the investigation and prosecution of strangulation cases

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"I saw stars and I passed out. When I came to, he's on top of me, banging my head against the kitchen floor and strangling me."

— Reena

"He woke up and immediately started choking me and put me up against the wall. I fell and urinated on myself. Right after I hit him he let go from choking me and he started punching me on the floor."

— Julie

"I was trying to get away and he grabbed me, spun me around, started to choke me, brought me down to the ground, and at the same time that he was trying to choke me, he was trying to slam my head on one of the rocks."

— Jan

"I would always remember soreness and bruises on my neck. [My neck] would be sore for at least four or five days."

— Survivor

"The very first time he was violent with me he strangled me. He pushed me up against a wall. He held his hands on my throat and had me pinned against the wall with my feet in the air. At that moment I really thought he was going to kill me."

— Lana

"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."

— Ruth

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Chapter 1
Introduction and Overview of Strangulation Cases

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

Strangulation impacts all professionals working on sexual assault, domestic violence, dating violence, and stalking cases. **Today, it is understood unequivocally that strangulation is one of the most lethal forms of domestic violence.**

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.

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 strangulation cases there are no visible external injuries. The lack of external injuries on the victim and the lack of medical training among domestic

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.*

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.

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. As of April 2013, 37 states have passed felony strangulation laws. 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 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.

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 also 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. Rather, implementation has been intermittent and unpredictable due to poor leadership, management, and frequent turnover of staff in these fields.

Casondra Stewart and Tamara Smith did not die in vain. Their tragic deaths have clearly led to dramatic changes within the system. And the work continues.

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Chapter 2
Strangulation and the Law

by Casey Gwinn, J.D.

> *"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. The first section of this chapter is designed to help prosecutors in California and elsewhere argue the seriousness of these cases in front of judges and juries. Next, the chapter focuses on understanding the current state of the law in California, including the 2012 strangulation/suffocation amendment to Penal Code section 273.5. Then, this chapter advocates for the passage of a specific, stand-alone felony strangulation statute in California. And finally, there is a look at lessons to be learned from other states.

For many years in California and 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 January 2013, 37 states 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] Recently, the newly re-authorized Violence Against Women Act added strangulation and suffocation language to federal law for the first time.[3] California's newest statute, as well, helps to raise the awareness of professionals about the serious nature of such assaults even if there is no visible injury after the act.

Without the passage of The Diana Gonzalez Strangulation Prevention Act of 2011, California prosecutors, police officers, and advocates would be left with only two felony charges for non-lethal strangulation cases with minimal or no visible injury—Penal Code section 245(a)(1), which requires proof of intent to do great bodily injury (even if great bodily injury is not inflicted), and Penal Code section 187/664 (attempted murder), which requires intent to kill. Penal Code section 245(a)(1) does not cover the vast majority of assaults where intent to do great bodily injury is not present. And Penal Code section 187/664 does not cover the many cases where the offender is not trying to kill his partner.

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.

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, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, 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).

- 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).[4]

- 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."[5]

- 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.[6]

- 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.[7]

- The San Diego Study found major signs and symptoms of strangulation that corroborated the assaults, but little visible injury.[8]

4. 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).
5. 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.
6. Nancy Glass et al., "Non-Fatal Strangulation Is an Important Risk Factor for Homicide of Women," (2008) 35 *J. Emergency Med.* 3: 329, 329.
7. 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.
8. *Id.*

- Strangulation is more serious than professionals have realized. Loss of consciousness can occur within 5–10 seconds, and death within 4–5 minutes.[9] 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.[10]

- 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).[11]

- 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.[12]

- 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.[13]

- 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.[14]

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

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9. 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).
10. *Id.* at 4.
11. *Id.* at 1.
12. Glass et al., *supra,* note 5, at 329.
13. *Id*. at 3.
14. 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.

  - 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.[15]

- 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.[16]

- 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.[17]

- In 2008, the Abuse Assessment Screen was revised to address non-lethal strangulation due to the body of research on seriousness of the assault.[18]

15. 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).
16. Hawley, *supra*, note 8.
17. IACP *National Law Enforcement Policy Center, Domestic Violence* (2006).
18. Laughon et al., *supra,* note 13.

- 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.[19]

- 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.[20]

- 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 Diana Gonzalez Strangulation Prevention Act of 2011

In 2011, California passed Senate Bill 430 (Kehoe), which for the first time added definitional language to Penal Code section 273.5 in order to assist prosecutors in specifically charging non-fatal strangulation offenses as felonies.[21] The new statutory language became effective January 1, 2012.

California's Penal Code section 273.5 has been considered one of the leading spousal-abuse statutes in the United States for decades for a number of reasons. First, it is a general intent crime and does not require specific intent to inflict a certain level of injury. Second, it allows the filing of felony spousal-abuse charges even with minimal injury (defined as "traumatic condition") if the relationship between the victim and the offender falls within the categories covered by the statute:

19. 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 polices 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).
20. 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.
21. SB 430, in its original form, is discussed later in this chapter, but the compromise language that unanimously passed the State Senate and the Assembly and was signed by the Governor still moved the dial and created a valuable tool for California prosecutors due to the already powerful, innovative nature of Penal Code section 273.5.

spouse, former spouse, cohabitant, former cohabitant, or the mother or father of his or her child.[22] Traumatic condition is defined as "a condition of the body, such as a wound or external or internal injury, whether of a minor or serious nature, caused by a physical force."[23] Finally, section 273.5 provides for an upper term of four years in state prison, excluding other statutory enhancements that may apply.

California courts have consistently upheld felony convictions under Penal Code section 273.5 even if there are minimal internal or external injuries.[24] This made amending Penal Code section 273.5 the perfect approach to enhancing consequences for non-fatal domestic violence strangulation assaults in California. The Legislative Counsel explained the amendment to Penal Code section 273.5 this way: "This bill, the Diana Gonzalez Strangulation Prevention Act of 2011, would specify that 'traumatic condition' includes injury as a result of strangulation or suffocation and defines the terms 'strangulation' and 'suffocation' for those purposes."[25]

Penal Code section 273.5(c) now reads:

> As used in this section, "traumatic condition" means a condition of the body, such as a wound, or external or internal injury, including, but not limited to, *injury as a result of strangulation or suffocation*, whether of a minor or serious nature, caused by a physical force. For purposes of this section, "strangulation" and "suffocation" include impeding the normal breathing or circulation of the blood of a person by applying pressure on the throat or neck. [Emphasis added.][26]

The amendment added language clarifying that strangulation is serious criminal conduct in intimate relationships and, by the very nature of the offense, causes internal and often external injuries that result in a "traumatic condition." The amendment to section 273.5 now provides clear direction to judges and juries as finders of fact in domestic violence cases when an abuser has

22. Unfortunately, by placing the definitional language on strangulation and suffocation in 273.5, dating relationships and other intimate partner relationships—where the parties have never been married, never lived together, or not had a child together—are not covered by SB 430. However, legislation has recently been introduced to include the latter type of relationships under the statute. AB 16, 2013-2014 Sess. (Ca. 2012).
23. See Pen. Code § 273.5(c).
24. See, e.g., *People v. Silva* (1994) 27 Cal.App.4th 1160, 1166. "[California Penal Code] Section 273.5 applies to 'corporal injury resulting in a traumatic condition.' Thus, a defendant who inflicts only 'minor' injury violates the statute. *People v. Wilkins* (1993) 14 Cal.App.4th 761, 771, 17 Cal.Rptr.2d 743."
25. See SB 430, 2011–2012 Reg. Sess. (Ca. 2011) <*http://www.familyjusticecenter.com/Strangulation/sb_430_bill_20110726_chaptered.pdf* > (accessed Apr. 4, 2013) for the full text of the bill.
26. The full text of Penal Code section 273.5 is included in the Appendix of this manual at page A-75.

strangled his partner. It also lays the foundation for a jury instruction to help guide juries in cases involving non-fatal strangulation.[27]

In most cases where a domestic violence offender strangles his partner, he wants her to know that he can kill her, and therefore, she will live with the knowledge of her partner's lethality day and night. The abuser may not want to kill his partner or cause great bodily injury; nevertheless, 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. Whether the ultimate offense is charged as a misdemeanor or felony under Penal Code section 273.5, the statute allows criminal justice professionals to protect victims and hold abusers accountable before there is serious injury or death.

Women who are strangled by their partners and survive are 800 percent more likely to be killed by their partners in a subsequent assault and 700 percent more likely to suffer an attempt on their lives by their abusive partners at a later time.[28] Thus, SB 430 has become a homicide-prevention measure by allowing prosecutors to file spousal-abuse charges, with a specific focus on the strangulation portion of any assault, as a misdemeanor or felony before the abuser ends up killing his partner.

What's Needed Next in California?

The original version of SB 430 was a stand-alone felony strangulation statute, but due to California prison overcrowding in 2011, the Legislature was unwilling to create any new felony offenses.[29] So the next step is to get a stand-alone felony statute through the Legislature.

The original version of SB 430 reads as follows:

> (a) Any person who willfully and unlawfully strangles, suffocates, or attempts to suffocate a person is guilty of a felony punishable by incarceration in the state prison for a term of two, three, or four years.
> (b) For a defendant to be convicted of a violation of subdivision (a), evidence of either of the following is **not** required: (1) An intent to kill or injure the victim; or (2) visible injuries.

27. The text of California Criminal Jury Instruction for Penal Code section 273.5 is included in the Appendix of this manual at page A-77.
28. Glass et al., *supra,* note 5, at 329.
29. See AB 2357 Analysis, 2011–2012 Sess. (Ca. 2012) (discussing Receivership/Overcrowding Crisis Aggravation in California prisons), available at <*http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_2351-2400/ab_2357_cfa_20120611_123513_sen_comm.html*> (accessed Apr. 4, 2013); see Criminal Justice Alignment, AB 109, 2011–2012 Sess. (Ca. 2011). The original version of SB 430 is in the Appendix of this manual at page A-73.

> (c) If the defendant and the victim are in a relationship described in subdivision (b) of Section 13700, the defendant shall be subject to an enhanced penalty of two additional years imprisonment in the state prison.
> (d)(1) "Strangle" for purposes of this section means to intentionally, knowingly, or recklessly impede the normal breathing or circulation of the blood of a person by applying pressure on the throat or neck.
> (2) "Suffocate" for purposes of this section means to intentionally, knowingly, or recklessly impede the normal breathing of a person.
> (e) Nothing in this section shall preclude prosecution of a person under any other provision of this code.

This language mirrors the language in many current strangulation statutes across the United States. It also provides protection for victims of non-fatal strangulation who do not fall within the narrow relationship categories of Penal Code section 273.5.

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 "Attempted Strangulation" cases. The belief, though unstated in most research, was that strangulation meant death. So 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.[30] It should be viewed as a bad habit. Today, 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 potential strangulation assault. The perpetrator did not "attempt" the assault. He completed it.

Recently, the core group of prosecutors in California who wrote and implemented the strangulation/suffocation amendment to Penal Code section 273.5 discussed this matter and determined that an "attempted strangulation" could occur, but it would be a highly unusual set of facts.[31] The group postulated that 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

30. 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/gIQA9sxfrS_story.html?tid=wp_ipad*> (accessed Apr. 3, 2013).
31. Training Institute on Strangulation Prevention and California District Attorneys Association *Strangulation Working Group Conference Call* (Dec. 27, 2011) (on file with the Training Institute).

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.

Lessons Learned from Strangulation Laws Across the Country

Even as California moves forward on this journey to prevent domestic violence homicides through the investigation and prosecution of non-fatal strangulation cases under Penal Code section 273.5, it is helpful to understand what is happening across the country as many states implement stand-alone strangulation statutes. Currently, 37 states have passed statutes and one state has passed a Legislative resolution.[32] 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. This has not happened in any state but California. Third, cases should be presumptively handled as felonies or law enforcement, prosecutors, and court systems will quickly relegate them to misdemeanors. A brief discussion around each of these lessons learned is helpful.

The Wording of the Statute

The statutory themes generally focus on impeding breathing and blood flow to the brain.[33] 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 and Idaho strangulation statutes[34] are considered by most experts to be among the best in the country.

32. See *supra*, notes 1–2.
33. Laughon et al., *supra,* note 18.
34. Tex. Penal Code Ann. § 22.01 (West 2012). See also Idaho Code Ann. § 18-923 (West 2013): "Attempted strangulation. (1) Any person who willfully and unlawfully chokes or attempts to strangle a household member, or a person with whom he or she has or had a dating relationship, is guilty of a felony punishable by incarceration for up to fifteen (15) years in the state prison. (2) No injuries are required to prove attempted strangulation. (3) The prosecution is not required to show that the defendant intended to kill or injure the victim. The only intent required is the intent to choke or attempt to strangle. (4) 'Household member' assumes the same definition as set forth in section 18-918(1)(a), Idaho Code. (5) 'Dating relationship' assumes the same definition as set forth in section 39-6303(2), Idaho Code." The Idaho statute is also excellent on the elements of the offense that must be proved, but Idaho incorrectly classifies the offense as "Attempted Strangulation." This language is not supported by the National Strangulation Training Institute nor is it reflective of the nature of the offense.

The relevant portion of the Texas statute reads:

> (a) A person commits an offense if the person:
>
> (1) intentionally, knowingly, or recklessly causes bodily injury to another, including the person's spouse;
>
> (2) intentionally or knowingly threatens another with imminent bodily injury, including the person's spouse; or
>
> (3) intentionally or knowingly causes physical contact with another when the person knows or should reasonably believe that the other will regard the contact as offensive or provocative.
>
> (b) An offense under Subsection (a)(1) is a Class A misdemeanor, except that the offense is a felony of the **third** degree if the offense is committed against:
>
> ¶
>
> (2) a person whose relationship to or association with the defendant is described by Section 71.0021(b), 71.003, or 71.005, Family Code, if:
>
> (A) it is shown on the trial of the offense that the defendant has been previously convicted of an offense under this chapter, Chapter 19, or Section 20.03, 20.04, 21.11, or 25.11 against a person whose relationship to or association with the defendant is described by Section 71.0021(b), 71.003, or 71.005, Family Code; or
>
> (B) the offense is committed by intentionally, knowingly, or recklessly impeding the normal breathing or circulation of the blood of the person by applying pressure to the person's throat or neck or by blocking the person's nose or mouth;
>
> ¶¶
>
> (b-1) Notwithstanding Subsection (b)(2), an offense under Subsection (a)(1) is a felony of the **second** degree if:
>
> (1) the offense is committed against a person whose relationship to or association with the defendant is described by Section 71.0021(b), 71.003, or 71.005, Family Code;
>
> (2) it is shown on the trial of the offense that the defendant has been previously convicted of an offense under this chapter, Chapter 19, or Section 20.03, 20.04, or 21.11 against a person whose relationship to or association with the defendant is described by Section 71.0021(b), 71.003, or 71.005, Family Code; and
>
> (3) the offense is committed by intentionally, knowingly, or recklessly impeding the normal breathing or circulation of the blood of the person by applying pressure to the person's throat or neck or by blocking the person's nose or mouth.[35]

35. Tex. Penal Code Ann. § 22.01 (emphasis added), *supra,* note 33.

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. In sum, the Texas legislation embraces the dynamics of domestic violence by holding high-risk and repeat offenders accountable via sentences commensurate with their criminal behavior.

The following are examples of challenging or problematic statutes found across the country.

- **Alabama**: Requires the intent to cause asphyxia (does not directly define asphyxia) and also requires that the offender strangle the victim with intent to cause physical harm or menacing.
- **Alaska**: Strangulation only comes in via the "dangerous weapon" definition. The offender must have recklessly placed the person in fear of imminent serious physical injury via a dangerous weapon (strangulation) or caused physical injury via a dangerous weapon (strangulation).
- **Florida**: The offender must knowingly AND intentionally impede normal breathing or circulation of the blood of a family member SO AS to create a risk of, or cause, great bodily harm by applying pressure on the throat or neck.
- **Maryland**: Only applies to sexual assault offenses, not intimate partner violence cases.
- **Massachusetts** and **Michigan**: Strangulation only falls under attempted murder.
- **New York**: Contains a higher bar for prosecutors to reach for a felony offense. Strangulation in the second degree (felony) requires the offense to cause stupor, loss of consciousness, or any other physical injury or impairment. Strangulation in the first degree (felony) requires the offense to cause serious physical injury.
- **Ohio**: The offense only relates to setting bail.[36]

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. Unfortunately, a review by the Training Institute on Strangulation Prevention found little implementation planning in any state. Due to this failure over the last seven years, the Training Institute and the California District Attorneys Association partnered to develop such a plan when the California strangulation

36. See Alabama Code (§ 13A-6-138); see Alaska Code (§ 11.41.220 Assault in the third degree; § 11.81.900 definition of deadly weapon); see Florida Code (§ 784.041); see Ohio Code (§ 2919.251).

law was passed in 2011. 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 on Strangulation Prevention developing a 30-minute online course for police officers, and publishing this manual.[37] The results have already been impressive.

Prosecutors across California are reporting on successful felony prosecutions with minimal external visible injury based on the training they have received during the implementation process.[38] A few sample cases are illustrative of the success of the implementation plan in California during the first year of the statute.

In *People v. Andrew Vicary*, Imperial County Deputy District Attorney Michael Domenzain prosecuted a strangulation case in which the victim was strangled to the point of unconsciousness. The victim also presented petechiae, slight bruising on her neck, redness in her eyes, and neck and throat pain. The jury convicted the defendant of Penal Code section 273.5 and Penal Code section 664/187. Jurors noted that a major deciding factor in their guilty verdict was because the defendant held on to the victim after she had lost consciousness.

The Riverside County District Attorney's Office recently prosecuted two strangulation cases. In *People v. Buddy Ugwumba,* the defendant was charged under section 273.5 using expert witness testimony, and, in *People v. Jesus Acevedo*, the defendant was charged under section 245(a)(4), with no external injuries. In both cases, the jury returned with felony verdicts. The first case was successfully prosecuted by Deputy District Attorney Allison Pace and the second by Deputy District Attorney Christina Rule.

Challenge Everyone to View Strangulation First as a Felony

One of the greatest lessons learned since 2005, as strangulation statutes have been passed across the country, is that strangulation assaults should be a presumptive felony. Prosecutors must lead this effort. If prosecutors do not treat these cases as serious felonies, police officers, medical professionals, advocates, and survivors will not treat them as such. Recent media coverage of the New York statute, passed in 2010, confirms this reality.[39]

37. 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.*
38. The NSTI solicited feedback from a core group of jurisdictions during 2012 and received feedback on the case scenarios included here.
39. Julie Besonen, "A New Crime, But Convictions Are Elusive," *N.Y. Times* (Feb. 17, 2013), <*http://mobile.nytimes.com/ 2013/02/17/ nyregion/choking-someone-is-now-a-felony-but-convictions-are-elusive.xml;jsessionid=CE93130E7BC4DDD644D5B87A91164BF8?f=22* > (accessed Apr. 3, 2013).

The New York statute created a strangulation crime that can be prosecuted as a misdemeanor or a felony, but statistics show that most cases are being prosecuted as misdemeanors.[40] A number of reasons have been postulated for this, but New York's results appear similar to many other states with new statutes. The lessons learned from this national trend should challenge all states to:

1. include a directive from the state for prosecutors to treat these cases as presumptive felonies,
2. create an implementation plan,
3. provide ample resources,
4. make prosecutor training immediately available, and
5. enact a concerted effort to create a team of experts to testify in court in all cases.

Without these efforts, most strangulation cases will continue to be filed as misdemeanors, and the outcomes at trial will be unimpressive across the country.

As the strangulation laws evolve in California and across the country in the years ahead, the lessons learned from other states must guide our efforts. State statutes should maintain a general-intent requirement only, and any statute should be based on the critical medical research on the nature of suffocation and strangulation in non-fatal assaults. No state should pass a law without an implementation plan, and prosecutors seeking to pass such laws must lead the effort to frame these offenses for the public as serious felonies.

Conclusion

Non-fatal strangulation cases are the edge of a homicide.Abusers who strangle are among the most dangerous. California now has a tool with the amended language of Penal Code section 273.5. The next step in California is to pass a separate, stand-alone felony strangulation statute. Until that time, however, prosecutors in California and across the country can benefit from understanding the strengths and weaknesses of various strangulation statutes in the United States. 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 domestic violence.

40. *Id. See also* Krista Madsen, "Gorski's Death Highlights New York's Recent Strangulation Law," *Patch* (Jan. 18, 2013), <*http://ossining.patch.com/articles/gorskis-death-highlights-new-yorks-recent-strangulation-law* > (accessed Apr. 3, 2013); Andrew Wheeler, N.Y. St. Div. Crim. Just. Serv., Office Just. Res. & Performance, "Arrests and Arraignments Involving Strangulation Offenses: November 11, 2010 – June 30, 2012" (Sep. 2012), available at <*http://www.criminaljustice.ny.gov/pio/research-update-strangulation-apr2012.pdf* > (accessed Apr. 4, 2013).

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Chapter 3
Investigation of Strangulation Cases

by Gael B. Strack, J.D. and Michael Agnew

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.

In the past, "choking" cases were often minimized by victims, police officers, prosecutors, judges, and medical personnel. The lack of visible injury and inadequate training caused the entire criminal justice system to unintentionally treat non-fatal strangulation cases (as we now call them) as minor assaults with little or no consequence.

Today, it's unequivocally understood that strangulation[1] is one of the most lethal forms of domestic violence: Unconsciousness may occur within seconds and death within minutes.

Strangulation is one of the best predictors for the subsequent homicide of victims of domestic violence. One study has showed that the odds of becoming a homicide increased by about seven-fold for women who had been strangled by their partner."[2] Strangulation is also a culturally sensitive issue. The same study showed that African-American women, as compared to Caucasian women had increased odds of experiencing attempted and completed homicide.[3] Victims may have no visible injuries whatsoever, yet because of underlying brain damage caused by the lack of oxygen during the strangulation assault, they may have serious internal injuries or die days, even weeks, later. These factors make any investigation of domestic violence cases, especially strangulation cases, challenging.

1. Strangulation is defined as a form of asphyxia (lack of oxygen) characterized by closure of the blood vessels and/or air passages of the neck as a result of external pressure on the neck. (K.V. Iserson, "Strangulation: A Review of Ligature, Manual, and Postural Neck Compression Injuries," (1984) 13 *Ann. Emergency Med.* 3: 179–185; Stanley Line WS et al., "Strangulation: A Full Spectrum of Blunt Neck Trauma," (1985) 94 *Ann. Otol Rhinol Laryngol.* 6: 542–536.
2. Nancy Glass et al., "Non-Fatal Strangulation Is an Important Risk Factor for Homicide of Women," (2008) 35 *J. Emergency Med.* 3: 329–355.
3. *Id.*

When domestic violence perpetrators use strangulation to assault their victims, it is most likely a felonious assault and should be treated as such in the law and by police, prosecutors, medical personnel, and other professionals involved in domestic violence response and prevention.

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 in district attorney and city attorney offices in California.

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 California, as in many states, has forced police agencies to define guidelines for arrest practices and protocols for the investigation of domestic violence cases. California's 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.[4] 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,[5] 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.

4. Larry L. Tift, *Battering of Women: The Failure of Intervention and the Case for Prevention* 131 (1993).
5. 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.

Some jurisdictions across the country are also including lethality assessments within their domestic violence reports.[6]

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.[7] 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 descibed in Chapter 5, "Medical Evidence in Non-Fatal Strangulation Cases."

Special attention should also be paid to the 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

6. 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.
7. DVD: *Strangulation: What We Have Learned* (Inez Odom Prod. 2010), available at <*http://strangulationtraininginstitute.com/index.php/training-dvd.html*>.

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.[8]

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. In California, most prosecutors will likely charge the defendant with felony assault under Penal Code section 245(a) when it is shown that the defendant had the intent to commit great bodily injury (even if the victim had very little or no visible injuries).[9] It is also appropriate in California to arrest a suspect for felony spousal abuse under Penal Code section 273.5 where there is some evidence of internal injury, such as symptoms of strangulation.[10]

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.

8. Marna L. Anderson, Report Part II: *The Impact of Minnesota's Felony Strangulation Law*, WATCH 3 (2009).
9. *People v. Covino* (1980) 100 Cal.App.3d 660.
10. *People v. Kinsey* (1995) 40 Cal.App.4th 1621.

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 condtion; (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. A printout 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 Evidence Code section 1240 as trustworthy, reliable, and admissible as an exception to the hearsay rule. The 911 printout 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 it's important 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. A lack of oxygen to the brain may cause unconsciousness, brain injury, or death days later. If the victim survives a strangulation assault, she may have been strangled to the point of unconsciousness and likely suffered some level of brain injury. Evidence of unconsciousness includes loss of memory, 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. 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.

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.[11]

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 application[12] available to assist in documenting strangulation cases, called "Document It."

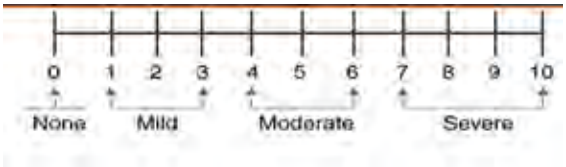
Method

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,

11. 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).
12. Visit *www.strangulationtraininginstitute.com* for more information.

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, ask the victim to physically demonstrate how she was strangled. Photograph 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.)
- 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
☐ Red or flushed ☐ Pinpoint red spots (petechiae) ☐ Scratch marks	☐ Petechiae to **R** and/or **L** eyeball (circle one) ☐ Petechiae to **R** and/or **L** eyelid (circle one) ☐ Bloody red eyeball(s)	☐ Bloody nose ☐ Broken nose (ancillary finding) ☐ Petechiae	☐ Petechiae (external and/or ear canal) ☐ Bleeding from ear canal	☐ Bruising ☐ Swollen tongue ☐ Swollen lips ☐ Cuts/abrasions (ancillary finding)
Under Chin	**Chest**	**Shoulders**	**Neck**	**Head**
☐ Redness ☐ Scratch marks ☐ Bruise(s) ☐ Abrasions	☐ Redness ☐ Scratch marks ☐ Bruise(s) ☐ Abrasions	☐ Redness ☐ Scratch marks ☐ Bruise(s) ☐ Abrasions	☐ Redness ☐ Scratch marks ☐ Fingernail impressions ☐ Bruise(s) ☐ Swelling ☐ Ligature mark	☐ Petechiae (on scalp) **Ancillary findings:** ☐ Hair pulled ☐ Bump ☐ Skull fracture ☐ 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 seek 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
☐ Difficulty Breathing	☐ Raspy voice	☐ Trouble swallowing	☐ Agitation	☐ Dizzy
☐ Hyperventilation	☐ Hoarse voice	☐ Painful to swallow	☐ Amnesia	☐ Headaches
☐ Unable to breathe	☐ Coughing	☐ Neck Pain	☐ PTSD	☐ Fainted
Other:	☐ Unable to speak	☐ Nausea /Vomiting	☐ Hallucinations	☐ Urination
		☐ Drooling	☐ Combativeness	☐ 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? (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 florid petechiae.[13] 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 checks, 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.

13. See note 11, *supra*.

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 florid petechaie, 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 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.[14] 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.

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.[15] It is also important for officers to take this opportunity to educate the victim about the seriousness of strangulation.

14. 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).
15. IACP Nat'l L. Enforcement Pol'y Ctr., Domestic Violence (2006).

Reports from 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.

The treating 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.

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 Dominant 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 dominant 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 dominant 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.

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 strangulated as discussed in both Chapter 4 and Chapter 6.

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.

A sample police report is included in the Appendix to this manual at page A-70.

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 for corroboration 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 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 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.[16] 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 of forfeiture by wrong doing.[17]

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.

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 "subject … is sufficiently beyond common experience that the opinion of an expert would assist the trier of fact."[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.

16. 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.
17. To learn more about forfeiture by wrongdoing, see Scott Kessler, "How to Build and Handle Forfeiture Cases in Court," *Nat'l Family J. Ctr. Alliance* (2008), available at <*http://www.familyjusticecenter.org/jdownloads/finish/15-forfeiture-hearings/80-prosecution-webinar-powerpoint-how-to-build-and-handle-forfeiture-cases-in-court-kessler-a-nfjca-11-08.html* >
18. Evid. Code § 801(a).

Within the last 15 years, police officers 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 dominant 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.

The first documented case where a domestic violence detective testified as an expert in strangulation was in June 2000, before the Honorable Judge Bonnie Dumanis in San Diego Municipal Court. Judge Dumanis allowed San Diego Police Detective Mike Gulyas to testify in a misdemeanor strangulation case during the prosecutor's case-in-chief. Detective Gulyas testified he had received training on strangulation in 1996. Since 1996, he applied the training he had received to the cases he investigated involving strangulation. Based on that training and experience, he was familiar with the signs and symptoms that are consistent with a victim being strangled. His testimony was admissible because it was based on his training and experience. The case resulted in a guilty verdict that was upheld on appeal.

While there are no recently published cases in California where police officers have testified as experts in strangulation cases, officers from San Diego to Redding are qualifying to testify as experts. In San Diego, several detectives have become experts in documenting strangulation cases and routinely testify as experts, including Detectives Bill Puente, Sylvia Vella, and Gary Phillips. In Fresno, Detective Mike Agnew took the lead in training and handling strangulation cases and has testified as an expert in domestic violence cases. In Shasta County, District Attorney Investigator Mike Wallace took the Training Institute on Strangulation Prevention's course on Advanced Strangulation in August 2012, and subsequently qualified as an expert, as did former prosecutor and CDAA's VAWA Director Jean Jordan. Investigators who are currently developing their expertise in this area are encouraged to reach out to the California District Attorneys Association or the Training Institute on Strangulation Prevention to connect with these experts or others.

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.

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.

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.

Chapter 4
Prosecuting Strangulation Cases

by Gerald W. Fineman, J.D.

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
- [a] 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 the defendant had been successful in killing the victim, 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 office. If your jurisdiction cannot allow for pre-filing interviews, the investigation conducted by law enforcement becomes even more critical in the filing determination.

California law entitles the victim to have an advocate and a support person present at the follow-up interview.[1] Early contact informs victims about their rights and the court process. 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. It provides prosecutors 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 are cautioned against demonstrating the strangulation on the victim. To avoid re-traumatization, use a mannequin or wig head.

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

1. Pen. Code § 679.04 for sexual assault victims and § 679.05 for domestic violence victims. This also relates to a victim's right to be free from unnecessary harassment as set forth in the California Constitution (Art. 1, § 28(b)(1)—Marsy's Law).

treat strangulation victims. 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.**[2] 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

Because 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 8 of this manaul.

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. She 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 accurately reflect the incident. She may 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 she normally behaves.

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.

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

The Filing Decision

The California Constitution guarantees victims the right to a prompt decision regarding the filing of cases and the right to be informed of that decision.[3] 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.[4] 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 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. 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.[5]

3. Cal. Const. Art. 1, § 28.
4. CDAA *Uniform Crime Charging Standards* (1996).
5. See *Crawford v. Washington* (2004) 541 U.S. 36 and *Davis v. Washington* (2006) 547 U.S. 813.

