussion of *Miranda* rights.

Post-conviction protections for the victim can include protective orders. The court may impose no contact with the victim as a condition of probation.³⁸ The parole board may impose a no contact provision as well. When a defendant is being considered for parole, victims have the right to attend parole board meetings or may submit written comment.³⁹ Additionally, a victim may request a civil protective order pursuant to AS 18.66.100.

Gerald W. Fineman is a supervising deputy district attorney with the Riverside County District Attorney's Office. His career has involved all types of prosecution, but his focus has been on family violence. He has prosecuted a variety of domestic violence cases, including stalking, domestic violence rapes, and homicides, and he has handled high-profile cases including those involving law enforcement officers as victims and defendants. He has testified in court as an expert witness on domestic violence, and he has also testified on DV issues before the California State Legislature. Mr. Fineman teaches Criminal Law at California Southern Law School, and has been a board member of Alternatives to Domestic Violence, Riverside Area Rape Crisis Center, and Friends of the Family Justice Center. He is currently co-chair the CDAA Domestic Violence Committee.

38. AS 12.55.101.

39. AS 33.16.120.

Chapter 5: Medical Evidence in Non-Fatal Strangulation Cases

By William Green, M.D

“Oftentimes, even in fatal cases, there is no external evidence of injury.”

Dean Hawley, MD, A Review of 300 Attempted Strangulation Cases, Journal of Emergency Medicine, 2001

Strangulation is one of the most lethal forms of 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 injuries at all. 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? And how does the assault translate into the level of threat posed to the victim’s life? This chapter discusses the medical evaluation of non-fatal strangulation patients.

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.

CHALLENGES IN EVALUATING STRANGULATION CASES

In clinical forensic medicine, there are two sets of needs the medical professional must address. The first is the patient’s needs. This includes any acute medical issues, emotional support, and crisis intervention. It may also include health issues and prevention strategies for STIs and unwanted pregnancy. Safety and social issues may also need to be addressed, such as risk-assessment, safety planning, and follow-up care.

Injuries sustained in a non-fatal strangulation evolve forensically, so a follow-up medical visit is imperative—both for victim care, as well as for the continuing documentation of evolving symptoms and physical findings for the criminal case.

The second area that must be addressed is the criminal justice needs, and this requires specialized training. A detailed assault history is necessary to determine the mechanism(s) of injury. The proper collection of evidence (including DNA) 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. Medically, we are only now increasing our knowledge about level of risk associated with strangulation. It is not unusual for everyone involved in the case to under-appreciate the medical risk of strangulation. Patients may initially present with minimal or subtle injuries and symptoms. Consequently, this can result in limited medical evaluation and treatment, which may allow subsequent deterioration and a bad outcome for the victim. Forensic issues may include limited or poor documentation and little or no medical testing, therefore, no objective proof of injury.

BASIC PHYSIOLOGY TO UNDERSTAND

The brain needs a continuous supply of oxygen. Without it, brain cells quickly malfunction and die. And brain cells do not regenerate. There are two vital bodily systems that must work perfectly and in unison—the respiratory (breathing) system and the cardiovascular (blood flow) system. Multiple areas of vulnerability exist in both of these systems, and the compromise of a single area can rapidly produce a very bad outcome.

TERMS AND DEFINITIONS TO UNDERSTAND

- **Symptoms** are the things that the patient tells us; what the patient reports to the care provider. These things include medical history or complaints as well as the description of pertinent emotions (fear, panic, impending doom, etc.). Note that symptoms are inherently subjective.
- **Signs** are the things that are objective; they are the things the care provider sees, hears, and feels during the physical examination and includes lab reports and imaging studies (X-rays, CT scans, MRI scans, etc.).
- **Respiration** describes the delivery of oxygen into the blood. Air must pass through the mouth and nose into the upper air passages, the voice box (larynx), the wind pipe (trachea), and finally into the lungs. Air must freely flow in and out of the lungs. The chest and the diaphragm muscle work together to create the “bellows” that moves the air (breathing).
- **Oxygenation** is when the lungs extract oxygen from the air and shift it into the blood.
- **Cardiovascular** refers to the system of heart and blood vessels that is responsible for pumping the oxygen-rich blood from the lungs, through the heart, into the carotid arteries in the neck, and up to the brain. After the oxygen is delivered to the brain cells, carbon dioxide and other waste products are transferred from the cells into the blood, and returned by the jugular veins in the neck to the lungs to be exhaled.
- **Asphyxia** occurs when brain cells are deprived of oxygen. 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. Common clinical features—in other words, the symptoms and signs—of asphyxia from any cause, may include pain, anxiety, and altered level of consciousness. Unconsciousness may occur within 10–15 seconds of the application of pressure on the neck.
- **Strangulation** occurs when external pressure is applied to the neck until consciousness is altered. This does not necessarily mean the victim has become completely unconscious; it can mean just lightheadedness. 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., knee or choke hold). **Ligature strangulation** is accomplished when a cord-like object is used to apply pressure to the neck.
- **Suffocation** is the process that halts or impedes respiration. Suffocation can include choking, smothering, and compressive asphyxia.
 - **Choking** is what happens when an object mechanically blocks the upper airway or windpipe (trachea). It’s when something gets in the airway and stops airflow *internally*. Choking can occur when food or some other object obstructs the airway. *Caution:* This term is often used inappropriately. Patients may use it to describe what happened when they were strangled.
 - **Smothering** is a mechanical obstruction of airflow into the nose and mouth (e.g., putting a pillow over the victim’s nose and mouth).
 - **Compressive asphyxia** occurs when an assailant puts his body weight on the victim, limiting the expansion of the lungs, which interferes with breathing.

PATHOPHYSIOLOGY

Pathophysiology is the study of the functional changes associated with disease or injury. Because two complex systems (respiratory and cardiovascular) are involved, functional vulnerabilities exist in many areas—singly 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. Forces may damage structures that will require treatment and/or time to heal. Examples include fractures, tears, ruptures, or crushing of airway or blood vessel structures. These injuries may pose an immediate threat to life. Bleeding and swelling deserve special emphasis. 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.

SPECIFIC FUNCTIONAL CHANGES IN STRANGULATION

Functional changes in a strangulation case may include damage to the voice box (larynx) and/or the hyoid bone. (*Note:* The hyoid bone is the only bone in the body that is not directly connected to any other bone; it aids in tongue movement and swallowing.) Bruising (contusion) and bleeding (hemorrhage) are common in strangulation cases, as well as swelling (edema). Swelling is something that should be of grave concern given that it may not be apparent until hours after the strangulation occurs. These findings may develop with as little as 22 pounds of pressure to the neck. The temporary blockage or closing of the blood vessels (occlusion) requires 33 pounds of pressure, and fracture of the hyoid bone requires 35–46 pounds of pressure.

Various combinations of functional changes may occur, leading to severe trauma to the upper airway. For example, the airflow can be compromised, the voice box 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.

Damage to the carotid arteries may occur, which compromises the blood flow to the brain. The use of frontal force—anywhere from 5.5 to 22 pounds—may result in arteries being compressed against the neck bones. 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 rapid loss of consciousness. Any damage to the carotid arteries may result in compromised blood flow to the brain.

Delayed findings may include bleeding and internal artery damage (intimal tears). This is a very 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 inside the artery may form and grow (thrombosis). 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.

If the return of blood from the brain is compromised (venous outflow obstruction), blood coming back to the heart begins to back up. This creates a situation called *stagnant hypoxia*. Blood is building up that does not have enough oxygen. Only 4.4 pounds of pressure on the jugular veins may cause this back up of oxygen-lacking blood. Altered consciousness results with only 15–30 seconds of sustained compression. Common clinical findings in this situation are tiny surface blood vessels that rupture from increased internal pressure. Those found on the face and other mucus membranes are known as *petechiae*. Others may be found in the white part of the eye (sclera), and are called *sub-conjunctival hematoma*. Further, ruptured blood vessels may occur internally, so they are not visible.

Some less-common medical problems that may result from strangulation include compression of the carotid body—an important neurologic structure in the neck that acts as a switching station for nervous impulses. Compression of the carotid body (sustained for 3–4 minutes) may stimulate the *carotid sinus reflex*, which results in a slowing of the pulse (bradycardia) and may lead to altered consciousness (lightheadedness or loss

of consciousness). If pressure is sustained or the reflex response is severe, the situation may progress to cardiac arrest.

A rare problem is neck (cervical vertebrae) fractures, which are most commonly seen in long-drop hanging. Strangulation may also cause fluid overload in the lungs (pulmonary edema), a symptom that may not present for up to two weeks.

CLINICAL SYMPTOMS REPORTED BY STRANGLER PATIENTS

Neck and sore-throat pain is very common in victims of strangulation—it is reported in 60–70 percent of cases—and is usually related to direct trauma (blunt force). Injury to the voice box (larynx), swelling, and bleeding are also painful. Breathing changes or difficulty breathing is even more common, appearing in up to 85 percent of cases. One type of breathing abnormality, *psychogenic hyperventilation*, can be caused by anxiety. Fluid in the lungs, breathing problems, and worsening of other conditions such as asthma, may not be evident until days after an assault.

Voice changes, such as a hoarse or raspy voice, and the inability to speak are also common, reported by up to 50 percent of strangulation victims. Coughing may also be seen, due to injury, swelling, or bleeding in or near the voice box (larynx).

Practice Tip for First Responders and Healthcare Personnel: Document with voice recording both at time of initial consultation and follow-up appointments.

Swallowing abnormalities are common and occur in up to 44% of victims. Victims may have difficulty swallowing (dysphagia), painful swallowing (odynophagia), voice box (larynx) swelling and bleeding, and the swallowing tube (esophagus) may bleed and swell. These symptoms may be immediate or delayed.

Mental status and consciousness changes may include lightheadedness and dizziness, loss of memory, and loss of consciousness. Loss of memory may compromise the accuracy and credibility. It is important for healthcare providers to document the victim’s level of certainty when documenting the patient’s history of events.

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 dementia. 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 (anoxic brain damage), the damage can be permanent and devastating.

Other neurologic signs and symptoms may include vision changes (dimming, blurring, decrease of peripheral vision, and seeing “stars” or “flashing lights”). Victims also may experience ringing in the ears (tinnitus), facial or eyelid droop (palsies), one-sided weakness (hemiplegia), incontinence (bladder or bowel), and miscarriage.

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. Documentation is essential, and it must be thorough and detailed. Multiple interviewers who take statements tend to provide objectivity when the descriptions are consistent. Over time, symptoms will change or even resolve, so recording the victim’s experience provides a degree of objectivity. Some symptoms may be non-specific and or have multiple causes—these must be thoroughly explored and recorded.

CLINICAL FINDINGS

In up to 50 percent of cases, there are no visible neck 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 victim may experience pain (subjective discomfort described by the patient) or tenderness (discomfort with palpation).

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

Visible injuries may include petechiae, which is the result of compression that impedes venous blood flow. As this internal pressure increases, small blood vessels near skin or mucous-membrane surfaces rupture, causing multiple, tiny (1–2 mm) red spots to appear. Petechiae are non-palpable, in other words, they are flat and cannot be felt when touched. The area is not tender and there is no discomfort when touched. Also, they do not blanch, in other words, they will not change color when pressed, unlike when you press on your fingernail.

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.” Petechiae will remain for several days and may not resolve for up to two weeks.

Other visible findings include *sub-conjunctival hematoma*. This occurs when the compression impedes venous blood flow. As the internal pressure increases, small blood vessels on the surface of the eye (the sclera or white part) rupture and allow blood to pool. These “blood spots” (much larger than petechiae) can be very disturbing to the patient and those around her. However, they are not dangerous and they do not impair vision. No treatment is required and they resolve within two weeks.

Practice Tip for First Responders and Healthcare Personnel: Use the forensic approach. Look for a patterning of findings. The appearance of the finding may give information about the cause or mechanism of injury.

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. It provides for the assessment of consistency. The follow-up exam needs to include forensic imaging that can document emerging or evolving injuries. Further, it provides for a comparison and clarification of non-specific injuries (i.e., redness).

Practice Tip for First Responders and Healthcare Personnel: Give patients a wig head on which they can demonstrate and describe what happened.

Findings can be caused by patients trying to save their own lives. For example, a victim scratching her neck to remove a ligature. Scratch marks may have small breaks that are caused when the fingernails move over the ligature. Marks on the bottom of the chin can represent a victim holding her chin down, trying to get the ligature or hands off of her neck.

CLINICAL MANAGEMENT OF THE MEDICAL EVALUATION

First and foremost, the patient must be stabilized. Any patient who has altered mental status (unconscious, confused, combative, significantly intoxicated, etc.) or has severe symptoms should be considered a 911 emergency. All strangled patients, even those with minimal symptoms should have a medical evaluation by a healthcare provider experienced in evaluating and managing strangulation. This includes patients who say they are now “fine.” At minimum, the medical evaluation should include a careful history and physical exam. Lab tests, imaging studies (X-ray, CT, MRI, etc.), specialty consultation, and observation are frequently needed to assess the risk and actual extent of injury. Forensic management may include using neck swabs to collect assailant touch DNA or saliva. The follow-up evaluation may also include exams and imaging studies.

