TRAINING INSTITUTE on STRANGULATION PREVENTION

a Program of Alliance for HOPE International

National Advisory Meeting

August 19-20th, 2016 in San Diego, California

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Overview of The Training Institute

The Training Institute on Strangulation Prevention (Institute), a program of Alliance for HOPE International, was launched in October 2011. The Institute was developed in response to the increasing demand for Intimate Partner Violence Strangulation Crimes training and technical assistance (consulting, planning and support services) from communities across the world. Launched with support from the United States Department of Justice, Office on Violence Against Women, the Institute provides consulting, training, resources, and support services to professionals working in the fields of domestic violence and sexual assault.

The goals of the Institute are to:

- Enhance the knowledge and understanding of professionals working with victims of domestic violence and sexual assault who are strangled;
- Improve policy and practice among the legal, medical, and advocacy communities;
- Maximize capacity and expertise;
- Increase offender accountability;
- and ultimately enhance victim safety.

The Institute provides training through technical assistance, web-based education programs, a directory of national trainers and experts, and a clearinghouse of all research related to domestic violence and sexual assault strangulation crimes. The Institute provides the most current and up-to-date curriculum on strangulation crimes from a multi-disciplinary perspective. Our trainings have been recognized throughout the country as the premier source for information related to strangulation and we have been featured for our work in dozens of articles and media outlets from the New York Times, USA Today, Cosmopolitan Magazine, the Domestic Violence Report and more!

Attendees of our trainings learn how to:

- identify the signs and symptoms of non-fatal strangulation cases;
- understand and recognize the anatomy and medical aspects of surviving and non-surviving victims;
- investigate and document cases for prosecution;
- prosecute cases,
- including using experts in court;
- and, most importantly, enhance victim safety through trauma-informed advocacy services.

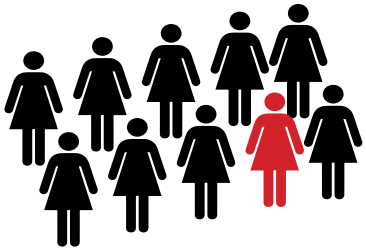
The Institute trains over 5,000 professionals per year on Domestic Violence and Sexual Assault Strangulation Crimes

History of and Need for the Training Institute on Strangulation Prevention

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

Of women who experience IPV...

10% **experience near-fatal strangulation by their partner.**



For many years, medical training for the identification of 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 then-San Diego City Attorney Casey Gwinn to study existing "choking" cases being prosecuted within his 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 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 then spread around the country.

VAWA 2013
added strangulation and suffocation
to FEDERAL LAW

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. Currently, over forty states have passed felony strangulation laws according to the National Strangulation Training Institute. 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 National Strangulation Training Institute's Faculty and Advisory Team.

The National Advisory Board

The widespread success and expansion of the Institute is in large part due to the committed core of faculty and advisors committed to helping save the lives of potential victims of deadly domestic violence. We are especially grateful to our Advisory Board, a group of medical, law enforcement, legal, and social service professionals, who help us to dream big for the future of our program.

Advisory Board List

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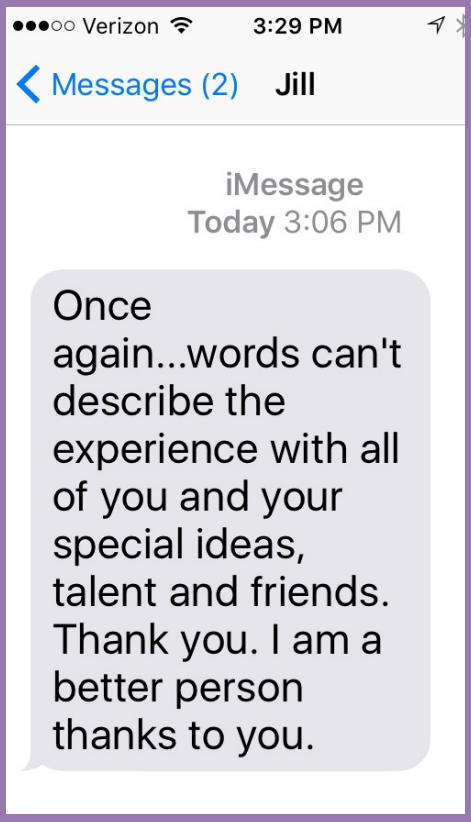
Advisory Board Meeting Description