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.[6]

Choice of Charges

California strangulation legislation is incorporated into Penal Code section 273.5. The statute does require some type of traumatic condition. "Traumatic condition" has been defined as a condition of the body, such as a wound or internal or external injury, whether minor or serious, caused by physical force.[7]

The defendant needs to inflict the injury. While domestic violence is a general intent crime,[8] the defendant still needs to have caused the injury. In *People v. Jackson,*[9] the court found the defendant did not inflict injury upon the victim where the victim injured herself when she tripped over a curb while fleeing from the defendant. The court goes on to say that for the conduct to constitute a violation of Penal Code section 273.5, the defendant's actions must result from direct contact by the defendant.[10]

Continuous Course of Conduct or Multiple Charges

Two cases address the issue of domestic violence as a continuous course of conduct. In *People v. Thompson,*[11] the court found that Penal Code section 273.5 can cover a continuous course of conduct. The *Thompson* decision does not preclude the charging of multiple domestic violence incidents. In *People v. Healy,*[12] the court ruled that prosecutors may still charge multiple acts of domestic violence as separate incidents, provided that each act meets the elements of Penal Code section 273.5. With the *Healy* decision in mind, prosecutors should consider charging strangulation as a separate crime when there are additional incidents of Penal Code section 273.5.

6. Evid. Code § 1390.
7. See *People v. Abrego* (1993) 21 Cal.App.4th 133.
8. *People v. Thurston* (1999) 71 Cal.App.4th 1050.
9. *People v. Jackson* (2000) 77 Cal.App.4th 574.
10. *Id*. at 579.
11. *People v. Thompson* (1984) 160 Cal.App.3d 220.
12. *People v. Healy* (1993) 14 Cal.App.4th 1137.

Penal Code section 273.5 is not the exclusive charge in a case involving strangulation. A number of other criminal charges may be appropriate:

- Penal Code § 664/187—Attempted Murder
- Penal Code § 664/273.5[13]—Attempted Willful Infliction of Corporal Injury
- Penal Code § 206—Torture
- Penal Code § 245(a)(4)—Assault with Force Likely to Cause Great Bodily Injury
- Penal Code § 243(d)—Battery
- Penal Code § 211—Robbery
- Penal Code § 422—Making a Criminal Threat
- Penal Code § 136.1—Intimidation of a Witness or Victim
- Penal Code § 368—Crime Committed Against an Elder or Dependent Adult
- Penal Code § 459—First-Degree Burglary
- Penal Code § 646.9—Stalking
- Penal Code § 602—Misdemeanor Trespassing
- Penal Code § 487—Grand Theft
- Penal Code § 597—Cruelty to Animals
- Penal Code § 243(e)(1)—Spousal Battery
- Penal Code § 273a—Willful Harm or Injury to a Child
- Penal Code § 594—Vandalism
- Penal Code § 273.6—Intentional Violation of a Court Order
- Penal Code § 653m—Using Telephone Calls or Electronic Communication to Annoy
- Penal Code § 591—Maliciously Taking Down/Obstructing a Telephone Line
- Penal Code § 591.5—Maliciously Destroying a Wireless Communication Device
- Various sex offenses

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

Felony or Misdemeanor Charges

Strangulation 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.

13. The author recognizes that "attempted strangulation" is a phrase that has been misused by many in describing strangulation cases that do not result in fatality. Still, there may be occasions when a defendant's actions do not result in evidence the prosecution believes will support a completed 273.5, so 664/273.5 may be viewed as a viable charging option. A jury that might have difficulty reaching a verdict on 273.5 because of an issue over "traumatic condition," may be able to reach a verdict on the 664/273.5. While the author does not prefer this type of charge, it is included as a possible option.

Enhancements

In addition to the substantive charges, the prosecutor should also consider the existence of any enhancements such as great bodily injury and/or coma.

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 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. Prosecutors should also consider other protective measures such as Criminal Protective Orders.

Preliminary Hearing

The preliminary hearing provides another opportunity to break the power and control of the abuser. The lower standard of evidence and the use of hearsay evidence at a preliminary hearing make it relatively easy for the prosecution to present its case and obtain a holding order. 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.

Although the preliminary hearing presents this opportunity, it should not be taken lightly. The prosecution needs to demonstrate the seriousness of the incident or risk the case being reduced to a misdemeanor under Penal Code section 17(b). Failure to make an adequate record may allow the defense to seek a dismissal under Penal Code section 995. For these reasons, the preliminary hearing should include evidence from an expert witness in the area of strangulation. This testimony will establish the seriousness of the incident, as well as the injury to the victim. Testimony should also be obtained from the victim. This will help ensure that the victim's statements will be admissible at trial, even if the victim should become unavailable as a witness, since the defendant will be afforded the opportunity to confront her.

Case Preparation

Electronic evidence is prevalent today. Prosecutors 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 that typically arise. Adequate case preparation involves being able to address these defenses:

The victim self-inflicted. 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 will likely involve either getting the victim to court or showing due diligence in trying to get her 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. The court may also order the victim back or the victim may be placed on call.[14] A material witness bond may be sought in order to obtain the victim's attendance.[15] Prosecutors should strongly consider the implications of proceeding in this manner. 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.[16]

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.[17] 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 402 hearing with the expert witness.

Motion for Conditional Examination of the Witness

In both felony and misdemeanor domestic violence cases, a motion for a conditional examination can be used to help preserve victim testimony if there is evidence the victim's life is in jeopardy[18]

14. Pen. Code § 1331.5.
15. Pen. Code § 1332.
16. See *People v. Cogswell* (2010) 48 Cal.4th 467.
17. Pen. Code § 1054.1.
18. Pen. Code § 1335(b).

or if there is evidence that a victim or material witness has been or is being dissuaded by the defendant or any person acting on behalf of the defendant.[19]

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:

- 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.

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.

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. An expert is anyone with special knowledge, skill, experience, training, and education.[20] Jurors must be willing to accept that your nurse practitioner or law enforcement officer may have

19. Pen. Code § 1335(c).
20. Evid. Code § 801.

sufficient knowledge, skill, experience, training, or education to testify as a competent expert, even without a degree in "strangulation."

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 7 discusses the need for a strangulation expert, 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.[21]

21. Evid. Code § 1107.

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.[22] Defendants who claim that they placed their hands on the victim to "calm them down" should be questioned in detail regarding how this action turned into strangulation.

Closing Argument

The 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. Because cross-examination by the defense is usually limited at such hearings, this may provide another opportunity to test and train your experts.

Post-conviction protections for the victim can include protective orders. Such orders are required under the law if the defendant is placed on probation.[23] Protective orders may even be included if the defendant is sentenced to state prison or receives some other type of non-probationary sentence.[24]

22. This type of examination assumes that the defendant did speak to law enforcement and does not take into account a discussion of *Miranda* rights.
23. Pen. Code § 1203.097.
24. Pen. Code §§ 273.5(i) and 136.1(i).

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Chapter 5
Medical Evidence in Non-Fatal Strangulation Cases

by William Green, M.D.

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 STDs 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).

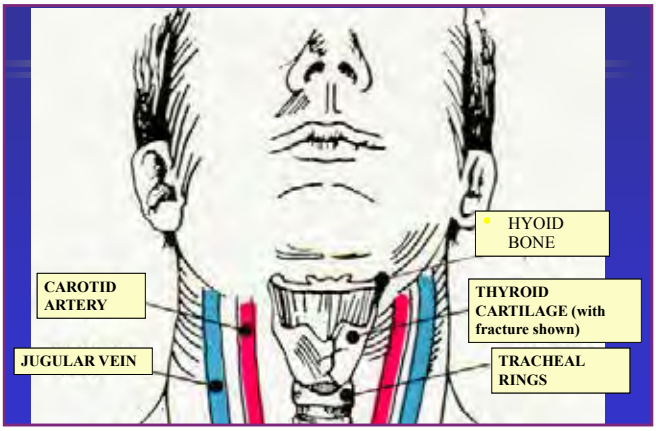
- **Compressive asphyxia** occurs when an assailant puts his body weight on the victim, limiting the expansion of the lungs, which interferes with breathing.

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.

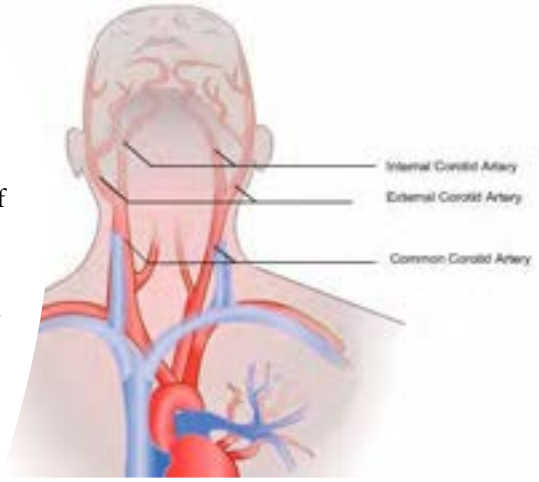
Specific Functional Changes in Strangulation

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 (scelra), 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 Strangled 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 percent 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.

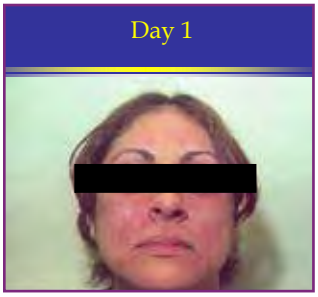
eyelid droop

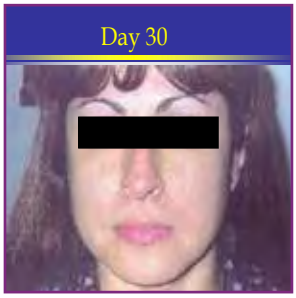
Behavioral changes that may appear during or immediately after the assault include agitation, restlessness, and combativeness. Victims may be fearful (or frantic) because they do not have enough oxygen. Weeks to months after an assault, a victim may display impairment in memory and concentration, and 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.





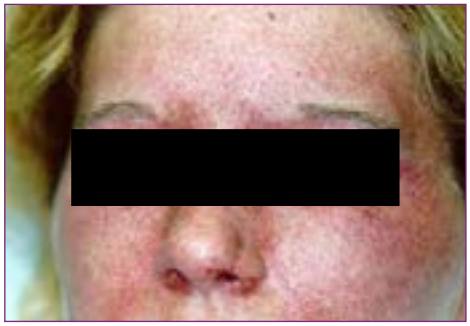
Clinical Findings

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.

petechiae over the eyelid

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.



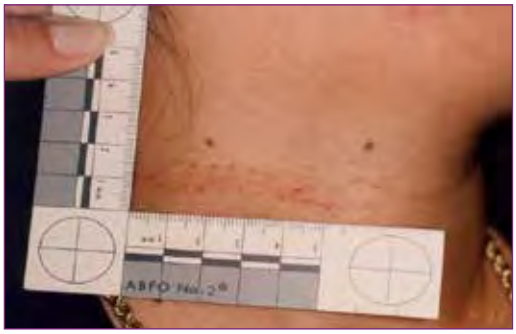
petechiae

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

sub-conjunctival hematoma

! ***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.

self-inflicted defensive "claw" injuries

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.

abrasions under chin due to instinctual chin lowering.

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. The Cal EMA 2-923 Sexual Assault Forensic Exam form will include an addendum to be used for strangulation cases (this form is under development). The form will require the medical professional to document the patient symptoms, the physical exam findings, lab and imaging results, and provide a narrative history of event. It will also include a check list plan and diagrams on which to draw visible and palpable findings. Until specific documentation systems (like the Cal EMA 2-923 addendum form under construction) are in standard use, both the medical and criminal justice system will have to rely upon standard medical record documentation.

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Chapter 6
Death by Strangulation or Suffocation

by Dean A. Hawley, M.D.

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

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].

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.
- 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.

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

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).

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 cave 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 mucus 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 or 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

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

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

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 7
Use of Experts: Tips for Prosecutors and Expert Witnesses

by Jean Jordan, J.D., LL.M.

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 no 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

1. Evid. Code § 720(a).
2. Strack G., "How to Improve Your Investigation and Prosecution of Strangulation Cases," at 13 (updated 2007 with the assistance of D. George McClane).

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 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

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 *Id.* at 10.
5. *Id.* at 13.

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.)

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.

6, Evid. Code §§ 201 and 801.2.
7. NDAA *Introducing Expert Testimony to Explain Victim Behavior in Sexual and Domestic Violence Prosecutions*, p. 35.

Qualifications

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.

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 victims 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.

Jean Jordan is the VAWA director and executive director of administrative services for the California District Attorneys Association. A former California prosecutor in Yolo, San Diego, and Santa Cruz Counties, she is member of the Training Institute for Strangulation Prevention's Advisory Committee and serves on the board of the Yolo County Family Justice Center.

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Chapter 8
Victim Advocacy in Strangulation Cases

by Catherine M. Duggan

Day after day, retold in crime reports and news stories, women are enduring the demonstration of power and control, power over life or death. The wrong step, ever so slight—perhaps serving a meal at the wrong temperature—can invoke a blackened eye, a broken nose, a split lip, or a near-death experience from manual strangulation. And yet, paradoxically, victims will often struggle for justice while opposing the efforts of law enforcement and prosecution. "If someone else hadn't called the cops," said one victim at the sentencing of her husband, who had broken her nose, multiple ribs, and beaten her face until she was unrecognizable, "I don't think I would have called for help. I think I would have just slept it off." Another victim, as she was being strangled, reported to law enforcement that she whispered, "I love you," with what she thought was her last breath.

How is it that a person does not want her batterer incarcerated? How is it that a woman will refuse to testify against the person who has harmed and oppressed her? How is it that a victim professes love for the person responsible for inflicting physical and psychological injury? Such ideas sound strange and frustrate the efforts of law enforcement officials, prosecutors, and advocates. Still, those victimized by violence perpetrated by an intimate partner need help and their batterers should be punished for their violent behaviors. Not merely because it is the law, but because it is morally correct.

Understanding Victimology

Untangling the myriad reasons and overlapping characteristics that explain why a woman would stay in an abusive relationship is vital to providing meaningful advocate interventions and services. To illustrate the point, a woman who grows up with a father who batters her mother may learn how to be the wife of a batterer—how to live in the functional abnormality. Violence, planted by example and reinforced by experience, has become her *demon-familiar*. Early childhood abuse and neglect may also create at the core a *demon-familiar*. It is the *demon-familiar* that causes her to repeat behaviors that bring the effect she has learned to expect. She may equate some measure of violence with love, believing the batterer is hurting her because he loves her. She may feel defective, as if she deserves it. Feeling helpless, she may view herself as unable to support herself or her children without the very person who is maltreating her. Battery gets in its punches and it is a great devastator of will. Repeated assaults, physical or verbal, weaken morale and at the same

time work on deteriorating self-esteem, making the victim reluctant, sometimes unwilling, to end the relationship. Even if she is willing, she may lack the needed financial resources. She may not be able to afford housing, childcare, or basic life necessities. She may worry that her children will lack financial security if she leaves the batterer. Insufficient funds for housing, access to childcare, and limited shelter stays that do not allow enough time to reconstruct a life, are but a few of the obstacles confronting a battered woman.

Learned helplessness is another factor to consider in determining how best to serve victims. Learned helplessness is an observable stress response, which consists of self-blame, chronic anxiety, extreme passivity, or denial of anger while directing anger inwardly. Unable to protect her own life or the lives of her children, the battered woman may present a tone of fatalism. She may not want to be publicly identified as a victim. She may wish to control others' perceptions of her to avoid a stigmatizing condition.

Cultural and religious influences may also prevent a battered woman from separating or divorcing under any circumstance. Cultural beliefs may cause her not to want to bring shame on the family, so she will try to keep the violence a private matter. Cultures operating under ancient themes of female subordination may offer the batterer impunity. This tells the woman that the batterer can take justice into his own hands and mete out arbitrary punishments for transgressions he does not wish to tolerate.

Battered women know the batterer will use force to maintain power if challenged. Violence is the spine of the relationship, in the name of power, conquest, dominance, and submission. The victim knows that leaving can be a deadly course of action for her. She also knows that staying is not much safer. Still, the risk of staying may be less than the risk of living on the streets. The risk of staying may be less than the risk of losing custody of her children.

Guiding Advocacy Principles

Guiding advocacy principles should be grounded in an understanding of trauma and victimology. Services and interactions should speak to the unique challenges confronting women in violent relationships, sometimes with rogues as dark as fiction could create. Advocates who have an understanding of trauma and victimology issues will be better equipped to meet the needs of the victim. Additionally, advocate responses to cultural and religious influences are best achieved by building a staff that mirrors the demographics of the community served.

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

- Victims should be treated with dignity and compassion, 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 cultural background and belief systems.
- Victims are best positioned to judge the danger the batterer poses.
- Victims have the right to make their own decisions, and have those decisions supported with compassion and understanding.

Advocacy Goals

Advocacy goals generally include the following:

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

Initial Contact

The initial victim contact is critical in affecting the relationship between the advocate and the victim. The primary purposes of the initial contact is to gather information needed to respond to the needs of the victim, and to assess the level of risk. Evaluating risk level and understanding the needs of the victim is easier said than done. For that reason, it is important for advocates to use the initial contact as an opportunity to look and listen, approaching the victim from a supportive position. The process is one of listening, asking questions, asking for clarification, asking additional questions, and observing. The goal is to join in a partnership with the victim for the protection of the victim and any children involved. Safety is the paramount goal.

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

- Whether the batterer has threatened to kill the victim.
- Whether the batterer has brandished a knife or gun.
- Whether the batterer has been abusive to animals or pets.
- Whether the batterer has strangled the victim.

These behaviors epitomize the power dynamic and may be predictors for the batterer's escalation to more lethal behavior. Advocates should appreciate the dangers associated with risk factors and be able to explain the dangers of such brutal conduct to the victim.

For example, to appreciate the dangers associated with strangulation, it is essential for the advocate 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. It has only recently been identified as one of the most lethal forms of domestic violence: 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 batterer 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.)

Advocates should recognize the signs and symptoms of strangulation, including: hoarseness, raspy voice, or loss of voice; redness, swelling, abrasions, or bruising on the neck; and petechiae (tiny ruptured capillaries) on the eyes, face, or neck.

Advocates should encourage strangulation victims (especially pregnant ones) to seek medical attention. Even innocuous symptoms (dizziness, swallowing difficulties, headache, lightheadedness, hoarse voice) warrant medical treatment.

Advocates should consider using a standard intake form that the victim completes at the time of initial intake. The intake form will help the advocate gather a history of the violence, including the types and severity. The intake form used by the Ventura County District Attorney's Crime Victim's Assistance Unit for victims of domestic violence who are seeking a restraining order is included in the Appendix to this manual on page A-156 as an example. The Ventura County District Attorney's Office has the victim sign the intake form under penalty of perjury, making it a witness statement. Advocates are encouraged to provide strangulation victims with a brochure specifically addressing this form of violence. A sample brochure developed by the Family Justice Center Alliance is included in the Appendix on page A-139. Encourage strangulation victims to monitor signs and symptoms, using a log to record the date and time of symptoms. Information received at the time of initial intake should trigger an appropriate triage process. In all cases, the first step should be to provide for the physical safety of the victim and any children

residing in the home. The advocate should work with the victim to develop an appropriate safety plan designed to reduce risk. However, advocates should not assume that leaving the batterer is the best way to increase safety. There is ample evidence that violence frequently worsens after separation.

Advocates often experience a compelling urge to protect the victim from future harm. But they must understand the limitations of their ability. Victims of intimate partner violence have a significant relationship with the batterer, making it likely the victim wants the abusive behavior to stop, but may not want the batterer to be punished. Advocates need to resist any judgments, understanding that the victim is likely to be ambivalent. If the advocate overly supports one set of feelings—such as anger at the batterer—the advocate may discourage the victim from expressing her uncertainty. It is not the purpose of advocacy to instruct the victim on whom she should love or about what choices she should make in her life. Nothing gives the advocate that wisdom or authority.

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 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. Interactions between the advocate and the victim should be based on the idea that something wrong was done to the victim, rather than something is wrong with the victim. Fundamental to trauma-informed services in domestic violence cases is increasing the victim's self-esteem.

Victims of domestic violence develop ways to shut down, numb-out, or disassociate, to survive the violent, demeaning, and degrading behavior of the batterer. Spiritual strategies, such as prayer, are often used by victims. Faith in God can be a source of strength for many victims. The advocate should recognize the victim's adaptation strategies as originating from the violence, rather than judging strategies as part of the avoidance dynamic. Compassionate understanding is the key to reducing the victim's guilt and shame.

Well-being and Safety of the Children

The results of violence against women are not borne alone by the victim. Advocates should not overlook the harm to the children growing up in the violent home. Children who witness domestic violence often have symptoms similar to children with other forms of child maltreatment. The home environment is unstable and highly unpredictable. Inferior education, unstable housing, and inadequate mental health care are all bitter components of the maltreatment in their environment. Emotional responses can range from aggression to withdrawal and depression. The violence contributes to chaos, neglect, and a sense of unpredictability.

The victim may be concerned with being labeled a neglectful parent and losing custody of the children. This may cause the victim to conceal violent events or to recant accusations. Batterers regularly use child custody disputes, visitation, and joint custody arrangements as opportunities to threaten, intimidate, and harm the victim. The advocate should be sensitive to these issues while working to ensure the children are safe and receive the services they require.

The Victim's Voice

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, stay away orders are being considered, cases are being continued, and sentencing is being determined. It is important for advocates to remind victims of their rights. For purposes of sentencing, it is highly recommended that 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 the 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 fears or hopes do you have?
- What do you want to happen to the defendant? (jail/prison/treatment, etc.)
- In your experience, do you think this defendant can be rehabilitated?
- How do you think it will affect you, your family, or the community when the defendant is released?

Restitution

The people of California have been unequivocal in their meaning: Victims of crime are owed restitution from the offender for the full amount of the economic loss incurred as a result of the crime.

Californians have passed two voter initiatives—one in 1982 and another in 2008—amending the state constitution and guaranteeing victims of crime the right to offender restitution. There is nothing ambiguous about the law in this area. The law provides for all economic losses, meaning: medical expenses, mental health treatment fees, lost wages, dental care, emergency relocation, enhanced security, and others. If the victim's loss relates to the crime, it is the offender's responsibility to reimburse the victim. It is the duty of the offender, not the victim, to show a claimed expense did not result from the crime.

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.

Victim advocates should also advise the victim on how restitution is collected while the offender is in custody, on supervised probation, or as a civil judgment following custody or supervision.

It is equally important that victim advocates share with victims the reality of restitution collection in California. While the law could not be more explicit on the subject of offender restitution, collection of the order is a different matter. Typically, offenders pay little of the restitution owed to the victim. The average monthly restitution payment by an offender incarcerated in the California Department of Corrections and Rehabilitation is $10. County collection does not fare much better. It is anticipated that the Public Safety Realignment Act of 2011 will further decrease the amount of victim restitution collected. 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. Victims expect local or state authorities to collect court-ordered debt.

The primary dictate of advocacy is to avoid re-traumatizing or secondary victimization. Factors that foster trust between the advocate and the victim include consistency, accessibility, and competence. Victims cannot trust the advocate's competence if the advocate does not fully inform

them regarding their rights, which includes a fair and open discussion of the current state of victim restitution collection. The advocate ought to be able to discuss in detail all aspects of restitution. It is not the situation, but how the situation is experienced by the victim that induces trauma. If the victim is well informed, the victim's expectation surrounding restitution collection will be grounded, which may prevent or minimize re-victimization.

Promising Strategy

The Ventura County District Attorney's Crime Victims' Assistance Unit and the District Attorney's Bureau of Investigation have applied a collaborative strategy to document injuries to domestic violence victims.

Victims of domestic violence will often seek a Domestic Violence Restraining Order through the Crime Victims' Assistance Unit as a way of stopping the violence. Oftentimes, victims have not made a report to law enforcement. The victim may have visible injuries that have not been photographed by law enforcement. Even if the victim has reported to law enforcement, the injuries may not have been visible at the time the report was made. This is especially true for strangulation victims who may suffer no visible injuries whatsoever.

To assure victim injuries are photographed, the advocate will explain to the victim that when domestic violence is not reported to law enforcement as soon as possible, the prospect of conducting a thorough investigation may be diminished. In a neutral manner, the advocate will offer the victim the option of collecting evidence by photographing the injuries. Once the evidence is collected, the victim may either report the violence to law enforcement immediately or at a later time. If a report has been made to law enforcement, the advocate will explain how injuries "stage" over time, and the importance of photographing the injuries at different stages. In either scenario, the decision is one the victim makes voluntarily.

If the victim agrees to have the injuries photographed, the advocate contacts the Bureau of Investigation and requests an investigator for the purpose of photographing the injuries. The investigator meets the victim, explains what he/she will be doing, then photographs the injuries. In cases where a law enforcement report was made and charges are pending, the investigator routes the photographs to the assigned deputy district attorney. If the victim wishes to defer reporting to law enforcement, the photographs are held by the Bureau of Investigation.

The strategy has positive outcomes for both the victim and prosecution, including:

- The victim has the opportunity to have the evidence collected while deferring reporting to law enforcement; and
- Successful prosecution is enhanced through evidence collection.

The Ventura County District Attorney's Office is currently engaged in monitoring the effectiveness of the new strategy.

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.

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Chapter 9
Conclusion

by Casey Gwinn, J.D. and Gael Strack, J.D.

The tragic deaths of 17-year-old Casondra Stewart and 16-year-old Tamara Smith in 1995 have lead 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 helpings 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. 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 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 and the California District Attorneys Association. The partnership and allies across California helped pass and implement the Diana Gonzalez Strangulation Prevention Act of 2011, and have now produced this manual.

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 in California and 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 Casondra 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.

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.

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On the Edge of Homicide:
Strangulation as a Prelude

BY GAEL B. STRACK AND CASEY GWINN

In March 1995, Sgt. Anne O'Dell, head of the San Diego police domestic violence unit, contacted her counterpart at the domestic violence unit of the San Diego City Attorney's Office to report the city's first domestic violence homicide of the year. Casondra Stewart had been repeatedly stabbed by her 21-year-old boyfriend, Alfonzo Terrell Merritt, and had died in front of her friends. Stewart was just 17 years old and mother to a young child.

There was a history of domestic violence in the relationship. Just two weeks prior to her death, Stewart had called the San Diego Police Department to report an incident in which her boyfriend had choked her; however, by the time police arrived, she was already recanting. Stewart minimized the attack, refusing to give police a detailed statement, and, as a result, no photos were taken of the red marks on her neck. The case was assigned to a domestic violence unit detective who, observing San Diego's law enforcement protocol, followed up with the victim. Stewart, though, did not budge from her original statements and refused to cooperate. With no independent corroboration, the case was closed due to a lack of evidence and never submitted for prosecution.

Two months later, Sgt. O'Dell placed another call to report San Diego's second domestic violence homicide of the year. Her admonition was simple: "Check out today's paper." The newspaper report stated:

> A Tierrasanta man, who is accused of strangling his 16-year-old girlfriend and setting her body ablaze in an Oak Park field, was charged with two counts of murder yesterday after prosecutors disclosed that the victim was 5½ months pregnant.

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> Mario Andre Rushing, 18, pleaded not guilty to the murder charges and an arson charge. The body of Tamara Smith was found by firefighters Friday night in a field off Federal Blvd and an autopsy determined she had been strangled.

Rushing was the father of the child Smith had been expecting at the time of her murder—as well as the victim's 11-month-old daughter.

Like Casondra Stewart, Tamara Smith had a history of domestic violence. According to family members, Smith and her boyfriend, Rushing, had had a violent relationship since the eighth grade. They repeatedly broke up and reconciled. San Diego police had responded to at least two disturbance calls. One of those calls resulted in Rushing being arrested for domestic violence, but he was released on his own recognizance. The day Rushing was scheduled to appear for arraignment was the day that Tamara Smith was found dead.

The deaths of Casondra Stewart and Tamara Smith triggered profound changes in San Diego and, ultimately, around the world. The San Diego City Attorney's Office conducted an informal death review to learn what needed to be changed within the school district and the criminal justice system in the hopes that maybe San Diego could prevent the same thing from happening to another victim. While the law enforcement and prosecution protocols for San Diego were followed to a "T," the fact remained that two teenagers with a history of domestic violence were dead, and the informal death review team concluded both were preventable. Jointly, the San Diego City Attorney's Office and the San Diego Police Department determined it was critical to educate front-line police and prosecutors on how to better handle "choking" cases—at the scene and in court. Both Casondra Stewart and Tamara Smith had been "choked" prior to their deaths and neither case had been prosecuted. A better criminal justice response was key. Sadly, it wasn't until their deaths that San Diego came to understand the seriousness and the significance of a "choking" case.

Within 30 days of completing the informal death review, then-San Diego City Attorney Casey Gwinn launched an education campaign, in partnership with teen educator Nancy Regas, within the city school district and with county law enforcement. Gwinn called on his domestic violence unit—established 10 years earlier and already a nationally recognized program—under the leadership of Assistant City Attorney Gael Strack, to conduct a study of existing "choking" cases that had been submitted for prosecution. The results of the study were eye-opening. 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 was causing the criminal justice system to treat many "choking" cases as minor incidents, when, in fact, such cases were among the most lethal and violent cases in the system. The city attorney's 1996 study was later published in the *Journal of Emergency Medicine* as "Review of 300 Attempted Strangulation Cases" (2001), but at the time, the findings launched the most comprehensive effort in the United States to educate criminal and civil justice professionals about strangulation. The 1996 San Diego strangulation study has spawned research, protocols, policies, and laws across the country and around the world.

The major findings are now common knowledge:

- most strangulation cases produce minor or no visible injury;
- many victims, however, suffer internal injuries and have documentable symptoms;
- strangulation is a gendered crime—virtually all perpetrators are men (299/300);
- most abusers do not strangle to kill—they strangle to show they *can* kill;
- victims often suffer major long-term emotional and physical impacts; and
- victims of prior attempted strangulation are seven times more likely to become homicide victims.

Today, it is known unequivocally that strangulation is one of the most lethal forms of domestic violence. When a victim is strangled, she is at the edge of a homicide. Unconsciousness may occur within seconds and death within minutes. In *Intimate Partner Violence* (Connie Mitchell ed., Oxford Univ. Press 2009), the authors describe the terms "strangulation," "choking," and "suffocation" (*see* ch. 16). These terms are often confused, yet they all lead to asphyxia—a lack of oxygen to the brain. In "strangulation," external compression of the neck can impede oxygen transport by preventing blood flow to or from the brain or direct airway compression. "Choking" refers to an object in the upper airway that impedes oxygen intake during inspiration and can occur accidentally or intentionally. "Suffocation" refers to obstruction of

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RESOURCES

To find out more about strangulation or to receive training through the Strangulation Training Institute, visit the National Family Justice Center Alliance's resource library at www.familyjusticecenter.org.

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Please note: Those in an abusive situation should call the National Domestic Violence Hotline at 1-800-799-SAFE.

the airway at the nose or mouth and can also occur accidentally or intentionally. Therefore, the term "strangulation" should always be used to specifically denote external neck compression. The term "choking" should be reserved for internal airway blockage. When the victim, perpetrator, or witness uses the term "choking," document the statement with quotation marks since, in nearly all cases, they are describing strangulation, not choking. Professionals working in this field should always use the word "strangulation" when referring to external compression of the neck.