Many experts recommend admission/observation for all strangulation patients for at least 24 hours. 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, incontinence (urinary or

fecal), intoxication, and/or the potential for poor home observation. It is probably safe to discharge a patient when there has been no loss of consciousness, no or very minimal neck soft-tissue injury, no neurologic complaints or findings, and reliable home monitoring.

It may be difficult to understand the medical records. History and physical exam documentation may be brief and include medical abbreviations and jargon. It is not unusual for a number of different types of doctors to be called in to consult. Laboratory and imaging study reports may be difficult for non-medical personnel to interpret. Available in the appendices is an example of how one hospital in Alaska currently screens for and documents strangulation signs and symptoms.

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Chapter 6: Strangulation in Children

By Cathy Baldwin-Johnson, MD and Tracey Wiese, DNP, ANP

“Mom choked me on my neck and then I talked like a duck.”

INTRODUCTION

As highlighted in previous chapters, strangulation can be a lethal form of assault. Investigation and medical care of patients who have experienced strangulation can be complicated by the fact that there are often little to no physical signs that strangulation occurred. 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. This chapter will discuss considerations which are intended to guide one’s critical thinking and judgment in cases where strangulation of the pediatric patient is suspected or witnessed.

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. These challenges only compound those barriers already discussed in chapter 5 of this publication. 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 does 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, if their development is normal. 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 times 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 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.

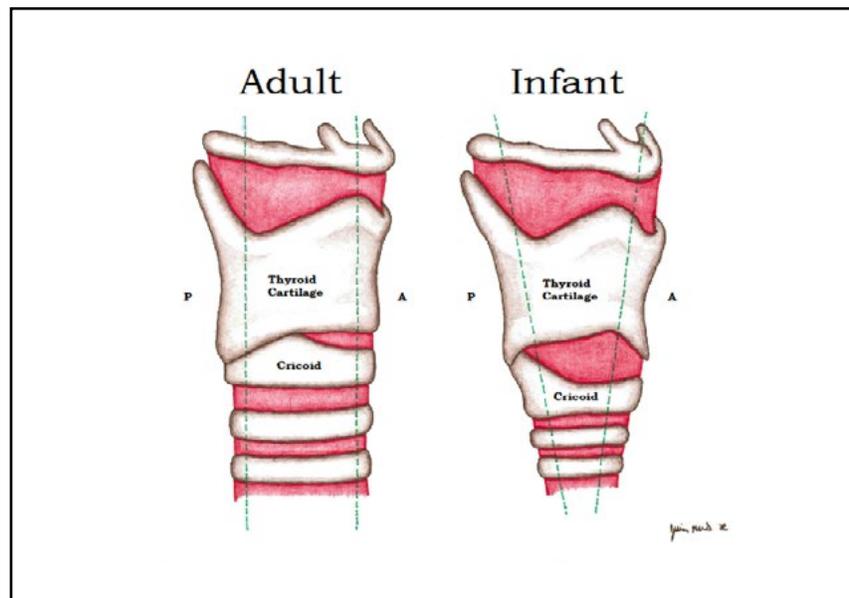
In conclusion, the emotional, behavioral, cognitive and developmental status of a child will have a significant impact on their ability to provide an accurate account of their strangulation assault, further complicating the job of medical professionals and law enforcement personnel.

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 (Figure 1). 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 most narrow 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.



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.¹ It is unknown what implications these differences may have during a strangulation assault. The medical provider may infer however, that given

1. 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.x

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.² 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 breathe. 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.³ While there is no literature 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. This means that the infant skull is not capable of supporting bending loads, especially across suture lines or fontanelles. 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.⁴ 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.⁵ 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

“Mom choked me on my neck and then I talked like a duck.”

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,

2. ² Ommaya, A.K., Goldsmith, W., Thibault, L. (2002). Biomechanics and neuropathology of adult and paediatric head injury. *British Journal of Neurosurgery*, 16(2): 220-242.

3. ³ 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

4. Jain et al. Strangulation Injury, A Fatal Form of Child Abuse. *Indian Journal of Pediatrics* 2001,86:571-572

5. Dayapala et al. An Uncommon Delayed Sequela After Pressure on the Neck. *Am J Forensic Med Pathol* 2012, 33(1):80-82

such as incontinence. And just as in adults, up to 50% of children will not have clinically apparent signs of strangulation.

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.⁶ 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.^{7, 8, 9, 10} Thyroid storm induced by strangulation has been reported as an uncommon but potentially life-threatening complication in adults.¹¹ Poor prognostic signs include prolonged coma, seizures, need for ventilatory support, elevated intracranial pressure, diabetes insipidus, or blood sugar >300 on admission.¹²

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/

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

7. Bird et al. Strangulation in child abuse: CT Diagnosis. *Radiology* 1987, 163(2):373-5

8. Jain et al. Strangulation Injury, A Fatal Form of Child Abuse. *Indian Journal of Pediatrics* 2001,86:571-572

9. Dayapala et al. An Uncommon Delayed Sequela After Pressure on the Neck. *Am J Forensic Med Pathol* 2012, 33(1):80-82

10. Yadav et al. Carotid sheath haematoma: A case report. *Journal of Forensic and Legal Medicine* 2008, 16:411-13

11. Ramirez et al. Thyroid Storm Induced by Strangulation. *Southern Medical Journal* 2004, 97(6):608-610

12. Sabo et al. Strangulation Injuries in Children. Part I. Clinical Analysis. *The Journal of Trauma: Injury, Infection, and Critical Care* 1996, 40(1):68-72

assault, abusive head trauma, and other forms of physical abuse.

DIFFERENTIAL DIAGNOSIS 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 strangle 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.¹³ 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.¹⁴ 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.^{15,16}

Accidental

Infants and young children are especially vulnerable to accidental strangulation injuries from cribs, other furniture, ropes and cords, and entanglement in clothing, high chairs, and playground equipment.¹⁷ A careful history that includes child’s developmental status along with a scene 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 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 HEALTH CARE PERSONNEL

History

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 with without visible external injuries.¹⁸ A medical history should include:

13. Unintentional Strangulation Deaths from “The Choking Game” Among Youths Aged 6-19 Years – United States, 1995-2007. *MMWR* 2008; 57(6)
14. “Choking Game” Awareness and Participation Among 8th Graders – Oregon, 2008. *MMWR* 2010; 59(1)
15. Egge et al. The Choking Game: A Cause of Unintentional Strangulation. *Pediatric Emergency Care* 2010; 26(3):206-208
16. Andrew et al. Update on “The Choking Game”. *The Journal of Pediatrics* 2009; 155(6):777-780
17. Feldman, K. and Simms, R. Strangulation in Childhood: Epidemiology and Clinical Course. *Pediatrics* 1980; 65(6):1079-1085
18. Shields et al. Living Victims of Strangulation. *Am J Forensic Med Pathol* 2010; 31(4):320-325

- 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

Specific questions are included on the pediatric strangulation assessment and documentation form found in appendices.

Physical Exam

A child presenting with a potential strangulation injury should have a thorough medical evaluation that includes:¹⁹

- 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
- 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
- Otosopic 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:

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

- 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.

Diagnostic Testing

Depending on the clinical presentation of the child and time elapsed since strangulation incident, consideration should be given to obtaining:

- 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)^{20, 21}
- Carotid Doppler Ultrasound or CT angiogram for lateralizing neurologic signs
- Pharyngoscopy or laryngoscopy if stridor or voice changes
- 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
- Skeletal survey for occult fractures in children <2-3 years of age, with consideration for children up to 5

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
- 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

20. 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

21. Christe et al. Can MRI of the neck compete with clinical findings in assessing danger to life for survivors of manual strangulation? A statistical analysis. *Legal Medicine* 2010, 12:228-232

- 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.

A specific pediatric strangulation assessment and documentation tool is included in the appendices (see Pediatric Assessment Form).

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 Advocacy Center, clinic, emergency department or child's primary care provider should occur within 1-2 weeks.

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.²² It is therefore important that these children have appropriate long term medical follow up for monitoring and treatment of any identified adverse outcomes.

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

Reporting

Remember that Alaska law requires a report to the Office of Children's Services if a mandatory reporter has 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 (in Alaska often associated with a local Child Advocacy Center) can provide invaluable assistance with forensic evidence collection and photo-documentation, as well as recommendations and referrals.

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Artwork courtesy of Jesse Nichols, BSW with Alaska CARES in Anchorage, Alaska.

Chapter 7: Strangulation and Suffocation of Adults with Special Vulnerabilities: Medical Considerations, Medical Evidence, and Multidisciplinary Investigation

By Dean A. Hawley, M.D. and Candace J. Heisler, J.D with additions by Patricia Liss and Gayle Garrigues

“Elder strangulation and suffocation is overlooked and minimized...When the conduct results in homicide, failure to recognize the act results in a “missed homicide.”

Strangulation and suffocation as methods of abuse and homicide affect all segments of the population. Certain adults are at alarmingly increased vulnerability to serious injury by strangulation or suffocation assault. Simultaneously, these most vulnerable people have decreased likelihood of detection of victimization. These adults present special challenges for investigators and prosecutors. They are collectively what Alaska defines as “vulnerable adults”:

“Vulnerable adult means a person 18 years of age or older because of incapacity, mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, fraud, confinement, or disappearance [Physical or Mental Impairment] is unable to meet the person’s own needs or to seek help without assistance (AS 47.24.900 (16)).”

Crime victims who have mental illness, mental retardation, dementia or physical disabilities pose significant challenges for detection of injuries of abuse. Such victims may not report at all, or may not be believed; some are essentially non-verbal, and often they are simply dismissed as incapable of offering testimony in court. Some victims have intense attachment to their abuser as their only means for sustaining any element of independence. There are many special facets to these investigations that must be covered to insure victim safety and abuser accountability. At the extreme end of the abuse spectrum is murder. There is increased public awareness of strangulation and suffocation as subtle mechanisms of elder abuse homicide, with media interest in our systemic failures to detect and prosecute “missed homicides,” especially in the most vulnerable older and elderly population. For these reasons, Indiana’s prosecutors need significant awareness and training in the techniques for detecting and investigating strangulation and suffocation assaults among the vulnerable adult population.

Strangulation and suffocation assaults and homicides of Alaska’s “vulnerable adults” deserve and require a special separate discussion. These crimes are particularly difficult for police and Adult Protective Service (APS) investigators to detect. In general, elder abuse goes undetected and is severely underreported. For every one case of elder abuse or neglect that is reported, at least five go unreported. A recent study in New York found that for some forms of abuse only 1 in 23-24 is reported. Injuries, if present, may be discounted as a component of aging or due to medications or underlying medical conditions.

With recognition that strangulation and suffocation have often been overlooked or minimized and may lead to life changing consequences for the victim, many jurisdictions have enacted laws to specially address this criminal conduct. Since 2004, more than 30 states have enacted state criminal statutes defining strangulation and suffocation. Please refer to chapters 2 and 4 for previous discussions pertaining to Alaska statutes on strangulation and suffocation.

The federal statute (18 U.S.C. §113(b)(4)-(5); see also Pub. L. 113-114, §906) incorporates long-substantiated medical findings that fatal strangulation and/or suffocation may exist as inflicted injuries, even though there are no visible external injuries on the body. For the “endangered adult” population, the co-occurrence of illnesses that impair the victim’s ability to resist assault magnify the likelihood of serious injury or death in the absence of visible marks on the body, especially when considering common suffocation assault mechanisms.

Recognition by investigators and prosecutors of the types of offender behaviors, and contexts in which strangulation and suffocation may occur, can improve detection of crimes in which the victim’s advanced age and/or

health condition may preclude direct victim reporting, and may decrease the likelihood of external evidence of injury. One purpose for separately discussing elder strangulation and suffocation cases is to provide death scene investigators with information that may help guide decision-making about whether an autopsy is warranted, in a circumstance where the scene investigation indicates “only” advanced age, complex natural disease, and little or no external evidence of violent crime.

Strangulation as the cause of death increases in frequency with the victim’s age. Safarik, et al. (2002) examined cases of elder sexual assault homicide to arrive at their conclusion. This finding is especially surprising because strangulation actually becomes more difficult to detect in death investigations of older adults.

In reality, the detected cases may only represent “the tip of the iceberg.” A study of elder homicide found only two strangulation deaths among 50 successive elder homicides. Other studies suggest that the low priority that coroners and medical examiners assign to elder death investigation is at least one important reason why these deaths go undetected.

Strangulation and suffocation, which occur at a greater frequency in domestic violence relationships across the lifespan, may be fatal without external evidence of injury on the body. When the victim is cognitively or medically impaired, cases will be missed unless investigators develop suspicion at the scene. Screening for domestic violence, and specific screening for domestic violence-related strangulation injury, is recommended for all physicians providing healthcare to elders who have signs of neglect, and elders who have any physical injury.