In August, 2016, for the first time in several years, our advisory group met face-to-face to dream about the Institute's future together. Attendees of this meeting left inspired to spread their knowledge and committed to concrete steps to make their programs even more successful.



Outcomes of the Advisory Board Meeting

Unanimous Approval of Medical Radiological Evaluation Recommendations

Development of Legal Webinar Programming

Strategic Directions: How Can We Take the Institute to the Next Level?

- Public Awareness & Education
- Legislation & Legal Strategies
- Developing Uniform Best Practices & Protocols
- Focus on Health Impacts & Long Team Health Consequences of Strangulation
- Multi-Disciplinary Strangulation Response Team
- Funding & Implementation of Strangulation Programs
- Research & Development
- Professional Education & Training
- Making New Friends to Expand Our Reach

RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION

Prepared by **Bill Smock, MD** and **Sally Sturgeon, DNP, SANE-A**
Office of the Police Surgeon, Louisville Metro Police Department
Endorsed by the **National Medical Advisory Committee**: Bill Smock, MD, Chair; Cathy Baldwin, MD; William Green, MD; Dean Hawley, MD; Ralph Riviello, MD; Heather Rozzi, MD; Steve Stapczynski, MD; Ellen Tailiaferro, MD; Michael Weaver, MD

GOALS:
1. **Evaluate carotid and vertebral arteries for injuries**
2. **Evaluate bony/cartilaginous and soft tissue neck structures**
3. **Evaluate brain for anoxic injury**

Strangulation patient presents to the Emergency Department

History of and/or physical exam with ANY of the following:

- **Loss of Consciousness** (anoxic brain injury)
- **Visual changes**: "spots", "flashing light", "tunnel vision"
- **Facial, intraoral or conjunctival petechial hemorrhage**
- **Ligature mark or** neck **contusions**
- **Soft tissue neck injury/swelling of the neck/cartoid tenderness**
- **Incontinence** (bladder and/or bowel from anoxic injury)
- **Neurological signs or symptoms** (LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorders, stroke-like symtoms.)
- **Dysphonia/Aphonia** (hematoma, laryngeal fracture, soft tissue swelling, recurrent laryngeal nerve injury)
- **Dyspnea** (hematoma, laryngeal fractures, soft tissue swelling, phrenic nerve injury)
- **Subcutaneous emphysema** (tracheal/laryngeal rupture)

Recommended Radiographic Studies to Rule Out Life-Threatening Injuries*
(including delayed presentations of up to 6 months)

- **CT Angio of carotid/vertebral arteries** (***GOLD STANDARD*** for evaluation of vessels and bony/cartilaginous structures, less sensitive for soft tissue trauma) ***or***
- **CT neck with contrast** (less sensitive than CT Angio for vessels, good for bony/cartilaginous structures) ***or***
- **MRA of neck** (less sensitive than CT Angio for vessels, best for soft tissue trauma) ***or***
- **MRI of neck** (less sensitive than CT Angio for vessels and bony/cartilaginous structures, best study for soft tissue trauma) ***or***
- **MRI/MRA of brain** (most sensitive for anoxic brain injury, stroke symptoms and intercerebral petechial hemorrhage)
- **Carotid Doppler Ultrasound** (***NOT RECOMMENDED:*** least sensitive study, unable to adequately evaluate vertebral arteries or proximal internal carotid)

*References on page 2

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Continued ED/Hospital Observation (based on severity of symptoms and reliable home monitoring)