Strangulation is, in fact, one of the best predictors for the subsequent homicide of victims of domestic violence. One study showed that the odds of becoming an attempted homicide victim increased by 700 percent, and the odds of becoming a homicide victim increased by 800 percent for women who had been strangled by their partner. (Nancy Glass et al., *Non-Fatal Strangulation Is an Important Risk Factor for Homicide of Women*, 35 J. Emergency Med. 329 (2008).) The occurrence of strangulation has been reported in 47–68 percent of women who were being assessed for intimate partner violence, and smothering or strangulation has been identified in 25 percent of women killed by an intimate partner. (J. Stephan Stapczynski, *Strangulation Injuries*, 31 Emergency Med. Rep. 193–203 (2010).) These studies clearly show the need for any professional working with victims of intimate partner violence to take strangulation seriously and to educate themselves on local resources and laws. In their practices and in court, legal professionals should make use of risk assessment tools, create personalized safety plans, and improve their screening and documentation of strangulation victims.

Victims may have no visible injuries, yet because of underlying brain damage due to the lack of oxygen during the strangulation assault, they may have serious in-

ternal injuries or they may die days—even weeks—later. The lack of external injuries and the lack of medical training among domestic violence professionals have led to the minimization of this type of violence, exposing the victims to potentially 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. Domestic violence perpetrators who use strangulation to silence their victims not only commit a felonious assault but can also be charged for an attempted homicide. Strangulation is a form of power and control that can have a devastating psychological effect on victims in addition to the potentially fatal outcome, which includes the victim committing suicide.

The horrific deaths of Casondra Stewart and Tamara Smith ultimately changed the course of domestic violence history and caused us to recruit experts and improve the criminal justice system's response to the handling of "choking" cases—now referred to as "near-fatal strangulation" cases. The momentum for specialized training has spread nationwide. An initial partnership between the San Diego City Attorney's Office and medical physicians George McClane and Dean Hawley in 1995 started with a simple goal: Train police officers and prosecutors in San Diego on how to improve their investigation and prosecution of "choking" cases.

By 1996, the training curriculum had been shared at statewide conferences and training programs. Former prosecutor Candace Heisler helped the initial partnership to introduce the training to the California District Attorneys Association. Former police officer Ray Bray helped to integrate the strangulation curriculum into police training via California's Commission on Peace Officer Standards and Training. Linda Burger, the then-director of the Statewide Coalition for Battered Women, invited the San Diego team to train domestic violence and sexual assault advocates across California. In 1997, the training curriculum was shared on a national level through the National District Attorneys Association, the Law Enforcement Television Network (LETN), state domestic violence coalitions, district attorney and law enforcement associations, and other international organizations. The core team of trainers (Gwinn, Strack, McClane, and Hawley) steadily expanded to include other doctors, attorneys, forensic nurses, detectives, and prosecutors to help with the training. In 2002, the San Diego Family Justice Center partnered with the Minnesota-based Battered Women's Justice Project to develop a two-day advanced strangulation workshop for domestic violence professionals.

As a result of those early efforts, many strangulation cases are now being elevated for felony-level prosecution due to professionals' understanding of the lethality of strangulation. Police and prosecutors are using existing statutes or working with legislators to create new felony legislation. Currently, 30 states have passed felony strangulation laws with New York, Wyoming, Tennessee, and California being the most recent. States such as Ohio, South Dakota, and Maine have statutes pending or under consideration. Specialized medical forms have been developed to help legal and medical professionals document victim injuries and identify strangulation symptoms. 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 many conferences and included at some regional police training academies, often aided by the strangulation training videos produced in San Diego through partnerships with the LETN (1997) and IMO Productions (2000/2010). In addition, many articles on strangulation have been written by the core team of trainers and others.

Doctors, forensic nurses, and domestic violence detectives are testifying in courts as expert witnesses on strangulation.

The specialized strangulation laws are working and becoming a valuable law enforcement tool to address domestic violence cases, even when the identified offenses are charged as misdemeanors. One recent study on the New York strangulation law by the New York State Division of Criminal Justice Services found 2,003 charges were filed against perpetrators in New York in just the first 15 weeks of the law's passage. Of the filed strangulation cases, 83 percent were misdemeanor charges—only 17 percent were felony filings. Nevertheless, the study found that perpetrators who had previously avoided *any* punishment because of a lack of visible injuries were now facing criminal sanctions for their life-threatening behavior. Researchers concluded, as they have in many states, that the previous gap in the law, between no charges and murder charges, was now being rectified by

this innovative intervention tool.

Casondra Stewart and Tamara Smith did not die in vain. Their tragic deaths have led to dramatic changes within the system. However, more needs to be done. Most civil legal professionals have never received training on the signs and symptoms of strangulation. Even many police officers and prosecutors have very little knowledge of the dynamics regarding strangulation assaults due to high turnover rates in public law offices and law enforcement agencies. The type of training received by domestic violence and sexual assault professionals varies widely from jurisdiction to jurisdiction. Police officers, prosecutors, civil attorneys, advocates, and medical professionals rarely receive medical training concerning the identification and documentation of injuries, or the signs and symptoms associated with strangulation.

There is a need to develop more experts in this field and to use those experts in court proceedings to educate juries and judges about the seriousness of strangulation and to understand the signs and symptoms associated with a strangulation case. Expert testimony is generally admissible on any subject that is sufficiently beyond common experience in which the opinion of an expert would assist the trier of fact. Expert witnesses can be used for various reasons, including teaching jurors about medical, technical, or scientific principles or expressing an opinion after evaluating the significance of the facts of the case. For strangulation cases, attorneys should consider using medical experts such as a coroner, medical examiner, emergency room physician, forensic nurse, or a paramedic who has been trained and has experience handling strangulation cases. Forensic nurses make particularly good witnesses because of their medical background, experience in evaluating patients and documenting evidence, as well as their willingness to testify.

Much time over the last 15 years has been spent educating the criminal justice system on the seriousness of strangulation. It is now time to train civil practitioners in order to improve their response to the handling of strangulation cases in court. At the top of the list are family law attorneys and civil legal clinics handling restraining orders. Since opening the Family Justice Center Legal Network (restraining order clinic) at the San Diego Family Justice Center, it has become clear that civil practitioners are generally not trained in the power and control dynamics of domestic violence, interviewing traumatized victims, gathering evidence, safety planning, danger/risk assessment tools, or other types of evidence that police and prosecutors have used for years to establish an abuser's guilt in criminal court proceedings.

Much time has been spent educating the criminal justice system on the seriousness of strangulation. It is now time to train civilian practitioners.

No legal professional should work with family law, personal injury, or criminal law matters without receiving training in strangulation assaults, medical symptoms, documentation techniques, and long-term effects. Thousands of women continue to suffer such assaults without effective prevention and intervention efforts in place in communities across America. But the research is now clear: When a victim is strangled, she is at the edge of a homicide. We are all responsible for becoming educated and acting aggressively with the information now available. Responsible professionals can prevent major injuries to victims of abuse, facilitate needed treatment, and support—even save—lives. ■

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Please note: *This list contains work from all over the world. There is funded research and some citations from research journals that have a high "impact factor" for this kind of science.*

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Obtaining Justice for Victims of Strangulation in Domestic Violence: Evidence Based Prosecution and Strangulation-Specific Training

By Brigitte P. Volochinsky
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Abstract

Strangulation accounts for 10-percent of violent deaths in the United States, with six female victims to every male victim. A common form of abuse in domestic violence, strangulation may result in many harmful health effects and it often indicates either an ongoing pattern of abuse or it foreshadows escalating violence. Yet, strangulation is often minimized by the criminal justice system, including law enforcement officials, emergency room medical personnel, and prosecutors, who equate strangulation with a slap on the face. The phenomenon of minimizing a violent and life-threatening act occurs for two reasons: first, and most importantly, victims of strangulation often do not present with visible injuries; and second, domestic violence cases in general are inherently difficult to prosecute. As this article advocates, in order to obtain justice for victims of strangulation in domestic violence, the criminal justice system must unite and work together in a system which combines strangulation-specific trained investigative skills with evidence-based prosecution.

Strangulation accounts for 10-percent of violent deaths in the United States, with six female victims to every male victim.[1] In the domestic violence context, strangulation is particularly a dangerous problem because the victim usually does not present with visible injuries. Therefore, despite the harmful health effects of strangulation and its indication of an ongoing pattern of abuse and a foreshadowing of escalating violence in the relationship, strangulation is minimized by the criminal justice system, often going un-arrested and un-prosecuted.

In general, there are many obstacles that prevent the successful arrest and prosecution of batterers in domestic violence cases. The two main hurdles are victim reluctance to participate in the criminal justice system, including victims recanting their initial statements, and three problematic Supreme Court cases regarding the Confrontation Clause and Forfeiture by Wrongdoing, which limit the admissibility of hearsay evidence and testimony. These two problems are amplified in the specific context of strangulation in domestic violence cases because, as previously mentioned, the victim often does not present with visible injuries. Consequently, the allegation of strangulation is frequently not acknowledged or investigated by either emergency room medical personnel or law enforcement officials. For all intents and purposes, there is no possibility of a successful case against the abuser who allegedly strangled his victim because evidence is not collected or documented.

This article discusses both the general obstacles to successfully prosecuting a domestic violence case as well as the specific difficulties when strangulation is involved. It suggests the use of evidence-based prosecution in combination with strangulation-specific training for law enforcement officials and, when feasible, emergency room medical personnel to overcome these difficulties. These measures will increase the likelihood of successful prosecution of strangulation in domestic violence cases and render batterers accountable for strangling their victims.

Strangulation: A Killer in Domestic Violence

Strangulation is one of the most dangerous forms of actual violence that occurs in the context of domestic violence cases.[2] There is usually an allegation that the abuser grabbed, squeezed or crushed the victim's throat with his hands or used a ligature.[3] Although serious injuries may result from being strangled and strangulation is often an indication of an ongoing pattern of abuse or a foreshadowing of escalating violence, the victim often does not have visible injuries.[4] Therefore, despite the frightening description of events, the victim does not receive medical attention, the act of strangulation is not included in police reports, strangulation is not charged by law enforcement as a crime and it is not prosecuted in court. In essence, strangulation, a lethal form of assault, is minimized or disregarded entirely, making it an even more life-threatening crime.

Strangulation is formally defined as "asphyxia" or "lack of oxygen caused by the closure of blood vessels and air passages in the neck resulting from external pressure."[5] It is commonly and incorrectly referred to as "choking" which involves an "internal blocking of the windpipe by an object,"[6] such as a piece of food or candy. The two forms of strangulation relevant in the context of domestic violence are ligature and manual strangulation. Ligature strangulation occurs when the strangler uses a "cord-like object,"[7] which can include anything from a rope or cable to a scarf or a belt, to strangle the victim.[8] In contrast, manual strangulation is done with the hands or, alternatively, with the forearm, in a position commonly known as the carotid restraint.[9]

Serious injuries, if not death, can result from strangulation within seconds. The "general clinical sequence of a victim who is being strangled is one of severe pain, followed by unconsciousness, followed by brain death."[10] Even if the victim does not go through all three stages of the clinical sequence, there can be many harmful health effects at each stage. These negative effects may be physical and include dizziness, nausea, sore throat, voice changes, throat and neck injuries, breathing problems, or swallowing problems.[11] More critically, neurological effects from a lack of oxygen to the brain can occur in less than a minute, and include eyelid droop, facial droop, left or right side weakness, loss of sensation, loss of memory, or paralysis.[12] Finally, and quite commonly, a victim can suffer from negative psychological effects including Post-Traumatic Stress Disorder, depression, suicidal ideation, or insomnia.[13]

The act of strangulation also symbolizes an abuser's power and control over the victim.[14] More importantly, the extremely violent nature of strangulation in domestic violence can serve as two important warnings. First, strangulation may indicate an ongoing pattern of abuse in the relationship.[15] Reports have indicated that 40-percent of domestic violence victims described being strangled as part of abusive conduct at least once in their relationship.[16] Second, it can foreshadow escalating violence within the already abusive relationship.[17] Strangulation is typically one of the last abusive acts committed by a violent domestic violence partner before actual murder.[18] When an abuser decides to put his hands around the victim's neck and squeeze, he has indicated intent to cause great physical harm, if not death.[19]

Strangulation is more lethal than other forms of violence because, unlike a punch or a kick, it frequently does not leave marks on the skin or any other visible indications.[20] As previously indicated, strangulation accounts for 10-percent of violent deaths each year and many of these victims "die without a single visible mark to the neck."[21] The San Diego Study, conducted by the San Diego City Attorney's Office, reviewed 300 domestic violence cases involving attempted strangulation that were submitted for misdemeanor prosecution. The study showed that 50-percent of victims who had survived strangulation had no visible markings to the neck.[22] Given the potential for serious injury, all allegations of strangulation should be taken seriously, investigated thoroughly and, if there is substantiation, the perpetrator should be arrested and prosecuted.[23] However, because there are often no visible injuries, strangulation is minimized and treated as a trivial incident, comparable to pushing or a slap on the face, where only redness may appear.[24] In actuality, strangulation is a much more serious and deadly crime.

Minimization is what makes strangulation one of the most dangerous forms of actual violence that occurs in domestic violence. Strangulation is minimized by both the victim and the criminal justice system including 911 dispatchers, emergency room medical personnel, law enforcement officials, prosecutors and judges.[25] After being strangled, a victim may experience painful symptoms, such as difficulty breathing or lightheadedness. Yet, the victim often fails to inform law enforcement officials of these symptoms or declines medical attention.[26] The victim's attitude may cause a 911 dispatcher, a medical personnel employee, or a law enforcement official to underestimate allegations of strangulation. The lack of visible injuries only further underrates strangulation in the eyes of medical personnel and law enforcement officials. Consequently, many victims do not receive medical attention, strangulation does not appear in the police report and law enforcement officials do not document or collect evidence of strangulation.[27] If there is no evidence, a prosecutor cannot prosecute a batterer for strangulation and a judge is not provided with all important information regarding a domestic violence incident. Thereby, both allowing the pattern of minimizing strangulation to continue and allowing a strangler to go unpunished.

General Obstacles to Successfully Prosecuting a Domestic Violence Case

Domestic violence can be challenging to prosecute because it is a crime that occurs in the privacy of one's home.[28] As a result, the only witnesses to the crime are often just the victim and the abuser.[29] Despite the typical he-said/she-said complexities, a live victim, who has the ability to testify against her abuser, is the most common barrier to successfully prosecuting a batterer. Although it seems illogical that a live victim who can testify is a hurdle, studies have indicated that 80 to 85-percent of battered women will deny their allegations against an abuser at some point after the domestic violence incident and refuse to testify in court against their abuser.[30] When a victim is reluctant to participate in the criminal justice system and recants her statements, a prosecutor faces the major obstacle of explaining to a judge or the jury why a victim is unavailable. It can be a very difficult task to convince a judge or the jury to accept that it is not a legal requirement for a victim to testify in court.[31] Furthermore, a victim who is unavailable or is reluctant to testify as a witness also causes a judge or the jury to question the legitimacy of the initial domestic violence complaint.

As a substitute for victim testimony, prosecutors have been attempting to introduce hearsay evidence, in order to prosecute a batterer and explain the severity of the crime(s) committed.[32] This evidence includes verbal statements given by the victim to the police upon arrival at the scene of a crime and written statements made by the victim in the form of affidavits or civil restraining orders.[33] However, these efforts have been thwarted by the Supreme Court in three specific cases dealing with the Confrontation Clause and Forfeiture by Wrongdoing. Although it can be assumed that the Supreme Court did not intend to hinder prosecution of domestic violence cases, the practical effect of the rulings was to limit hearsay that may be admitted into evidence during trial.

Victim Reluctance to Participate in the Criminal Justice System

Although some women want their abusers arrested and prosecuted to the fullest extent of the law, many do not. Some victims will even take steps to obstruct prosecution.[34] Society typically does not understand why a victim would protect her abuser from the criminal justice system. Although the phenomenon is perplexing, it can be explained, to some extent, by the unique and cyclical nature of domestic violence. In the first stage of domestic violence, an abuser acquires control by manipulating his victim's daily activities and independence. The batterer also expands his control by demeaning the victim's self-esteem through a combination of verbal and emotional abuse.[35] In the next stage, the abuse escalates to physical assaults with "varying degrees of severity."[36] Finally, during the last stage, an abuser may apologize, make promises that the violence will end or profess his continued love and affection.[37] The final stage tends to be followed by a period of calm before the cycle begins again. The

victim often finds herself trapped in this endless cycle of power and control, too scared, fragile or hopeful the violence will end to break away.[38]

Often, even if a victim was initially cooperative in the investigation of her case and willing to testify in court against her abuser, batters use many methods to convince the victim to recant, or withdraw her statements and not testify. Batterers are skilled at the "art of manipulation,"[39] they know how to exploit a victim's weaknesses, especially drug and alcohol dependence, physical and mental disabilities, personal insecurities or her love for their children.[40] Abusers use a variety of methods, which typically relate to the cycle of violence, in order to make a victim feel scared that she might lose the things she loves or cares about or make a victim feel guilty for calling law enforcement in the first place.

The first method used to convince a victim to recant her statements is to instill fear. Due to the first and second phases of the cycle of violence, a victim believes that her abuser will view cooperation with law enforcement or a prosecutor as a "hostile act."[41] The already established dynamic within the relationship causes a victim to fear that her abuser will retaliate.[42] In fact, abusers often do retaliate; studies have shown that 30-percent of batterers physically or emotionally abuse their victims again, during their prosecution.[43] The retaliation can take many different forms, ranging from the abuser physically attacking the victim, threatening to financially cut-off the victim if she testifies, or tricking the victim into believing that she can lose her job or her children when society finds out about the abuse.[44]

Another method used by abusers to dissuade a victim from testifying relates to the final stage of the cycle of violence. The abuser will make "promises of reform."[45] Abusers send love letters and flowers promising future happiness or they leave apologetic voicemails swearing that the abuse will never happen again.[46] A victim often believes her abuser because she wants to. She may be in denial about the abuse, she may think that she and the victim are in love, or, if they have children together, she does not want to break up the family.

Finally, there are many situations in which a batterer's family or friends also approach the victim to dissuade her from cooperating with law enforcement or testify in court against her abuser. A batterer's family and friends are loyal to the batterer, often "to the detriment of the victim."[47] Family and friends use coercive methods, such as turning off the electricity, denying the victim and her children a place to live, or paying a victim to leave town so that she will not testify.[48]

The cycle of violence, which often leaves a victim fragile and scared, combined with pressure from an abuser and his family or friends not to testify, is likely to cause a victim to feel alone and that she is wrong for cooperating with law enforcement or a prosecutor. Predictably, many victims, who once sought police assistance, "surrender under the pressure of such effective manipulation and intimidation."[49]

Three Problematic Supreme Court Cases

It has been demonstrated that relying on victim testimony can be extremely challenging; most victims do not want their abuser arrested and, more importantly, are reluctant to participate in the criminal justice system. As a result, law enforcement and prosecutors began to use other strategies and techniques to prosecute domestic violence abusers. Focus shifted from relying on victim participation to using hearsay or out-of-court statements made by victims and, in few cases, by observing witnesses.[50] When a victim is unwilling to testify about a domestic violence incident, hearsay can be the only way to provide a description of what really happened.[51] Hearsay also diminishes the incentive for abusers to threaten or manipulate their victims while awaiting trial because the abuser can still be prosecuted without a victim's live testimony.[52] Despite the effectiveness of hearsay in the prosecution of domestic violence cases, the Supreme Court determined that there are many instances in which the use of

hearsay violates the Confrontation Clause and a defendant's Sixth Amendment rights, and is therefore inadmissible evidence.[53]

In 2004, the Supreme Court significantly altered the doctrine of the Confrontation Clause in its treatment of "testimonial" statements made by an out-of-court declarant. In *Crawford v. Washington*,[54] the Court ruled that out-of-court statements made by witnesses, which are testimonial in nature, are "barred" under the Confrontation Clause, unless the "witnesses are unavailable and defendants had prior opportunity to cross-examine the witnesses."[55] Although the Court did not specifically define "testimonial" statements, it did indicate that these statements were comprised of testimony given at a prior hearing, trial or grand jury proceeding and included police interrogations, as well.[56] Unfortunately, most hearsay evidence used in domestic violence cases fell outside the scope of "testimonial" statements explained by the Supreme Court. As a result, the *Crawford* decision left behind "interim uncertainty,"[57] a period in which courts split, had multiple definitions for "testimonial" statements, and prosecutors were unsure as to which hearsay evidence would be admissible, thereby complicating the prosecution of domestic violence cases.[58]

Two years later, the Supreme Court slightly clarified *Crawford* with its ruling in *Washington v. Davis*.[59] The Court explained that statements are "non-testimonial" when they are made "in the course of police interrogations under circumstances objectively indicating that the primary purpose of the interrogation is to enable police assistance to meet an ongoing emergency."[60] With this ruling, the Court refined "testimonial" to statements made when the "circumstances indicate that there is no such ongoing emergency and the primary purpose of the interrogation is to establish or prove past events."[61] Basically, a court must now evaluate the nature of questions asked by a 911 dispatcher or a law enforcement official responding to a crime scene to determine the "level of formality"[62] and to "assess the primary purpose"[63] of the questions.[64] If a court determines that the questions were asked to "preserve information for later prosecution,"[65] the statements will be considered testimonial and, in effect, inadmissible.[66] Therefore, although the Supreme Court assisted prosecutors by more clearly distinguishing between "testimonial" and "non-testimonial" statements, the Court also definitively limited the type of hearsay which may be admitted into evidence during a domestic violence trial.

Domestic violence prosecution encountered another hurdle in 2008 with the decision in *Giles v. California*.[67] This time, the Supreme Court addressed Forfeiture by Wrongdoing, a doctrine which allows the introduction of a witness's out-of-court statements when the witness is "detained or kept away by the means or procurement of the defendant."[68] For example, prior to *Giles*, if an abuser killed his victim during a domestic violence incident, the victim's previous statements regarding the abuse could be admitted as hearsay evidence during trial. The Court's ruling in *Giles* limited the doctrine of Forfeiture by Wrongdoing. Now, if "the evidence suggested that the defendant had caused a person to be absent, but had not done so to prevent the person from testifying,"[69] previous statements are inadmissible. After *Giles*, "testimony is excluded unless it was confronted or fell within the dying declarations exception."[70] The actual effect of *Giles* was to add an additional requirement for prosecutors. They must now prove that the defendant "specifically intended to keep a witness from testifying against him at [this] trial."[71]

The Supreme Court's rulings in *Crawford*, *Davis*, and *Giles* were intended to protect a defendant's Sixth Amendment rights by limiting admissible hearsay evidence. Unfortunately, due to the unique nature of domestic violence, prosecutors relied on this type of hearsay evidence to prove their cases. Therefore, the practical effect of the Supreme Court's rulings was to limit hearsay evidence which can be presented at trial for the successful prosecution of a domestic violence case.

Specific Obstacles to Successfully Prosecuting Strangulation in a Domestic Violence Case

The general obstacles to successfully prosecuting domestic violence also exist in the specific context of strangulation in domestic violence cases. As discussed above, victims are reluctant to participate in the criminal justice system and they often recant initial statements made to law enforcement officials. Furthermore, prosecutors face challenges during trial because of the Supreme Court's decisions in *Crawford*, *Davis*, and *Giles*. However, these obstacles, which exist in almost all domestic violence cases, are amplified when a victim is strangled by her abuser. As previously discussed, unlike domestic violence incidents where a victim has bruises or broken bones, victims of strangulation do not present with visible injuries. Also, as previously discussed, this lack of visible injuries causes the criminal justice system to minimize strangulation from the beginning of the investigation. Emergency room medical personnel and law enforcement officials often either disregard or do not collect evidence of strangulation. As a result, unlike typical domestic violence cases which are simply difficult to prosecute, strangulation cases cannot be prosecuted at all. Furthermore, victims may be hesitant to even claim that strangulation occurred due to the low rate of domestic violence related strangulation cases addressed by emergency room medical personnel, law enforcement officials, and prosecutors.

When a victim of domestic violence informs medical personnel at an emergency room that she has been strangled, the report is often "under-evaluated."[72] The description of the attempted strangulation does not coincide with the fact that there are no visible markings to the neck. As a result, medical personnel consider strangulation to be an "exaggerated claim" by an "emotionally unstable victim" and do not look for medical evidence or entirely disregard symptoms of strangulation which may be present.[73] For example, hoarseness, which occurs in up to 50-percent of strangulation victims, is often attributed to screaming during an argument.[74] Or, subconjuctival hemorrhages, which are broken blood vessels in the eye common in victims of strangulation, are misdiagnosed as pink eye or as an indication of drug use.[75] If there is, in fact, any evidence or admission of drug or alcohol use by the victim, emergency room medical personnel are usually even more unwilling to examine allegations of strangulation.[76] In reality, medical personnel should be performing the appropriate workup because they have the most training in determining if there are serious internal injuries resulting from strangulation. Instead, emergency room personnel are the first to minimize the severity of strangulation.

Similarly, law enforcement officials frequently do not investigate allegations of strangulation either. Law enforcement officials rely on physical evidence to determine if there is probable cause to arrest a perpetrator. Therefore, when a victim does not present with visible injuries, law enforcement officials typically do not think an arrest-able or prosecutable crime has occurred. Unfortunately, this occurs all too often; the San Diego Study, previously discussed, reported that police officers found no visible injuries in 62-percent of strangulation cases and only minor injuries, such as redness or scratch marks, in 22-percent of cases.[77] Due to the lack of physical evidence, law enforcement officials typically do not document allegations of strangulation in police reports or investigate. The major flaw in this practice is that even though there are no visible injuries present, a victim can still inform an investigator of other "subjective indications of strangulation or the [abuser's] intent."[78] However, victims may be too emotional to know what information is important to disclose and law enforcement officials often overlook evidence of strangulation simply because they do not know what questions to ask to prove strangulation.

When emergency room medical personnel and law enforcement officials do not properly evaluate allegations of strangulation and minimize the incident, a prosecutor cannot bring charges or prosecute a batterer for strangling his victim. As a result, batterers who strangle their victims are not held accountable. This outcome is an indication that a new practice should be developed which combines the elements needed for a successful prosecution with

the investigative skills of law enforcement, and when possible, emergency room medical personnel, to ensure that abusers are prosecuted for strangling their victims.

Obtaining Justice for Victims of Strangulation in Domestic Violence Cases

The practice of emergency room medical personnel, law enforcement officials, and prosecutors focusing on visible injuries to prove strangulation in domestic violence cases is not effective. Stranglers are not held accountable and, according to previously mentioned statistics, strangulation remains a killer in domestic violence. The dangerously minimized nature of strangulation requires the criminal justice system to re-think their reliance on visible injuries and develop a new, uniform method of investigation, collection of evidence and prosecution. As previously introduced, this article suggests and argues that the practice of evidence-based prosecution in combination with strangulation-specific training for law enforcement officials, and when feasible, emergency room medical personnel, is an effective approach for successfully prosecuting abusers who strangle their victims and obtaining justice for victims of strangulation in domestic violence.

Evidence-Based Prosecution

The practice of evidence-based prosecution, also known as "victimless prosecution," is not a new occurrence.[79] Evidence-based prosecution in domestic violence strangulation cases is the process of using "independent corroborative evidence to prove elements of a crime without relying on the victim's testimony."[80] In effect, evidence-based protection requires law enforcement officials and prosecutors to treat the offense as a homicide case, where there is no victim.[81] There are five types of evidence, both collected at the scene of a domestic violence incident and supplemented through other means, which can be used to effectively prosecute an abuser who strangles his victim. The five types of evidence are: a 911 phone call recording, photographs, physical evidence, medical evaluation forms, and expert testimony.

The first, and perhaps the most valuable, piece of evidence used by prosecutors is a recording of the 911 phone call, made by the strangulation victim after being attacked. A 911 phone call is important and valuable because it is the first time that a victim may have explained what has happened to her. Typically, when a 911 phone call is being made, the abuser is in or around the home and the victim is still feeling scared, traumatized, or may still be in danger. Any questions asked by the 911 dispatcher would be to address an ongoing emergency. Therefore, the recording should be considered non-testimonial and admissible as hearsay evidence during trial, even in light of *Crawford* and *Giles.* A recording of the 911 phone call is also weighty evidence because hearing the voice of a scared and emotional victim seeking help immediately after being attacked can be very "moving for a jury."[82] More importantly, in the specific context of a strangulation case, a recording of the victim's voice may show that her voice was hoarse, she was coughing, or that she was having difficulty breathing, thereby confirming that victim was in fact strangled. During trial, prosecutors have historically provided a transcript of the 911 phone call recording to the jury so that they can read along during the actual playing of the phone call and more easily comprehend what is being said.[83] Or, for a more dramatic effect, prosecutors have presented the transcript of the phone call as a PowerPoint presentation at the same time the recording was being played in court.[84] However, even without prosecutorial theatrics, a recording of a 911 phone call is an extremely valuable piece of evidence for evidence-based prosecution in domestic violence strangulation cases.

Photographs and physical evidence are also essential elements to evidence-based prosecution in domestic violence strangulation cases. Photographs of the home where the domestic violence and strangulation incident occurred are important for establishing context for the judge and jury.[85] Pictures of overturned furniture, holes in walls, or bodily fluids on the floor may show a judge and the jury how dangerous or frightening the assault was.[86] Specifically, urine, defecation, and vomit are signs that the victim was strangled.[87] Pictures of these bodily fluids

on the floor may help to prove that the victim was in fact strangled even though there were no visible injuries to her neck. However, if there are visible injuries, no matter how minimal they may be, photographs of these injuries are important to show a judge and the jury what the victim went through. In some cases, a victim may actually have fingerprints on her neck or markings resembling a ligature used during strangulation. It can be case-winning to physically line up the ligature used to strangle the victim with a photograph of the victim's injured neck and have it match perfectly. Even better is to have the ligature that was used to strangle the victim. Some prosecutors actually use the ligature on themselves or on a volunteer to make the incident come to life for a judge or the jury. Physical evidence collected at the scene of a domestic violence incident also helps prosecution. Similar to photographs, physical evidence, such as ripped clothing helps to establish the context of the assault.[88] A combination of various photographs and physical evidence is ideal for an evidence-based prosecution.