CONTEXTS FOR ELDER STRANGULATION AND SUFFOCATION

Most cases of strangulation and suffocation in later life involve domestic violence, abuse in later life, or sexual assault. Domestic violence and abuse in later life will involve persons in ongoing and trusted relationships. Sexual assault may involve parties in relationships, but all-too-often involves strangers who target older persons, may have stalked them to learn their living patterns and plan the attack, and then sexually assault and murder victims often using far more violence than necessary to overcome resistance. Some of the Safarik (2002) research studied these kinds of cases.

Safarik, et al. (2002), pointed out that “stranger” was the most prevalent perpetrator / victim relationship in sexual assault homicide of the elderly, but it is important to note that this category included perpetrators that the victims casually knew or previously had encountered, such as delivery drivers. The study also included one case in which the scene investigation directly revealed incestuous sexual violence as a component of intergenerational domestic violence. Otherwise, the remainder of the sexual assault cases fell into the “unknown” or “no living witness” categories.

SUFFOCATION INJURY

This section only addresses injuries in suffocation cases. For a discussion of injuries strangulation cases, refer to chapter 5.

FACE AND LIP INJURIES

By Manual Compression of the Face

Forceful closure of the mouth and pinching closed the nostrils by positioning one or two hands over the face is a common practice. Abrasion of the nasal ala (sides of the nostrils) or abrasion of the upper lip below the nostrils may be subtle.

By Pillow or Bedding Compression over the Face

Covering the face with a pillow, blanket or similar soft object causes the victim to re-breathe the exhaled breath which is depleted of oxygen. This will produce a gradual suffocation depending on the extent to which fresh air can mix with the exhaled breath. A conscious and alert victim will struggle to get free, but a frail, diseased, cognitively-impaired elder may not resist at all. Injury may be completely absent.

By Compressing the Face into Bedding

In a face-down position, the head can be shoved downward into bedding, creating a circumstance very similar to the use of a pillow from the front.

By Application of Duct Tape over the Face

In the investigation of abuse of adults in need of services, whether the victim is at risk by advanced age, or is at risk by mental incapacity even at a young age, the use of physical restraints is commonly found. Restraint mark injuries of the wrists, ankles, and body are commonly observed when a felony assault is perpetrated by physically restraining the victim, typically to a bed or chair. Additional restraint of the mouth is sometimes also observed when there is deliberate effort to prevent the victim from making noise. Such restraints pose a great risk of suffocation, primarily by obstruction of the airway. Additionally, it is possible for the restrained victim who is struggling to take in breath to swallow some air into the stomach, and then vomit that air and gastric contents against the gag device, with risk of aspiration of gastric contents.

CHEST AND ABDOMEN INJURIES

Sitting atop or straddling the chest or abdomen will produce a force that may prevent the victim from expanding the chest wall to breathe in air. Depending on the position of the knees, the relative size of the assailant on the victim, and the amount of force exerted, there may be bruising or there may be none. Bruising requires a certain force per square inch, so the surface contact area is important. Other factors to consider will include natural disease like chronic liver disease that increases bruising, and medications like anticoagulants (“blood thinners”) sometimes used to protect against clotting or stroke. Bruising of the chest wall muscles or of the internal organs of the abdomen may be readily apparent at autopsy, but completely invisible through the skin surface. This pattern of injury may produce petechiae, both external and internal. When combined with strangulation, this pattern of injury increases the lethality of a strangulation assault.

PETECHIAE IN SUFFOCATION

There is a difference in the distribution of petechiae for suffocation death, versus pure strangulation injury. In strangulation, petechiae will only occur above the strangle hold, if there are petechiae at all. A strangulation forceful enough to close off the carotid arteries may show no petechiae at all. A pure suffocation death may have petechiae, including petechiae within the conjunctiva of the eyes and the skin of the face, but usually would also have petechiae in the thin skin on top of the feet, the skin over the front abdominal wall, and petechiae within the internal organs and surfaces of organs in the chest and abdomen. With a pure suffocation assault there is typically an attempt by the victim to generate negative intra-thoracic pressure by struggling to breath, and this force can be enough to offset venous return pressure at the heart, resulting in a relative backup of blood in veins throughout the body.

ASPHYXIATION BY OVER-SEDATION (“CHEMICAL STRAIGHTJACKET”)

Over-sedation with drugs or alcohol can also produce asphyxiation with a pattern of tissue and organ damage that resembles suffocation assault. Toxicology testing is an important part of the evidence used to determine suffocation assault as the cause of death. Over-sedation can be a deliberate mechanism of elder abuse, used by a perpetrator to keep the victim quiet and out of the way. An investigator should determine the complete list of medications that are currently prescribed; a list of all the medications that have actually been obtained from a pharmacy; and a list of all the medications available at the scene. When this information is combined with complete forensic toxicology, it may be able to prove that controlled substances are being used in excess to over-se-date; but it may also be proof in a case where the caregiver is abusing the controlled substances that should be available for the victim.

CONCOMITANT NATURAL DISEASES

With advancing age, the likelihood of natural disease increases. Many of the commonest diseases increase the

lethality risk of a strangulation or suffocation assault. With arteriosclerotic heart disease, chronic obstructive pulmonary disease, and congestive heart failure the ability of the victim's cardio-respiratory systems to compensate for temporary asphyxiation may be sufficiently impaired so that an assault that would not have killed a victim at age 40, will kill that same victim at age 75. Chronic liver disease increases the amount of bleeding into injuries, as does medication like anticoagulants (blood thinners), commonly used to prevent stroke and heart disease. Osteoporosis increases the risk of serious bone fracture, and dementia with atrophy of the brain increases the risk of fatal bleeding into the brain. In Indiana, a theory for prosecution is, "take the victim as you find them." This theory allows that poor health does not mitigate the determination of Manner of Death. If the assault shortened the victim's life in any fashion, or if complications of the assault injuries eventually lead to death, then the assault injury is the *Cause of Death*, and Homicide is the *Manner of Death*; regardless of the severity or complexity of the underlying natural disease conditions, and regardless of the skill of any applied or missed medical diagnosis or treatment.

RISK FACTORS AND LETHALITY

A 2002 study used the Hanzlick-Koponen typologies, which consider three components of the victim/perpetrator circumstances to define risk factors for murder/suicide cases in elder populations:

- 1) The personal relationship between the victim and the perpetrator
- 2) Social factors in play in that relationship, and
- 3) The perpetrator's history of violent behavior,

Subsequently, that study associated between 25 and 30% of cases of murder-suicide with domestic violence in later life; and then further associated those murder-suicides with specific perpetrator behaviors -- domination and control. Specifically this research which dates from the mid-1990s has found that most dyads are elderly married couples. The perpetrator was nearly always the male partner who usually used a firearm and was not demented. The homicide-suicide was not a result of "suicide pact," or "mercy killing".

Common features in elder murder/suicide cases are the controlling, dominant personality of the male partner and the perpetrator's perception of separation such as hospitalization or need to move to a nursing home due to illness of either party. That separation is viewed by the perpetrator as a threat to the integrity of the relationship. Risk factors include husband is caregiver, advanced age; declining health of either party, pending hospitalization or institutionalization; a history of domestic violence; a depressed or suicidal perpetrator, a perpetrator who is abusing alcohol or controlled substances; and a perpetrator who feels isolated, angry, hopeless, or believes he has lost control.

Lethality risk indicators in younger couples seem to also apply to elderly couples whether they have a domestic violence relationship that has lasted for decades or a new abusive relationship. In addition abuse in later life may involve power and control tactics but the abuser may be a family member, trusted caregiver, or other person with whom the victim has an ongoing relationship in which there is a societal expectation of trust.

Factors identified and validated for younger couples should still be considered and evaluated. These include: abuser used or threatened victim with a weapon; threats to kill the victim; attempts to strangle the victim, abuser is violently and constantly jealous; victim is forced to engage in unwanted sexual contact; presence of a gun in the house; increasing frequency and severity of the violence, abuser controls most or all of victim's daily activities, and the victim believes defendant is capable of killing victim.

Studies about homicide risks for the elder population are complicated by the relative rarity of elder homicides. However, like domestic violence homicide in younger persons, domestic violence strangulation homicide of the

elderly may be predictable, and service providers may be able to use this information to improve victim safety.

DEATH INVESTIGATIONS

In 2002, Safarik, et al published a behavioral science study in which they identified strangulation as an unusual and relatively specific feature of offender typology in elder sexual assault homicides, which they further concluded were crimes of power and anger, manifested by domination and control of the victim. There are certain links between sex-crime serial killers and domestic batterers. Both types of perpetrators utilize sexual violence to degrade the victim; both types of perpetrator seek power and control over the victim, and both types of perpetrators utilize strangulation and suffocation. Like with sexual homicide of the elderly, detection of strangulation or suffocation in elder victims of domestic violence may be impaired by investigator's bias toward assuming that natural disease caused the death.

Understanding the atypical domestic violence relationships that predominate in cases of elder strangulation and suffocation homicides will assist the scene investigators in selecting cases for referral, even when external evidence of injury is lacking. When the death scene investigator suspects a domestic violence relationship, then s/he should investigate for strangulation. When the scene investigator suspects strangulation, s/he should determine if there is a history of a typical or atypical domestic violence. Healthcare providers, advocates, and adult protective services investigators may be able to apply knowledge of elder abuse dynamics to specifically screen for non-fatal strangulation and suffocation assaults in at-risk elders, and provide interventions to prevent homicide. Courts may use this data when considering restraining and protective orders, setting bail, determining whether to order a psychological evaluation, considering pretrial release, and sentencing convicted persons to enhance victim safety and to hold offenders accountable.

Alaska statute AS 12.65.005 directs when an individual death investigation must actually be submitted to the state medical examiner's office. AS 12.65.005 provides when the state medical examiner shall be notified when the death appears to have caused by "unknown or criminal means, during the commission of a crime, or by accident, suicide, or poisoning... or under suspicious or unusual circumstances... or occurs while the deceased in a foster home, mental institution or mental health treatment facility or when the deceased was in the custody of the state or local government".

The cases selected for coroner's autopsy do not represent a random sample of all age-related deaths in a geographic area. There is deliberate over-representation of cases where the first-responder at the death scene thought that the death was a homicide, suicide, or an accident, but not a natural death. Subtle homicidal injury, such as strangulation without external marks, strangulation with decomposition obscuring injury, or suffocation by placement of a pillow over the face, may be overlooked. Specific training on the association of elder homicide with domestic violence and sexual assault may help coroners make informed decisions about selecting cases for autopsy.

MULTIDISCIPLINARY APPROACH

Alaska currently has a system for child death review, but no mandated organized systematic elder death review process. Death scene investigators can quickly determine whether an elder has been previously "an adult in need of services" and thereby supplement available scene information with risk factors that increase vulnerability and lethality risk for death by suffocation or strangulation. The system and data-sharing mechanisms are described elsewhere within this book. The concept of a multi-disciplinary team approach to elder death, incorporating APS with police, coroner investigators, and medical experts is not new and has been employed in many other states. Additional follow up fatality review can also provide a second layer of community protection in these difficult investigations. On a county-by-county basis model programs do exist which should be evaluated and adapted broadly.

Elder strangulation and suffocation is overlooked and minimized. Improved recognition and investigation in non-lethal situations will identify criminal conduct, save lives, and prevent suffering. When the conduct results in homicide, failure to recognize the act results in a "missed homicide," and failure of justice. Improvement

requires a higher index of suspicion at scenes, more informed fact finding and interviewing, and working across disciplines. Indiana has a helpful statute which can be used more often and more effectively with these improved efforts

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Chapter 8: Death by Strangulation or Suffocation

By Dean A. Hawley, M.D.

“The best way to document a strangulation case is still by an autopsy.”

Dean Hawley, MD, Forensic Pathologist and Professor,
University of Indiana Medical School

Strangulation and suffocation produce death by asphyxiation—loss of oxygen and cell death in body organs that are required to sustain life. Fatal strangulation and suffocation can occur without any external evidence of violence on the human body. In the absence of significant suspicion on the part of the death investigator, and in the presence of certain pre-conditions in the victim’s history, strangulation and suffocation homicides can be missed. Declining budgets in the criminal justice system and increasing workloads for police and medical examiners have been blamed for the declining rate of autopsy examinations and a national failure to detect homicide among at-risk victims. The first priority for getting evidence of a crime is to secure an autopsy, and that requires a reasonable index of suspicion on the part of the death investigator. The association of strangulation and suffocation assaults with intimate partner violence should reflexively cause question whenever a victim of suspected intimate partner violence dies.

Once a medical determination has been made for strangulation or suffocation in a death investigation and the police have made an arrest, the prosecutor then begins the process of determining who to enlist for testimony in a prosecution. Training in strangulation and suffocation injury is fairly uniform among Board-certified forensic pathologists, but experience of autopsy pathologists varies considerably in this specific area, and a governmental duty to provide adequate supervision of private contract or state-regulated autopsy is not always followed. Autopsies are not always conducted by Board-certified forensic pathologists, and it is incumbent on the prosecutor to determine whether to seek a second opinion. If the prosecutor decides to seek outside expertise to assist at trial, he or she must determine a mechanism to satisfy confrontation under *Crawford v. Washington*, *Melendez-Diaz v. Massachusetts*, *Bullcoming v. New Mexico*, and *Williams v. Illinois* to allow that expert to testify from records produced by another person.¹

The purpose of this chapter is to familiarize prosecutors with evidence that is common in these cases, and with the autopsy procedures that routinely secure that evidence so prosecutors can better assess the experience and potential limitations of witnesses in a trial. There is no intent herein to train pathologists in autopsy examination in strangulation and suffocation, because the scope of that knowledge exceeds the limitations of this chapter. An ethical discussion of potentially exculpatory evidence is offered within this chapter, and in medical discussions in other chapters.