(+)

- Consult Neurology Neurosurgery/Trauma Surgery for admission
- Consider ENT consult for laryngeal trauma with dysphonia

History of and/or physical exam with:

- **No LOC** (anoxic brain injury)
- **No visual changes**: "spots", "flashing light", "tunnel vision"
- **No petechial hemorrhage**
- **No soft tissue trauma to the neck**
- **No dyspnea, dysphonia or odynophagia**
- **No neurological signs or symptoms** (i.e. LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorder, stroke-like symtoms)
- And **reliable home monitoring**

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

Brochure Design by Yesenia Aceves
StrangulationTrainingInstitute.com
Version 17.9 9/16 WSS

Multi-Disciplinary Team Break Out Session

Emerging Issues

- Traumatic Brain Injuries and long-term health consequences of domestic violence incidents.
- Title IX issues and sexual violence on campuses.
- Child abuse and pediatric strangulation.
- Children as witnesses, not enough attention paid to trauma of children who testify.
- Elder abuse, strangulation, and complications in reporting due to mental issues (such as dementia).
- Dealing appropriately with the men who strangle. Working at underlying rage issues to prevent future abuse and injury.
- Recording devices, how will worn body cameras impact strangulation investigations? Concerns about privacy mixed with a potential for greater success in prosecuting crimes.

What are the Existing Challenges for Professionals Handling Strangulation Cases?

- Lack of education: not enough professionals know about the issue, need to institutionalize the education process because of high turnover in the field. The education of the community should also be a high priority in order to inform victims of serious health consequences and to prevent future injuries.
- Crime Scene Response is non-existent for non-fatal strangulation. Crime Scene Investigations are generally reserved for homicides and there are not enough resources for lesser crimes. This is especially difficult because so often strangulation cases become extremely dependent on physical and photographic evidence collected at the scene.
- Fighting against existing protocols in departments, it takes a lot of effort to change how things have always been done.
- Increased occurrence of using strangulation as a defense tactic. Defense attorneys are becoming more sophisticated in their arguments.

Who is Missing From Our Advisory Team?

- Racial diversity
- Rural representation, how can communities with limited resources address strangulation?
- Funders
- Neurologists
- Researchers who can help with scientific studies for national legitimacy. We need more long-term and in-depth studies