Medical evaluation forms are another essential piece of evidence used in evidence-based prosecution for proving strangulation. As has been discussed multiple times in this article, strangulation often does not leave visible injuries on the victim. As a result, photographs may not always be available as evidence. Furthermore, the abuser does not always use a ligature, he may just use his hands, and so physical evidence may also be scarce. Therefore, a medical evaluation form detailing strangulation symptoms described first-hand by the victim is valuable. Furthermore, medical personnel documenting internal injuries which were most likely caused by strangulation may be the only way to indicate that a victim was in fact strangled. For these reasons, medical evaluation forms are a critical piece of evidence during trial.[89]

The final type of evidence, expert testimony during trial, serves two distinct and important functions during a domestic violence strangulation case. First, regardless of whether the victim has obtained medical treatment or not, it can be informative to use a medical expert who can educate the judge and the jury about the physical danger of the act of strangulation.[90] Strangulation statistics are not common knowledge, both the judge and the jury need to understand that strangulation can cause unconsciousness within seconds and death in just minutes.[91] Explaining the severity of strangulation also assists in demonstrating an abuser's potentially deadly intent when he put his hands around the victim's neck and squeezed.[92] Second, an expert witness, such as a social worker or psychologist, can be beneficial in explaining the dynamics of domestic violence.[93] For the majority of judges and jury members, the issue of power and control in an abusive relationship and the cycle of violence, discussed earlier in this paper, are outside of their understanding or experience.[94] Most judges and jury members cannot comprehend why a victim of domestic violence continues to stay in an abusive relationship or refuses to testify against her abuser, especially when he strangles her.[95] Judges and juries incorrectly believe that a victim can leave an abusive relationship at any point. In reality, a victim may make numerous unsuccessful attempts to escape her abusive relationship. Often, these attempts result in the victim being physically punished by her abuser, sometimes even strangled.[96] An expert witness who can teach a judge and a jury about the dynamics of domestic violence can provide an explanation of the victim's feelings and thoughts. This may be helpful in explaining why a victim has not left her abuser or why she is not testifying against him.

Although not all five types of evidence are always available, a combination of just a few of the types discussed will make strangulation in domestic violence cases stronger than they currently are.

Strangulation-Specific Training

The nature of evidence-based prosecution requires a prosecutor to rely on both law enforcement officials and, in some cases, emergency room medical personnel to collect evidence at the scene of the domestic violence incident. In doing so, even if a victim refuses to participate or recants, the prosecutor can still have sufficient evidence to bring the strangulation case to trial.[97] Unfortunately, as previously discussed, law enforcement officials and medical personnel often focus on visible injuries and overlook the other symptoms and indications of

strangulation. The focus of law enforcement officials and emergency room medical personnel is skewed simply because they are not familiar with strangulation, they do not know what signs and symptoms to look for or what questions to ask.[98] Strangulation-specific training for law enforcement officials and, when feasible, emergency room medical personnel, will help to ensure that evidence is properly collected so that a prosecutor can go forth with evidence-based prosecution and convict a batterer of strangling his victim. The curriculum of strangulation-specific training for law enforcement officials and emergency room medical personnel should teach three fundamentals: what questions to ask, what symptoms to look for, and the importance of documentation.

Law enforcement officials and emergency room medical personnel are faced with the very important task of figuring out what happened during a strangulation incident. The purpose of questioning a victim is to put together a description of the crime. The initial question should relate to the "mechanism of the injury."[99] It is imperative that law enforcement and medical personnel ask the victim how she was strangled: Did the abuser use one or two hands or was the victim strangled with a ligature?[100] A victim or the abuser can even be asked to demonstrate the incident.[101] Next, it should be determined for how long a victim was strangled for.[102] Follow up questions may include if the victim lost consciousness or experienced any pain including dizziness or faintness, nausea, or difficulty swallowing or breathing.[103] These questions are important for two reasons; first, to determine whether or not the victim is in need of immediate medical assistance and second, to create the foundation of the strangulation case against the abuser.[104]

Victims of domestic violence strangulation may be embarrassed or may minimize the incident.[105] Therefore, law enforcement officials and emergency room medical personnel must also be trained in what symptoms of strangulation to look for.[106] Law enforcement and medical personnel should check for bruises and fingertip or thumb prints typically located around the ears.[107] Tiny red spots, known as petechia, may be found inside of or around the eyes.[108] Petechia is a common symptom resulting from strangulation due to ruptured capitularies, but is often confused with pink eye or an indication of drug use.[109] Redness and scratches on a victim's neck may have been caused by the abuser while strangling or by the victim's own fingernails while trying to fight against the abuser. Abrasions to the chin may have been caused by holding it down in defense of her neck during the attack.[110] Law enforcement and medical personnel should also check the suspected abuser for defensive wounds to confirm where his hands or arms were during the strangulation; in particular, bite marks are a common injury.[111]

Finally, and most importantly, law enforcement officials and emergency room medical personnel need to understand the importance of documentation. There may be a lot of evidence of strangulation, however, if it is not fully and accurately documented, a prosecutor cannot use it at trial.[112] Everything that the victim, suspect or witnesses say must be either written down verbatim or electronically recorded.[113] Every symptom described by the victim, however insignificant it might seem, must also be noted and photographed.[114] It is often helpful to use audio taping to document a change in the victim's voice due to strangulation. Law enforcement should take multiple photographs of the crime scene and all of the victim's injuries, no matter how minor they appear.[115] Follow-up photographs, taken two to three days after the incident, are also helpful in demonstrating the severity of certain injuries sustained because bruises may not appear until a few days after the incident.[116] Although it is not always possible to document all of this evidence, law enforcement officials and emergency room medical personnel need to be educated about the importance of documenting everything and take ever step possible to ensure complete and accurate documentation.

By understanding what questions to ask, what symptoms to look for, and the importance of documentation, law enforcement officials and emergency room medical personnel will help guarantee that prosecutors have all necessary evidence and testimony to bring the strongest case possible to trial.

Conclusion

Although strangulation, one of the most lethal forms of domestic violence, has a history of being minimized by all members of the criminal justice system, it is still possible to curtail this occurrence. However, ending strangulation in domestic violence cannot be done by one group; it requires all members of the criminal justice system to work together.[117] If emergency room medical personnel, law enforcement officials, and prosecutors collaborate, in a system which unites evidence-based prosecution with trained investigative skills, it is possible to hold abusers accountable and obtain justice for victims of strangulation. Although this may not happen immediately, cases previously thought to be inadequate, could possibly be prosecuted as misdemeanors and cases previously thought to be misdemeanors should be prosecuted as felonies.[118] In general, ending minimization of strangulation and aggressively addressing the problem may alert abusers and prevent them from strangling their victims or, at least, encourage more strangulation victims to seek help.

Notes

1. Allison Turkel, *Understanding, Investigating, and Prosecuting Strangulation Cases*, 41 DEC PROSC 20, 20 (2007) (discussing the dangerous nature of strangulation)

2. Gael B. Strack & Eugene Hyman, *Your Patient. My Client. Her Safety: A Physician's Guide to Avoiding the Courtroom While Helping Victims of Domestic Violence*, 11 DePaul J. Health Care L. 33, 59 (2007) (describing strangulation as one of the most lethal forms of domestic violence).

3. Turkel, *supra* at 20 (describing an allegation of strangulation).

4. Fact Sheet of Strangulation Assaults in Domestic Violence Cases, Ortner-Unity, *http://www.sp2.upenn.edu/ortner/docs/factsheet_strangulation.pdf* (last visited October 30, 2011) (discussing strangulation may indicate an ongoing pattern of abuse and foreshadows escalating violence); *See also*, Strack & Hyman, *supra* at 59 (explaining strangulation leaves no visible injuries).

5. Gael B. Strack, Dr. George E. McClane & Dr. Dean Hawley, *A Review of 300 Attempted Strangulation Cases, Part II: Clinical Evaluation of the Surviving Victim*, 21 J. Emergency Med. 311, 311 (2001) (formally defining strangulation).

6. *Id*. (formally defining choking).

7. *Id.*

8. *Id.*

9. *Id.*

10. Strack, McClane & Hawley, *supra* at 311 (describing the clinical sequence of strangulation).

11. Fact Sheet of Strangulation Assaults in Domestic Violence Cases, Ortner-Unity, *http://www.sp2.upenn.edu/ortner/docs/factsheet_strangulation.pdf* (last visited October 30, 2011) (listing possible physical injuries of strangulation).

12. Fact Sheet of Strangulation Assaults in Domestic Violence Cases, Ortner-Unity, *http://www.sp2.upenn.edu/ortner/docs/factsheet_strangulation.pdf* (last visited October 30, 2011) (listing possible neurological injuries of strangulation).

13. Fact Sheet of Strangulation Assaults in Domestic Violence Cases, Ortner-Unity, *http://www.sp2.upenn.edu/ortner/docs/factsheet_strangulation.pdf* (last visited October 30, 2011) (listing possible psychological injuries of strangulation).

14. Gael B. Strack, Dr. George E. McClane & Dr. Dean Hawley, *A Review of 300 Attempted Strangulation Cases, Part I: Criminal Legal Issues*, 21 J. Emergency Med. 303, 308 (2001)

15. Fact Sheet of Strangulation Assaults in Domestic Violence Cases, Ortner-Unity, *http://www.sp2.upenn.edu/ortner/docs/factsheet_strangulation.pdf* (last visited October 30, 2011) (discussing strangulation may indicate an ongoing pattern of abuse).

16. Resource Materials on Strangulation, New York Correction History Society, *http://www.correctionhistory.org/northcountry/html/knowlaw/strangulation3.htm* (last visited on November 30, 2011) (providing material used at the New York Prosecutors Training Institute).

17. Fact Sheet of Strangulation Assaults in Domestic Violence Cases, Ortner-Unity, *http://www.sp2.upenn.edu/ortner/docs/factsheet_strangulation.pdf* (last visited October 30, 2011) (discussing strangulation may foreshadow escalating violence).

18. Resource Materials on Strangulation, New York Correction History Society, *http://www.correctionhistory.org/northcountry/html/knowlaw/strangulation3.htm* (last visited on November 30, 2011)

(providing material used at the New York Prosecutors Training Institute).

19. Turkel, *supra* at 21 (discussing a perpetrator's homicidal intent).

20. Strack & Hyman, *supra* at 59

21. Strack, McClane & Hawley, *supra* at 314

22. *Id.* at 312

23. Turkel, *supra* at 21

24. Strack & Hyman, *supra*, at 59 (describing strangulation as one of the most lethal forms of domestic violence).

25. Strack & McClane, *supra* at 13 (discussing minimization of strangulation by police officers and prosecutors).

26. *Id.* at 1 (discussing victim minimization of strangulation).

27. *Id.* at 3.

28. Eleanor Simon, *Confrontation and Domestic Violence Post-Davis: Is There and Should There be a Doctrinal Exception?*, 17 Mich. J. Gender& L. 175, 185 (2011)

29. *Id*.

30. Tom Lininger, *Prosecuting Batterers after Crawford*, 91 Va. L. Rev. 747, 768 (2005).

31. Erin Leigh Claypoole, *Evidence-Based Prosecution: Prosecuting Domestic Violence Cases Without a Victim*, 39 Feb Prosc 18, 20 (2005).

32. Laurence Busching, *Rethinking Strategies for Prosecution of Domestic Violence in the Wake of Crawford*, 71 Brook. L. Rev. 391, 394 (2005) (describing hearsay evidence used in domestic violence prosecutions).

33. *Id.*

34. Donna D. Bloom, *"Utter Excitement" About Nothing: Why Domestic Violence Evidence-Based Prosecution Will Survive Crawford v. Washington*, 36 St. Mary's L.J. 717, 728 (2005) (describing a domestic violence victim's lack of cooperation).

35. Katherine G. Breitenbach, *Battling the Threat: The Successful Prosecution of Domestic Violence after Davis v. Washington*, 71 Alb. L. Rev. 1255, 1255 (2008) (describing the tension-building stage)

36. *Id*. at 1257 (describing the violent stage).

37. *Id*. (describing the honeymoon stage).

38. *Id*.

39. Bloom, *supra* at 728.

40. *Id*. at 728-729 (explaining how batterer's manipulate their victims).

41. *Id*. at 728

42. *Id*.

43.Aiysha Hussain, *Reviving Hope for Domestic Violence Prosecutions: Giles v. California*, 46 Am. Crim. L. Rev. 1301, 1302 (2009).

44. Bloom, *supra* at 728-729 (describing retaliatory methods used by batterer's against victims); *See also* Breitenbach, *supra* at 1257 (listing reasons why victims recant).

45. Bloom, *supra* at 728.

46. *Id*. at 728-729.

47. *Id*. at 729.

48. *Id*. at 728-729.

49. *Id*. at 729.

50. Busching, *supra* at 394.

51. Lininger, *supra* at 771 (describing the value of hearsay in prosecuting a domestic violence case).

52. *Id.*

53. *See Generally, Crawford v. Washington,* 541 U.S. 36 (2004) (stating that hearsay may violate the Confrontation Clause and a defendant's 6th Amendment rights).

54. *Crawford v. Washington*, 541 U.S. 36 (2004)
55. *Id.* (holding of case).

56. Bloom, *supra* at 720-721 (listing examples of testimonial statements).

57. *Id.* at 737.

58. *Id.* 737-738 (defining interim uncertainty).

59. *Washington v. Davis*, 547 U.S. 813 (2006).

60. *Id.* at 814 (defining non-testimonial statements).

61. Simon, *supra* at 181 (defining testimonial statements in light of *Washington v. Davis*).

62. *Id*.

63. *Id*.

64. *Id.* (describing the primary purpose and ongoing emergency test articled by the Court in *Washington v. Davis*).

65. Breitenbach, *supra* at 1276.

66. *Id.* at 1276-1277.

67. *Giles v. California*, 554 U.S. 353 (2008).

68. *Id.* at 358 (defining Forfeiture by Wrongdoing).

69. *Id.* at 361-362 (holding of case).

70. *Id.*

71. Hussain, *supra* at 1309 (describing the practical effect of *Giles*).

72. Stack, McClane & Hawley, *supra* at 312.

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. Strack & McClane, *supra* at 1.

78. Turkel, *supra* at 21.

79. Claypoole, *supra* at 18.

80. *Id.* (defining evidence-based prosecution).

81. *Id.*

82. *Id.* at 21 (describing benefits of a 911 phone call recording).

83. *Id.*

84. *Id.*

85. *Id.* at 20 (describing benefits of photographs).

86. *Id.*

87. Turkel, *supra* 21-22.

88. *Id.*

89. Strack & Hyman, *supra* at 51.

90. Strack & McClane, *supra* at 11-12 (discussing use of an expert witness).

91. *Id.*

92. Turkel, *supra* at 21.

93. Claypoole, *supra* at 21.

94. *Id.*

95. *Id.*

96. Strack & Hyman, *supra* at 41.

97. Breitenbach, *supra* at 1279.

98. Strack, McClane & Hawley, *supra* at 308.

99. Turkel, *supra* at 21.

100. *Id.* at 21-22 (listing questions to ask a victim of strangulation).

101. *Id.*

102. *Id.*

103. Strack & McClane, *supra* at 6-7 (listing follow-up questions).

104. Turkel, *supra* at 21

105. Strack & McClane, *supra* at 8.

106. *Id.*

107. Tukel, *supra* at 22.

108. *Id.*

109. *Id.* (discussing and describing petechia).

110. *Id.*

111. *Id.*

112. Strack & Hyman, *supra* at 51.

113. *Id.* (discussing importance of documentation).

114. *Id.* at 60.

115. *Id.*

116. Strack & McClane, *supra* at 8 (discussing importance of follow-up photographs).

117. Strack & Hyman, *supra* at 34.

118. Strack, McClane & Hawley, *supra* at 308.

Addressing the Health Consequences of Domestic Violence

The Pandora Effect

By
Ellen Taliaferro, MD

Keynote Speech
May 2003
Amarillo Texas
Texas Tech Women's Health Conference

I begin today with a compelling old myth: The story of Pandora's box. You probably remember something of it: Beautiful Pandora, created by the Olympian gods for Zeus, received a box as a gift and was forbidden to open it. But beautiful Pandora was curious and she opened the box anyway. In one horrifying moment, all the earth's furies—trouble, old age, insanity, plague, sorrow, vice, crime—flew out of the box, never again to be contained by humankind.

Furies and trouble. That is why, when we hear the phrase "opening Pandora's box," we think we are being warned, as in the old adage, "Let sleeping dogs lie." Don't wake trouble up, we say. But many people don't realize that there is more to the Pandora story, and that is the story's ending.

All the furies flew out of the box, but something remained. And what do you suppose remained in the box that had held the furies? It was hope. Hope: implying that after trouble, hope never entirely leaves us.

I come to you this morning with a challenge. And that is to *rethink* the phrase, "opening Pandora's box." As you'll see, many healthcare providers in the past have declined to recognize signs and symptoms of domestic violence precisely because they were afraid to open what they saw as Pandora's box. They didn't want to deal with the complexities and uncertainties of domestic violence. But we can rethink that Pandora phrase, remembering the hope that remained in the box, as we address the issues of domestic violence.

Today's terminology refers to domestic violence as intimate partner violence (IPV). Traditionally, healthcare has approached this issue by using a standard healthcare intervention for cases of intimate partner violence. Today I challenge you to move beyond this limited intervention. It is time to now incorporate violence prevention into our medical practice by diagnosing and treating the healthcare ***consequences*** of intimate partner violence. It is time to open

Pandora's box and find the hope, still there, at the very bottom.

A. Definition

By definition, intimate partner violence is a form of family violence. It has been interchangeably referred to as domestic violence, spouse abuse, partner abuse, wife abuse or wife battering. It is characterized by an unhealthy pattern of coercive behaviors with the intent of one partner to dominate, control and victimize the other partner. The goal of controlling another through the abuse of power and control is the common feature in IPV.

B. Impact on the Healthcare System

Intimate partner violence is definitely a healthcare issue. Recent studies have shown that most healthcare visits are made because of common symptoms for which no identified pathology is found.[1] We now have evidence that suggests that victims of violence seek healthcare more often than nonvictims and that the *severity* of victimization is a powerful predictor of health care costs.[2] IPV is not cheap. The cost to our society is enormous. Physical injury from interpersonal violence causes approximately $10 billion of direct healthcare cost each year. Another $23 billion results from lost production per year.[3]

C. Current expectations of the Healthcare System

The overall goal intervention in IPV is to assure patient safety and well-being. It is a lengthy process requiring experts in domestic violence who have access to a wide range of legal and community-based services. This overall process is beyond the scope of healthcare providers at any given moment. It is, however, aided by a very specific healthcare intervention consisting of five easy and significant steps: (1) Identification, (2) documentation, (3) provision of safety, (4) referral and (5) assurance. The actual intervention, conducted by IPV prevention experts, is undertaken after the specific healthcare intervention is performed.

This is no different from what we expect of physicians in any healthcare setting. Consider the case of the patient presenting to an urgent care setting with a chief complaint of right lower quadrant (RLQ) pain. Information is obtained and analyzed to discern whether or not this pain might represent a diagnosis of appendicitis (Identification). Findings of the history and physical examination are recorded along with progress notes of what happens during the evaluation of the patient (Documentation). If it appears that surgery may be needed, fluids and food are restricted (Provision of safety). A surgeon is called to see the patient (Referral). The patient is reassured that the best care will be provided (Assurance). These five steps comprise the initial healthcare intervention of addressing the patient's problem. The actual, more specific intervention, exploratory surgery, occurs at a later time in the OR.

This specific healthcare intervention has gained acceptance by many experts. This is appropriate because in the healthcare field, we tend to believe that most of the IPV victims are the patients presenting with fresh or healing injuries.

While many IPV patients do present with injuries, it is not the most common presentation. Far more common are the women presenting with medical problems that do not reflect current or very recent injuries.

D. Consider this scenario

A young woman, Anita, presents with abdominal pain that seems to defy diagnosis and medical help. She has seen many doctors to no avail. Her current doctor doesn't seem to have the opportunity to spend much time with her during her visits, but he never gives up trying to find out what is causing her pain. She has undergone test after test and each time the newest one comes back negative, her physician orders a new test, prescribes a new medication and assures Anita that they will keep pursuing the problem until he can find an answer.

Time goes by. Anita's husband takes a new job and the family moves across the country. Shortly after the move, the abdominal pain returns. Anita makes an appointment to see a new doctor in her husband's healthcare plan.

When Anita arrives for her appointment, she finds posters lining the hallway of the clinic. Some advertise flu shots and give tips on how to manage blood pressure. Others stress the value of exercise and good diet. In the bathroom, Anita sees a large poster asking if the she is a victim of domestic violence. Beside the poster is a rack of pamphlets telling her where to get help for domestic violence.

In the new doctor's waiting room, Anita is given a healthcare inventory form to complete. Buried in the questionnaire is a question asking about the presence of domestic violence, now or in the past.

She answers "no." Paul, her gentle husband would never touch a fly. He treats her like a princess.

When Anita meets her new doctor, she is asked a number of questions about her pain. Suddenly her new doctor asks her if anyone she knew was hurting her in anyway? Did she feel safe at home? When Anita answers, "no," she is asked if that might have occurred in the past. The question triggers her memory of her first abusive marriage, which Anita has long since gotten "over it." Anita asks her doctor why this question is being asked.

Her new doctor says, "Well, in my experience, I find that sometimes abdominal pain that comes and goes and doesn't lend itself to a definite diagnosis is not uncommonly linked

to a history of abuse. That's why I want to know if anyone is hurting you now or has hurt you in the past."

Anita begins to sob and pours out the story of her first marriage. Suddenly she stops. Anger flares up, "Does this mean you think that this is all in my head?" she challenges her new doctor.

The doctor smiles and says no. Then she points to Anita's chart and reads the chief complaint aloud, "Abdominal pain." She looks at Anita and smiles. Then she says, "I think if this were all in your head, your chart would read, 'headache.'"

The new doctor goes on to explain that past abuse sometimes produces deep pain that literally seems to "bury itself" inside the body. Long after the memory of the abuse has faded, the body remembers and carries around pain down deep. She also explains that there are a number of other things that cause abdominal pain and that they will be doing a thorough diagnostic evaluation. Meanwhile she provides Anita with information about domestic violence and its impact on the body. She also arranges for Anita to see the social worker who runs a weekly support group for women who have suffered domestic violence and are now in the process of putting their lives back together.

Does Anita's case represent the healthcare response to domestic violence in the United States at this time? Rarely. But the good news is that it could well have happened in Dallas, TX at the Parkland Hospital's Violence Intervention Prevention (VIP) Center. This Center was the first full-service, hospital-based, treatment-oriented and physician directed center in the United States dedicated to victims of violence.

Now, many other agencies and healthcare systems are beginning to understand the link between domestic violence and healthcare problems. Towards this end, widespread education and training is underway to teach physicians and healthcare providers how to identify and address domestic violence. These educational endeavors seek to explain to them what they can each one of them can do to "break the cycle of violence" by helping to prevent future episodes of domestic violence in their patient population.

From these centers and activities we are beginning to learn that the impact of repeated abuse does, indeed, leave a lasting "impression" on the health of the victim of abuse. This impact, what I call the Pandora effect, lingers long after the bruises fade, the bones mend and the abuse is over. Still, many of the victims, their friends and relatives and those who serve them in the domestic violence advocacy, medical and law enforcement communities fail to understand how significantly this lingering footprint of violence is effecting their well-being and their ability to function and carry on a normal life.

There is now mounting evidence in the medical literature that IPV has long-term negative health consequences for survivors, even after the abuse has ended. To investigate this issue, Dr. Jacquelyn Campbell and colleagues published a study on *Intimate Partner Violence and Its Physical Health Consequences* in May of 2002. These researchers surveyed 2005 women who were between the ages of 21 and 55 years of age and enrolled in a metropolitan health maintenance organization servicing multiple sites. Using an accepted screening tool known as The Abuse Assessment Screen, the researchers identified 201 women who had been physically and/or sexually abused between January 1, 1989, and December 31, 1997. From the remaining women, they randomly selected a sample of 240 never-abused women who served as case controls. They then compared the general health perceptions of the abused women to the never-abused women.

They found that the abused women had significantly more headaches, back pain, sexually transmitted diseases, vaginal bleeding, vaginal infections, pelvic pain, painful intercourse, urinary tract infections, appetite loss, abdominal pain, and digestive problems than the never abused women. The abused women also had more gynecological, chronic stress–related, central nervous system, and total health problems.[4] In addition, recent case reports in the literature describe stokes and Transient Ischemic Attacks following carotid trauma, sustained from manual strangulation,[5] a not uncommon form of abuse which occurs in domestic violence attacks.

Many authors report that there are even numerous health problems associated with past abuse. Walker, et al in their article, *Adult Health Status of Women with Histories of Childhood Abuse and Neglect*, found that the 25 most commonly used diagnostic codes used for these patients included infectious diseases (vaginitis, urinary tract infection, upper respiratory infection, sinusitis, rhinitis, pharyngitis, bronchitis, cellulitis), pain disorders (neck pain, migraine, dysmenorrhea, headache, back pain, abdominal pain), mental health diagnoses (stress, depression, adjustment problems, marital discord), and other diseases (hypertension, diabetes, dermatitis, asthma, allergy, acne, abnormal menstrual bleeding). These authors also found repetitive adult behaviors that have the potential for creating or worsening health problems. These included smoking, use of alcohol, driving while intoxicated, avoiding regular gynecological examinations, not wearing seat belts, sedentary lifestyle, and high-risk sexual encounters.[6]

II. Pandora Effect

It is time for the healthcare system to step forward and lead the way in addressing the healthcare consequences of intimate partner violence.

Domestic violence advocates, family, friends and knowledgeable law enforcement officials, healthcare providers and the patients themselves, from their own experience, have known for sometime that there was something "not quite right" about the victim of abuse who is trying to reclaim her life. To date, however, there has been no name for this.

IPV victims, current or recovering, carry their own unique burden: Life after repetitive abuse is never the same. The abuse leaves a strong imprint on the body and soul long after the bruises have faded and the bones have mended. There are lingering health and social consequences that impact the IPV victim's post-abuse functioning and well-being. Let us begin by giving the problem a name. I call this constellation of lingering consequences the Pandora Effect. When we give a name to this condition, we validate the issue and our patients. Let us validate our patients by addressing this Pandora Effect through focused healthcare, education and research. The name, the Pandora Effect, does one more thing. This name defines IPV as a women's health issue.

I leave you today with this challenge: the next time you see a women who presents with a headache or chronic pain or a sexually transmitted diseases or digestive problems, open your eyes and look hard. You may find that you are "seeing Anita." When you see "Anita," have the courage to open Pandora's Box and help her with confidence, skill and the healer's art. Do so and you will find … ***Hope.***

Thank you.

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Facts That Victims of Choking (Strangulation) Need to Know!

Strangulation has only recently been identified as one of the most lethal forms of domestic violence: **unconsciousness may occur within seconds and death within minutes.** When domestic violence perpetrators use strangulation to silence their victims, not only is this felonious assault, but it may be an attempted homicide. Strangulation is also a form of power and control which may have devastating psychological effects or a potentially fatal outcome.

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

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

Be aware that strangulation may cause the following symptoms and/or consequences: difficulty breathing, raspy, hoarse or loss of voice, coughing, difficulty swallowing, nausea, vomiting, changes in behavior, hallucinations, headaches, light headedness, dizziness, urination or defecation, miscarriage, swollen tongue or lips. These symptoms may be an early indication of an internal injury such as swelling, bleeding, fractured larynx ("voice box") or hyoid bone, seizures, pulmonary edema (lungs filled with fluid) or death within 36 hours due to progressive internal injuries and/or complications.

Victims should look for injuries on their face, eyes, ears, nose, mouth, chin, neck, head, scalp, chest and shoulders, including: redness, scratches or abrasions, fingernail impressions in the skin, deep fingernail claw marks, ligature marks ("rope burns"), thumbprint-shaped bruises, blood-red eyes, pinpoint red spots called "petechiae" or blue fingernails.

Victims should also seek medical attention if they experience difficulty breathing, speaking, swallowing or experience nausea, vomiting, light headedness, involuntary urination and/or defecation.

Although most victims may suffer no visible injuries whatsoever and many fully recover from being strangled, all victims, especially pregnant victims, should be encouraged to seek immediate medical attention. A medical evaluation may be crucial in detecting internal injuries and saving a life.

STRANGULATION IN DOMESTIC VIOLENCE CASES: OVERCOMING EVIDENTIARY CHALLENGES TO REDUCE LETHALITY

By: Melissa Paluch
Developments in New York State Family Law
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Domestic Violence[1] is a pattern of various types of behaviors used by one person in a relationship against the other in order to maintain power and control over that person.[2] Strangulation is one method of physical abuse used by many batterers to silence their victims, and assert power and control over them. It "epitomizes the power dynamic" that exists in nearly all cases of domestic violence because it "sends a message to the victim that the batterer holds the power to take the victim's life, with little effort, in a short period of time, and in a manner that may leave little evidence of an altercation."[3] Strangulation has recently been identified as one of the most lethal methods of domestic abuse.[4] Ten percent of violent deaths that occur each year in the United States are directly due to strangulation, with six females to every one male.[5]

In acknowledging the severity of strangulation as a method of domestic abuse, nearly thirty states across the United States have passed legislation making strangulation a separate, felony level criminal offense.[6] In New York, on November 11, 2010, the State Legislature passed and Governor David Paterson approved a law that added three strangulation offenses constructed solely for the purpose of criminalizing the act of strangulation to the Penal Law, all of differing levels of crime.[7]

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[1] New York State Domestic Violence Dashboard Project 2011 Data, New York State Office for the Prevention of Domestic Violence, http://www.opdv.state.ny.us/ (last visited April 5, 2013) (stating that each year, the New York State Office for the Prevention of Domestic Violence (OPDV) complies a report of statistics reflecting the number of victims impacted by domestic violence across New York State in that particular year. These reports are part of the New York State Dashboard Project. The most recently published report is for the year 2011 and contained the following statistics: 89 intimate partner homicides were reported, 49 of them in New York City alone; police agencies outside of New York City reported 30,096 assaults committed at the hands of intimate partners; and 20,340 applicants applying for public assistance indicated danger due to domestic violence, a 34% increase from 2010.)

[2] Definition of Domestic Violence, http://www.domesticviolence.org/definition (last visited May 9, 2013) (stating that the violence can be physical, sexual, or emotional, or it can be a combination of all three.)

[3] Letter of Memorandum in Support of Legislation, dated November 25, 2010, Bill Jacket, L. 2010, ch. 405, at 9-11.

[4] Id.

[5] Gael B. Strack & Dr. George McClane, *How to Improve Investigation and Prosecution of Strangulation Cases* (2007), *available at* http://www.strangulationtraininginstitute.com/libray.html.

[6] *States cracking down on strangulation attempts*, USA Today (May 13, 2012), http://usatoday30.usatoday.com/news/nation/story/2012-05-13/strangulation-crackdown-law/54935268/1.

[7] Introducer's Memorandum in Support, dated June 29, 2010, Bill Jacket, L. 2010, ch. 405, at 7-9, (stating that this law also amended the Penal Law by adding Strangulation 1st and Strangulation 2nd to the list of "specified" offenses that may be prosecuted as "Hate Crimes" and "Sexually Motivated Felonies." It amended the Social Services Law

Aside from acknowledging the severity and frequency of strangulation, these new strangulation offenses have a direct effect on victim lethality.[8] Non-fatal strangulation increases the risk of attempted or completed homicide, and thus "remains a significant independent risk factor" for future intimate partner death.[9] A woman who is strangled is seven times more likely to become the victim of a domestic violence homicide later.[10]

As important as it is for states to acknowledge the severity of strangulation as a method of physical domestic abuse by creating separate and distinct strangulation offenses, it is just as important that these offenses be prosecuted successfully. These batterers need to be held accountable for their abhorrent actions. Unfortunately though, evidentiary challenges are continuously making it difficult for prosecutors to successfully prosecute these crimes. There are, however, several recommendations that could potentially solve these evidentiary struggles.