DEFINITIONS

The commonality for strangulation and suffocation is that each produces serious bodily injury and death by asphyxiation. Asphyxiation is dysfunction or cell death within vital organs by loss of oxygen delivery to those cells. Asphyxiation will occur from many divergent events.

- It is the most frequent mechanism of death in drowning.
- It occurs in suicidal hanging.
- It may happen from accidental internment, such as when a construction worker is buried in a collapsed trench.

¹ . . . *Crawford v. Washington* (2004) 541 U.S. 36; *Melendez-Diaz v. Massachusetts* (2009) 557 U.S. 305; *Bullcoming v. New Mexico* (2011) 564 U.S. ___ [131 S.Ct. 2705]; and *Williams v. Illinois* (2012) ___ U.S. ___ [132 S.Ct. 2221].

- It will happen during coma from drug or alcohol sedation.
- It will occur if the head is confined in a plastic bag.
- And it occurs with many other possible scenarios.

Strangulation has been defined as pressure placed upon the neck, such that there is a reduction of blood flow through the brain, or constriction of breathing through the airway in the throat, resulting in disruption of brain function by asphyxiation. Strangulation is a specific type of blunt force injury of the neck. Pressure by an object that does not penetrate the skin (a blunt object) is applied to the neck resulting in injury by asphyxiation. The pressure is sustained, not instant, in such a way that the combination of time interval, surface contact area, and quantity of force, create sustained obstruction of oxygen delivery. This distinguishes strangulation from a blunt force neck injury—such as a punch or slap—where the momentary interval of contact is too brief to affect oxygen delivery to the brain.

Suffocation is defined as obstruction or restriction of breathing by external mechanical forces. Suffocation does not require blunt force injury. It can occur by obstructing air from entering the air passages (smothering) or by keeping the lungs from expanding to take in air by external compression of the chest or abdomen (compression). Compressing the ribcage of the chest so that the chest cannot expand to take in air, or compressing the abdomen so that the diaphragm is forced up to prevent breathing, are both typical examples of suffocation by compression.

Death due to homicidal strangulation or suffocation may be delayed by hours, days, or even months when there is interval medical care such as life support, or when there is gradual progression of an internal injury such as aspiration pneumonitis, or internal bleeding or swelling that collapses the airway. There can be homicidal assault where death follows an extended period of medical life support, where the autopsy is long after the injury, affording time for healing. Sometimes the search for evidence of the cause of death can turn to the investigation, because the condition of the body or the delay in death has obscured the injury.

Ligature Strangulation

A ligature is a cord, wire, article of clothing, or otherwise flexible object that is wrapped around the circumference of the neck so that pressure applied to the free ends creates compression and constriction of the neck. Overall, ligature strangulation is not found in the preponderance of intimate partner strangulation cases, but the frequency of ligature use is probably increased in the homicide cases. Ligature strangulation may follow an act of manual strangulation in a sequence of escalating violence leading up to death. Skin injury is more frequent when a ligature is used as compared to manual strangulation. It is possible to determine the direction of the applied force for a fatal ligature: hanging shows a head-to-toe force vector against the skin and ligature strangulation typically shows a front-to-back or back-to-front force vector. A ligature with a broad surface contact area, such as a coiled bed sheet, is expected to leave less skin injury than a ligature with a smaller surface contact area, such as an electrical extension cord. One confessed murderer made a public self-incriminating statement claiming that he could inflict a ligature strangulation that would simulate the typical injury of suicide, thereby creating a defense against murder.²

Manual Strangulation

Manual strangulation is the most frequent pattern of strangulation assault in intimate partner violence cases. Manual strangulation includes the quintessential mental picture of two people standing, facing each other, where one has hands around the other's throat. While that may happen, it is not the usual mental image that should be conjured in intimate partner violence homicidal strangulation cases. For the most part, these assaults occur in the bedroom, on the bed, with the victim lying down and the assailant on top. It can be with one hand from the front or from behind, two hands from the front or from behind, or often just by placing the forearm across the victim's neck while she is face up on the bed. The forearm can also be used from behind, reaching around the throat. Manual strangulation also includes stepping or kneeling on the victim's throat. In any one posture of victim and assailant, the pattern of defensive injuries that might be made by a struggling victim will depend on the accessible part of the victim's own body, the accessible or exposed parts of the assailant's body, and whether the assailant has employed some mechanism to chemically or physically restrain the victim prior to the assault.

2 . See White, Charlie. "Indiana suspect confesses to media in rape, murder of teen" *Louisville Courier Journal* (Mar. 8, 2013) <<http://www.usatoday.com/story/news/nation/2013/03/08/suspect-jailhouse-confession-rape-murder-teen/1972785/>> (accessed Apr. 17, 2013).

Suffocation by Smothering

Suffocation by smothering is a very common concomitant injury in strangulation assault, and may be the preponderant pattern of lethal force if the victim is significantly weak or frail compared with the assailant, as in infants or disabled elders. Placing a pillow over the mouth and nose with very little force is all that is required to smother an infant or a very ill, impaired, or intoxicated adult. In intimate partner assaults, suffocation may occur by obstructing the mouth and nose, for example during an attempt to prevent the victim from screaming, awakening children, or alerting neighbors. Smothering will happen if the face is covered with duct tape or is confined inside a plastic bag during the assault.

Suffocation by Compression

Alternatively, suffocation commonly occurs in intimate partner violence when the victim is on the bed or floor, and the assailant is sitting on the body, compressing the victim's chest or abdomen with or without simultaneous compression of the neck by strangulation.

UNDERLYING PHYSIOLOGY OF MECHANISMS OF FATAL ASPHYXIATION

Jugular Vein Occlusion

The jugular veins return blood to the heart from the brain and head. The blood within the jugular veins has had most of the useable oxygen and nutrients extracted during its circuit through the head. The jugular veins are under the skin of both the right and left sides of the neck. These veins connect together within the brain, such that blockage of one jugular vein still permits complete venous drainage of the brain and head through the one remaining opposite jugular. Occlusion (complete obstruction) of both jugular veins, if done with a strangulation force that is not so severe as to obstruct the carotid arteries in the neck, starts a process of venous engorgement in the head and brain, where the veins above the restriction in the neck will promptly start dilating to absorb the continuing influx of blood that cannot exit the neck back to the heart.

Over a period of time, the dilating veins rupture, causing bleeding under the skin, into the brain, and into the eyes in a pattern known as *petechial hemorrhage* or *petechiae*. The duration of time required for complete jugular obstruction while the carotids are open and the end result is petechiae, is best estimated at 20–30 seconds. If one jugular is released prior to the necessary time, then the clock must start again. Petechiae in the skin, under the scalp, and in the eyes heal in a few days, so observed petechiae are no more than a few days old. Petechiae in the brain are never completely healed, but they change in color and quality over time. The time interval may be crudely estimated from microscopic tissue sections of the petechiae. The requisite force need not be severe, as the jugulars can be compressed during medical manipulation of the neck without causing noticeable pain. Most suicide hangings are painless and involve an identical mechanism.

Asphyxiation within the brain develops because the incoming arterial blood flow eventually becomes restricted by the venous overfilling, and oxygen delivery to the brain is gradually impaired. Unconsciousness occurs after about two minutes, and the point of no return for death occurs at about four minutes. These time intervals are only approximations, as the onset of unconsciousness and death may occur faster or be more protracted. Leading up to loss of consciousness, the victim, unless physically or chemically restrained, is medically able to fight back; there is often a very severe effort by the victim to escape.

Carotid Artery Occlusion

The carotid arteries come out of the arch of the aorta at the top of the heart. They carry nutrient-rich and oxygen-saturated blood through the neck up to the head and brain. Pressure within the carotids is significantly higher than in the jugular veins, and the heart pulsation is evident in the arteries. The carotids lie quite deep within the neck, shielded from the front and side by neck muscles and the edge of the cartilage of the larynx (voice box). Considerable force is required to obstruct the carotid arteries. The physiology for carotid obstruction is significant for two independent factors that operate together in a strangulation, making carotid obstruction a dramatic and rapidly lethal event. First, the carotids are the oxygen source for the brain, so cutting off carotid flow abruptly stops oxygen delivery. Second, the blood pressure within the carotid arteries is the physical force that allows oxygen within the blood to be pushed out through the wall of the vessel into the tissues of the brain. Absent that blood pressure, oxygen diffusion stops very abruptly, and the consequences for the brain are quite dire. With carotid obstruction, unconsciousness is reported to occur in as few as 10 seconds. Petechiae do not develop if the carotid arteries are obstructed. Therefore, the presence of petechiae caused by strangulation serves as proof that, at one point in life, the jugular veins were compressed while the carotids were open. Once the carotids are closed off, there are no more petechiae. As with jugular vein compression, permanent brain damage can happen within two minutes. Death by carotid occlusion has happened in as little as 15–20 seconds when the strangle hold is done with sufficient force

to crush the artery, causing thrombosis or carotid dissection, followed by cerebral infarction (stroke). The quantity of applied force required to compress the carotids is considerably higher than with jugular compression, but the rapid onset of loss of consciousness may reduce the likelihood that the victim was able to fight back. Fatal strangulation by carotid obstruction has happened with “the choking game,” and it has happened inadvertently by law enforcement use of the “carotid restraint” or “lateral vascular neck restraint.”

Absence of External Injury

External skin injuries may or may not be present after a carotid compression. The presence of skin injury produced by the assailant depends on the surface area for application of the force, the texture of the surface against the skin, and the rapidity of loss of consciousness for the victim. The presence of defensive skin injuries on the victim’s neck, produced by the victim clawing at a choke hold on the neck, or injuries on the assailant from clawing at the assailant, may or may not be present and depend on circumstances that include body posture, the element of surprise, and even demeanor. In law enforcement demonstration exercises, the person subject to the restraint rarely fights back. In demonstrations of lateral vascular neck restraint when trained as deadly force for police agencies and the military, external injuries are seldom present. With fatal carotid compression, internal injuries are likely in the muscles and perhaps within the vessels, but external injuries are often completely absent even in homicidal assaults.

Repeated Applications of Strangle Holds

In homicide cases, it may be observed that there are so many petechiae in the skin and under the scalp that the entire skin appears suffused with petechiae. Such a pattern implies that a jugular compression was applied more than once during life, where some petechiae developed with each successive assault until the whole skin is suffused.

Suffocation by Smothering

When the air passages into the mouth and nose are partially or completely obstructed, there will be a relative impediment to breathing. Depending on the severity of airway restriction, there will begin a process of asphyxiation. The airway obstruction will result in a struggle by the victim to breathe through the obstructed airway. Depending on factors that might co-occur, such as blunt force injuries of the head, bleeding injuries in other parts of the body, or respiratory depressant drugs or alcohol, the victim will struggle, attempting to use more and more force to take in air. The force is generated by the chest and abdominal wall muscles and diaphragm, producing a negative intra-thoracic pressure. If the chest pressure reaches the threshold pressure for central venous return of blood through the vena cava into the heart, then there will be a generalized, body-wide, obstruction of venous return, which resembles jugular vein compression in a strangulation. At that point, there may be a shower of petechiae that develop from the obstructed veins throughout the body. It is easiest to recognize and document this in the thin skin at the top of the feet, the skin on the front abdominal wall, and within the linings of the liver capsule, lung pleura, and epicardium of the heart. These petechiae may also appear in the eyes and skin of the face.

Petechiae caused by suffocation are therefore generalized, while the petechiae of strangulation are isolated to the head above the line of strangulation force. The interval for loss of consciousness during a pure smothering assault depends on the extent to which the airway is obstructed. With total obstruction, that timing should look like drowning or jugular compression, where two minutes is typical. If the obstruction is not complete, like if the victim was able to get in just a little air through a pillow, then the assault may take longer. Smothering has been determined to be associated with a very prompt (in seconds) change of human physiology even at the molecular level of DNA, where there is a rapid activation of a gene that is transcribed from DNA to RNA, and that RNA is then translated to a protein, where that final protein in the circulating blood causes the lungs to exude edema fluid. This protein may eventually be a useful forensic marker to prove suffocation assault.

Suffocation by Compression

Forcing the lungs to collapse by sitting on the chest or abdomen will result in compressional asphyxia. The mechanism and distribution of petechiae is identical with a smothering, and the timing for loss of consciousness should be about the same. The importance of recognizing compression suffocation is that it does very frequently happen simultaneously with a strangulation assault, and the petechiae that become generalized due to the compression can confuse the observer who might not have considered compression suffocation in the matrix of possible injuries. There may be contusions under the skin of the chest or abdomen that fit a position for the assailant on top of the victim.