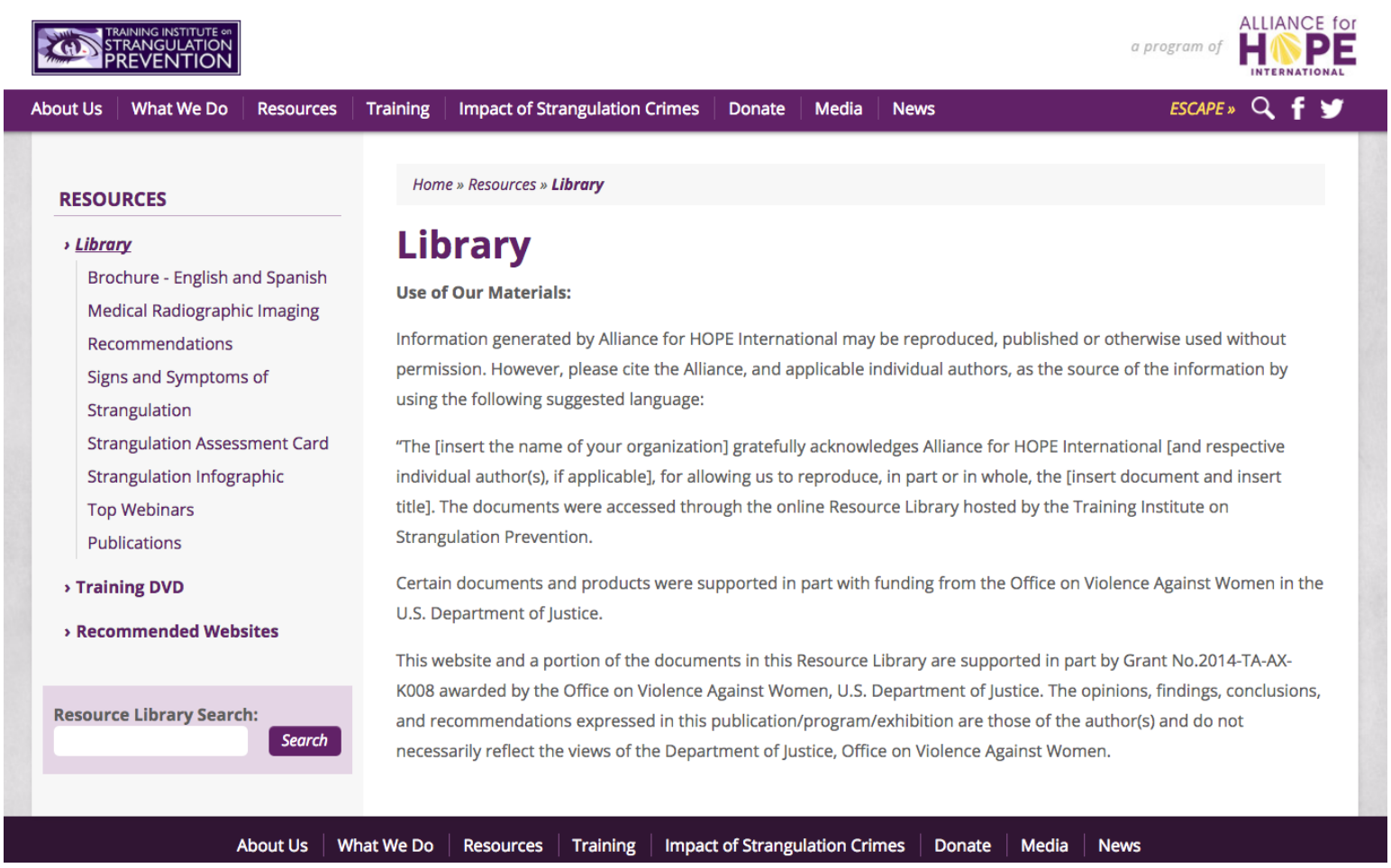
Reviewing Existing Curriculum

How can our Trainings be Improved?

- Modify the Advanced Course in order to allow it to occur in less time than four days.
  - Create homework requirement so more time can be spent working together during the training.
- Create a follow-up course for past advanced course attendees in order to focus on implementation.
  - Could be divided by affinity groups.
- Create a 1-hour program to get basic information out to a wide audience.
- Make courses count for accreditation in medical and other fields besides for attorneys.
- Focus on interactive trainings whenever possible.

Creating New Tools

- Resource Library: The Institute has created a searchable bibliography with the goal of having it be accessible on our website.
- Make legal research accessible on the website. Include pertinent cases, state legislation, and briefs related to strangulation.