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by adding Strangulation 1st and Strangulation 2nd to the definition of "spousal abuse" for the purpose of obtaining access to the records of conviction of a prospective foster parent, and added Strangulation 1st and Strangulation 2nd to the definition of "spousal abuse" under the Domestic Relations Law. Also, it amended the Executive Law by adding COBBC to the list of "designated offender" misdemeanors that require submission of a DNA sample upon conviction. It amended the Mental Hygiene Law by adding Strangulation 1st and Strangulation 2nd to the list of "designated" felony offenses that, if "sexually motivated," may be eligible for sex offender civil commitment. And, it amended the Vehicle and Traffic Law by adding Strangulation 1st and Strangulation 2nd to the list of conviction offenses that can disqualify a person from driving a school bus.)

[8] Susan J. Dansie, *Lethality Assessment and Safety Planning* (1992), *available at* http://www.ncdsv.org/images/LethalityAssessmentSafetyPlanning.pdf, (stating that in lethality assessments, a prosecutor or victim's advocate will often look to see if a variety of risk factors are present in a relationship containing domestic violence. Some of these factors include prior violence, mental illness, illicit drug use, prior criminal involvement, unemployment, pet abuse, suicidal thoughts/threats, stalking/obsession/escalating jealously. The more lethality factors present in a relationship, the more lethal the situation is for the victim.)

[9] Nancy Glass, *Non-fatal strangulation is an important risk factor for homicide of women*, 35 J Emerg. Med. 329, (2008).

[10] Julie Besonen, *A new crime, but convictions are elusive*, New York Times (Feb. 16, 2013), http://www.nytimes.com/2013/02/17/nyregion/choking-someone-is-now-a-felony-but-convictions-are-elusive.html?pagewanted=all&_r=0.

I. Description of Strangulation[11]

Strangulation is defined as "a form of asphyxia (lack of oxygen) characterized by closure of the blood vessels and/or air passages of the neck as a result of *external* pressure on the neck"[12] (emphasis added). For an adequate understanding of strangulation, it is important to acknowledge the difference between strangulation and choking. Choking is usually accidental and is an internal compression of the neck, such as a foreign object or food partly or entirely blocking the trachea (windpipe).[13] There is minimal potential for long-term effects after the blockage is removed.[14] Strangulation, on the other hand, is usually intentional and is an external compression. The external pressure to the neck closes the blood vessels and air passage, which restricts circulation to and from the brain.[15] Unlike choking, there is potential for serious physical injury or death even after the external pressure ends.[16] More specifically, because of underlying brain damage caused by the lack of oxygen during the strangling, victims may have serious internal injuries and die days or even several weeks later.[17]

It does not take a lot of time or a large amount of pressure to cause a victim to sustain serious injuries. An obstruction of the carotid arteries is the most common consequence of

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[11] Strack, at 3, (stating that in order to adequately understand the clinical features of a strangled victim, an elementary understanding of neck anatomy is important (*see* Appendix A). First is the hyoid bone, a "small horseshoe-shaped bone in the neck" that "helps to support the tongue." Next, the larynx, which is made up of cartilage and consists of two separate parts: the thyroid cartilage and the tracheal rings. The carotid arteries are "the major vessels that transport oxygenated blood from the heart and lungs to the brain" and are found at the side of the neck. These are the arteries that are often checked by a person administering cardiopulmonary resuscitation (CPR) when they are checking for a pulse. Last are the jugular veins, which are "the major vessels that transport deoxygenated blood from the brain back to the heart." There are three different forms of strangulation: hanging, ligature, and manual. Since hanging is not a form that is used in the context of domestic violence, it is only important to distinguish between ligature and manual. Ligature strangulation is strangulation using a cord-like object, such as a telephone cord, a rope, or even articles of clothing. Manual strangulation, also referred to as throttling, is usually done with the hands or forearms, or by standing or kneeling on the victim's throat.)

[12] Id.

[13] G. E. McClane et. al., *A Review of 300 Attempted Strangulation Cases Part II: Clinical Evaluation of the Surviving Victim*, 21 J Emerg. Med. 311, 311, (2001).

[14] Id.

[15] Id.

[16] Id.

[17] Strack, at 6.

strangulation, and it takes only "eleven pounds of pressure placed on both carotid arteries for ten seconds" for a victim to lose consciousness.[18] Obstruction of the jugular veins is the second most common consequence, and it takes only 4.4 pounds of pressure for a period of ten seconds for unconsciousness to result.[19] An obstruction of the trachea, more commonly referred to as the closing of the airway, takes 33 pounds of pressure.[20] This form of obstruction is severe because a tracheal fracture can occur, which generally results in the death of the victim.[21] Regardless of the type of obstruction, if strangulation persists for a period of *four to five minutes*, brain death *will* result.[22]

II. Strangulation Offenses

Prior to November 2010, "no specific crimes aimed at conduct involving the intentional blocking of a victim's breathing or circulation" existed within the New York State Penal Law.[23] Under the pre-2010 penal law, "where no physical injury is present, even the misdemeanor crime of assault in the third degree is not applicable. This leaves only the noncriminal offense of harassment in the second degree, a violation, as the only viable charge" in cases involving the intentional blocking of a victim's breathing or circulation (strangulation).[24] A person could be strangled almost to the point of death, yet more frequently than not, criminal charges could not be pursued. As a result, batterers were not being held accountable, and victims were not receiving justice.

In acknowledging the severity and frequency of strangulation, three offenses were added to the Penal Law on November 11, 2010. The first offense added was Criminal Obstruction of

[18] Id., at 3.
[19] Id., at 4.
[20] Id.
[21] Id.
[22] Id., at 3.
[23] Introducer's Memorandum in Support, dated June 29, 2010, at 7-9.
[24] Id.

Breathing or Blood Circulation (COBBC), which makes it a crime to "impede the normal breathing or circulation of blood of another person" by either "applying pressure on the throat/neck of such person, or blocking the nose or mouth of such person."[25] This offense is a class A Misdemeanor[26] punishable by no more than one year of imprisonment.[27] However, the sentence is left to the discretion of the court in the event that the defendant has not been previously convicted in the five years immediately preceding the commission of the offense for a felony or a class A misdemeanor and if the court, "having regard to the nature and circumstances of the crime and to the history and character of the defendant, finds on the record that such sentence would be unduly hard and that an alternative sentence would be consistent with public safety and does not deprecate the seriousness of the crime."[28] The addition of this misdemeanor level strangulation offense is crucial because it does not require proof of physical injury, thereby providing law enforcement with the tools needed to charge these devastating acts.[29]

The second offense added, Strangulation in the Second Degree "makes it a class D violent felony to commit the misdemeanor crime of COBBC, and cause stupor, loss of consciousness for any period of time, or any other physical injury or impairment.[30] This violent felony is punishable by an indeterminate imprisonment sentence of at least two years, not to exceed seven years.[31] The last offense, Strangulation in the First Degree makes it a class C violent felony to commit the misdemeanor crime of COBBC and cause *serious* physical injury to

[25] NY Penal § 121.11 (2010).
[26] Id.
[27] NY Penal § 70.15 (1993).
[28] Id.
[29] Letter of The Office for the Prevention of Domestic Violence, dated June 28, 2010, Bill Jacket, L. 2010, ch. 405, at 15-16.
[30] NY Penal § 121.12 (2010).
[31] NY Penal § 70.02 (2003).

another person.[32] This class C violent felony is punishable by the indeterminate imprisonment sentence of at least three and one-half years, not to exceed fifteen years.[33]

While this law was still in the legislative process stage, several anti-domestic violence groups from across the State expressed their support for the addition of these three strangulation offenses to the Penal Law. Some of these supporters include, but are not limited to: Survivors Advocating for Effective Reform (SAFER); Erie County Coalition Against Family Violence; Alternatives for Battered Women; Safe Homes of Orange County; Unity House; Advocacy Center of Tomkins, County, Inc.; the New York State Coalition Against Domestic Violence; etc. In expressing their support, all of the groups stated the same three goals:

> PROTECT the confidentiality of domestic violence victims,
> PROMOTE the economic justice for victims of domestic violence, and
> ENHANCE the legal system's response to domestic violence.[34]

The Office for the Prevention of Domestic Violence strongly supported the law for various reasons, one of which was because it contains "enhanced protections for victims."[35] Another reason was because the law designates strangulation offenses as family offenses. This is significant because:

> When a crime is recognized as a family offense, victims are eligible to petition for orders of protection in family court; the orders of protection are listed on a state-wide registry; and the police must arrest an individual who is being charged with these offenses under mandatory arrest laws. As this is a crime that unfortunately occurs frequently within the context of domestic violence, victims of these crimes will be afforded the special protections that come with the family offense designation.[36]

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[32] NY Penal § 121.13 (2010).
[33] NY Penal § 70.02 (2003).
[34] Letter of The New York State Coalition Against Domestic Violence, dated August, 2010, Bill Jacket, L. 2010, ch. 405, at 18-19.
[35] Letter of The Office for the Prevention of Domestic Violence, dated June 28, 2010, at 16.
[36] Id.

Additional supporters made statements alluding to the effectiveness and importance of this new law. Derek P. Champagne, Franklin County District Attorney and President of the District Attorney's Association of New York State, said:

> …This statute is a great example of what can happen when domestic violence victim advocates, law enforcement, and elected officials work collaboratively to solve a real and compelling problem. The strangulation laws provide law enforcement with strong and effective tools to stop domestic abusers and rapists who use strangulation as a means to subdue their victims.[37]

Supporters also expressed their concerns with the charging of strangulation incidents prior to the November 2010 strangulation offenses, along with the overall impact the law has on domestic violence as a whole. Jack Mahar, Rensselaer County Sheriff and President of the New York State Sheriff's Association said: "…With this new law, we have a tool that allows us to charge the perpetrator and begin the process of *protecting the victim* and holding the perpetrator accountable" (emphasis added).[38] And, Amy Barash, Executive Director of OPDV, stated:

> Strangulation occurs frequently in domestic violence situations, with it often characterized as 'choking' in domestic incident reports and charged as harassment. …This new law recognizes the severity of this particular crime and enables law enforcement to *hold offenders appropriately accountable* (emphasis added).[39]

According to the New York State Division of Criminal Justice Services (DCJS), "More than 2,000 individuals were charged with strangulation offenses across New York State in the fifteen weeks following the law's effective date."[40] More specifically, between November 11, 2010 and February 22, 2011, there were 2,003 arrest events (arrests or arraignments) across the State where a suspect was charged with any of the three strangulation offenses.[41] Of the 2,003

[37] Janine Kava, *New strangulation statute proving an effective tool for law enforcement* (2011), *available at* http://criminaljustice.state.ny.us/pio/press_releases/2011-04-07_pressrelease.html.
[38] Id., at 2.
[39] Id., at 1.
[40] Id.
[41] Id.

arrest events, 803, or forty percent, occurred outside of New York City, with 81 reported in Erie County alone.[42] Additionally, nearly 83 percent, or 1,660 of the arrest events reported statewide were for the Misdemeanor level strangulation offense.[43]

III. Current Evidentiary Challenges

The November 2010 addition of the strangulation offenses to the Penal Law was a step in the right direction towards addressing the struggle to reduce the number of strangulation incidences occurring throughout the state. However, challenges to the prosecution of these offenses still exist, resulting reoccurring *un*successful prosecutions. This problem can be further illustrated by a story told through the eyes of a juror who sat on a trial in New York City in early 2013, where the crimes charged were misdemeanor Assault and the violent felony, Strangulation in the Second Degree.[44]

Defendant and batterer, Anthony DeMaio, wrapped his hands around his girlfriend's neck and strangled her for approximately fifteen seconds, until "it got dark".[45] He then bashed her head against the bathtub, and moved to the bedroom where he threw her to the floor, kicked her in the back, punched her all over her body, spit in her face, and "slammed her down so hard on the bed that the frame broke."[46]

DeMaio was charged with the nearly brand new crime of Strangulation in the Second Degree, but was found not guilty on this charge because, in the words of the juror, "strangulation was a tough sell."[47] According to this juror,

> We quickly agreed that Mr. DeMaio had committed misdemeanor Assault. On the Strangulation charge, though, it was as if we'd tuned into different instruments

[42] Id.
[43] Id.
[44] Besonen, N.Y. Times (2013).
[45] Id.
[46] Id.
[47] Id.

> at a concert. …Other jurors argued that the first officer on the scene and the emergency-room team would never have failed to overlook something as major as 'choking' (quotations added). We reviewed the judge's instructions. Was the victim's normal breathing impeded? Yes. Was it intentional? I thought so. And the red dots on [victim]'s neck, I argued, constituted the necessary 'physical injury.' 'That could have happened if he punched her with his watch on and it scraped across her neck,' one juror countered. 'Maybe if he dragged her by her hair across the carpet.' In the end, I went along to avoid causing a mistrial. …As we filed back into the jury room, one juror said, 'We all know he did it. We just couldn't prove it'.[48]

Even though this story is very troubling in its entirety, the most alarming thing that the juror said is, "Our verdict, as it turned out, fit the pattern: none of the nineteen people who have been tried (to date) on Second-Degree Strangulation charges in New York City have been convicted of it, according to the state."[49]

With all of this said, there is but one main reason why the prosecution of COBBC, Strangulation in the Second Degree, and Strangulation in the First Degree have been widely unsuccessful: lack of evidence. To describe this evidentiary struggle more specifically, emergency room physicians, sexual assault nurse examiners (SANE Nurses), and police officers are not being adequately trained on strangulation, or on the documentation of strangulation (how it *should* be done, and how important it is for the prosecution that it *is* being done.)

> There is an urgent need for emergency physicians and nurses to be trained … on how to thoroughly assess, document, and obtain appropriate treatment. …In addition, it is important for emergency medical technicians and police officers, as first responders, to be trained on the importance of ensuring that these incidents are evaluated in an emergency department, both to document the attempt and to thoroughly evaluate the injury.[50]

In 2009, the San Diego District Attorney's Office conducted a study consisting of 300 strangulation cases, selected at random from all police reports submitted within a five-year

[48] Id.
[49] Id.
[50] Glass, at 311-315.

period that contained a strangulation incident.[51] The victims reported being strangled "by their partners with bare hands, arms, or objects such as electrical cords, belts, ropes, bras, or bathing suits."[52]

The purpose of this study was to examine how frequently, or as it turns out infrequently, visible signs of strangulation can be found on a victim (*see* Appendix B).[53] 50 percent of the 300 reported cases involved victims who had ***no*** visible injury.[54] Another 35 percent had injuries that were too minor to photograph.[55] Out of the 300 reported cases, only fifteen percent involved victims that exhibited an injury sufficient to photograph.[56] And of these fifteen percent, while their injuries were significant, the majority of the photographs displaying these injuries were unusable (washed out or blurry) due in large part to the inadequate training of police officers in close-up photography.[57] To give this information context, consider this statistic expressed earlier but with a slight variation to account for the this new data: ten percent of all violent deaths that occur each year in the United State are directly due to strangulation, and *many die without a single visible mark to the neck* (emphasis added).[58]

It seems that the evidentiary struggle is two-fold: first, a large number of strangled victims will present without a single visible injury to the neck; and second, the lack of training of emergency room examiners and police officers of <u>all</u> of the signs and symptoms of strangulation has left them with the ability to identify *only* visible injuries, a skill that could be considered useless in a large number of strangulation cases. And further, even if these nurses and police

[51] Strack, at 2.
[52] <u>Id</u>.
[53] <u>Id</u>.
[54] <u>Id</u>.
[55] <u>Id</u>.
[56] <u>Id</u>.
[57] <u>Id</u>.
[58] <u>Id</u>., at 3, and McClane, at 311.

officers came in contact with a large number of victims that did exhibit visible injuries, the lack of training has left them with little guidance on how to properly document these injuries.

As previously stated, there are many other signs and symptoms of strangulation aside from visible injuries. One commonly known symptom is a symptomatic change in the victim's voice, which occurs in up to 50 percent of victims.[59] These changes may be mild (hoarseness), or severe (complete loss of the voice).[60] The second sign is swallowing and/or breathing changes.[61] Swallowing may become difficult or painful, and the victim may become unable to breathe or find breathing difficult.[62] Third, involuntary urination and defecation have been noted in strangled victims, along with miscarriages that can occur hours or even days after the incident.[63] Fourth, lung damage may occur as a result of the inhalation of vomit during the strangulation.[64] The inhalation of vomit often leads to pneumonia and/or aspiration pneumonitis, a very serious condition where the gastric acids contained in the vomit begin to digest the lung tissue.[65] Further lung damage, known as pulmonary edema, can occur if the lungs fill with fluid as a result of direct pressure being exerted on the neck.[66] And fifth, swelling of the neck may occur as a result of any one or combination of the following: "internal bleeding (hemorrhage), injury of any of the underlying neck structures, or fracture of the larynx allowing air to escape into the tissues of the neck (subcutaneous emphysema)."[67]

[59] Strack, at 4.
[60] Id.
[61] Id.
[62] Id.
[63] Id.
[64] Id., at 6.
[65] Id.
[66] Id.
[67] Id., at 4.

Aside from the various physical signs and symptoms, behavioral changes and changes in a victim's mental status can also occur.[68] As a result of the strangulation, the victim can experience Temporary Brain Anoxia, or a severe stress reaction to the incident "resulting in frank psychosis and amnesia".[69] Brain anoxia occurs when oxygen levels are significantly low for a period of four to five minutes.[70] As a result, brain cells begin to die, causing cognitive problems and disabilities such as short-term memory loss, poorer performance in executive functions, anomia (difficulty processing what words mean), visual disturbances, lack of coordination, headaches, movement disorders, quadriparesis, etc.[71] Other behavioral changes include restlessness and combativeness, and severe stress reactions.[72]

When visible injuries are exhibited, they often include fingernail markings, generally shaped like commas or semi-circles; redness of the neck; bruises, often found in clusters along the sides of the victim's neck, along the jaw line, and extending onto the chin and collar bones; chin abrasions; petechiae, which is the most common visible injury found and can be described as tiny red spots that are often found in or around the victim's eyes, on the face, behind the ear, and around the neck where the constriction occurred; and ligature marks, which can be as subtle as a red mark or more dramatic, reflecting the type of ligature used.[73]

Proper identification and documentation of all signs and symptoms exhibited by strangled victims is vital to the prosecution of these cases. This information also helps establish corroboration[74], which can be helpful to the prosecution of strangulation cases, and all domestic

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[68] Id.
[69] Id.
[70] Id.
[71] Id.
[72] Id.
[73] Id., at 4-6.
[74] *Black's Law Dictionary*, 154 (3rd ed. 2006), and *Black's Law Dictionary*, 256 (3rd ed. 2006) (defining corroboration as "confirmation or support by additional evidence or authority," and corroborating evidence as

violence cases in general, where the victim is "unable or unwilling to cooperate in the prosecution of her abuser."[75] Victims are often unwilling to testify and assist in the prosecution of their batterer for various reasons (for example, to ensure her own safety, maintain financial security, etc.).[76] Even though corroboration is not required to prove crimes that do not involve an element of physical injury, and a victim's testimony is all that is needed, medical evidence and additional evidence collected by law enforcement officers will help bolster the case dramatically. Of the 300 strangulation cases used in the study described earlier, the prosecution of these cases by the San Diego District Attorney's Office occurred only when there was independent corroboration of strangulation.[77]

In sum, the evidentiary challenges described above are hindering the prosecutor's ability to successfully prosecute these offenses because of the physical injury element required in both Strangulation in the Second Degree and Strangulation in the First Degree. In order to meet these physical injury elements, the collection of medical evidence is crucial. The physical injury element of Strangulation 2nd is the same physical injury element contained within many of the specific offenses presented in the Penal Law, and requires the manifestation of an "impairment of physical condition or substantial pain."[78] This element has been further described in case law as pain that is more than slight or trivial but need not be severe or intense.[79] If nurses and police officers, which have not been adequately trained on this topic, are not collecting evidence to

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"evidence that differs from but strengthens or confirms what other evidence shows (esp. that which needs support)".)

[75] Erin Leigh Claypoole, *Evidence-based Prosecution: Prosecuting Domestic Violence Cases without a Victim*, 39 FEB Prosecutor 18, 19 (2005).

[76] Claypoole, at 19, (stating that the prosecution of perpetrators of domestic violence without the cooperation of a victim is a type of "evidence-based prosecution," and "describes the practice of using independent corroborative evidence to prove the elements of the crime without relying on the victim's testimony.")

[77] Allison Turkel, *Understanding, Investigating and Prosecuting Strangulation Cases,* 41 DEC Prosecutor 20, 21 (2007).

[78] NY Penal Law § 10.00(9) (2013).

[79] People v. Chiddick, 834 N.Y.3d 445, 447 (2007).

demonstrate an "impairment of physical condition or substantial pain," then this element cannot be substantiated and, thus, Strangulation 2nd cannot be successfully prosecuted. The prosecutor cannot rely on the victim to describe his/her injuries because he/she may not be able to clearly articulate his/her physical condition.[80] Although it is true that the physical injury element of Strangulation 2nd can be substantiated by showing that the victim loss consciousness[81], this will be nearly impossible to prove without proper medical evidence.

The prosecution of Strangulation 1st is met with even more challenges because this offense requires the attestation of *serious* physical injury (emphasis added).[82] Serious physical injury is "physical injury which creates a substantial risk of death, death or serious and protracted disfigurement, protracted impairment of health, or protracted loss or impairment of the function of a bodily organ."[83] If prosecution of Strangulation 2nd has been proven increasingly difficult, requiring even more evidence to meet a higher specification of physical injury is going to be even more challenging. Lastly, although COBBC does not require the establishment of physical injury, prosecution of this offense is consistently difficult when victims are unwilling or unable to testify, and medical evidence is lacking, which is often the case.

The following quote found in an article on strangulation published in the Journal of Emergency Medicine accurately sums up the current problems prosecutors are facing in the prosecution of these strangulation offenses. "Better attention to strangulation on the part of police officers on the scene and better documentation of the physical findings by physicians, nurses and other health care professionals could immediately improve prosecution."[84]

[80] Letter of The New York State Coalition Against Domestic Violence, dated August, 2010, at 19.
[81] NY Penal § 121.12 (2010).
[82] NY Penal § 121.13 (2010).
[83] NY Penal Law § 10.00(10) (2013).
[84] Glass, at 329-335.

IV. Potential Solutions

There are several programs, procedures, and tools that, if implemented, could help prosecutors successfully prosecute these three strangulation offenses, which, in turn holds batterers accountable and provides victims with the feeling of a sense of justice. Most importantly, the increase in the successful prosecution of these offenses can be directly correlated to the decrease in the victim's lethality. In other words, as each strangulation offense is successfully prosecuted, another victim is released from a very lethal situation. More specifically, statewide trainings could be offered to nurses, doctors, and police officers; hospitals and law enforcement agencies could be provided with necessary tools and equipment to assist in the prosecution of these offenses; a nationwide could begin discussion amongst prosecutors and judges on the element of physical injury, and the evidence currently being offered to show this element; and programs could be offered that would educate the public on the severity of strangulation and the potential for death or serious injury hours or weeks after the incident.

First, statewide trainings to emergency room nurses, doctors, police officers, and anyone else who may come in contact with a strangled victim during the critical stages immediately following the incident will provide the most benefit to prosecutors attempting to prosecute these offenses. These trainings will be beneficial because they could provide these professionals with information on the anatomy of a neck, the potential health consequences of strangulation, the clinical sequence of a strangled victim, all potential signs and symptoms of strangulation, and practical tips and techniques of working with a victim of strangulation.

Various groups across New York and the United States provide information to assist anyone who wishes to host trainings for other individuals within their professional community. One of these groups is the National Strangulation Training Institute, which provides copies of

training DVDs, and/or access to various training power points.[85] Additionally, the International Association of Chiefs of Police (IACP) National Law Enforcement Policy Center has recently included training on strangulation within their model police protocols on domestic violence.[86]

Discussed earlier in this paper was the concept that a large majority of strangled victims present without a single visible injury. For nurses, doctors, and even police officers to identify these victims as victims of strangulation, they must be adequately trained on all potential signs and symptoms of strangulation. That is, they must be aware that strangled victims often experience a change in their voice, in their breathing/swallowing, and in their mental/behavioral status. Also, victims often experience swelling of the neck, and involuntary urination/defecation.

Anyone who comes in contact with a victim of strangulation should be aware that victims often identify with the term "choked" as opposed to "strangled." Many people are under the assumption that strangulation always results in death, so if they are still alive, they were not strangled, but rather they were choked. But, as described earlier in this paper, strangulation and choking are not one in the same: "Strangle means to obstruct, seriously or fatally, the normal breathing of a person. Choke means having the windpipe blocked entirely or partly by some foreign object, like food."[87] It is important that nurses, doctors, and officers use words such as "strangle, attempted strangulation, near-fatal strangulation and/or strangulation,"[88] but they must also be cognizant of the fact that victims may not understand the definition of these terms. Therefore, these professionals should not be afraid to use the term "choked" during *initial*

[85] Casey Gwinn and Gael Strack, *Background information for a California strangulation statute* (2011), *available at* http://www.strangulationtraininginstitute.com/index.php/training.html, (stating that the National Strangulation Training Institute, a program of the National Family Justice Center Alliance, consists of a "specialized team of police officers, prosecutors, advocates, and survivors of domestic violence and sexual assault that provide training across the United States and around the world on the investigation, prosecution, and advocacy issues related to strangulation. Training DVDs can be purchased for $100, and training power points can be accessed by contacting the Training Institute via email and requesting the password.)
[86] Gwinn, at 2.
[87] Strack, at 6.
[88] Id.

contact with a strangled victim, but should immediately switch to using the proper terms, described above, thereafter.

As described in footnote eleven, an elementary understanding of the anatomy of a neck will help professionals identify and understand the various structures that can be impacted by strangulation, and how severe the impact may be or may become in the near future. It is important to include training on future health consequences that can occur as a result of strangulation. For example, if a victim is pregnant at the time that she is strangled, a miscarriage can occur days or weeks after the incident.[89] Additionally, strokes can occur hours or days after an incident as a result of the lack of oxygen arriving to the brain.[90] Providing information on future health consequences of strangulation will ensure that these victims are being provided with the medical care they desperately need. Furthermore, these professionals could be provided with information on the clinical sequence[91], or stages the victim will experience during the strangulation incident to help the professionals understand the severity of the incident from victim's perspective.

The National Family Justice Center Alliance has also created a list of practical tips and techniques as part of its training curriculum. These tips and techniques can be provided to nurses, doctors, law enforcement officers, prosecutors, and anyone else coming in contact with victims of strangulation through the use of a training program. Some of these tips include, but are not limited to, the following[92]: 1) Treat all strangulation cases seriously – If you treat the case seriously, starting from the moment you come into initial contact with a victim, everyone

[89] Id., at 4.
[90] Id.
[91] Id., at 3-4, (stating that the clinical sequence of a strangled victim is generally severe pain, followed by unconsciousness, and then brain death. The loss of consciousness is generally caused by any of the following: the "blocking of the carotid arteries," which deprives the brain of oxygen; the "blocking of the jugular veins," when prevents deoxygenated blood from exiting the brain; or, the closing off of the airway, "causing the victim to be unable to breath.")
[92] Id., at 6-15.

else will treat the case seriously too, including the victim. 2) Conduct a thorough investigation and interview – It is important to identify all signs and symptoms of strangulation. "The level of injuries and symptoms will depend on many different factors including the method of strangulation, the age and health of the victim, whether the victim struggled to break free, … the size and weight of the perpetrator, the amount of force used, etc." 3) Use follow-up questions[93] – Ask the victim questions regarding the method and/or manner of strangulation used; questions to help identify visible injuries, or symptoms and signs of internal injuries; to help gather evidence; to help establish motive or intent; and questions in anticipation of minimization/recantation, or to eliminate defenses/excuses. 5) Take plenty of photographs and follow-up photographs. 6) Encourage the victim to seek medical attention – "There may be internal injuries that may later cause complete obstruction, even 36 hours after an injury. … Even if the paramedics determine a lack of objective symptoms to support internal injury, a medical examination will prove very helpful to assess a victim's health and to document the victim's visible injuries and/or symptoms. More importantly, … you may save a life by providing the victim with immediate medical attention. *It is better to be safe than sorry*" (emphasis added).

In addition, law enforcement agencies located in Sweetwater County, Wyoming, have created and implemented the use of a Strangulation Uniform Reporting Form[94] (*See* Appendix D) when coming into contact with victims of strangulation. This form could be beneficial because it lists and describes all signs and symptoms of strangulation; instructs officers to ask the victim whether his/her voice "sounds normal," and also instructs them to ask others present who knows the sound of the victim's voice; instructs officers to strongly encourage medical treatment, especially if they are having trouble breathing or speaking; etc.

[93] *See* Appendix C
[94] Sweetwater County, Wyoming Strangulation Uniform Reporting Form (2012), *available at* http://www.strangulationtraininginstitute.com/index.php/library/viewcategory/837-documentation-forms.html.

Domestic violence victims frequently avoid seeking medical attention after an incident, even in the event that the police are called. Police Officers are typically the first responders, and often the only individuals in contact with victims of strangulation. This means that these officers are the only individuals able to gather and collect evidence. This form creates a set of guidelines ensuring that all officers are collecting all available evidence. This form is something that all law enforcement agencies should consider requiring its officers to use.

A second recommendation that will address the evidentiary challenges at issue is to provide all hospitals and law enforcement agencies across the State could be provided with various equipment and tools that would help with the prosecution of these strangulation offenses. Cameras are critical tools that all nurses, doctors, and police officers should have access to, but unfortunately, that is not the case. Although it is impossible for every single nurse, doctor, and police officer to have his or her own camera, a community camera for each hospital and enforcement agency should not be out of the question. It is crucial that all visible injuries, and any other signs and symptoms of strangulation be documented as photographic evidence. This will tremendously help the prosecutor prosecute these offenses, especially in the prosecution of Strangulation 2nd and Strangulation 1st, where a physical injury element exists. Additionally, the inability to access a camera to document injuries forces nurses, doctors, and officers to use their own personal camera or cellular phone, which is then in danger of being subpoenaed.

Aside from cameras, the use of a documentation chart (*see* Appendix E) and/or self-report pain assessment chart (*see* Appendix F) will also help with the successful prosecution of these strangulation offenses. The Documentation Chart for Attempted Strangulation Cases[95] lists every possible sign or symptom of strangulation by breaking them down into five different

[95] San Diego District Attorney's Office Documentation Chart for Attempted Strangulation Cases, *available at* http://www.strangulationtraininginstitute.com/index.php/library/finish/837-documentation-forms/3634-documentation-chart-for-non-fatal-strangulation-cases.html.

categories: breathing changes, voice changes, swallowing changes, behavioral changes, and other. The chart also lists potential injuries and where these potential injuries might be found. For example, the chart lists "Face" and then describes the following injuries that could potentially be found on a strangled victim's face: red or flushed, pinpoint red spots (petechiae), scratch marks. Further, the chart provides a diagram of the face and neck, in three different positions (left, front, right), that could be used to document the exact location of any and all visible injuries found on a victim.[96] The self-report pain assessment chart is another chart that can be used in order to illustrate the severity of the victim's pain after the strangulation incident. It might be difficult for the victim to demonstrate and explain his/her pain level, but this pain assessment could be of assistance.