Assaults Involving More Than One Mechanism

The point of no return, where the strangled victim will not spontaneously start breathing again after an assault, varies considerably depending on the overall injuries. Commonly the assailant misjudges the onset of death and discovers that the unconscious victim starts gasping for breath or actually arouses. This may precipitate another round of assault by a different mechanism. Using a ligature to tie off the neck following a manual assault is common. Using blunt force is also common. The process by which the assailant seeks to “make sure” that the victim is dead can result in injuries that a prosecutor might use in an argument for “overkill” as proof of specific intent to kill. It is not in the purview of the pathologist to make this determination as an opinion, but is an argument that the state may make later.

Suffocation by Drowning and Oxygen-Depleted Environments

There is more than one mechanism for death by drowning, but the preponderance of cases occur by asphyxiation. Unable to breathe, the submerged person becomes unconscious after an interval of about two minutes. If not removed from the water within a couple more minutes, the victim will arrive at the point of no return, where medical resuscitation becomes necessary, and then even that effort becomes useless. Cases of very prolonged submersion followed by survival are reported in news stories, but actual medically documented 20-minute survivals where one can absolutely prove absence of accessibility of an “air pocket” even with cold water drowning, are lacking. The concept of very prolonged submersion is either a myth, or it is dependent on a trick of physiology such as weighted rapid descent, which offsets asphyxiation by using deep-water pressure to increase the diffusion of remaining oxygen out of the blood. There are many myths about autopsy findings in drowning cases. Best stated, drowning cannot be definitively and scientifically proven. Medical determination of drowning as a cause of death is made after a complete autopsy, and is based upon the absence of immediately fatal injuries such as gunshot wound or stab wound, and the presence of a wet body in the context of known submersion. If an already-dead person is subsequently submerged in water, there will be water that flows into the lungs by simple gravity, so a finding of water in the lungs does not substantially prove death by drowning. Water in the lungs only means that the body has been wet. Findings reported such as the osmolality of heart blood, the presence of diatoms from the water, and water in the lungs, have not proved helpful as definitive proof of drowning. Medical evidence of homicidal drowning may be frustratingly non-specific.

Exposure to an atmosphere that is depleted of oxygen is another mechanism of suffocation. The process of forming rust from iron leads to a chemical binding of oxygen from the air. When a compartment aboard a ship, or a structural steel container, or a sewer-access portal is made of iron, and the compartment is sealed, there can be a gradual chemical extraction of oxygen from the air within that compartment. A human entering that compartment can be abruptly asphyxiated by lack of oxygen. Forensic pathologists use the term “hostile environment” to describe a room with extreme heat or cold, or a room with no oxygen. The deliberate placement of another person into a hostile environment is a premise in forensic pathology for which we can determine homicide as the manner of death, even though the victim has no wounds. Medical evidence of homicidal asphyxiation by “hostile environment” may be non-specific.

Special Considerations for Co-Occurring Medical Risks for Elders, Children, and Victims with Medical Conditions

Homicide by strangulation or suffocation does sometimes occur for victims who are not able to put up a violent defense. For the very old, very young, and adults who are impaired with severe physical limitations or disease, death by strangulation or suffocation can happen without significant evidence of assault. The typical defensive injuries of fingernail marks and internal contusions of the neck may be completely absent because the force required to cause strangulation or suffocation is very low. In these cases, forensic pathologists are highly dependent on the investigative information. It is a firm premise of forensic pathology to always consider the death-scene investigation and history in arriving at cause and manner of death. For a victim who also has significant coronary artery disease, chronic pulmonary disease, or a prior stroke, the forces necessary to cause death are minimal and the inclination to assign that death to the co-occurring natural disease may be expedient but hazardous.

VISIBLE AND/OR CLINICAL INJURIES

Visible injuries are not always present on the skin in homicidal strangulation and suffocation. When the physiology of death is related to jugular vein compression only, then there will be petechiae. But in darkly pigmented skin, the natural skin color can be so close to the color of the hemorrhages that those petechiae may not be visible even when present. Death can occur without those petechiae appearing in the eyes or mucous membranes, so external examination may not show a clue to the mechanism of death. With carotid compression there are no petechiae and, if the force is applied over a broad surface area, there may be no abrasion or contusion in the skin. With suffocation, there should be generalized petechiae, but again, the skin color may prevent these from being visible on the outside of the body. With either strangulation or suffocation, homicide can occur without any external evidence of injury. When skin injuries are present,

exclusive of petechiae, the skin injuries fall into categories depending on the mechanism of injury. The 2013 federal strangulation and suffocation statute within the Violence Against Women Act amended the federal statute to fully express this concept of “no visible injury.”³

Skin

Injuries Caused by the Assailant: Ligature abrasions in suicidal hanging show a definite upward track somewhere around the circumference of the neck, often just behind one ear, proving the direction of force to be head-to-toe. In contrast, ligature strangulation should produce a horizontal band around the neck showing constriction of the skin. While it might be speculatively possible to affect a ligature strangulation assault by lifting the victim up off the floor using only the ligature, this scenario would require a number of conditions, such as unconsciousness.

Manual strangulation can show bruises from the assailant’s hands or fingers, sometimes with fingerprints that can be lifted from the surface injuries on the victim’s skin. Abrasion of the victim’s skin under the chin is common and related to the victim wiggling the chin from side to side in an attempt to get the chin under the stranglehold. Patterned stamp abrasions may be created by a necklace, where the necklace is inside the stranglehold and becomes deeply indented into the skin.

Blunt force impact injuries created by punching or slapping the neck and face sometimes overlie the strangulation injuries.

In suffocation, where the mechanism is forcing the mouth and nose closed, there may be incised tooth marks on the inner mucosal surfaces of the upper or lower lips, but these are not generally present in victims who have no teeth. The tooth marks, when present, may be associated with lip swelling. There may be visible patterned skin abrasion over the nostrils or symmetric abrasions on the upper lip below the nostrils to show that the nose was pinched closed with great force. If suffocation is done with duct tape, there can be linear abrasions and tape adhesive residue across the face or within the hair.

Injuries Caused in Self-Defense (Defensive Injuries) on Victim and Assailant: Abrasion of the victim’s skin under the chin is common and related to the victim wiggling the chin from side to side against the assailant’s hand in an attempt to get the chin under the stranglehold. Patterned curvilinear abrasions made by victim’s fingernails are quite common in strangulation cases. The victim will often dig in with the fingernails to try to get fingers under the stranglehold (either manual or ligature), and create scrapes in the neck. The victim may also strike out at the assailant, causing scratches on the face or body of the assailant, which may indicate “defensive injury” in the assault. In the context of an assault taking place on a bed, with both victim and assailant unclothed, and the assailant on top of the victim, there are many possible locations on the assailant’s body for the victim to reach. Finding assailant DNA under the victim’s fingernails may be useful in proving identity of a perpetrator.

Medical Procedure Evidence (Radiographs, Medical Imaging): If there is a time interval after the assault during which the victim is medically supported (on life support) and, therefore, injuries are afforded an opportunity to heal before death, then the medical record may be useful in disclosing evidence of strangulation. In this circumstance, there may be no useful autopsy findings of the original strangulation injury, and the medical record must be used for evidence of the injury.

There are also rare cases where an assault resulted in medical assessment, the victim was discharged without recognizing the scope of injury, and death occurred days later outside the supervision of a healthcare facility. In this circumstance, there will be autopsy evidence of the internal injury that progressed to fatality, but the acute injury evidence may depend on the observations made by the original clinicians through the original medical record.

Medical records can contain many findings that would support a conclusion of strangulation or suffocation, where these findings are not necessarily attended in the record by the word “strangulation” or the word “suffocation” as a medical conclusion. Signs and symptoms as previously discussed in this manual may be documented in the record. Further, as related to homicidal injuries, there may be more elaborate medical imaging studies like arteriograms of carotid artery dissection, or bronchoscopic or laryngoscopic procedures where there can be photos of internal petechiae, or vocal cord paralysis. A careful review by a healthcare professional well-versed in signs and symptoms of strangulation and suffocation may be necessary.

INTERNAL INJURIES

Location and Mechanisms of Internal Injuries Found at Autopsy

3 . 18 U.S.C. § 113(b)(4)-(5); see also Pub. L. 113-114, § 906.

Internal injuries potentially present in homicidal strangulation include blunt force crushing injuries of the structures within the neck. An autopsy examination by layered dissection of the neck can show crush or tendon avulsions of the large muscles that support the turning and tipping movements of the head over the shoulders. There may be crush contusions within the small intrinsic neck muscles that support swallowing and permit the epiglottis to open and close. There may be ligament tears between the larynx and hyoid bone. There may be crush contusions in the swallowing muscles of the esophagus between the larynx and esophagus, or in the esophagus against the bone of the cervical vertebrae. In rare cases, there can be fractures of calcified cartilages of the larynx. Hyoid bone fracture may occur, but it is not common in strangulation homicide, contrary to much of the entertainment industry dialogue about strangulation. Crush contusion between the jugular vein and carotid artery, within the carotid connective tissue sheath, or internal crush contusion of the intima (the inner-most lining) of one or both carotid artery, sometimes also associated with a dissection of blood under the intima, may be present. Bone fracture of the cervical spine, and even spinal cord laceration, may happen with extreme force.

In strangulation and suffocation, the injury evidence of asphyxiation includes petechiae in the skin and eyes, within the mucosa of the larynx, under the scalp, and within the brain. Microscopic tissue sections of the brain may show asphyxial (anoxic) changes within specific neurons.

With delayed death, there may be evidence of aspiration of gastric contents within the lungs, chemical pneumonitis, swelling of the mucosa of the larynx or vocal cords, or an air leak resulting in subcutaneous emphysema (bubbles of free air within the tissues).

With suffocation, there can be external petechiae in the skin of the legs or the chest and abdomen, as well as in the face, eyes, and head. Internal petechiae commonly appear on the bowel, liver, heart, and lungs. Suffocation by compression may result in contusions of the muscles of the chest or back and broken ribs.

There are other potential internal injuries as well, but that discussion would be more technical than the scope of this chapter. The intent here is to teach prosecutors how to approach autopsy evidence, and evaluate the quality of an autopsy medical file with respect to evaluating the expertise of the clinician. The reader is referred to the reference list at the end of this chapter for more technical anatomic resources.

Symptoms That Would Appear in Survivors with Similar Internal Injuries

If there is an interval of survival after sustaining injuries, then the common strangulation symptoms of hoarseness of voice and pain on swallowing typically precede fatality. Vocal cord paralysis is related to neuropraxia (temporary nerve paralysis) by compression of the left recurrent laryngeal nerve, which may or may not show crush contusion over the left side of the upper laryngeal cartilage. Pain on swallowing would relate to visible crush contusion in the muscles between the larynx and esophagus (arytenoid) or between the esophagus and cervical spine (posterior pharyngeal constrictor).

Injuries of Forcible Sexual Assault

In intimate partner homicide, sexual assault is common. There may or may not be injuries of forcible sexual assault, but a detailed examination for injury must be done. At autopsy, both external examination and internal examination is necessary, along with collection of evidence. Sexual contact areas of the mouth, anus, and vagina need to be documented for injury as well as molecular evidence.

IMPACT OF DRUG AND ALCOHOL INTOXICATION ON THE “EXPECTED” PATTERN OF INJURIES

What Investigators and Prosecutors Need to Know About Post-Mortem Toxicology

Toxicology testing will ordinarily be done as a matter of protocol by medical examiners involved in homicide investigations. Toxicology may not be done if violent crime was not suspected prior to the autopsy. The result of post-mortem toxicology tests depends on the protocol of the individual laboratory; there are no statutory requirements or practice standards that dictate what must be done. The final reports may not specify the tests actually conducted, and if there is a medical intervention prior to death, the results of testing done in a hospital may be difficult to interpret without specific knowledge about the lab protocol. For example, a hospital emergency room “drug screen” reported as “negative” may have been nothing more than a urine screen for cocaine and THC. Knowing what was tested and what was not, is essential before interpreting results. Also, designer drugs such as substituted amphetamines (bath salts) may not show up in any toxicology test unless specifically ordered.

Blood alcohol (ethanol, drinking alcohol) can be altered by late post-mortem decomposition with obvious putrefaction,

but otherwise the post-mortem blood alcohol is probably fairly representative of the true alcohol content of the blood at the time of death. Other drugs can change blood levels dramatically at the time of death, through a process of “post-mortem redistribution,” where it may require significant expertise to decide the meaning of the blood levels of some drugs. Toxicology can be helpful in explaining why an individual is dead with minimal injury, and toxicology can be exculpatory in an argument that death was caused by substance abuse and not by suffocation.

Determination of “Vital Response” in Injuries

If the toxicology tests suggest lethal levels of drugs and alcohol, where death may be attributed to substance abuse alone, then careful consideration must be given to the injuries in strangulation or suffocation to make certain that those injuries occurred during life and not after death. A discussion follows concerning the appearance of putrefactive changes in the decomposing body that could be misinterpreted as strangulation injury. If decomposition is not an issue, then microscopic sections of the injuries are helpful to show that they occurred in life, resulting in a vital reaction such as hemorrhage or inflammation. In any case, the toxicology tests can make prosecution more difficult, but there are often autopsy findings that can help confirm injury as the true cause, even in a severely compromised victim.