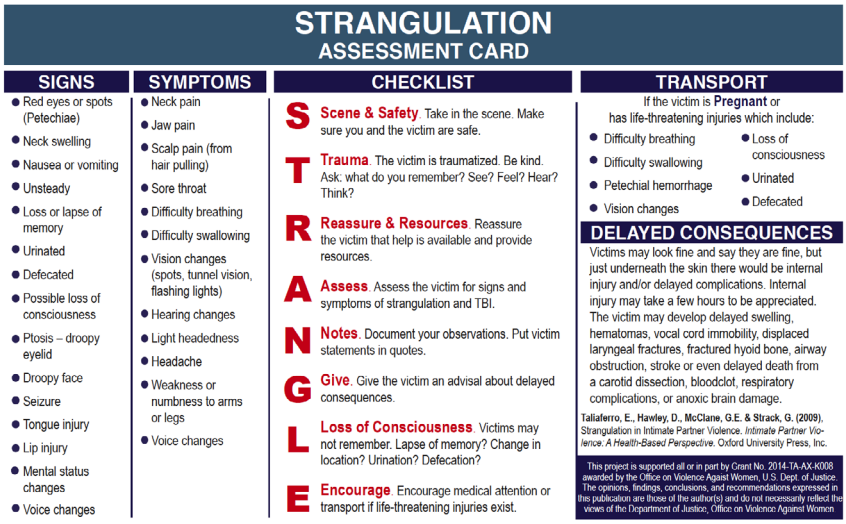


Affinity Group Break Out Sessions

Medical

- **Issues and potential solutions.**
  - Increase buy-in from medical professionals.
    - Publish in “Critical Decisions in Emergency Medicine.”
    - Disseminate Dr. Smock’s recommendations for the Medical/Radiographic Evaluation of Acute Adult, Non-Fatal Strangulation.

- **Considered some edits to soften some language. Created suggestive language, rather than mandated language. Acknowledge that this is based on case reports and case series, not necessarily evidence-based.**
    - Emergency Department Protocol: create a template through TISP and promulgate it including discharge instructions and advisory to patients.
    - Long term goal: larger studies, with larger samples.



STRANGULATION
ASSESSMENT CARD

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

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

CHECKLIST

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

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

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

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

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

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

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

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

TRANSPORT

If the victim is **Pregnant** or has life-threatening injuries which include:
- Difficulty breathing
- Difficulty swallowing
- Petechial hemorrhage
- Vision changes
- Loss of consciousness
- Urinated
- Defecated

DELAYED CONSEQUENCES

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

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

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Legal

- **Issues and potential solutions.**
  - Laws that do not incorporate positional asphyxia.
    - We should be contacting people in jurisdictions across the country to encourage the addition of positional asphyxia to existing legislation.
  - How to improve success rate of prosecution for strangulation cases.
    - Create a brief brank to help prosecute strangulation cases.
    - Create a bank of experts for use on strangulation trials.
    - Improve implementation training for prosecutors.

- **Create step by step webinars for strangulation cases. Which would include case prep, voir dire, motions, opening, use of experts, working with victims of trauma, law enforcement, defenses.**
  - Judges are difficult to reach for training.
    - Supposed to be neutral, may be hesitant. Written materials may be a good way to reach them. These should include citations to legal and medical articles and laws from other states.

Law Enforcement

- **Issues and potential solutions.**
  - Training a wider audience of professionals.
    - Online trainings could be effective for law enforcement professionals.
    - Important to get department head buy in and ensure a succession plan is in place.
    - Training should be consistent throughout the country.
  - Body Worn Cameras.
    - Have to weigh concerns about privacy/legal issues with the potential for use as evidence. Best practices are starting to be developed and policies are being challenged in court. It will take a while to see where the law comes down on body worn cameras and when recordings can be used in court or released to the public.
  - Crime Scene Response.
    - Establish protocols to mandate policies.
    - Failure to prioritize DV crimes. Have to get the word out that this is a life-threatening felony.
    - Increase accountability by requiring supervisors to sign off on reports.

- **Webinar topic ideas.**
  - Leadership accountability for law enforcement.
  - Report writing for police officers, how to deal with DV, strangulation.
  - Building collaborations and partnerships (police with other orgs, advocacy groups, etc).

Advocates

- **Issues and potential solutions.**
  - Education of communities with an emphasis on vulnerable populations.
    - Reach communities through new avenues of communication: PSAs, DMV, Public Health Centers, Head Start/Schools, Module in Citizenship Classes, WIC classes, Pre-Natal classes.
    - Create a community education toolkit for distribution.
  - Improving Emergency Room protocol to better serve domestic violence victims.
    - Change assessment questions to include procedures for referrals of what to do next.
    - Include information about and diagnosis of potential long-term health consequences of injuries.
  - Create an algorithm to assess level of loss of consciousness and then determine the likelihood of specific consequences.