There are various other brochures and flyers that could be stored at hospitals and law enforcement agencies reminding these professionals of the seriousness of strangulation, of all potential signs and symptoms of strangulation, and of other additional information on strangulation.[97] For example, one brochure created by the Family Justice Center Alliance and distributed through the National Strangulation Training Institute provides a general definition, and explains the severity of strangulation.[98] It also provides a diagram of the anatomy of a neck, as well as the diagram provided on the Documentation Chart discussed above. On the back, the brochure lists every possible sign and symptom of strangulation, and provides a chart that can be used for monitoring any existing signs and symptoms.

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[96] *See* Appendix G (showing a completed Documentation Chart for reference).
[97] *See* generally http://www.strangulationtraininginstitute.com/index.php/library/viewcategory/835-brochures-and-flyers.html
[98] Facts Victims of Choking (Strangulation) Need to Know!, *available at* http://www.strangulationtraininginstitute.com/index.php/library/finish/835-brochures-and-flyers/3636-fjc-legal-network-strangulation-victim-log-nfjca-2009.html, (brochure stating, "When domestic violence perpetrators choke (strangle) their victims, not only is this a felonious assault, but it may be an attempted homicide. Strangulation is an *ultimate form of power and control*, where the batterer can demonstrate control over the victim's next breath; having devastating psychological effects or a potentially fatal outcome.")

Additionally, the Wisconsin Office of Justice Assistance created a strangulation / suffocation card (*See* Appendix H) that could be kept in all police officers' wallets, similar to the way in which Miranda Warnings cards are used by many officers. This card states, "Strangulation or Suffocation can cause a medical emergency which can result in death days after an incident. Best Practice: Call for immediate medical evaluation."[99] The card also lists several signs and symptoms of strangulation on the front, and lists examples of medical and investigative questions to ask all victims of strangulation on the back.[100]

Aside from the various programs and procedures that can be used to prosecute these offenses, there are also several simple and non-invasive procedures that could be used by doctors and nurses to determine the extent of a victim's injuries, and provide them with adequate medical care.[101] These procedures will help address any and all health consequences of the strangulation early on, and avoid the possibility of these victims facing serious health problems, or even death, in the near future.

A third recommendation that will address the evidentiary challenges at issue is to start a nationwide discussion on medical evidence deemed acceptable to meet a physical injury element in other states across the United States. Thirty states across the United States have passed legislation making strangulation a separate, felony level criminal offense, and most of these offenses contain some element of physical injury. That is, the prosecutors in a majority of these

[99] Wisconsin Office of Justice Assistance, Justice System Training Program Strangulation/Suffocation Card (2010), *available at* http://www.strangulationtraininginstitute.com/index.php/library/finish/835-brochures-and-flyers/3670-strangulationsuffocation-information-card-wi-office-of-justice-assistance-06-2010.html.

[100] Id.

[101] McClane, at 314, (listing these procedures: Pulse Oximerty, fingertip transducer that measures a patient's oxygen saturation; Chest X-Ray Study, rapid diagnosis of pulmonary edema, pneumonia, or aspiration; Nasal X-Ray Study, ancillary evaluation for the strangled patient presenting with hemoptysis; Soft Tissue Neck X-Ray Study, evaluation of subcutaneous emphysema within the soft tissues because of fractured larynx; Cervical Spine X-Ray Study, could reveal fractured hyoid bones; Axial Computed Tomography (CT) Scan, cross-sectional evaluation of neck structures; Magnetic Resonance Imaging (MRI) Scan, Comprehensive evaluation of the soft tissues of the neck; Carotid Doppler Ultrasound, critical in patients with neurological lateralizing signs (i.e. stroke); Pharyngoscopy, may reveal pharyngeal petechiae or edema; and Fiberoptic Laryngobronchoscopy, vocal cord and tracheal evaluation in patients with dyspnea, dysphonia, aphonia, or odynophagia.)

states must prove physical injury or serious physical injury in order to successfully prosecute these offenses. Since the successful prosecution of the New York State Penal Law strangulation offenses are few and far between, it might be helpful to look into the type of medical evidence prosecutors in other states are using as sufficient evidence to show physical injury. Also, it could be helpful to converse with judges across the United States on the type of evidence they deem appropriate in showing a physical injury element of a strangulation offense. Any information gathered within this nationwide discussion could in turn be used as a reference for New York prosecutors when prosecuting these strangulation offenses.

A fourth recommendation that will address the evidentiary challenges at issue is to put programs in place to help educate the public, including victims and potential victims of strangulation, on the severity of strangulation and the potential for death or serious injury hours of even weeks after the incident. All to often victims of strangulation do not seek the medical attention they need after an incident, which can exacerbate relatively minor injuries. It is important that victims of strangulation seek medical help immediately after the incident, but there are several reasons why victims are not doing so. First, they may not identify themselves as a victim of strangulation; second, they may not realize the extent of their injuries.

There are several reasons why victims might not identify themselves as a victim of strangulation, but the most common is because they are not aware that their batterer's actions constitute strangulation. For instance, many people think that strangulation is the act of taking a cord-like object and putting it around another's neck, which is ligature strangulation. And for people who identify manual strangulation as another type of strangulation, aside from ligature, many think that placing the hands around another's neck is the only type of manual strangulation that exists. In reality, it is common for a batterer to throw their victim onto the ground on their

stomach, get on top of their victim's back, and place their knees on the back of their victim's neck. This is also manual strangulation, but many victims do not associate these actions as such.

In addition, victims often do not remember the details of the strangulation incident, and forget that this type of abuse even took place. Unfortunately for many of these victims, abuse occurs daily. He/she is incapable of remembering all of the details of the strangulation incident because this is something that he/she experiences on a reoccurring basis. Or, the strangulation might not be the most significant thing that happened to the victim during an entire period of abuse.[102]

Public education programs could disperse information to victims of strangulation allowing them to identify themselves as a strangled victim and provide them with information on the nearest hospital or law enforcement agency. Additionally, the programs could disperse information to non-strangled members of the community, who could then use this information to help a domestic violence victim they know has been strangled. The very limited information on strangulation that is portrayed by the media typically involves situations where the strangled victim dies while the strangulation is in progress. The media is reporting the story as a homicide, and the strangulation is usually hidden in the background. This creates a false notion that victims who are at risk of death as a result of strangulation will die immediately, while the incident is still in progress. But, this theory is incorrect because, as stated earlier, as a result of underlying brain damage caused by lack of oxygen, victims may have serious internal injuries and die days or even several weeks after the incident.[103] Using the media to inform the public on the seriousness of strangulation, the common occurrence of delayed deaths as a result of serious underlying injuries sustained during the strangulation incident, and the importance of seeking

[102] Interview with Lisa M. Baehre, Assistant District Attorney, Niagara County District Attorney's Office, in Lockport, NY (Feb. 2013).
[103] Besonen, N.Y. Times (2013).

medical attention immediately, the number of fatal-strangulation incidents will decrease, and these victims will live to see their batterers held accountable for their actions.

V. Conclusion

The benefit to the prosecutor of obtaining medical evidence is tremendous, and can be best illustrated by a quick summary of a case prosecuted by the City Attorney's Office in San Diego.

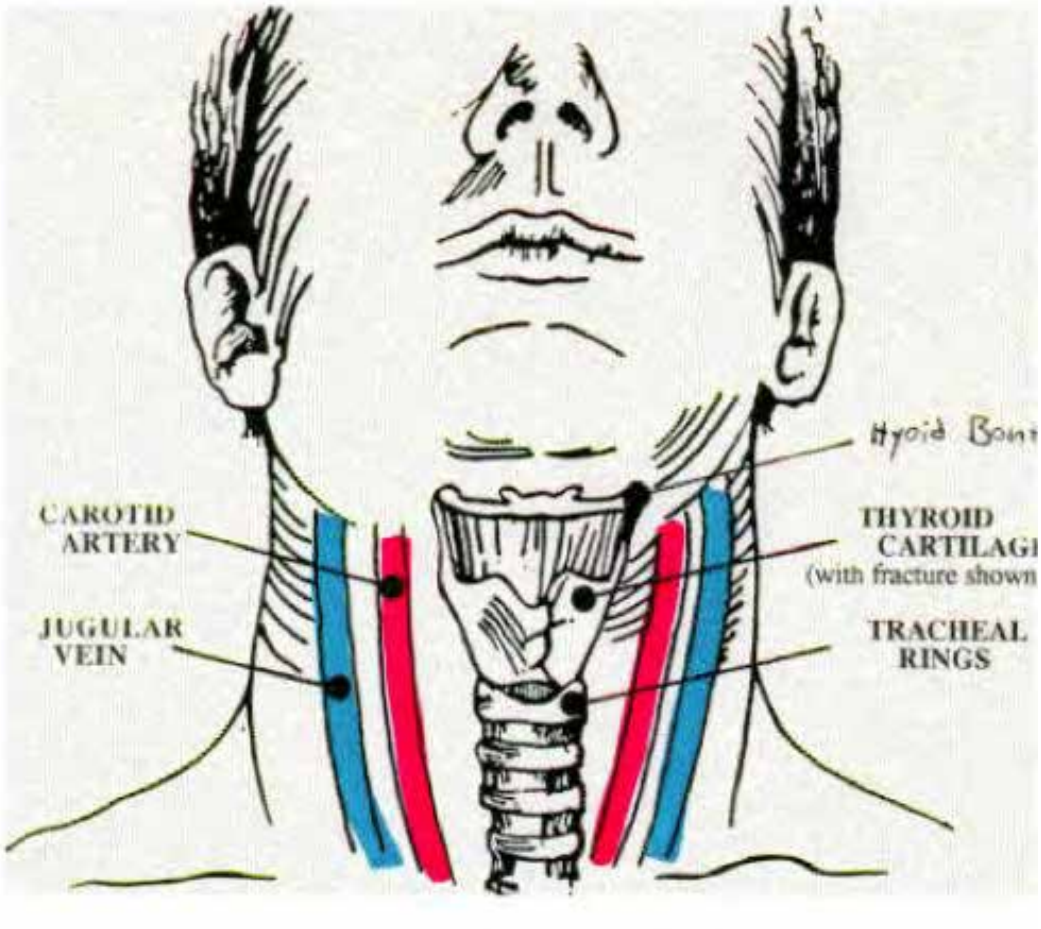
> The police officer indicated in his police report that the victim had 'red abrasions to the neck.' He encouraged the victim to (*sic*) seek medical attention, which she did. In reviewing the medical records, the treating physician indicated the patient 'had multiple linear contusions to both sides 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.[104]

Although the successful prosecution of these offenses might not address all of the issues behind strangulation, it is a step in the right direction. The successful prosecution of these offenses will hold batterers accountable for their abhorrent actions, will provide victims with justice and a feeling of safety, and will decrease the number of strangulation incidents that occur yearly. The evidentiary challenges that exist in prosecuting these offenses can be overcome by ensuring that nurses, doctors, law enforcement officers, and anyone else who may come in contact with victims of strangulation are adequately trained on strangulation.

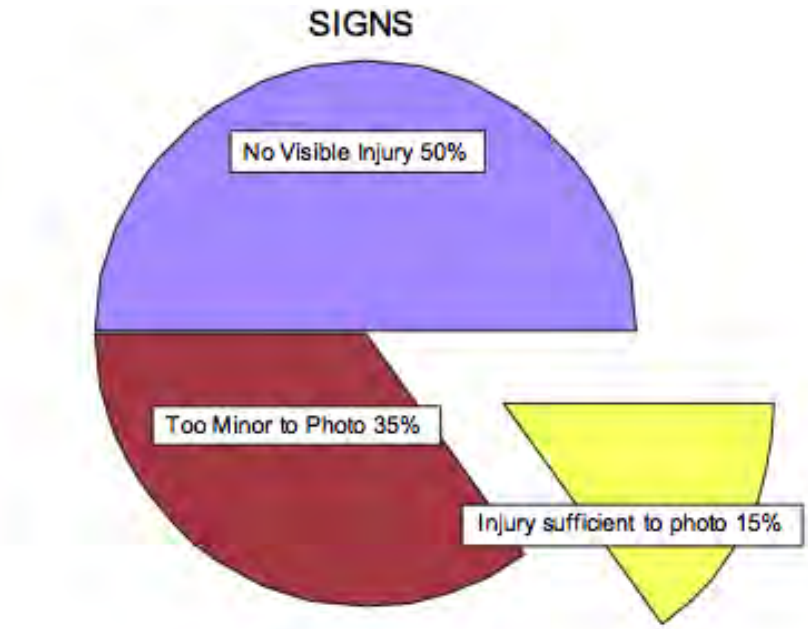
The New York State Legislature recognized a gap in the Penal Law, and the severity and frequency of incidents of strangulation, which led to the November 2010 addition. It is now time for New York to recognize a gap in the prosecution of these offenses. If we, as a State, come together and work to adequately train these professionals, the number of successful prosecutions will increase, and the number of fatal-strangulation incidents will decrease. Now is the time to protect a fundamental guaranteed to these victims, the fundamental right to life.

[104] Strack, at 11.

APPENDIX A


Hyoid Bone
CAROTID ARTERY
JUGULAR VEIN
THYROID CARTILAGE
(with fracture shown
TRACHEAL RINGS

APPENDIX B


SIGNS
No Visible Injury 50%
Too Minor to Photo 35%
Injury sufficient to photo 15%

APPENDIX C[105]

Strangulation – Interview Questions

Determining the victim's physical and mental condition

- Do/did you have any difficulty breathing?
- Do/did you feel shortness of breath?
- Do/did you have a sore throat?
- Do/did you feel pain, discomfort, or have trouble swallowing? (Larynx Injury)
- Do/did you faint or lose consciousness?
- Did you black out?
- Did you vomit, cough up blood, urinate, defecate, or lose any bodily functions?
- Do/did you have any "visible" injury? Where?
- About how long did the strangulation last? How long did it feel like?
- How did it stop? (I broke away; someone came by; police shouted at the door)
- Did you try to protect yourself? (Describe and photograph)
- Ask victim to describe and demonstrate how she was strangled (Videotape the demonstration, if possible)
- How hard was the grip? How much pressure was applied?
- If injuries, did you show them to anyone?
- Is medical attention needed? Was medical attention sought?
- What did you think was going to happen?

Determining the suspect's actions during strangulation

- What did he use? Hands? Forearms? Chokehold? Knee?
- If hands, did he use one or two hands?
  - ✓ If one, was it the right hand or the left hand?
  - ✓ If one, what was he doing with his other hand?
- How much force did he use?
- Was he wearing any rings? (Look for marks, photograph)
- Were any objects used? (Shows intent, weapons use)
  - ✓ If yes, what was the object?
  - ✓ How did the weapon get there? (Intent)
  - ✓ Photograph and impound the weapon; take it into evidence
- Did he shake you while strangling you? (Describe)
- Did he throw you against a wall? On the floor?
  - ✓ Describe facts and surface, photograph
- What was his facial expression?
  - ✓ "I saw hatred in his eyes."
  - ✓ "He seemed possessed – he looked like the devil!"
- How was he acting? (Describe his demeanor)

[105] New York State Office for the Prevention of Domestic Violence (2010).

Determining history of other strangulations and prior abuse

- Has he ever strangled you before or threatened to do so? (Describe each incident and method)
- Has he ever strangled the children or anyone else?
- Do you have any pre-existing conditions?
  - ✓ Recurrent injuries from previous strangulations?
  - ✓ Medical problems, e.g., asthma, allergies (document)?

APPENDIX D

Sweetwater County Wyoming
Strangulation Uniform Reporting Form

CASE #

Investigating Agency:
❑ Sweetwater County Sheriff ❑ Rock Springs Police ❑ Green River Police ❑ Wyoming Highway Patrol

Victim:	first	middle	last
Suspect:	first	middle	last

Symptoms and/or Internal Injury:

BREATHING CHANGES	VOICE CHANGES	SWALLOWING CHANGES	BEHAVIORAL CHANGES	OTHER
❑ Difficulty Breathing ❑ Hyperventilating ❑ Unable to Breathe ❑ Coughing	❑ Raspy Voice ❑ Hoarse Voice ❑ Unable to Speak	❑ Trouble Swallowing ❑ Painful to Swallow ❑ Neck Pain ❑ Nausea ❑ Vomiting	❑ Agitation ❑ Amnesia ❑ PTSD ❑ Hallucinations ❑Combativeness	❑ Dizzy ❑ Headache ❑ Passed Out ❑ Muscle Spasms ❑ Urination ❑ Defecation

Visible Injuries:

FACE	EYES AND EYELIDS	NOSE	EAR	MOUTH
❑ Red or Flushed ❑ Pinpoint red spots (petechiae) ❑ Scratch Marks ❑ Palsy (Facial Drooping) ❑ Eye Drooping	❑ Petechiae R and/or L eyeball ❑ Petechiae R and/or L eyelid ❑ Bloody Red Eyeball(s)	❑ Bloody Nose ❑ Broken Nose ❑ Petechiae	❑ Petechiae (external and/or ear canal) ❑ Bleeding From Ear Canal	❑ Bruising ❑ Swollen Tongue ❑ Swollen Lips ❑ Cuts/Abrasions ❑ Bite marks

UNDER CHIN	CHEST	SHOULDERS	NECK	HEAD
❑ Redness ❑ Scratch Marks ❑ Bruise(s) ❑ Abrasions	❑ Redness ❑ Scratch Marks ❑ Bruise(s) ❑ Abrasions	❑ Redness ❑ Scratch Marks ❑ Bruise(s) ❑ Abrasions	❑ Redness ❑ Scratch Marks ❑ Fingernail Impressions ❑ Bruise(s) ❑ Finger-shaped bruising ❑ Swelling ❑ Lumps ❑ Ligature Mark	❑ Petechiae (on scalp) ❑ Hair Pulled ❑ Bump ❑ Skull Fracture ❑ Concussion

Reporting Officer: _____ **Date & Time:** _____

Strangulation Investigative Checklist:

- **VICTIM'S BREATHING MUST HAVE BEEN IMPEDED IN SOME WAY (even if minor)**
- Felony Strangulation is domestic violence: **Use and have victims complete Uniform DV forms as well.**
- MUST HAVE a **Recorded Statement from victim at the scene**
- **Ask Victim: Does your voice sound normal? Ask anyone present who knows V's normal voice.**
- Look for injuries behind the ears, all around the neck, chin, jaw, eyelids, shoulders and chest area. **Take clear photographs of any visible injury, however minor, and describe injuries.**
- **Have victim demonstrate ON YOU EXACT MANNER. *i.e. One hand, two hands, forearm.***
- **Document points of contact and method of strangulation.**
- How many times was the victim strangled? **Describe each incident & method in detail.**
- **DOCUMENT ANY PAIN** victim felt while being strangled.
- **Ask for and take proof of "I'm sorry" texts, voicemails, emails or letters.**
- ENSURE follow up photos are attempted.
- **Photographs: Take numerous clear photos.**
  - Front of house/trailer/car where incident occurred
  - **All witnesses**, including ALL CHILDREN, EVEN IF THEY ARE SAID TO BE SLEEPING
  - Overall frontal view of suspect and victim
  - Any injuries or claimed injuries
  - Location where *any* violence took place
  - Evidence of anger (Holes in walls [even if they're old]; plants knocked over, broken pictures, etc.)
- How much pressure was used? Describe. Was it continuous?
- Ask to feel for bumps/goose eggs on head, document in narrative on and on DV form body diagram
- Ask victim to describe suspect's demeanor and facial expressions
- What did the victim think was going to happen? (e.g. Did she think she was going to die?)
- If an object was used to harm or threaten the victim, describe, photograph and impound object as evidence.
- Was the suspect wearing any rings? Look for marks caused by rings.
- Was victim wearing necklace? Look for marks made by necklace.
- Any prior incidents of strangulation? Document each one.
- Did the victim try to protect/defend herself or himself? Describe.
- **Strongly encourage medical treatment. If they are having trouble breathing or speaking, insist on treatment.**
- During follow-up investigation, take follow-up photos of any injuries. Ask if she showed injuries to anyone else, took any subsequent photographs or sought medical attention.
- Was the victim or her head thrown against wall, floor or ground? Describe facts & surface thrown against.

Suspect:

- Check suspect for scratches to face, arms
- **Ask suspect, "What is [victim's name] going to tell me happened?"**

Sweetwater County

Strangulation Uniform Report *(Victim's Statement and Account)*

CASE #

Victim: first middle last	**Suspect:** first middle last
Victim Contact: first middle last Person who will **always** know how to contact you	**Victim Contact Address:** **Phone:** home cell work

There is evidence that you may have been strangled or "choked." If this is true, please help us understand what happened by answering the following questions.

What did the suspect use to strangle you? Check all that apply. ❑ One hand (circle *R* or *L*) ❑ Both hands

❑ Forearm (R or L) ❑ Knee/Foot ❑ Other object What object? _____

During this incident, how many times did the suspect attempt to strangle you? _____

Please describe each instance of strangulation and attempted strangulation to the officer including manner, i.e. both hands around neck, one hand against wall.

How long did the most serious instance of strangling last (in seconds): _____

Did the suspect's actions make it harder than normal for you to breathe? Y or N (Circle one)

During strangulation, did you feel dizzy, faint or like you were going to lose consciousness? _____

Did you lose consciousness? _____ For how long? _____

Did suspect *intentionally* cover your nose or mouth? _____ How many times? _____

Is the suspect RIGHT or LEFT handed? (Circle one)

On a scale of 0 to 10, with 10 being hardest, how hard was the suspect's grip? _____

On a scale of 0 (no pain) to 10 (worst pain ever) how painful was it while you were being strangled? _____

On a scale of 0 (no pain) to 10 (worst pain ever) how painful is your neck/throat right now? _____

Are you in pain anywhere else on your body? _____

Please describe every place you're hurting because of the suspect's violent actions: _____

_____

What did the suspect say while he was strangling you? (Exact quotes if possible)

_____

What did you think was going to happen while you were being strangled?

_____

Did suspect threaten to harm or take action against you or anyone else? Yes or No (Circle one)

Who did suspect threaten to harm or take action against? _____

What did suspect threaten to do? _____

Why do you think the suspect stopped strangling you? _____

Describe what suspect's face looked like during strangulation: _____

_____

Did you lose control of your bladder or bowels? _____

Did you vomit? _____

Did you try to defend yourself? _____ If so, what did you do? _____

_____

Did suspect try to blame you for the violence? How so? _____

_____

While you were being strangled, were you: *Shaken? Straddled? Held against a wall or object?* (Circle all that apply)

Did your head strike a *wall, floor, ground, or other object* _____? (Circle all that apply)

How many times total has the suspect strangled you in the past? _____

Victim's Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

APPENDIX E

Documentation Chart for Attempted Strangulation Cases

Symptoms and/or Internal Injury:

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

Use face & neck diagrams to mark visible injuries:

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

APPENDIX F

Sefton Vulnerable Victims' Advocacy Team

Self Report Pain Assessment

Point to each face using the words to establish if there is any pain and its intensity. Ask the service user to choose a face that best describes their own pain and record the appropriate number below. *(Adapted from Wong & Baker, 1988)*

No pain | Hurts little bit | Hurts little more | Hurts even more | Hurts a lot | Worst pain imaginable

0	1	2	3	4	5	6	7	8	9	10
No pain										Worst pain imaginable

APPENDIX G

Documentation Chart for Attempted Strangulation Cases

Use this chart when a victim reports being "choked" or strangled

Symptoms and/or Internal Injury:

Breathing Changes	Voice Changes	Swallowing Changes	Behavioral Changes	OTHER
☐ Difficulty Breathing ☐ Hyperventilation ☐ Unable to breathe Other:	☒ Raspy Voice ☐ Hoarse Voice ☒ Coughing ☐ Unable to Speak	☐ Trouble swallowing ☒ Painful to swallow ☒ Neck pain ☒ Nausea ☒ Vomiting	☐ Agitation ☐ Amnesia ☐ PTSD ☐ Hallucinations ☐ Combativeness	☒ Dizzy ☒ Headaches back ☒ Fainted ☒ Urination during strangle ☐ Defecation

Use face & neck diagrams to mark visible injuries:

Face	Eyes & Eyelids	Nose	Ear	Mouth
☒ Red or flushed ☒ Pinpoint red spots (petechiae) ☐ Scratch Marks	☐ Petechiae to R and/or L eyeball (circle one) ☒ Petechiae to R and/or L eyelid (circle one) ☒ Bloody red eyeball(s) bilat	☒ Bloody nose ☐ Broken nose (ancillary finding) ☐ Petechiae	☐ Petechiae (external and/or ear canal) ☐ Bleeding from ear canal	☒ Bruising both lips ☐ Swollen tongue ☒ Swollen lips ☒ Cuts/abrasions (ancillary findings) ↑ + ↓ lips
Under Chin	**Chest**	**Shoulder**	**Neck**	**Head**
☐ Redness ☐ Scratch marks ☐ Bruise(s) ☐ Abrasions pain under (L) chin	☐ Redness ☐ Scratch marks ☒ Bruise(s) blue ☐ Abrasions center of chest	☒ Redness ☐ Scratch marks ☒ Bruise(s) ☒ Abrasions (R) shoulder	☐ Redness ☐ Scratch marks ☐ Finger nail impressions ☐ Bruise(s) ☒ Swelling ☐ Ligature mark pain to (L) clavicular area	☐ Petechiae (on scalp) **Ancillary findings:** ☐ Hair pulled ☐ Bump ☐ Skull fracture ☐ Hair pulled Hair bloody

Strangulation Questions

Ask the victim to describe how they were strangled. Was it-one or two hands, forearm, object, etc.

What did the suspect say before, during and after they strangled the victim?

Was the victim shaken simultaneously while being strangled?

Was the victim thrown or held against the wall, floor, or ground? Describe how and the results? Describe the surface area.

How long did the suspect strangle the victim?

How many times was the victim strangled? Describe each incident and method.

How much pressure was used? Describe it on scale of 1-10 and was it continuous?

What was the victim thinking when they were being strangled?

What caused the suspect to stop?

Any difficulty breathing during the assault or now?

Describe any voice changes.

Any complaint of pain to the throat?

Any coughing or trouble swallowing?

How did the victim feel during the assault? (dizzy, nauseous, loss of consciousness)

How does the victim feel now?

Did the vicitm experience any visual changes during the strangling?

Did the victim vomit, urinate or defecate as a result of being strangled?

Was the suspect wearing any rings or other jewelry? Look for marks from these objects.

Did the victim do anything to try and stop the assault? Will the suspect have injuries?

Look for injuries behind the ears, all around the neck, under the chin and jaw, eyelids, shoulders and chest area.

Ask the victim to look in a mirror and point out injury sites including petechiae

Are there prior incidents of strangulation?

Any visible injury? Photograph injuries and the entire area. Photograph the lack of injury and any areas the victim feels pain

Any object used? Document where it came from. Photograph and book the item as evidence.

Encourage medical treatment

Information provided courtesy of Dr. George McClane and Gael Strack JD

Strangulation

A Quick Reference Guide

Strangulation is a form of asphyxia (lack of oxygen) characterized by closure of the blood vessels and or air passages of the neck as a result of external pressure on the neck.
Based on the mechanism of attack and the victim's signs and symptoms, charge more than a PC 243(e) (1). Absence of a visible injury is common. Consider:

- PC 273.5(a)
- PC 245(a)(1)
- PC 664 / 187

Symptoms

- **Voice changes**
- **Complete loss of voice**
- **Difficulty swallowing**
- **Difficulty breathing**
- **Raspy breathing**
- **Pain or tenderness on touch or movement**
- **Mental status changes**
  - Restlessness or combativeness
  - Psychosis, amnesia
- **Involuntary urination or defecation**
- **Coughing / vomiting**
- **Vision changes**
- **Loss of consciousness**

Signs

- **Redness of the neck-** may be fleeting
- **Scratch marks**-victim or suspects
- **Bruises** - may not appear for some time
- **Finger tip bruises** are circular and oval and often faint.
- **Tiny red spots** (petechiae) -ruptured capillaries. Found anywhere above the area of constriction. (Jugular restriction)
- **Blood red eyes** are due to capillary rupture in the white portion of the eyes. May suggest a vigorous struggle or intermittent pressure.
- **Swelling of the neck** may be caused by any one or combination of the following: internal bleeding, or an injury of any of the underlying neck structures.

Stages of Strangulation	
Disbelief	Victim cannot believe they are being strangled. Very short in duration.
Primal	Victim fights with whatever means to stop the strangling. *Ask the victim what they did to get away or stop the attack. This may explain injuries.*
Resignation	Victim gives up, feeling they can do nothing and go limp. *Ask the victim what they were thinking about. What did they think was going to happen?*

Indicators of Loss of Consciousness (LOC):

- Loss of memory
- Standing, then waking up on the floor
- Unexplained bump on the head
- Bowel or bladder incontinence
- A witness to the LOC.

Victims who decline Medical Care

- Discuss the warning signs
- Advise victim to log symptoms
- Encourage victim to seek medical attention if symptoms persist
- Next 24-48 hours could be critical

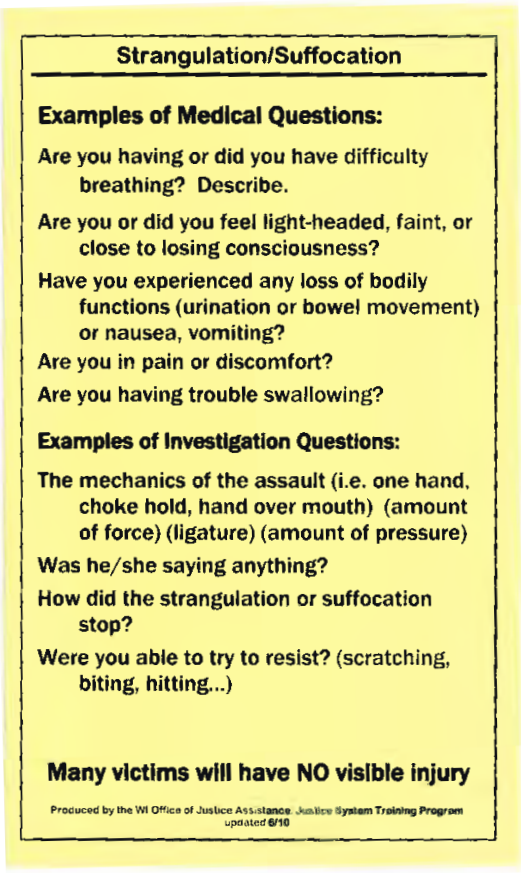
2012 Change

PC 273.5(c) includes an injury as a result of strangulation or suffocation as a traumatic condition whether of a minor or serious nature, caused by a physical force. For purposes of this section "strangulation" and "suffocation" include impeding the normal breathing or circulation of the blood

The arrest section is still PC 273.5(a)

Follow-up Questions

- Tell me how you feel now
- Have any new injuries appeared?
- Do you feel pain anywhere-Describe
- Does your voice sound the same?
- When you eat does it feel any different? Describe
- When you swallow does it feel different? Describe
- What is different now than before the assault? Describe
- Have you heard from the suspect?
- Please tell me what you remember about the assault. (Going for more details)
- How can I get in touch with you if you change your phone or address?
- Is there anything you want to talk about that we have not discussed?



Strangulation/Suffocation

Examples of Medical Questions:

Are you having or did you have difficulty breathing? Describe.