Charging Considerations When Toxicology is Significant

Toxicology is often an issue for homicide victims and for survivors of strangulation and suffocation assault. At autopsy, toxicology will most likely be done. If there is a significant delay between injury and death, either by way of prolonged hospitalization or because there is a progressive injury, then the toxicology results must be interpreted in light of the time interval of survival from assault to death. There are a few minor adaptations that may need to be made for autopsy pathology when there is a significant time interval between death and autopsy, but for the most part the blood levels obtained at autopsy will substantially represent true blood levels at the time of death. Survivors should also be evaluated with comprehensive toxicology testing. A victim evaluation in an emergency room is not just a documentation of forensic evidence; it is an opportunity to provide diagnosis and treatment for disease. Often that will include substance abuse. If we do not know about substance abuse, we cannot formulate a treatment plan and start the process for recovery for the patient and her children. Further, it is going to come up at trial, and it is far better to offer the correct answer rather than let a defense attorney speculate about a completely unknown issue. Experience is that the toxicology test results are rarely as exculpatory as a defendant would have the jury believe. Failure to obtain toxicology may be viewed as evidence of bias on the part of the witness. It may be a liability issue if an intoxicated victim is released and drives home while impaired. It is a victim safety issue.

ARTIFACTS OF DECOMPOSITION AT AUTOPSY

Putrefaction and Hemorrhage in the Neck

Bacteria within the bowel and over the skin surface penetrate the body and tissues very quickly after death and begin the process of putrefaction. The bacteria emit bubbles of noxious, foul-smelling gasses that circulate widely through the bloodstream, carrying along the bacteria. Autopsy findings in putrid bodies may include the appearance of hemorrhage in the putrid muscles of the neck. This alone can give the false impression of strangulation.

Post-Mortem Hypostatic Petechiae

During putrid decomposition, a suspended body (hanging) can develop the appearance of petechial hemorrhages into tissues that are subject to the hydrostatic force of the blood column from blood inside vessels above the hemorrhages. Sometimes called “Tardieu spots,” these findings are associated with decomposition. Post-mortem hypostatic petechiae may be present if there is significant putrefaction, but they are not present at the moment of death, and depend on factors such as temperature and many hours or days of post-mortem interval. They are associated with other sequelae of putrefaction including gas bloat, skin slippage, and intravascular hemolysis.

Post-Mortem Injury Caused by Exhumation of Interred Remains

Exhumation of the body may be necessary. The suspicion of homicide may arrive after there has been a presumed natural or toxic death where the medical examiner declined autopsy, and the body has been embalmed and buried in a cemetery. Or the body may have been buried by the perpetrator in an effort to hide the crime. Death scene investigators have variable experience in the procedures for exhumation. Lack of experience can result in damage to the body during exhumation. Distinguishing late post-mortem damage from inflicted injury may not be a simple and obvious process, especially if the body is partly skeletonized at the time of exhumation. A forensic anthropologist with specific training in exhumation

techniques and with specific training in bone injury may be a very helpful adjunct to the investigation.

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Chapter 9: Use of Experts—Tips for Prosecutors and Expert Witnesses

By Jean Jordan, J.D., LL.M., with contributions from Casey Gwinn, J.D., Gael Strack and additions by Gayle Garrigues

“Not every injury is a visible injury.”

Attendee, 2014 Advanced Strangulation
Prevention Course

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 as an expert 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.¹ Expert witness can be used for various reasons, including educating the judge and jurors about medical, technical, or scientific principles. Experts may also be able to express an opinion after evaluating the significance of the facts of the case.²

A lack of physical evidence and injury may lead a jury to handle a strangulation case as a minor incident rather than a serious life-threatening assault. Consequently, even when the victim has not received medical treatment, it is important to use an expert to educate the judge and jurors about the seriousness of strangulation. There are reasons to consider using an expert in a strangulation case.

1. Lack of visible evidence is common and should not be used to minimize either the forensic significance or the medical risk to life.
2. Adequate medical evaluation does not happen as often as it should because: (a) the victim doesn’t think it is necessary or it will cost too much; (b) first responders don’t appreciate the degree of medical risk and therefore do not push for evaluation; and/or (c) emergency medicine physicians are not current regarding new information about the medical risk and appropriate testing, observation, and consultation.
3. The medical expert can discuss the seriousness of ANY strangulation event and educate the jury regarding the interpretation of whatever data is available for the specific case.
4. For instance, an expert can advise a judge and jurors about facts such as: (1) strangulation can cause unconsciousness within seconds, (2) strangulation is one of the best predictors of the subsequent homicide of victims of domestic violence,³ and (3) most strangulation cases produce minor or no visible injuries, however, victims may suffer internal injuries and have documentable symptoms.⁴

DEVELOPING, SELECTING, AND USING EXPERTS

You may be able to use an expert at different stages of the proceedings. Don’t overlook the possibility of using an expert at a bail hearing, trial, or at a sentencing hearing. Also, you must 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 a medical expert such as a coroner, medical examiner, emergency room physician, forensic nurse, or a paramedic who has

1 ¹ Rule 702, Alaska Rules of Evidence

2 ² Strack G., “How to Improve Your Investigation and Prosecution of Strangulation Cases,” at 13 (updated 2007 with the assistance of D. George McClane).

3 ³ Strack, G. and Casey Gwinn, “On the Edge of Homicide” (fall 2011) *Criminal Justice* 3: 32. See page A-1 in the Appendix of this manual.

4 ⁴ *Id.* at 10.

been trained and has experience handling strangulation cases.⁵

In other cases, a police officer or investigator trained in strangulation may be utilized. The Pennsylvania Virtual Training Network (PATVN) and the Pennsylvania Police Chiefs Association has developed a 25-minute online training module and exam for police officers. Upon receiving a passing score, officers receive a certificate indicating that they have taken and passed the course. PATVN has made this free training available at www.strangulationtraininginstitute.com.

Prosecutors may also be able to develop experts in advocates who work in the DA's office or at a community-based organization. While they may not be able to discuss in great detail the medical ramifications of strangulation, they may have attended specialized training and have experience working with strangulation victims. They may be able to discuss the basic anatomy of the neck and reiterate what they have learned in special trainings about the seriousness of strangulation. Further, they may be able to discuss the dynamic of strangulation in the context of intimate partner battering. Remember, experts do not necessarily have to have a long list of degrees—they just need to have relevant training and experience.

Once the category of expert has been decided, the next step is to locate the right one. Starting with suggestions from colleagues may be helpful. Also, the Training Institute for Strangulation Prevention has resources regarding experts, their qualifications, and transcripts at www.strangulationtraininginstitute.org. And the California District Attorneys Association also has an expert witness section on its website (www.cdaa.org) that can be searched by topic or name of the expert. Prosecutors should check references and the background of any expert they are not familiar with. 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.

MOTIONS

The guiding principle regarding introducing expert testimony is whether or not the testimony is relevant and whether or not it is related to a subject that is sufficiently beyond common experience that the opinion of the expert would assist the trier of fact.⁶ A written pretrial motion can set the stage for admissibility of the expert testimony and will alert the court to any particular issues in the case. A sample motion in limine is provided in the Appendix to this manual at page A-87. (Note: This motion is for a medical expert, but it can be easily modified to support the arguments for other types of expert witnesses, such as law enforcement or advocates.)

CASE LAW FROM AROUND THE COUNTRY:

Nurse's Non-Perceptible Expert Testimony on Domestic Violence and Strangulation Was Properly Admitted

Defendant was convicted of strangulation and domestic assault after attacking his girlfriend. At trial, and over Defendant's objection, the State introduced the expert testimony of a licensed registered nurse with specialized training in domestic violence and strangulation. The expert, who had neither met with nor interviewed Defendant or victim, testified specifically about the signs and symptoms of strangulation, including how the lack of visible injury is common and also the potential lethality of strangulation. On appeal, Defendant argued that the trial court erred in allowing expert testimony because the expert's definition of strangulation differed slightly from that of the statutory definition. The appellate court affirmed the convictions, finding that the expert's definition was "almost identical" to the statutory definition and thus did not risk unfair prejudice to Defendant. **State v. Cox, 842 N.W.2d 822 (Neb. Ct. App. 2014).**

Editor's Note: The judge properly recognized the need for expert testimony in the area of strangulation, especially when there is a lack of visible injury. The expert testimony from a non-perceptible witness, such as a nurse, was helpful in order to explain the significance of symptoms, signs of internal injury and lethality of strangulation.

Detective's Testimony that Strangulation Does not Necessarily Result in External, Physical Injury Relevant

5. *Id.* at 13.

6. Rules 701 & 702 Alaska Rules of Evidence..

Defendant was convicted of domestic assault by strangulation. During trial, the police officer testified that based on his experience, strangulation often leaves no visible injuries, to which Defendant objected. The trial court found that the officer's experience in investigating strangulation rendered his testimony relevant and helpful to the jury. The appellate court found that the testimony was relevant and the trial court did not err in admitting the testimony. **State v. Supino, No. A08-64, 2009 WL 1515255, *1 (Minn. Ct. App. 2009).**

Editor's Note: This case clearly demonstrates the importance of police officers receiving specific training on the signs and symptoms of strangulation and how their training and experience can help prosecutors prove strangulation even without visible injury. This case also opens the door for more professionals to testify as experts based on their specialized expertise even in the absence of any specific degree or certification

Doctor Without Formal Strangulation Training Was Qualified to Opine about Strangulation Injuries

Defendant appealed from his convictions for aggravated assault and simple assault for strangling his girlfriend because the trial court erred in allowing the testimony of a "strangulation expert," among other issues raised on appeal. Specifically, Defendant argued that Dr. Salik, although a physician had no specialized training on strangulation, suggesting his experience was insufficient to qualify him as an expert. The trial court found, and the appellate court confirmed that Dr. Salik, as a medical doctor with extensive experience working in emergency medicine had sufficient expertise "on the physical process a body undergoes during strangulation," and therefore was qualified as an expert. **State v. Delgado 303 P.3d 76 (Ariz. Ct. App. 2013).**

Editor's Note: As police and prosecutors begin to pursue more felony strangulation prosecutions, the defense bar will become more aggressive in opposing expert testimony. Here, the Defense filed a pre-trial motion to exclude the expert's testimony. Prosecutors should anticipate this approach and file trial briefs to provide all necessary case law on each charge, educate the judge on the facts, and make the case for expert testimony.

Detective Qualified to Testify about Bruising in the Context of Strangulation Even if Not Medical Expert

Defendant appealed from his conviction of second-degree domestic assault for strangling his partner. Defendant argued that the trial court abused its discretion by admitting, over defense counsel's objection, testimony from the detective about bruising appearing after strangulation assaults because the detective did not have medical training or experience. The trial court found, and the appellate court affirmed, that the detective's testimony did not purport to be expert medical testimony but instead it was the detective's opinion and personal observations based upon her extensive law enforcement experience to be able to testify to this matter. **State v. Battle, 415 S.W.3d 783 (Mo. Ct. App. 2013)**

Editor's Note: The ordinary juror does not have the same ability as a trained law enforcement officer to assess injuries and histories of victims who have been strangled. This case shows that police officers who regularly respond to domestic violence cases or forensic nurse and emergency room physicians who regularly evaluate and treat trauma patients can be important witnesses and experts for prosecutors in strangulation cases even without some specialized certification in strangulation assaults.

PREPARATION OF THE EXPERT

Pretrial preparation of even the most seasoned expert is essential.

Qualifications

First, experts should review their curriculum vitae (CV) and ensure that it is current. The prosecutor and the expert should review the CV together. 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 of the education, training, and experience that qualify the expert to testify.

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.⁷ 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. Additional sample questions are included in the Appendix at page A-97.

1. Name
2. Title
3. Education
4. Licenses
5. Certificates
6. Professional organizations
7. Teaching experience (if applicable)
8. Any experience in local policy development regarding the evaluation or care of strangled patients?
9. Published writings (if applicable)
10. Pertinent presentations at professional meetings
11. Previously qualified as an expert witness? How many times?
12. Testified for the prosecution?
13. Testified for the defense?
14. Current employer
15. Current duties
16. Years employed in current position
17. Prior work experience
18. Medical training (if applicable) including board or sub-specialty board certification(s)?
19. Law enforcement training? (If applicable)
20. Strangulation training?
21. Examine patients who have reported being strangled? (if applicable)
22. How many patients have you 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.

7. NDAA *Introducing Expert Testimony to Explain Victim Behavior in Sexual and Domestic Violence Prosecutions*, p. 35.

Questions Related to a Non-Fatal Strangulation Case

1. Define choking.
2. Define strangulation.
3. What is the difference between choking and strangulation?
4. Describe the three methods of strangulation? In this case, is the strangulation manual or ligature? If manual, one hand, both hands, or other 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 do you mean by behavioral changes? Please discuss 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? Please discuss the spectrum of “altered” consciousness beginning with light-headedness and dizziness to the other extreme of death. What are some of the variables?
16. What are the signs or symptoms of unconsciousness?
17. How long does it take a strangled victim to regain consciousness after unconsciousness? What are the variables?
18. How much external pressure must be applied before death occurs? What are some of the variables?
19. Aside from unconsciousness or behavioral disorders, are there other signs and symptoms of strangulation?
20. Would a chart help you explain those signs and symptoms? Did you bring a chart with you today?
21. Please describe the external signs of strangulation.
22. Where would you find visible findings such as redness or scratch marks?
23. Impression marks, or claw marks?
24. What is petechia?
25. How does it look?