- **Webinar topic recommendations.**
  - How to make VOCA funds accessible for survivors.
  - Feature therapists who trained in trauma.
  - Long-term consequences of domestic violence injuries.

SAN DIEGO CASE STUDY:
Tanika, survivor of carotid dissection

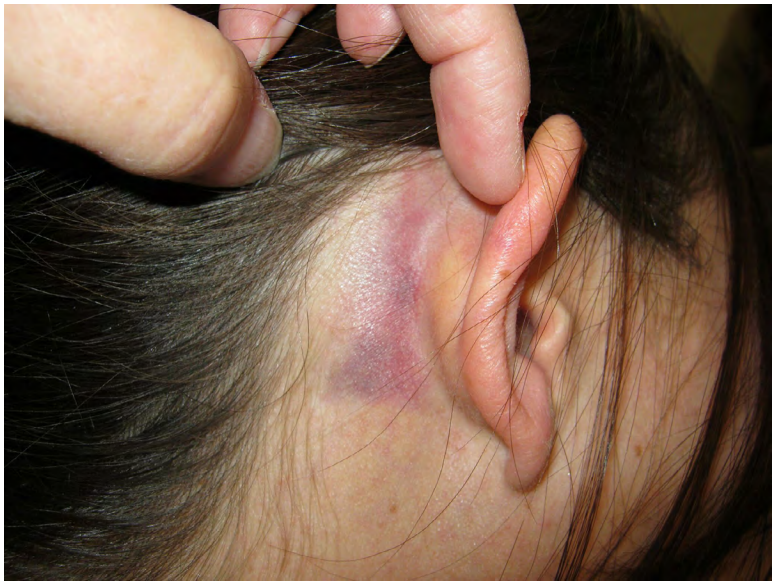
- Dr. Sylvia Vella – Law Enforcement Perspective
- Tanika
- Dr. Bill Smock
- Prosecutor
- Reflections/Recommendations

One of the most meaningful parts of the Advisory Meeting was a panel on a case study of a strangulation incident that occurred in San Diego. The survivor of the incident attended and shared her experience with the advisory board. A panel of experts (law enforcement, legal, medical) explained the incident in their professional views and fielded questions.

Tanika was assaulted by her then boyfriend and held from behind while he wrenched upwards, stretching her neck. The next day she went to the San Diego Family Justice Center and met with Detective Sylvia Vella. Sylvia noticed a bruise behind her ear and told her it could be a serious neck injury from strangulation. Documented her injuries with photographs and encouraged her to go to the ER. Tanika went to the Emergency Room and asked for a CT scan. Doctors were dismissive, but she was scanned eventually. The doctors discovered bilateral carotid dissections. She was immediately transferred to a secure floor and admitted
for treatment.

Dr. Smock pointed out that according to the charts, the doctors treating Tanika never followed through with her losses of consciousness.

The case was continued many times because of various issues, and defense attorneys started attacking Tanika. Eventually the defendant was convicted and sentenced to a year in jail.



List of recommendations from discussion

• Medical assessment/LE need to communicate with hospitals about DV training.

- Minimizing injuries. Power and control, etc.

• Memory and trauma, details need to be factored into doctor's assessment.

• Does the FJC send information to the hospitals?

- Could be helpful to victims so don't have to retell trauma.
- On the response card could add detective info so the hospital could contact.

• Calls with the forensic nurse before the victim arrives.

• DV response is not as good as Sexual Assault response team.

- We could create a DV response team. In CA well-organized rape crisis system throughout the state. Get services to people wherever we are.

• Nurse examiners (forensic) already trained for SA, should also be happening in DV

- Need legislative support for this, because no financial infrastructure for this.

Click here for video highlights of the
National Board Advisory Meeting

Respectfully submitted,

Gael Strack, Esq., CEO
Casey Gwinn, Esq., President
With the wonderful assistance of
Sarah Dawe and Yesenia Aceves