Are you or did you feel light-headed, faint, or close to losing consciousness?

Have you experienced any loss of bodily functions (urination or bowel movement) or nausea, vomiting?

Are you in pain or discomfort?

Are you having trouble swallowing?

Examples of Investigation Questions:

The mechanics of the assault (i.e. one hand, choke hold, hand over mouth) (amount of force) (ligature) (amount of pressure)

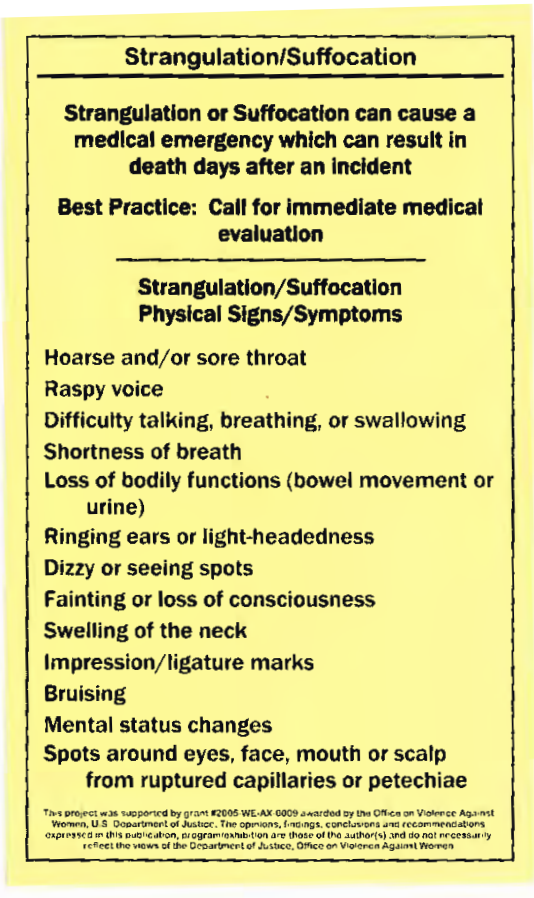
Was he/she saying anything?

How did the strangulation or suffocation stop?

Were you able to try to resist? (scratching, biting, hitting...)

Many victims will have NO visible injury

Produced by the WI Office of Justice Assistance, Justice System Training Program updated 6/10



Strangulation/Suffocation

Strangulation or Suffocation can cause a medical emergency which can result in death days after an incident

Best Practice: Call for immediate medical evaluation

Strangulation/Suffocation Physical Signs/Symptoms

Hoarse and/or sore throat

Raspy voice

Difficulty talking, breathing, or swallowing

Shortness of breath

Loss of bodily functions (bowel movement or urine)

Ringing ears or light-headedness

Dizzy or seeing spots

Fainting or loss of consciousness

Swelling of the neck

Impression/ligature marks

Bruising

Mental status changes

Spots around eyes, face, mouth or scalp from ruptured capillaries or petechiae

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

Topic: Strangulation

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

Strangulation Facts

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

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

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

What other procedures need to be followed?

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

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

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

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

domestic violence

CHICAGO POLICE DEPARTMENT

DOMESTIC VIOLENCE IN CHICAGO FEBRUARY 2010

IN THIS ISSUE

Office of the Superintendent, Domestic Violence Program

FAQS

Strangulation and Domestic Violence: Dynamics and Law

Every report of strangulation is serious. Only in recent years has strangulation been identified as of one of the most lethal forms of domestic violence. As a result, more than half of the states, in this country, have passed criminal laws specifically dealing with strangulation. On 1 January 2010, Illinois' first strangulation statutes went into effect. This newsletter defines and discusses strangulation as a form of domestic violence and the new statutes in Illinois.

DEFINITION

"Strangulation" is intentionally impeding the normal breathing or circulation of the blood of an individual by applying pressure on the throat or neck of that individual or by blocking the nose or mouth of that individual.

STRANGULATION AS A PREDICTOR OF HOMCIDE IN DOMESTIC VIOLENCE CASES

A Chicago study of 57 women, who were killed by a male partner during 1995-1996[i], revealed that 53% of the victims had experienced at least one incident of strangulation in the year preceding their murder, although the cause of death was most often a gun shot wound. Other studies have found similar correlations between incidents of strangulation and later homicide.[ii]

It is also important to note that while only 10% of murders nationally were by strangulation, 90% of those murders by strangulation were domestic violence-related. **Many of those victims died without a single visible mark to their neck.** [iii]

THE SAN DIEGO STUDY

The San Diego City Attorney's Office conducted a study of 300 strangulation cases submitted for prosecution in San Diego in 1995. The research, which included 911 tapes, police and medical reports and photographs, found the following:

- 97% of victims were manually strangled.
- In at least 41% of cases, the attack was witnessed by one or more children.
- Only 5% of victims sought medical treatment within 48 hours of the incident.
- In 50% of cases, officers reported seeing no physical injury when responding to the scene and in 35% of cases the injury was too minor to photograph. Photographs are important part of the investigation. Unfortunately only 15% of cases had a photograph of sufficient quality to be used in court as physical evidence of strangulation.[iv]
- 89% of victims reported prior history of domestic violence.

The study team also included an emergency room physician and a medical examiner. The medical portion of the study[v] found that while visible injury may not be present at the time of police response, there may be other physical signs of strangulation which include the following:

- Difficulty swallowing
- Hoarseness or coughing
- Breathing changes
- Pain to ear or headaches
- Nausea or vomiting
- Incontinence or defecation
- Pupils not the same size
- Loss of memory
- Miscarriage
- Red spots in the eyes

Disruption of oxygen to the brain may cause victim to have an aggressiveness or combative demeanor.

The medical examiner noted that a victim of strangulation may die from unseen internal injuries days, and in some cases, weeks after the incident. It is important to encourage victims of strangulation to seek medical attention.

For these reasons it is important to describe to police in detail the manner in which any domestic violence strangulation incident has occurred.

ILLINOIS' NEW STRANGULATION LAW

Illinois has amended the Aggravated Battery and Aggravated Domestic Battery statutes to allow what would otherwise be a misdemeanor battery to be charged as a felony.

AGGRAVATED BATTERY

A person who commits a battery against another person by strangulation may be charged with Aggravated Battery, 720 ILCS 5/12-4. Aggravated Battery is typically a Class 3 felony, carrying a penalty of 2-5 years. The sentence can be enhanced for Aggravated Battery by strangulation to a Class 1 felony, carrying a penalty of not less than 4 years and up to 15 years, if any of the following conditions apply:

- The person used or attempted to use a dangerous instrument while committing the offense;
- The person caused great bodily harm or permanent disability or disfigurement to the other person while committing this offense;
- The person has been previously convicted of this violation under the laws of this State or similar laws of another state.

AGGRAVATED DOMESTIC BATTERY

A simple battery against a family or household member that is committed by strangulation, will be charged as Aggravated Domestic Battery-720 ILCS 5/12-3.3 (a) (5). Aggravated Domestic Battery is a Class 2 felony.

[i] *The Chicago Women's Health Risk Study at a Glance*, Illinois Criminal Justice Information Authority (2000).
[ii] Nancy Glass, Kathy Laughon, Jacquelyn Campbell, Anne D. Wolf Chair, Carolyn Rebecca Block, Ginger Hanson, Phyllis W. Sharps, Ellen Taliaferro, *Non-fatal strangulation is an important risk factor for homicide of women*, J. Emerg Med, Vol. 35, No. 3 (2008)
[iii] Gael B. Strack, George E. McClane, Dean Hawley, *A Review of 300 Attempted Strangulation Cases* (Part 1: Criminal Legal Issues, Part 2: Clinical Evaluation of the Surviving Victim, Part 3: Injuries in Fatal Cases); J Emerg Med, Vol. 21, No. 3 (2001).
[iv] Id.
[v] Id.

For additional information regarding domestic violence issues or topics to be discussed, contact Sergeant Maude Noflin of the **Domestic Violence Program at: 312-745-6340 or FAX: 312- 745-6856**.

If you or someone you know needs immediate assistance, call 911.

The City of Chicago Domestic Violence Help Line number is:
1-877-863-6338 or 1-877-863-6339 (TTY)

domestic violence
CHICAGO POLICE DEPARTMENT
Content for the *Domestic Violence Newsletter* is provided by the Chicago Police Department, Domestic Violence Program, 3510 South Michigan Avenue, 3rd Floor, Chicago, Illinois, 60653 • Phone: (312) 745-6340 • Fax (312) 745-6856 FEBRUARY 2010

Recognizing and Investigating Strangulation

Victim Interview

Use the victim's own words in asking questions and recording statements. If he or she says "choked me" or "cut off my air" or "grabbed my throat," use those descriptions rather than substituting the word strangulation.

- Have you been hurt? Who hurt you?
- How did it happen?
- Do you have any current pain or discomfort?
  On a scale of 1 to 10, with 10 being the most, how much pain or discomfort?
- Have you noticed any change in your voice or speech?
- Are you having difficulty speaking or breathing now?
- Did you feel faint or dizzy or as though you might pass out? Do you feel that way now?
- Did you lose consciousness? If so for how long?
- Did you lose control of your bladder or bowels? Did you vomit?
- Did the person who hurt you use one or both hands?
  Use his/her arms, knees, or another body part on your throat or head area?
  Block your nose or mouth?
- Were you pinned or banged against a wall? Thrown to the floor or ground? Shaken?
- Did your head strike anything? If so, do you have any additional injuries?
- Did he/she use other objects, e.g., cords, ropes, straight objects, against your neck/throat?
- Where exactly were his/her hands or the object that was used on your neck/throat?
- Can you demonstrate how you were [strangled]?
- On a scale of 1 to 10, with 10 being the most pressure, how much pressure did he/she use?
- Did you have trouble breathing or catching your breath?
- How long do you think the [strangulation] lasted?
- How long did everything last, from the first argument or action until the police arrived?
- What did the person say before, during, and after [strangling] you?
- What did he/she do immediately prior to attacking you?
- What was her/his demeanor, facial expressions?
- What did you think was going to happen? Did you think you were going to die?
- Can you describe any attempts you made to protect yourself?
- Did you try to push, kick, bite, scratch, or pull his/her hair?
- Were you able to injure the person who did this? How and where?
- What caused him/her to stop the assault?

- Has this person [strangled] you before? How many times?
- Was this time more or less severe than the others? What was the most serious attack?
- Has this person attacked you or hurt you in any other ways before? How?
- Was the attacker/perpetrator wearing rings or a watch?
- Do you have any preexisting injuries? Any recent surgery? Are you pregnant?

Evidence Collection and Report Writing

1. Obtain specific, detailed descriptions and document:
   -How the victim was strangled
   -The mechanism for the assault (e.g. hands, cord, baseball bat)
   -Symptoms, and signs of strangulation
   -Visible injuries
2. Look for redness, scratch marks, scrapes, fingerprint marks, thumb-print bruising, ligature marks, bruising, tiny red spots, swelling and/or lumps on victim's neck.
3. Lock for neck swelling; ask victim to look in the mirror to assess any swelling.
4. Check suspect for wounds inflicted by the victim trying to defend themselves:
   -Scratches to face or arms
   -Bruises on the shins from being kicked
   -Scratches to hands and elbow area
   -Bite marks to arms or chest
5. Try to locate and seize any weapons used.
6. Look for corroborating evidence in the room where the victim was strangled
7. Locate, photograph, and impound any object used to strangle the victim
8. Photograph and collect any damaged property
9. Obtain medical/dental release from victim
10. Photograph all injuries of both parties, no matter how minor
11. Take the following photographs:
    -Distance photo (full body) to identify victim and location of injury
    -Close-up photos of face and neck area at different angles
    -Follow-up photos of injuries 24, 48, and 72 hours later
12. Document the totality of the incident, in addition to the strangulation

REPORT

- In report writing, use the word "strangulation" not choke, except when recording the victim's exact words.
- Use the phrase, "consistent with strangulation."
- In narrative, report all signs and symptoms observed, consistent with strangulation.
- Record victim's description of injury even if there are no visible signs (include all complaints of pain; type and location).
- Record victim's exact words (e.g., "he choked me").

National Strangulation Training Institute

Sample Detective's Report

Officer's Observations:

The victim had a bruise on her right arm and on the inside of her bottom lip. She also had red marks to her neck and red spots on her forehead and around her eyes that appeared to be small broken capillaries. This has been described to me in the past by Dr. George McClane during training in choking cases. The condition has been described as Thidieu's spots that are caused by tiny capillaries bursting from pressure of a chokehold. The victim complained of a sore throat and had a hoarse voice. I encouraged the victim to seek medical attention but she declined. I told her if her condition worsens she should seek a doctor's care immediately.

Evidence:

Printout of two prior incidents.

Printout of 911 tape.

Three photographs taken by the responding officer.

I took seven follow-up photographs of the victim's injuries and attached them to this report.

Charges:

I request that the Defendant be charged with the offenses listed on page one of this report. This request is based on the information listed in this report and the information in the police report.

Detective Real Smart Approved by Sgt. Even Smarter

Documentation Chart for Attempted Strangulation Cases

Symptoms and/or Internal Injury:

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

Use face & neck diagrams to mark visible injuries:

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

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Questions to ASK: Method and/or Manner:

How and where was the victim strangled?

☐ One Hand (R or L) ☐ Two hands ☐ Forearm (R or L) ☐ Knee/Foot

☐ Ligature (Describe):_____

☐ How long? _____ seconds _____ minutes ☐ Also smothered?

- ☐ From 1 to 10, how hard was the suspect's grip? (Low): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (high)
- ☐ From 1 to 10, how painful was it? (Low): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (high)

☐ Multiple attempts:_____ ☐ Multiple methods:_____

Is the suspect **RIGHT** or **LEFT** handed? (Circle one)

What did the suspect say while he was strangling the victim, before and/or after?

Was she shaken simultaneously while being strangled? Straddled? Held against wall?

Was her head being pounded against wall, floor or ground?

What did the victim think was going to happen?

How or why did the suspect stop strangling her?

What was the suspect's demeanor?

Describe what suspect's face looked like during strangulation?

Describe Prior incidents of strangulation? Prior domestic violence? Prior threats?

MEDICAL RELEASE

To All Health Care Providers: Having been advised of my right to refuse, I hereby consent to the release of my medical/dental records related to this incident to law enforcement, the District Attorney's Office and/or the City Attorney's Office.

Signature:_____ Date:_____

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SENATE BILL No. 430

Introduced by Senator Kehoe
(Coauthors: Assembly Members Atkins and Fletcher)

February 16, 2011

An act to add Section 249 to the Penal Code, relating to strangulation.

LEGISLATIVE COUNSEL'S DIGEST

SB 430, as introduced, Kehoe. Strangulation.

Existing law establishes various crimes against the person, such as assault and battery, and provides that any person who willfully inflicts upon a person who is his or her spouse, former spouse, cohabitant, former cohabitant, or the mother or father of his or her child, corporal injury resulting in a traumatic condition, is guilty of a felony punishable by imprisonment in the state prison for 2, 3, or 4 years, or as a misdemeanor with specified penalties.

This bill would provide that any person who willfully and unlawfully strangles, suffocates, or attempts to suffocate a person is guilty of a felony punishable by incarceration in the state prison for a term of 2, 3, or 4 years. The bill would provide that if the defendant and victim are in a specified relationship, the defendant would be subject to an enhancement of an additional 2 years in state prison. The bill would provide that evidence of either an intent to kill or injure the victim or visible injuries is not required to convict a defendant of violating these provisions.

By creating a new crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 249 is added to the Penal Code, to read:

249. (a) Any person who willfully and unlawfully strangles, suffocates, or attempts to suffocate a person is guilty of a felony punishable by incarceration in the state prison for a term of two, three, or four years.

(b) For a defendant to be convicted of a violation of subdivision (a), evidence of either of the following is not required:

(1) An intent to kill or injure the victim.

(2) Visible injuries.

(c) If the defendant and the victim are in a relationship described in subdivision (b) of Section 13700, the defendant shall be subject to an enhanced penalty of two additional years imprisonment in the state prison.

(d) (1) "Strangle" for purposes of this section means to intentionally, knowingly, or recklessly impede the normal breathing or circulation of the blood of a person by applying pressure on the throat or neck.

(2) "Suffocate" for purposes of this section means to intentionally, knowingly, or recklessly impede the normal breathing of a person.

(e) Nothing in this section shall preclude prosecution of a person under any other provision of this code.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

California Penal Code Code § 273.5 (2013)

Infliction of injury on present or former spouse or cohabitant or parent of child; Punishment; Conditions of probation; Issuance of restraining order

(a) Any person who willfully inflicts upon a person who is his or her spouse, former spouse, cohabitant, former cohabitant, or the mother or father of his or her child, corporal injury resulting in a traumatic condition is guilty of a felony, and upon conviction thereof shall be punished by imprisonment in the state prison for two, three, or four years, or in a county jail for not more than one year, or by a fine of up to six thousand dollars ($6,000) or by both that fine and imprisonment.

(b) Holding oneself out to be the husband or wife of the person with whom one is cohabiting is not necessary to constitute cohabitation as the term is used in this section.

(c) As used in this section, «traumatic condition» means a condition of the body, such as a wound, or external or internal injury, including, but not limited to, injury as a result of strangulation or suffocation, whether of a minor or serious nature, caused by a physical force. For purposes of this section, «strangulation» and «suffocation» include impeding the normal breathing or circulation of the blood of a person by applying pressure on the throat or neck.

(d) For the purpose of this section, a person shall be considered the father or mother of another person›s child if the alleged male parent is presumed the natural father under Sections 7611 and 7612 of the Family Code.

(e) (1) Any person convicted of violating this section for acts occurring within seven years of a previous conviction under subdivision (a), or subdivision (d) of Section 243, or Section 243.4, 244, 244.5, or 245, shall be punished by imprisonment in a county jail for not more than one year, or by imprisonment in the state prison for two, four, or five years, or by both imprisonment and a fine of up to ten thousand dollars ($10,000).

(2) Any person convicted of a violation of this section for acts occurring within seven years of a previous conviction under subdivision (e) of Section 243 shall be punished by imprisonment in the state prison for two, three, or four years, or in a county jail for not more than one year, or by a fine of up to ten thousand dollars ($10,000), or by both that imprisonment and fine.

(f) If probation is granted to any person convicted under subdivision (a), the court shall impose probation consistent with the provisions of Section 1203.097.

(g) If probation is granted, or the execution or imposition of a sentence is suspended, for any defendant convicted under subdivision (a) who has been convicted of any prior offense specified in subdivision (e), the court shall impose one of the following conditions of probation:

(1) If the defendant has suffered one prior conviction within the previous seven years for a violation of any offense specified in subdivision (e), it shall be a condition thereof, in addition to the provisions contained in Section 1203.097, that he or she be imprisoned in a county jail for not less than 15 days.

(2) If the defendant has suffered two or more prior convictions within the previous seven years for a violation of any offense specified in subdivision (e), it shall be a condition of probation, in addition to the

provisions contained in Section 1203.097, that he or she be imprisoned in a county jail for not less than 60 days.

(3) The court, upon a showing of good cause, may find that the mandatory imprisonment required by this subdivision shall not be imposed and shall state on the record its reasons for finding good cause.

(h) If probation is granted upon conviction of a violation of subdivision (a), the conditions of probation may include, consistent with the terms of probation imposed pursuant to Section 1203.097, in lieu of a fine, one or both of the following requirements:

(1) That the defendant make payments to a battered women's shelter, up to a maximum of five thousand dollars ($5,000), pursuant to Section 1203.097.

(2) That the defendant reimburse the victim for reasonable costs of counseling and other reasonable expenses that the court finds are the direct result of the defendant's offense.

For any order to pay a fine, make payments to a battered women's shelter, or pay restitution as a condition of probation under this subdivision, the court shall make a determination of the defendant's ability to pay. In no event shall any order to make payments to a battered women's shelter be made if it would impair the ability of the defendant to pay direct restitution to the victim or court-ordered child support. Where the injury to a married person is caused in whole or in part by the criminal acts of his or her spouse in violation of this section, the community property may not be used to discharge the liability of the offending spouse for restitution to the injured spouse, required by Section 1203.04, as operative on or before August 2, 1995, or Section 1202.4, or to a shelter for costs with regard to the injured spouse and dependents, required by this section, until all separate property of the offending spouse is exhausted.

(i) Upon conviction under subdivision (a), the sentencing court shall also consider issuing an order restraining the defendant from any contact with the victim, which may be valid for up to 10 years, as determined by the court. It is the intent of the Legislature that the length of any restraining order be based upon the seriousness of the facts before the court, the probability of future violations, and the safety of the victim and his or her immediate family. This protective order may be issued by the court whether the defendant is sentenced to state prison, county jail, or if imposition of sentence is suspended and the defendant is placed on probation.

(j) If a peace officer makes an arrest for a violation of this section, the peace officer is not required to inform the victim of his or her right to make a citizen›s arrest pursuant to subdivision (b) of Section 836.

History: Added Stats 1977 ch 912 § 3. Amended Stats 1980 ch 1117 § 3; Stats 1985 ch 563 § 1; Stats 1987 ch 415 § 2; Stats 1988 ch 576 § 1, effective August 25, 1988; Stats 1990 ch 680 § 1, (AB 2632); Stats 1992 ch 163 § 104 (AB 2641), operative January 1, 1994 (ch 184 prevails), ch 183 § 1 (SB 1545), ch 184 § 3 (AB 2439); Stats 1993 ch 219 § 216.4 (AB 1500); Stats 1st Ex Sess 1993-94 ch 28 § 2 (AB 93 X), effective November 30, 1994; Stats 1996 ch 1075 § 15 (SB 1444), ch 1077 § 16 (AB 2898); Stats 1999 ch 660 § 2 (SB 563), ch 662 § 9.5 (SB 218); Stats 2000 ch 287 § 5 (SB 1955). Amended Stats 2003 ch 262 § 1 (AB 134); Stats 2007 ch 582 § 1 (AB 289), effective January 1, 2008; Stats 2011 ch 129 § 2 (SB 430), effective January 1, 2012; Stats 2012 ch 867 § 16 (SB 1144), effective January 1, 2013.

CALCRIM 840

(iii) Spouse, etc.

840. Inflicting Injury on Spouse, Cohabitant, or Fellow Parent Resulting in Traumatic Condition (Pen. Code, § 273.5(a))

The defendant is charged [in Count] with inflicting an injury on [his/her] ([former] spouse/[former] cohabitant/the (mother/father) of (his/her) child) that resulted in a traumatic condition [in violation of Penal Code section 273.5(a)].

To prove that the defendant is guilty of this crime, the People must prove that:

1. The defendant willfully [and unlawfully] inflicted a physical injury on [his/her] ([former] spouse/[former] cohabitant/the (mother/father) of (his/her) child);

[AND]

2. The injury inflicted by the defendant resulted in a traumatic condition.

<Give element 3 when instructing on self-defense or defense of another>

[AND

3. The defendant did not act (in self-defense/ [or] in defense of someone else).]

Someone commits an act *willfully* when he or she does it willingly or on purpose.

A *traumatic condition* is a wound or other bodily injury, whether minor or serious, caused by the direct application of physical force.

[The term *cohabitants* means two unrelated persons living together for a substantial period of time, resulting in some permanency of the relationship. Factors that may determine whether people are cohabiting include, but are not limited to, (1) sexual relations between the parties while sharing the same residence, (2) sharing of income or expenses, (3) joint use or ownership of property, (4) the parties' holding themselves out as (husband and wife/domestic partners), (5) the continuity of the relationship, and (6) the length of the relationship.]

[A person may cohabit simultaneously with two or more people at different locations, during the same time frame, if he or she maintains substantial ongoing relationships with each person and lives with each person for significant periods.]

[A person is considered to be the (mother/father) of another person's child if the alleged male parent is presumed under law to be the natural father. *<insert name of presumed father>* **is presumed under law to be the natural father of** *<insert name of child>***.]**

[A traumatic condition is the *result of* an injury if:

1. The traumatic condition was the natural and probable consequence of the injury;

2. The injury was a direct and substantial factor in causing the condition;

AND

3. The condition would not have happened without the injury.

A *natural and probable consequence* is one that a reasonable person would know is likely to happen if nothing unusual intervenes. In deciding whether a consequence is natural and probable, consider all of the circumstances established by the evidence.

A *substantial factor* is more than a trivial or remote factor. However, it does not need to be the only factor that resulted in the traumatic condition.]

New January 2006; Revised June 2007, August 2012

BENCH NOTES

Instructional Duty

The court has a **sua sponte** duty to give an instruction defining the elements of the crime.

If there is sufficient evidence of self-defense or defense of another, the court has a **sua sponte** duty to instruct on the defense. Give bracketed element 3 and any appropriate defense instructions. (See CALCRIM Nos. 3470–3477.)

If causation is at issue, the court has a **sua sponte** duty to instruct on proximate cause. (*People v. Bernhardt* (1963) 222 Cal.App.2d 567, 590–591 [35 Cal.Rptr. 401]; *People v. Cervantes* (2001)

26 Cal.4th 860, 865–874 [111 Cal.Rptr.2d 148, 29 P.3d 225].) Give the bracketed paragraph that begins, "A traumatic condition is the *result of* an injury if . . . ."

If there is sufficient evidence that an alleged victim's injuries were caused by an accident, the court has a **sua sponte** duty to instruct on accident. (*People v. Gonzales* (1999) 74 Cal.App.4th 382, 390 [88 Cal.Rptr.2d 111].) Give CALCRIM No. 3404, *Accident*.

Give the bracketed language "[and unlawfully]" in element 1 if there is evidence that the defendant acted in self-defense.

Give the third bracketed sentence that begins "A person may cohabit simultaneously with two or more people," on request if there is evidence that the defendant cohabited with two or more people. (See *People v. Moore* (1996) 44 Cal.App.4th 1323, 1335 [52 Cal.Rptr.2d 256].)

Give on request the bracketed paragraph that begins "A person is considered to be the (mother/father)" if an alleged parental relationship is based on the statutory presumption that the male parent is the natural father. (See Pen. Code, § 273.5(d); see also *People v. Vega* (1995) 33 Cal.App.4th 706, 711 [39 Cal.Rptr.2d 479] [parentage can be established without resort to any presumption].)

If the defendant is charged with an enhancement for a prior conviction for a similar offense within seven years and has not stipulated to the prior conviction, give CALCRIM No. 3100, *Prior Conviction: Nonbifurcated Trial*. If the court has granted a bifurcated trial, see CALCRIM No. 3101, *Prior Conviction: Bifurcated Trial*.

If there is evidence that the traumatic condition resulted from strangulation or suffocation, consider instructing according to the special definition provided in Pen. Code, § 273.5(c).

AUTHORITY

- Elements. Pen. Code, § 273.5(a).
- Traumatic Condition Defined. Pen. Code, § 273.5(c); *People v. Gutierrez* (1985) 171 Cal. App.3d 944, 952 [217 Cal.Rptr. 616].
- Willful Defined. Pen. Code, § 7, subd. 1; see *People v. Lara* (1996) 44 Cal.App.4th 102, 107 [51 Cal.Rptr.2d 402].
- Cohabitant Defined. *People v. Holifield* (1988) 205 Cal.App.3d 993, 1000 [252 Cal.Rptr. 729]; *People v. Ballard* (1988) 203 Cal.App.3d 311, 318–319 [249 Cal.Rptr. 806].
- Direct Application of Force. *People v. Jackson* (2000) 77 Cal.App.4th 574, 580 [91 Cal.Rptr.2d 805].
- Duty to Define Traumatic Condition. *People v. Burns* (1948) 88 Cal.App.2d 867, 873–874 [200 P.2d 134].
- Strangulation and Suffocation. Pen. Code, § 273.5(c).
- General Intent Crime. See *People v. Thurston* (1999) 71 Cal.App.4th 1050, 1055 [84 Cal. Rptr.2d 221]; *People v. Campbell* (1999) 76 Cal.App.4th 305, 307–309 [90 Cal.Rptr.2d 315]; contra, *People v. Rodriguez* (1992) 5 Cal.App.4th 1398, 1402 [7 Cal.Rptr.2d 495] [dictum].
- Simultaneous Cohabitation. *People v. Moore* (1996) 44 Cal.App.4th 1323, 1335 [52 Cal.Rptr.2d 256].

Secondary Sources

1 Witkin & Epstein, California Criminal Law (3d ed. 2000) Crimes Against the Person, §§ 63, 64.

6 Millman, Sevilla & Tarlow, California Criminal Defense Practice, Ch. 142, **ASSAULTIVE AND BATTERY CRIMES CALCRIM No. 840**

LESSER INCLUDED OFFENSES

- Attempted Infliction of Corporal Punishment on Spouse. Pen. Code, §§ 664, 273.5(a); *People v. Kinsey* (1995) 40 Cal.App.4th 1621, 1627, 1628 [47 Cal.Rptr.2d 769] [attempt requires intent to cause traumatic condition, but does not require a resulting "traumatic condition"].
- Misdemeanor Battery. Pen. Code, §§ 242, 243(a); see *People v. Gutierrez* (1985) 171 Cal. App.3d 944, 952 [217 Cal.Rptr. 616].

- Battery Against Spouse, Cohabitant, or Fellow Parent. Pen. Code, § 243(e)(1); see *People v. Jackson* (2000) 77 Cal.App.4th 574, 580 [91 Cal.Rptr.2d 805].

- Simple Assault. Pen. Code, §§ 240, 241(a); *People v. Van Os* (1950) 96 Cal.App.2d 204, 206 [214 P.2d 554].

RELATED ISSUES

Continuous Course of Conduct

Penal Code section 273.5 is aimed at a continuous course of conduct. The prosecutor is not required to choose a particular act and the jury is not required to unanimously agree on the same act or acts before a guilty verdict can be returned. (*People v. Thompson* (1984) 160 Cal.App.3d 220, 224–225 [206 Cal.Rptr. 516].)

Multiple Acts of Abuse

A defendant can be charged with multiple violations of Penal Code section 273.5 when each battery satisfies the elements of section 273.5. (*People v. Healy* (1993) 14 Cal.App.4th 1137, 1140 [18 Cal.Rptr.2d 274].)

Prospective Parents of Unborn Children

Penal Code section 273.5(a) does not apply to a man who inflicts an injury upon a woman who is pregnant with his unborn child. "A pregnant woman is not a 'mother' and a fetus is not a 'child' as those terms are used in that section." (*People v. Ward* (1998) 62 Cal.App.4th 122, 126, 129 [72 Cal. Rptr.2d 531].)

Termination of Parental Rights

Penal Code section 273.5 "applies to a man who batters the mother of his child even after parental rights to that child have been terminated." (*People v. Mora* (1996) 51 Cal.App.4th 1349, 1356 [59 Cal.Rptr.2d 801].)

National Strangulation Training Institute

National Family Justice Center Alliance
Strangulation Training Institute
Background Information for a California Strangulation Statute
January 2011

Prepared by Casey Gwinn, Esq. and Gael Strack, Esq.