26. Where can it be seen on victims after strangulation has occurred?
27. How long does it last?
28. Are there other causes for it?
29. Why could there be swelling to the neck from strangulation?
30. Are there other internal injuries associated with strangulation?
31. Are there internal injuries associated with hypoxia?
32. What would cause the tongue to swell?
33. What are some of the symptoms of strangulation?
34. Can strangulation cause voice changes?
35. Can strangulation cause changes in swallowing?
36. Do some victims of strangulation vomit or feel like vomiting?
37. Do some victims of strangulation urinate and defecate? [During the event, all survivors will do both eventually.]
38. Is there a way to tell how close a strangulation victim has come to death?
39. Are all strangulation cases serious?
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

A diagram 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.

A photograph of the victim where signs of strangulation appear may also be helpful as the expert testifies. The expert can point out these signs and/or injuries and indicate they are consistent with strangulation. If ANY medical record exists from a post-strangulation exam conducted immediately to several days after the event, it should be scrutinized by the expert for any symptoms or findings consistent with strangulation.

Audio recordings, including the 911 dispatch tape, may be helpful as the expert explains that voice change, hoarseness, and shortness of breath are consistent with injury during an assault involving strangulation. If there are recordings of the victim's voice over a period of time, they may demonstrate changes and resolution of injuries after the assault.

A wig head may be used in court to demonstrate how the strangulation occurred and what amount of force was used.

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 and bias, and motive or prejudice.

Qualifications

The defense may or may not choose to attack all or some of these areas. 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. They are encouraged to know their CV inside and out. Remember that actual “hands on” experience with strangled patients—especially following or managing them over time—is the most germane and significant qualification for 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 very 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 in this area 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.

In general, remember 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. For example, a medical expert might be asked, “Are there other causes of petechiae other than strangulation?” Even if the expert knows that the other possibilities are ridiculous, he or she must acknowledge all possibilities, with an answer like, “I was not aware the patient was in active labor when she was strangled.”

TIPS FOR THE TESTIFYING EXPERT

Quality courtroom testimony starts with pretrial preparation.

Pretrial

Beyond the pretrial preparation referred to above, a potential expert should:

1. Be familiar with any publications in your area of expertise. (See at Appendix at page A-6 for a list of the top 13 articles on strangulation.)
2. Know the qualification or requirements for membership for any organizations to which you belong.
3. Know the ethical obligations or protocols that govern your profession or practice.

4. Watch other experts testify, if possible.
5. Participate in a mock trial.
6. If you have testified in the past, review any available transcripts of respected transcripts.

In Court

1. Dress professionally in something you are comfortable in.
2. Act professionally at all times in the courthouse—jurors may observe you outside of the courtroom.
3. Don't be afraid to look at the jury when you testify, make eye contact. This is especially important for "explain" questions.
4. Listen to the question asked and answer that question. Don't supply additional information that was not requested unless it is essential for jury comprehension.
5. When an objection is made, stop talking. It is often helpful to pause for a second or two after the question to allow for an objection.
6. Listen carefully to the judge regarding objections and rulings.
7. Ask for clarification if you do not understand a question.
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 of you by the defense.
10. Never overstate the facts or your opinion.
11. Never exceed the scope of your experience or your expertise.
12. Avoid conclusory statements.
13. ALWAYS TELL THE TRUTH.

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Chapter 10: Victim Advocacy in Strangulation Cases

By Lisa Mariotti with contributions from Catherine Dugan, and Christine King

How has the strangulation impacted you?

“I didn’t talk for three years. [I was told] that because of the shock I couldn’t speak. To this day, I get nervous sometimes and have a hard time speaking clearly.”

“I don’t understand why this happened to me.”

Community based victim advocates are professionals trained to support victims of domestic violence and sexual assault, including strangulation. Victim advocates offer victims emotional, non-judgmental support, information about the victim’s legal options and rights, non-legal options, and support victims’ decision-making; acknowledging that the victim’s expertise regarding her life is listened to and honored. Victim advocates do not tell victims what to do. In the case of strangulation, victim advocates ensure that the victim is informed regarding all procedures, options and available resources, the importance of seeking medical attention, and the value of immediate evidence collection. Under Alaska statute, victim advocates are referred to as “victim counsellors”. AS 18.66.250 provides in pertinent part:

(5) “victim counseling center” means a private organization, an organization operated by or contracted by a branch of the armed forces of the United States, or a local government agency that

(A) has, as one of its primary purposes, the provision of direct services to victims for trauma resulting from a sexual assault or domestic violence;

(B) is not affiliated with a law enforcement agency or a prosecutor’s office; and

(C) is not on contract with the state to provide services under AS 47;

(6) “victim counselor” means an employee or supervised volunteer of a victim counseling center that provides counseling to victims

(A) who has undergone a minimum of 40 hours of training in domestic violence or sexual assault, crisis intervention, victim support, treatment and related areas; or

(B) whose duties include victim counseling.

Victim advocates are committed to maintaining the confidentiality of all communications occurring solely between the advocate and the victim, unless otherwise instructed by prior written consent of the victim, or as required by one of eight limited statutory exceptions (threat to self or another or child abuse or neglect.)¹

1. Sec. 18.66.210. Exceptions.

The privilege provided under AS 18.66.200 does not apply to

(1) reports of suspected child abuse or neglect under AS 47.17;

(2) evidence that the victim is about to commit a crime;

GUIDING ADVOCACY PRINCIPLES

Basic principles creating the foundation for advocate interventions and services include:

- Victims should be treated with dignity, fairness and respect, even when uncooperative with law enforcement or prosecution.
- Victims are not responsible for the violent behavior of the batterer.
- Victims are deserving of respect with regard to their cultural background and belief systems.
- Victims are best positioned to judge the danger the perpetrator poses.
- Victims have the right to make their own decisions, and have those decisions supported with dignity, understanding and respect.

ADVOCACY GOALS AND ROLES

Advocacy goals include the following:

- Victim safety.
- Decreasing trauma-related symptoms.
- Clearly informing victims of their rights and responsibilities in the criminal justice system.
- Supporting victims during investigation and prosecution.
- Supporting victims during forensic examinations.
- Validating the victim's feelings which can counterbalance the batterer's minimization and blame.

Advocates' roles include:

- Providing information on victims' legal rights and protections;
- Providing information on the criminal justice process;
- Providing emotional support to victims;
- Helping victims with safety planning;
- Helping victims with violent crime victim compensation applications;
- Helping victims submit comments to courts, probation and parole boards;
- Helping victims find shelter and transportation; and
- Providing referrals for other services.

(3) a proceeding that occurs after the victim's death;

(4) a communication relevant to an issue of breach by the victim or victim counselor of a duty arising out of the victim-victim counselor relationship;

(5) a communication that is determined to be admissible hearsay as an excited utterance under the Alaska Rules of Evidence;

(6) a child-in-need-of-aid proceeding under AS 47.10;

(7) a communication made during the victim-victim counselor relationship if the services of the counselor were sought, obtained, or used to enable anyone to commit or plan a crime or to escape detection or apprehension after the commission of a crime; or

(8) a criminal proceeding concerning criminal charges against a victim of domestic violence or sexual assault where the victim is charged with a crime

(A) under AS 11.41 against a minor; or

(B) in which the physical, mental, or emotional condition of the victim is raised in defense of the victim.

ADVOCACY SERVICES PROVIDED BY COMMUNITY BASED ADVOCATES

Some of the services provided include:

- 24 hour access to advocates
- Individual advocacy
- System advocacy
- Risk/lethality assessments and safety planning
- Providing information and explaining legal and non-legal options
- Crisis counseling
- Referrals to community resources
- Empowering, non-judgmental emotional support
- Accompaniment/advocacy during the forensic examination
- Accompaniment/advocacy during the police investigation
- Accompaniment/advocacy during court proceedings
- Safety planning for victims and their families
- Education on the dynamics of domestic violence
- Assistance with filing a police report or with reporting the violation of a restraining order
- Providing assistance in filing for crime victims' compensation, preparing victim impact statements for sentencing, and preparing applications for protective orders

ADVOCACY ROLE IN STRANGULATION CASES

First, the initial victim contact is critical in affecting the relationship 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. In order 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. Also keep in mind, English may not be the first or primary language for victims of strangulation. It is important to ensure victims understand as much as possible about the dangers of strangulation and a language interpreter should be used when appropriate. See appendix Working with Interpreters in Alaska.

Strangulation epitomizes the power and control dynamic and is a predictor for a perpetrators escalation to more lethal behavior. Strangulation or suffocation generally occurs as part of an on-going pattern of escalating abuse and is strongly correlated with an increased risk of lethality. It is essential for victim advocates to understand that strangulation is a type of asphyxiation. Manual strangulation, which is the most common form of strangulation used in domestic violence cases, may be done with hands or forearms. Unconsciousness may occur within seconds and death within minutes. Not only is strangulation a felonious assault, but it may be an attempted homicide. 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 batterer. 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 of 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 ask if the perpetrator put his hands around the victim’s throat, put pressure on their neck in any way or covered their mouth or nose so that they could not breathe. Advocates can talk to and educate survivors about the correct terminology and explain that using the terms “strangulation” and “suffocation” to describe the behaviors is an important step towards creating the awareness of the dangers, increased lethality risk and serious criminal legal consequences of this type of assault. Advocates can help survivors by discussing with them the increased risks of serious injury or even death if strangulation has occurred.

SCREENING FOR STRANGULATION

Advocates should ask the following questions as part of an initial intake to determine whether there is a history of strangulation and/or whether strangulation has recently occurred. This can also be helpful during hotline crisis calls as well. Examples of these questions are:

- Has your partner ever put his hands around your neck?
- Has your partner ever put pressure on your neck?
- Has your partner ever covered your mouth and/or nose in a way that prevented you from breathing?
- Has your partner ever pushed your face into a pillow making it difficult to breathe?
- Has your partner ever put a bag over your head?
- Has your partner ever put a sock in your mouth?

Advocates should recognize the signs and symptoms of strangulation. It is important for victim advocates to look for these signs and symptoms of strangulation because victims may die from internal injuries from strangulation up to 72 hours after the incident has occurred. If the victim exhibits symptoms of having been strangled, the advocate should strongly encourage them to seek medical attention, especially if they are pregnant. Even innocuous symptoms (dizziness, swallowing difficulties, headache, lightheadedness, hoarse voice) warrant medical treatment. It is important for advocates to be aware that not all signs or symptoms occur immediately and while there may be very few visible signs of strangulation, there may be extensive internal injury. Therefore, advocates should encourage strangulation victims to monitor signs and symptoms, using a log to record the date and time of symptoms. Advocates need to be mindful of the fact that victims who are in physical shock may be unaware of injuries they have sustained or the dangers they still face.

Sign and symptoms of strangulation include:

- **Scratches** are sometimes inflicted by the victim’s own fingernails from defensive maneuvers, but are often a combination of marks made by victim and perpetrator.
- **Bruises** may be delayed in developing. They may be less visible in victims with darker skin.
- **Redness** on the neck or throat.
- **Red Spots** on the face and/or neck due to blood vessels that may have burst from the pressure of a restraining hold. These may appear as small red spots similar to freckles. The medical term for this is petechiae (pi-te-kee-ie) and this can occur around the nose, mouth, ears, and throat.

- **Bloody-red eyeball(s)** due to capillary rupture in the white portion of the eyes;
- **Neck swelling/stiff neck**
- **Raspy voice or sounding “out of breath”** – often these sounds are indicative of a narrowing of the air tube or even a broken trachea.
- **Abrasions** under chin
- **Rope or cord burns** or other linear injuries caused by an object used to strangle the victim
- **Difficulty speaking**
- **Sore throat/trouble swallowing**
- **Involuntary defecation or urination**
- **Numbness of extremities**
- **Headache**
- **Behavioral symptoms** – restlessness, psychosis, amnesia
- **Dizziness**

Due to injuries to the head, shaking of the brain or loss of oxygen to the brain, brain injuries may occur in strangulation victims which can cause mild, moderate, or severe impairments to cognition, behavior and physical functioning. Therefore all strangulation cases should be screened for potential traumatic or anoxic brain injury related symptoms and referred to the appropriate medical care professional. The HELPS screening tool available and was specifically designed for professionals whose expertise does not pertain to brain injuries.² It is important to identify and treat brain injuries as early as possible. Symptoms of a brain injury can explain many uncharacteristic behaviors exhibited by the victim that can increase their vulnerability to becoming a chronic victim or possibility of hindering the investigative process (see Traumatic Brain Injury and Domestic Violence Victims).

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. 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 experiences and choices of the victim should be validated. The right of the victim to choose must be made explicit. Advocate approaches must be perceived by the victim as being supportive, safe, and predictable. Fundamental to trauma-informed services in domestic violence cases is increasing the victim’s self-esteem.

VICTIM’S RIGHTS

Victim advocates can also play a key role in allowing the victim’s voice to be heard at hearings, especially where bail is being set, protective orders are being considered, cases are being continued, and sentencing is being determined by reminding victims of their rights.

Under Article I, section 24 of the Alaska constitution, crime victims are automatically afforded the following rights:

2. Traumatic Brain Injury and Domestic Violence. Empire Justice Center, Building Bridges: A Cross-Systems Training Manual for Domestic Violence Programs and Disability Service Providers in New York, 2006.

- Be treated with dignity, respect and fairness;
- Protection from the accused through the imposition of appropriate bail or conditions of release by the court;
- Confer with prosecution;
- Timely disposition of the case;
- Obtain information about and be allowed to be present at all criminal or juvenile proceedings where the accused has the right to be present;
- Restitution from the perpetrator.

The Alaska constitution also provides the following two additional rights upon request by the victim:

- Be heard, upon request, at sentencing, before or after conviction and at any proceeding where the accused release from custody is considered;
- Be informed, upon request, of the accused's escape or release from custody before or after conviction or juvenile adjudication.

In addition to these constitutional rights, additional statutory rights exist, including:

- Upon initial police contact, the right to obtain access to immediate medical assistance AS 12.61.010(a) (7);
- Transportation to safe house or shelter; 18.65.515(1)
- Assistance by a peace officer in obtaining a 72-hour protective order; AS 18.66.110(b)

A full list of victim's rights can be found on the Alaska Office of Victim's Rights website at <https://ovr.akleg.gov/> or see Appendix Alaska Victim' Rights.

VICTIM IMPACT STATEMENTS

For purposes of sentencing, it is highly recommended that victim advocates advise victims of their right to be present at the sentencing hearing and to submit a victim impact statement. Many strangulation victims report long-term consequences from the assault, and may be suffering from post-traumatic stress disorder, anoxic brain injury, traumatic brain injury, concussive syndrome or other related health issues that will likely change their lives forever. It would be important to discuss with the victim how the crime as changed her life. Some questions you might want to discuss with the victim are:

- 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?
- Is this crime a culmination of other crimes or violence committed by the same person?
- 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 when the defendant is released?

RESTITUTION

Victims of crime are owed restitution from the offender for the full amount of the economic loss incurred as a

result of the crime. The Alaska constitution, Article I, Section 24 provides for the right of restitution to crime victims. Several statutory provisions implement this right, by providing that:

- Public policy favors requiring criminals to compensate their victims for injuries and damages sustained. AS 12.55.045(a)(1);
- Restitution is not limited to a criminal court award; victims may also seek restitution in civil court proceedings. AS 12.55.045(b);
- Restoration of the victim shall be specifically considered as part of the sentencing criteria. AS 12.55.005(7).

Victim advocates should advise the victim of the right to restitution and assist in preparing the claim and supporting documentation. The information should then be provided to the probation officer preparing the pre-sentencing report or to the prosecutor handling the sentencing. Prosecutors should always seek a restitution order for the victim at sentencing in an amount determined. If the total amount owed is not known at the time of the sentencing, prosecutors should seek an order for the amount known, and a second order in an amount to be determined by further order of the court. It is equally important that victim advocates share with victims the reality of restitution collection. Typically, offenders pay little of the restitution owed to the victim. While it is true that victims may convert the restitution order to a civil judgment for collection, it is also true that victims do not wish to become the debt collector for the offender.

VIOLENT CRIMES COMPENSATION BOARD

Information regarding violent crimes compensation is required to be given to victims at the time of initial police contact per AS 18.67.175. Victims of strangulation who cooperate with law enforcement and prosecution may be entitled to compensation from the Violence Crimes Compensation Board (VCCB). While the State of Alaska is responsible for all costs associated with the collection of forensic evidence, victims may need medical assistance and may not have health insurance or the ability to pay for such medical care. In these cases, the victim advocate will assist the victim in filing for violent crime compensation. In addition to uninsured medical care, the VCCB may also reimburse for expenses incurred as a result of personal injury, loss of earning power as a result of partial or total disability from the crime, and other expenses resulting from the personal injury as the board determines reasonable per AS 18.67.110(a).

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Catherine M. Duggan is the director of Ventura County District Attorney's Crime Victim's Assistance Unit. She participated in the development of the District Attorney's Sexual Assault and Child Advocacy Center, the Family Violence Prevention Center, and the Elder Abuse Rapid Response Team. She has served on the Board of Directors and as president of the California Crime Victims Association.

Chapter 11: Conclusion

By Casey Gwinn, J.D. and Gael B Strack, J.D.

“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

The tragic deaths of 17-year-old Casondra Stewart and 16-year-old Tamara Smith in 1995 have led to dramatic changes in San Diego, California, and across the United States. Their deaths produced the first—and still largest—published study of non-fatal strangulation cases ever conducted. Their deaths inspired our team in San Diego to develop specialized multi-disciplinary training approaches that set the standard for training in this life and death area of criminal and civil legal practice. Their deaths led to partnerships among multiple disciplines, including the legal and medical communities in California and across the country. Today, specialized training has been developed and is now available throughout the country—enabling a more effective response to non-fatal strangulation crimes. No one any longer questions the life and death importance of investigation and prosecution of such crimes. The prosecution of non-fatal strangulation crimes has become one of the most important homicide prevention approaches ever identified.

Since 1997, both the California District Attorneys Association and the National District Attorneys Association have taken the lead in including training on strangulation issues at their conferences, workshops, and seminars. Many state and national organizations have followed their lead. Specialized training is now helping thousands of domestic violence professionals across the country improve their investigation, documentation, and prosecution of strangulation cases.

As a result of specialized trainings and partnerships, many strangulation cases are being elevated to felony-level prosecution in California and across the country due to improved investigations and documentation of these crimes. Cases we once thought unprosecutable are being routinely submitted for successful felony or misdemeanor prosecution.

The Training Institute on Strangulation Prevention has been monitoring how courts are ruling on new strangulation laws that have passed across the United States. While not all states have weighed in, the trends are clear: Strangulation statutes are being upheld as constitutional; police officers are being permitted to testify about their observations and experience in handling strangulation cases; nurses and doctors are being qualified as experts in strangulation cases; judges are finding the testimony of experts helpful especially where there is no visible injury; prosecutors are winning their cases even when victims recant or present with limited visible injuries; and sufficient evidence of strangulation can be based on the victim’s subjective symptoms, officer observations, and/or expert testimony.

Most recently, the United States Sentencing Commission issued recommendations for strangulation and suffocation cases. After seeking public comment and holding hearings, they found strangulation/suffocation cases should be a separate felony offense and taken seriously at sentencing. They recommended “strangulation and suffocation, or an attempt of either, is specific serious conduct that deserves enhanced punishment regardless of injury.” Defendants in the federal criminal system will likely facing 10 year minimum sentences for strangulation or suffocation offenses.

Law enforcement and prosecution protocols are being updated, best practices are being developed for the investigation and prosecution of strangulation cases, specialized medical forms and new tools are being developed to help medical professional document injuries and identify symptoms in hospital, and legislation has already been passed to facilitate the prosecution of strangulation cases in 37 states. Doctors, forensic nurses, domestic violence detectives, and other professionals are qualifying as experts and are testifying in court about strangulation dynamics. And as cases are being prosecuted, appellate case law is now supporting the work of

fearless and determined police officers, prosecutors, and medical professionals as they push the envelope and aspire to develop the field further.

“The neck is so easy to grab, so vulnerable, so vital to all life, connecting breathing and heart to mind. The viciousness and harm of this terroristic act is far different than mere broken bone or a physical injury. I have suffered the range of these injuries and nothing comes close to strangulation and suffocation in sheer terror.”

Jennifer Bishop Jenkins, Victim Testimony to the US Sentencing Commission

The United States Department of Justice has recognized the seriousness of strangulation cases and has funded the Family Justice Center Alliance to launch the Training Institute on Strangulation Prevention to train thousands of professionals through online technology, webinars, conferences, faculty, and partnerships with state and national organizations and technical assistance providers. Such funding and political support reflects rising awareness of the importance of prevention work by the top tiers of our criminal and civil justice system.

This manual is a direct result of the partnership between the Family Justice Center Alliance, the California District Attorneys Association and the following agencies from Alaska:

Alaska Department of Public Safety

Alaska Department of Law

Alaska CARES

Alaska Children’s Justice Act Task Force

Alaska Network on Domestic Violence and Sexual Assault

Alaska Council on Domestic Violence and Sexual Assault

University of Alaska, Center for Human Development

Alaska Institute for Justice

Fairbanks Memorial Hospital

We are grateful for their leadership, sharing our passion in this work, adding new chapters and improving many chapters. Working together, we will be able to share of collective learning and improve our response and handling of strangulation and suffocation cases for domestic violence, sexual assault, child abuse and elder abuse victims.

While much has been accomplished, and many lives have been saved due to the tremendous work of criminal justice, social service, and medical professionals, there is still so much more to do. We all look forward to the day when strangulation cases are treated as a serious criminal offense in every jurisdiction across the United States. It is our collective hope that this manual inspires others to develop comprehensive response protocols to strangulation crimes in every state in the nation, including developing similar training manuals using this manual as a template.

We are grateful to the hundreds of individual police officers, prosecutors, advocates, doctors, nurses, probation officers, and elected officials who have become champions of change and have made significant contributions to their respective systems. By investing time in becoming an expert in non-fatal strangulation cases, you are saving lives and improving our system response to the handling of non-fatal strangulation cases for years to come. Thank you for helping us ensure that Casandra Stewart, Tamara Smith, and many others did not die in vain. We must all now become passionate allies in the high calling of homicide prevention through the aggressive and relentless struggle to identify non-fatal strangulation cases, investigate them properly, and prosecute them successfully.

General

1. [On the Edge of Homicide: Strangulation as a Prelude \(2011\)](#)

Gael Strack and Case Gwinn discuss the lethality of IPV strangulation and the necessity for victim safety and offender accountability.

2. [Top 13 Articles to Read](#)

3. [Obtaining Justice for Victims of Strangulation in Domestic Violence: Evidence Based Prosecution and Strangulation-Specific Training \(2012\)](#)

4. [The Pandora Effect](#)

Text of the keynote speech to the Texas Tech Women’s Health Conference addressing the health consequences of domestic violence. (May 2003)

5. [Alaska Victims’ Rights Overview](#)

6. [Working with Interpreters](#)

Considerations for all service providers when working with victims’ whose primary language is not English. Provided by the Alaska Institute for Justice.

Law Enforcement

7. [Strangulation and Lethality Questions for Law Enforcement](#)

Example of laminated cards provided to law enforcement in the state of Alaska to aid in interviews and investigations.

8. [Strangulation/Suffocation Information Card](#)

This flier includes examples of medical questions, investigative questions, and physical signs/symptoms of strangulation, courtesy of the Wisconsin Office of Justice.\

9. [Strangulation Roll Training Card](#)

Includes questions to ask victims, procedures to follow, and facts about strangulation.

10. [Recognizing and Investigating Strangulation](#)

Checklist for law enforcement, including questions to ask victims, evidence collection, and report writing.

11. [Documentation Chart for Strangulation Cases](#)

Legal

12. [Why Strangulation Should Be a Felony \(2011\)](#)

White paper developed by the National Family Justice Center Alliance, Training Institute on Strangulation Prevention as background information for a California strangulation statute.

13. [Sample Questions for the Strangulation Expert](#)

Developed by Dr. George McClane, Dr. Dean Hawley, and Gael Strack, J.D.

Medical

14. [Strangulation Glossary](#)

Medical terms used in strangulation cases.

15. [Injuries of Fatal and Non-fatal Suffocation in Family Violence Cases](#)

Developed for the Training Institute on Strangulation Prevention by Dr. Dean Hawley.

16. [Forensic Medical Findings in Fatal and Non-fatal Intimate Partner Strangulation Assaults](#)

Developed for the Training Institute on Strangulation Prevention by Dr. Dean Hawley.

17. [IPV and Strangulation Chart Example](#)

Medical chart sample provided by Fairbanks Memorial Hospital.

18. [Pediatric Strangulation Assessment Form](#)

Medical assessment form developed by Dr. Cathy Baldwin- Johnson and Dr. Tracey Wiese

19. [Strangulation Card for Patients](#)

Card developed and provided by Fairbanks Memorial Hospital to educate patients about the risks of strangulation.

Victim Advocacy

20. [Strangulation Brochure](#)

Created by the FJC Legal Network, a program of the National Family Justice Center Alliance, this brochure contains information regarding strangulation injuries and provides a grid that can be utilized to monitor signs and symptoms.

21. [Traumatic Brain Injury and Domestic Violence Victims](#)

Reprinted with permission of the Empire Justice Center, Building Bridges: A Cross-Systems Training Manual for Domestic Violence Programs and Disability Service Providers in New York, 2006