Background

In recent years, research has confirmed that strangulation violence is one of the most lethal forms of violence in domestic violence and sexual assault cases. While the primary focus of this paper is on domestic violence, most of the research is relevant as well to sexual assault cases, particularly spousal sexual assault. Prior to the research and recent focus on strangulation training programs and specialized intervention processes, this lethal violence was often minimized. In many cases, the lack of physical evidence caused the criminal justice system to treat "choking" cases as minor incidents, much like a slap to the face where only redness might appear. Today, based on the involvement of the medical profession, specialized training for police and prosecutors, and ongoing research, strangulation has become a focus area for policy makers and professionals working to reduce intimate partner violence and sexual assault. Twenty-nine states have now passed strangulation laws which provide clear legislative definitions of the violent, life threatening assault now properly referred to as strangulation. California is one of only a handful of large states in the country that has not yet passed a statute. Yet domestic violence is a serious social, criminal, and civil justice issue in California.

According to the California Women's Health Survey (CWHS), approximately 40% of California women experience physical intimate partner violence in their lifetimes. There is no similar research for male victims though strangulation research has found that 99% of strangulation victims are women. The CWHS found younger women, 18-24 years of age, were significantly more likely (11%) to be victims of physical intimate partner violence in the past year than women in other age groups. The CWHS1 also revealed statistically significant higher rates of intimate partner violence among women who had been pregnant in the last five years (12%). Of those experiencing physical intimate partner violence, 75% of victims had children under the age of 18 years at home. The violence, including strangulation, is not confined to adults. According to the California Student Survey (CSS), at least one incident of physical dating violence was reported by 5.2% of 9th graders and 8.2% of 11th graders. Among students who had a boy/girlfriend, the rates of dating violence were 8.8% in 9th grade and 12.8% in 11th grade.

In many of the cases in California, strangulation is a primary cause of death though it is not reported or documented due to the lack of focus on the subject but general research confirms this reality. According to the California Department of Justice, Criminal Justice Statistics Center, there were 113 domestic violence fatalities in 2008 (the most recent year for which data is available). These accounted for 5% of all homicides in the State. Of the 113 domestic violence

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homicides in 2008, 99 of the victims were females (88%), and 14 were males (12%). The 1993 National Mortality Followback Survey of adults shows that the percent of women dying from strangulation was approximately 12%. While there is little research specifically examining strangulation in the context of intimate partner violence or homicide, some experts have suggested that those numbers could be as high as 20% of all domestic violence homicides. Applying numbers from the strangulation field, 20% of all domestic violence homicides could involve strangulation which would account for 20-25 homicides per year in California.

Law enforcement agencies in California are already investing enormous resources in addressing domestic violence cases but there is no consistent set of standards for the handling of strangulation cases. In most jurisdictions, the large majority of such cases are still being handled as misdemeanors and when handled as felonies there is little legal guidance for judges or juries on the nature of the crime when strangulation is involved. According to the California Department of Justice, Criminal Justice Statistics Center, there were174, 649 domestic violence-related calls for assistance in 2007 (the most recent year for which data is available).

Key Reasons to Pass a California Strangulation Statute

The Family Justice Center Alliance (www.familyjusticecenter.org) has become a national leader in the effort to educate professionals and policy makers on strangulation. The Strangulation Training Institute (http://www.familyjusticecenter.com/Strangulation-Training/strangulation-training.html) is a specialized team of police officers, prosecutors, advocates, and survivors of domestic violence and sexual assault that provide training across the United States and around the world on the investigation, prosecution, and advocacy issues related to strangulation.

The following reasons have been prepared to assist elected officials, policy makers, and caring community members in supporting the passage of a strangulation statute in California.

- Every state prosecutor's association in the country that has studied the issue has concurred in the need for a statute and has supported such legislation. The National District Attorney's Association (NDAA) has also studied the issue and recommended specific legislation.
- Twenty nine states have now passed statutes in the last ten years but California has failed to make this offense a priority focus area even though much of the research on strangulation has emanated out of California and specifically out of San Diego. (NDAA Article). After NDAA's recent research publication, Illinois, New York and Mississippi passed strangulation felony laws in 2010 with other states in process.
- The NDAA and the Battered Women's Justice Project have strongly endorsed the creation of such statutes. The National Family Justice Center Alliance has provided technical assistance to most, if not, all of the states that have passed strangulation statutes.

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- The largest strangulation study conducted to date is from San Diego, California where 300 cases were studied. (Taliaferro, 2009) The San Diego City Attorney's office found that most cases lacked physical evidence of strangulation – only 15% 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% of the cases. (Strack, 2001)
- Strangulation is more common than professionals have realized. Recent studies have now shown that 34% of abused pregnant women report being "choked" (Bullock, 2006); 47% of female domestic violence victims reported being "choked" (Block, 2000) and most experts believe the rate is higher given the lack of minimization by victims and the lack of education.
- Victims of multiple 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". (Smith, 2001)
- **Almost half of all domestic violence homicide victims had experienced at least one episode of attempted strangulation prior to a lethal or near lethal violent incident (Glass, Sage, 2008). Victims of prior attempted strangulation are 7x more likely of becoming a homicide victim. (Glass, et al, 2008).**
- Strangulation is more serious than professionals have realized. Loss of consciousness can occur within 5 to 10 seconds and death within 4 to 5 minutes. (Watch, 2009; Hawley, McClane, 2001). The seriousness of the internal injuries may take a few hours to be appreciated and delayed death can occur days later. (Hawley, McClane, 2001).
- Because most strangulation victims do not have visible injuries, strangulation cases are minimized or trivialized by law enforcement, medical and mental health professionals.
- **Oftentimes even in fatal cases, there is no external evident injury whatsoever**. (Hawley, Forensic Medical Findings in Fatal and Non-Fatal Intimate Partner Strangulation Assaults).
- Strangulation is lethal force and is one of the best predictors of a future homicide in domestic violence cases. (Glass, et al, 2008).
- All strangulation cases must be meticulously assessed and documented. Even in fatal strangulation cases, it has been reported that documentation is missed. According to Dr. Dean Hawley, a common scenario for homicidal strangulation is that the individual is found dead, often reported by the assailant, with a vague history of substance abuse or depression. There being no externally-evident injury, the body is taken for autopsy with a suspicion of drug overdose and the injury of strangulation is not found until the neck dissection is carried out at autopsy, ordinarily at the end of the case. Therefore, photographs and trace evidence collections are not made.

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- When strangulation is minimized by professionals, it also sends the wrong message to victims. They are generally in denial or minimizing their situation, yet they may not realize their level of danger, be referred to advocates or counselors nor be provided with adequate safety planning information.
- Strangulation does not fit neatly into any other crime. You can strangle someone nearly to death with no visible injury. What is it? A misdemeanor assault with a likely sentence of a $400 fine and public work service. It is not a PC273.5. We have documented many murders with no visible injuries.
    - It might be a felony assault but expert testimony is necessary and even then there are no elements that relate to the actual nature of the crime.
    - It is most likely an attempted murder but police officers and prosecutors will be reluctant to file those charges because of the lack of documentation and their lack of education, training and practice.
- The IACP National Law Policy Center has incorporated strangulation training into their policy and model police protocols on domestic violence. (IACP, 2006).
- In 2008, the Abuse Assessment Screen has been revised to address nonlethal strangulation due to the body of research. (JOGNN, 2008)
- In 2009, a review and analysis of laws related to strangulation in 50 states was conducted by Kathryn Laughon, University of Virginia; Nancy Glass, Johns Hopkins University School of Nursing, and Claude Worrell, Deputy Commonwealth's Attorney from the City of Charlottesville, which 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 recommended that all states develop polices 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).
- When laws are passed, it sends a strong message to the professionals handling such incidents that strangulation cases should be treated as serious cases and either generally requires them or gives them an incentive to receive training, develop policies and improve their practice of handling lethal domestic violence cases.
- Today, training materials on strangulation are readily available.
- 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 for the crimes they commit and prevent future homicides.

National Strangulation Training Institute

What Will Opponents Say?

Opponents of a California Strangulation statute may argue that such legislation is not necessary because existing laws address this type of violence. They may argue that more offenders may be incarcerated in state prison. They will argue that the cost of specialized investigations and increased incarceration will burden an already impacted state budget.

Responses to Opponents of a California Strangulation Statute

- Early intervention, prior to a homicide will save money and lives.
- In California, one domestic violence murder costs a minimum of $2.5 million in local and state expenses. (San Diego County, HHSA Study, 1994)
- More strangulation cases will be prosecuted as high-level misdemeanor or felony level and not result in long-term incarceration unless it is a homicide.
- Any felony strangulation statute should not be a substitute for strong, misdemeanor intervention in domestic violence cases. In one study, victims had been physically abused on average for 3 years before ever being strangled (Wilbur, 2001). In the San Diego Study, 89% of the victims had a long history of prior and documented domestic violence.
- How long does the state have to wait to adequately intervene in a serious, life threatening domestic violence case?
- The impact of children witnessing strangulation violence cannot be underestimated. Children witness approximately 50% of all strangulation incidents – causing deep, long-term emotional trauma and dramatically increasing the likelihood that male children will repeat the violence as teenagers and adults. (Bancroft, 2009)
- Strangulation violence is a felony under virtually any assault statute in the United States. A specialized strangulation statute will not create a new crime, it will simply provide clear elements of an offense for existing lethal force being used consistently by violent and abusive intimate partners in California.

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MOTION IN LIMINE TO ALLOW EXPERT TESTIMONY IN STRANGULATION CASE

INTRODUCTION

The People seek to introduce the testimony of Amy Carney, who will be offered as an expert witness on the subject of strangulation. Ms. Carney's testimony is relevant and she meets the qualifications as an expert witness on strangulation. Her testimony is necessary to educate jurors about strangulation, the mechanics of strangulation, the seriousness of strangulation, as well as to disabuse jurors of commonly held misconceptions about strangulation. The popularization of forensic medicine, particularly in television shows (such as CSI), has provided the public with a tremendous amount of misinformation, furthering the public's misunderstanding of strangulation and its severity.

Ms. Carney's testimony is vital to teach jurors that strangulation does not often produce visible injuries to the neck. She will explain the relevance of certain symptoms and explain how those symptoms are associated with internal injuries to the neck and how they are consistent with strangulation. She will also describe the significance of certain signs, such as Petechiae, which may be visible on a victim's face, head or neck. Such signs are consistent with asphyxia. Her testimony will also educate jurors that manual strangulation can cause unconsciousness within seconds and death within minutes. Further, Ms. Carney's testimony may include an expert opinion based on hypothetical facts as to whether a victim was strangled. Such expert testimony is admissible so jurors have the necessary knowledge to competently evaluate the evidence that will be presented in this case.

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EXPERT TESTIMONY ABOUT STRANGULATION IS ADMISSIBLE IN THE PEOPLE'S CASE IN CHIEF

A. EXPERT TESTIMONY IS RELEVANT

"Evidence relevant to the credibility of a witness or hearsay declarant" or evidence "having any tendency in reason to prove or disprove any disputed fact that is of consequence to the determination of the action" is relevant and thus, admissible. Evid. Code §210.

This case involves allegations of strangulation. Specifically, **[insert case facts].** Amy Carney's specialized knowledge about strangulation will assist the jury in understanding the strangulation evidence that will be presented in this case. As such, expert testimony on the subject matter of strangulation is relevant and admissible at trial. Evid. Code §210.

B. EXPERT TESTIMONY IS ADMISSIBLE WHEN IT IS RELATED TO SUBJECT MATTER BEYOND COMMON EXPERIENCE AND WHEN IT WILL ASSIST THE TRIER OF FACT

If a subject is "sufficiently beyond common experience" and an expert's "special knowledge, skill, experience, training or education" will "assist the trier of fact," an expert witness is authorized to testify in the form of an opinion or otherwise. Evid. Code §§720 and 801. In other words, expert testimony is allowed where jurors lack the necessary knowledge or experience to draw reasonable inferences from the facts presented at trial and the expert's testimony will help them do so. *Id.* The California Supreme Court has further recognized that "the jury need not be wholly ignorant of the subject matter of the [expert] opinion in order to justify its admission." *People v. Jones,* 54 Cal. 4th 1, 60 (2012).

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Expert testimony in the area of strangulation is of crucial importance in this case. Most jurors have been spared the experience of being strangled or of witnessing a strangulation and thus, lack the knowledge to competently evaluate facts about strangulation. For example, strangulation involves terminology which is foreign to most jurors (i.e., asphyxia, petechiae, choking versus strangulation, etc.). An expert can explain these and other medical terms and their relationship to the facts of this case.

An expert can further provide the jury with rudimentary knowledge about the anatomy of the neck. Such information is important for the jury to adequately understand the physical effects of strangulation to a victim, the medical seriousness of such an act, and how easily a person may be strangled to death. In addition, without an expert, jurors may lack knowledge about the different methods used to and the force required to strangle a person. For example, when a victim has difficulty swallowing, this indicates that the amount of force used was such that the victim's ligaments and/or cartilage were damaged. An expert witness can teach the jurors these and other principles so that they may intelligently evaluate the allegations of strangulation in this case.

Moreover, an expert can dispel jurors' misunderstandings about strangulation. Jurors often believe that strangulation is about compressing the airway. An expert can explain that strangulation is not only about stopping the flow of air to the brain, but more importantly, is about stopping flow of blood to and from the brain. Strangulation occurs when the arteries and veins, as well as the airway, are compressed or disrupted. An expert can further teach jurors that a victim loses consciousness by any one or all of the following: Blocking of the carotid

arteries (depriving the brain of oxygen), blocking of the jugular veins (preventing deoxygenated blood from exiting the brain) or closing off the airway (causing the victim to be unable to breathe).

Additionally, jurors often expect to see pronounced, visible injuries to a victim's neck as a result of strangulation. Expert testimony will help jurors understand that although strangulation usually does not produce photographable injuries to a victim's neck, it does typically cause other distinctive symptoms and consequences. For instance, an expert may explain that strangulation victims often experience voice changes, painful swallowing, and/or difficulty breathing. Such symptoms suggest specific internal injuries that are consistent with being strangled. What is seen on the skin, an expert can explain, is only an external manifestation of what happened internally to the victim. An expert can also teach the jury, for example, that a strangulation victim's difficulty in breathing is due to pain and swelling, which is caused by internal bleeding in the neck tissue. Similarly, hoarseness is due to paralysis of the vocal chord nerves in the neck.

Without expert assistance jurors would unlikely know that strangulation can produce petechiae, small red dots caused by ruptured capillaries. Petechiae from strangulation may result around the eyes, on the face or neck, under the eyelids, in the scalp, in the brain, inside the mouth, on the lips or in the ears. Petechiae also sometimes disclose how long the strangulation took place and if there have been multiple strangulations over a period of time. An expert can explain the clear medical associations from petechiae evidence.

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An expert can also explain the pattern of other injuries resulting from strangulation, such as redness of the neck, swelling of the tongue, pattern injuries to the neck consistent with manual or ligature strangulation, a "crackling" sensation under the skin of the neck (known as subcutaneous emphysema), involuntary urination or defecation, fainting, and hallucinations, as well as the delayed complications, such as concussions, progressive dementia, pneumonia, amnesia, miscarriage or post-traumatic stress disorder. An expert can inform the jury strangulation injuries can and do often turn fatal — even up to 24 hours after the strangulation event.

Without the assistance of expert testimony, a lack of visible injury on the victim's neck may lead jurors to view strangulation as minor, or worse, strong evidence that there was no strangulation at all. Minus such expert testimony, jurors may not realize the seriousness of strangulation. Unlike other types of physical assault, strangulation can cause unconsciousness in seconds and death in minutes—facts most lay people do not understand. *State v. Lui ,* 221 P.3d 948, 950 (2009) (manual strangulation would have resulted in death in four minutes); *Johnson v. State,* 969 So.2d 938, 944 (2007) (three to five minutes). An expert can also explain physiological reasons why victims of strangulation often do not understand what has happened and why victims may be combative or agitated when police respond.

In addition, an expert who has received training in the specifics of strangulation injuries, who has cared for or who has observed strangulation victims, can assist the jury by offering an opinion as to the victim's various emotional and physical reactions to being strangled or whether in fact the victim was strangled. The expert may do the latter by observing photographs or

opining based on a hypothetical facts -- a proper and permitted use of an expert. Evid. Code §801(b); s*ee also* CALJIC 2.82. An expert may also perform demonstrations or use props to help explain to the jury the intricacies of strangulation.

In sum, because most jurors are unfamiliar with strangulation, its symptoms and the appearance of strangulation injuries, Ms. Carney's testimony is necessary to provide the jury with the information it will need to resolve disputed factual issues.

C. EXPERT TESTIMONY REGARDING STRANGULATION IS PROPERLY ADMITTED THROUGH A MEDICAL EXPERT

Courts have determined that a diagnosis of the cause of pain or other bodily condition is a matter exclusively for medical experts. *See Perkins v. Sunset Telephone & Telegraph*, 155 Cal. 712, 715 (1909) ("an expert surgeon may state generally the sort of agency, means, or instrument which may have produced a given injury"); *Ramona v. Superior Court*, 57 Cal. App. 4th 107 (1997). "No line of inquiry is more thoroughly within the scope of a legitimate examination of an expert surgeon than that relating to the probable cause of a physical injury." *Perkins*, 155 Cal. at 716. Such a diagnosis is exclusively within an expert's domain when the diagnosis depends on the knowledge, skill or experience of medical experts and is not in the common knowledge of lay jurors. *See Truman v. Vargas*, 275 Cal. App. 2d 976 (1969), *Norden v. Hartman*, 111 Cal. App. 2d 751 (1952).

Further, a qualified expert may opine upon the origin of strangulation marks. In *People v. Rollison*, 2003 Westlaw 21966312 (Cal. App. 2 Dist.) at *2-*3 (Aug. 19, 2003) (slip opinion), a

family nurse practitioner was found to be qualified to testify about the origin of strangulation marks on a victim's neck. Additionally, a medical expert may opine upon whether a particular action by defendant could produce the injuries sustained. *Perkins,* 155 Cal. at 715-6. Further, an expert can help the jury understand the degree of force used to inflict the injury. *People v. Knapp*, 16 Cal. App. 682, 282 (1911).

An expert may opine upon the means or cause used to inflict the given injury based on the appearance of the injury. *People v. Wiley*, 18 Cal. 3d 162, 166 (1976); *People v. Jackson,* 18 Cal. App. 3d 504 (1971); Evid. Code §801. In fact, courts regularly allow expert testimony regarding the ultimate issue, such as the cause or probable cause of a victim's death. *People v. Mayfield*, 14 Cal. 4th 668, 766 (1997), *as modified on denial of reh'g* (Mar. 19, 1997); *Francis v. Sauve*, 222 Cal. App. 2d 102, 118 (1963).

II. AMY CARNEY IS QUALIFIED TO TESTIFY AS A STRANGULATION EXPERT BASED ON HER EXPERIENCE, TRAINING OR EDUCATION

A. EXPERT QUALIFICATION MAY BE BASED ON EXPERIENCE ALONE

The court must decide by a preponderance of the evidence whether a person is qualified to testify as an expert witness. Evid. Code §405. A person may qualify as an expert witness based on her "special knowledge, skill, experience, training or education." Evid. Code §720. Furthermore, "a witness' special knowledge, skill, experience, training, or education may be shown by any otherwise admissible evidence, including [her] own testimony." Evid. Code §720(b).

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A potential expert witness should not be excluded simply because he or she has never previously qualified as an expert witness. *McCleery v. City of Bakersfield,* 170 Cal. App. 3d 1059 (1985). Further, questions as to the degree of the expert's knowledge go to the weight of the testimony rather than its admissibility. *People v. Rance*, 106 Cal. App. 3d 245, 255 (1980); *see also* CALJIC 2.80.

Experience and education alone may qualify an expert witness. *Rollison*, 2003 Westlaw 21966312 at *2-*3; *see also* Evid. Code §§720(a), 801(b). The Court in *Rollinson* qualified a family nurse practitioner as an expert witness regarding strangulation based solely on her degree and experience. "No more was required." *Id.* at *3. The nurse testified that she had worked in hospital emergency departments, had examined 50-100 sexual assault victims including 20 strangulation victims and their injuries, and testified about her experience with "choke" marks. *Id.* at *2. Once qualified, the expert nurse then testified to the appearance of the marks, stating that they were the same width as a finger and were as close together as the fingers are in the hand. The expert witness testified that in her expert opinion, the victim "'had a hand around her neck and that's what made the marks.'" *Id.*

Experience alone may also qualify an expert witness. In *People v. Rance,* 106 Cal. App. 3d 245, 255 (1980), the court upheld the trial judge's decision to permit an emergency room nurse to testify that in her opinion the victim had been "physically violated by bruises," that she "had physical violence put upon her by someone else." The court concluded that she was qualified to render such an opinion:

> Here the witness had been a registered nurse for seven and a half years, and prior to working in the emergency room at Cottage Hospital she worked two winters in the emergency room clinic at UC Davis Medical Center. She took care of all kinds of

> patients who came through the door, including trauma victims. [¶] The trial court could reasonably conclude that even though she was not a medical doctor she had sufficient experience in observing wounds and bruises of victims of trauma to be capable of rendering an opinion that violence had been inflicted upon Miss S. *Id.*

Similarly, in *People v. McAlpin,* 53 Cal. 3d at 1289, the court approved the trial court's decision to qualify a police officer as an expert witness based solely upon his experience. The officer's expertise was necessary to explain why children and their parents might fail or delay reporting instances of child sexual abuse. The officer had investigated over one hundred child abuse cases during the preceding four years. He had received specialized training from a wide variety of sources, and he used what he learned on a daily basis. The court found the officer's experience to be a sufficient background to allow the officer to give expert testimony. *Id.*

B. AMY CARNEY IS A QUALIFIED STRANGULATION EXPERT

Ms. Carney has previously qualified as an expert witness in numerous sexual assault or domestic violence cases. In these cases, Ms. Carney has opined upon the origin of marks on a victim's body, explained various types of wounds, bruises, abrasions, bite marks or other injuries on trauma victims, and educated jurors as to the cause of injuries and the force required. Ms. Carney has qualified as an expert at least five times in sexual assault cases and once in a domestic violence case **[update]**. Moreover, Ms. Carney has examined upwards of 50 strangulation victims **[update]**.

Ms. Carney's medical background and experience in evaluating strangulation and other trauma patients makes her a particularly qualified expert witness regarding strangulation. Ms. Carney is a Board Certified Family Nurse Practitioner and has been involved in the medical field since 1977. In 2000, Ms. Carney became Certified in Basic Forensic Pathology, which includes strangulation. Ms. Carney has also trained alongside Dr. George McClane, the leading

strangulation expert in San Diego County. Ms. Carney is also a Sexual Assault Nurse Examiner (*see Rollison*, 2003 Westlaw 21966312 at *2), as well as a former San Diego County Paramedic.

Ms. Carney has worked in emergency response situations where she has assessed, evaluated and aided patients, including domestic violence or sexual assault victims who have been strangled. Ms. Carney has extensive experience in observing and documenting injuries, including strangulation, and is capable of rendering an opinion about such injuries. See *Rance*, 106 Cal. App. 3d at 255 (registered nurse qualified as expert in sexual abuse case and testified based on her experience in having observed wounds and bruises on trauma victims).

She has been trained specifically in handling strangulation patients not only through formal coursework, but also in the professional workshops and courses she attends regularly (*see* Ms. Carney's Curriculum Vita). Recently, Ms. Carney attended a two-day strangulation workshop at the International Domestic Violence, Sexual Assault and Stalking Conference. Additionally, Ms. Carney is regularly asked to teach and present regarding strangulation.

In sum, Ms. Carney has sufficient knowledge, education, medical training or experience to qualify as an expert on strangulation. Her experience and training is beyond jurors' common knowledge and her opinions will assist the jury in understanding the physical injuries associated with strangulation, among other things. Moreover, Ms. Carney has seen upwards of 50 strangulation victims and qualifies as an expert witness on that basis alone.

CONCLUSION

For the foregoing reasons, the People respectfully request the court admit the proposed strangulation expert's testimony.

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Questions for Strangulation Expert
(Developed by Dr. George McClane, Dr. Dean Hawley, and Gael Strack, JD)

Qualifications of Expert:

1. Name
2. Title
3. Current Employer?
4. Current duties?
5. Years employed in your current position?
6. Prior work experience?
7. Education?
8. Medical training?
9. Strangulation Training?
10. Licenses?
11. Certificates?
12. Professional organizations?
13. Teaching experience?
14. Published writings?
15. Previously qualified as an expert witness?
16. How many times?
17. Testified for prosecution?

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18. Testified for the defense?
19. Provided expert consultation in cases that did not result in trial?
20. Consult with prosecution?
21. Consult with defense?
22. Examine patients who have reported being strangled and survived?
23. How many have you examined as a treating physician?
24. Are you comfortable testifying today as an expert in the area of strangulation?

Questions for expert 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:
5. Define hypoxia?
6. What happens to the brain when there is a lack of oxygen after 10 seconds? 20? 30? 1 minute? 2 minutes? 3 minutes? 4 minutes?
7. What is hypoxic encephalopathy?
8. Define asphyxia:
9. What is the difference between hypoxia and asphyxia?
10. What happens to the brain when there is asphyxia or an interruption of

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oxygenation?

11. Can the lack of oxygen to the brain result in either temporary or permanent brain injury?
12. Other than unconsciousness, are there other signs of temporary hypoxia or asphyxia?
13. What do you mean by behavioral changes?
14. How much external pressure and time does it take to cause unconsciousness?
15. What are some 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?
18. What are the variables?
19. Please explain the “point of no return” that occurs after 50 seconds of continuous strangulation, with a complete disruption of oxygen supply to the brain:
20. How much external pressure must be applied before death occurs?
21. What are some of the variables?
22. Aside from unconsciousness, or behavioral disorders, are there other signs and symptoms of having been strangled?
23. Would a chart or charts help you explain those signs and symptoms?
24. Did you bring any charts with you today or may I direct to you to:

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25. Please describe the external signs of attempted strangulation?
26. Where would you find visible findings such are redness, scratch marks, impression marks, or claw marks?
27. Describe how Petechiae are formed.
28. Where can Petechiae be seen on victims after strangulation has occurred?
29. What do Petechiae look like?
30. How long do they last?
31 Are there other causes for Petechiae other than strangulation?
32. What are some of those causes?
33. How are these Petechiae different from the ones seen in strangulation?
34. Why could there be swelling to the neck from strangulation?
35. Are there other internal injuries associated with strangulation or hypoxia?
36. Why would cause the tongue swell?
37. What are some of the symptoms of attempted strangulation?
38. Why would strangulation cause voice changes?
39. Why would strangulation cause swallowing changes?
40. Why would a victim who's been strangled vomit or feel like vomiting?
41. Why would a victim who's been strangled urinate or defecate?
42. What if a victim didn't urinate or defecate, but felt like s/he was going to?

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43. Can the signs of a victim who survives strangulation be similar to the signs on a victim who has died as a result of strangulation?

44. Is there a way to tell how close a strangulation victim has come to death?

45. Are all strangulation cases serious?

46. What information and/or documents did you review in this case prior to testifying?

47. From your review, what were the signs and symptoms the victim exhibited?

48. In your opinion, are those signs and symptoms consistent with someone who has been strangled?

49. Is it your opinion that the application of force to the victim's neck for * seconds could cause internal injury?

50. Is it your opinion that the victim suffered internal injury? Serious injury? Potentially great bodily injury?

Below are questions for you may consider asking in a homicide by strangulation case (courtesy of San Diego County Deputy District Attorney Dan Goldstein):

1. Are you a medical examiner?
2. How long have you been a medical examiner?
3. What specific training goes into becoming a medical examiner?
4. What are your duties?
5. What is an autopsy?
6. How many autopsies have you conducted in your career?

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7. Have you testified in court?
8. What is a witnessing pathologist?
9. Were you the witnessing pathologist on *** during an autopsy of the victim?
10. Who was the pathologist?
11. Did you review the pathologist's report?
12. Please describe the external trauma of the victim that you saw.
13. Ask the witness to describe photos and injuries.
14. Ask the witness to describe any injuries to the eyes, face, and mouth.
15. Ask the witness to describe internal injuries.
16. What was the cause of death?
17. What are the reasons you believe the victim died from strangulation?

GLOSSARY
"On-Line Medical Dictionary"
www.graylab.ac.uk

Abrasion: A superficial injury to the skin or other body tissue caused by rubbing or scraping resulting in an area of body surface denuded of skin or mucous membrane.

Aphonia: The inability to produce speech sounds.

Apnea: Cessation of breathing.

Artery: Blood vessel carrying blood away from the heart.

Asphyxia: A condition caused by inadequate intake of oxygen.

Aspiration pneumonitis: The act of inhaling vomit into the lungs which causes inflammation of the lung secondary to viral or bacterial infection.

Autoerotic asphyxia: A case of accidental asphyxia during autoerotic activity. (This is not a suicide or a homicide.) It is the practice of using strangulation to enhance the pleasure of masturbating. Annually it claims the lives of between 250 and 1,000 young American men (Garza-Leal & Landrom, 1991, Wesselius & Bally, 1983).

Carotid artery: A key artery located in the front of the neck that carries blood from the heart to the brain.

Dysphagia: Difficulty swallowing.

Dysphonia: Involves the muscles of the throat that control speech. Also called spastic dysphonia. It caused strained and difficult speaking and effortful speech.

Dyspnea: Shortness of breath. Difficult or laboured breathing.

Ecchymosis: A small hemorrhagic spot, larger than petechia in the skin or mucous membrane forming nonelevated, rounded or irregular, blue or purpish patch. (A bruise).

Edema: The presence of abnormally large amounts of fluid in the intercellular tissue spaces of the body, usually applied to demonstrable accumulation of excessive fluid in the subcutaneous tissues . Edema may be localized due to venous or lymphatic obstruction or to increased vascular permeability or it may be systemic due to heart failure or renal disease. (Swelling).

Erythema: A name applied to redness of the skin produced by congestion of the capillaries

which may result from a variety of causes, the aietiology or a specific type of lesion often being indicated by a specific term. (Red marks).

Hemorrhage: The escape of blood from the vessels, bleeding.

Hemoptysis: The expectoration of blood or of blood strained sputum (coughing or spitting up blood).

Hyoid bone: The bone at the base of the tongue.

Hypoxia: Reduction of oxygen supply to the tissue below physiological levels despite adequate perfusion of the tissue by blood. (Cf. Anoxia).

Incontinence: The inability to control excretory functions, as defecation (fecal incontinence) or urination (urinary incontinence).

Laceration: The act of tearing. A torn, ragged, mangled wound.

Jugular Veins: The veins in the neck which drain the brain, the face and neck into the brachiocephalic or subclavian veins.

Larynx: The voice box.

Odynophagia: Pain on swallowing.

Petechia: A pinpoint, nonraised, perfectly round, purplish red spot caused by intradermal or submucous hemorrhage.

Pneumonia: Inflammation of the lungs with consolidation.

Pulmonary: Pertaining to the lungs.

Pulmonary emphysema: Condition of the lungs characterized by increase beyond normal in the size of air spaces distal to the terminal bronchioles, either from dialation of the alveoli or from destruction of their walls.

Sphincter: A ringlike band of muscle fibres that constricts a passage or closes a natural orifice, also called musculus sphincter.

Strangulation: The act of strangling or the state of being strangled. (Medical) Inordinate compression or constriction of a part of the throat that causes a suspension of breathing, of the passage of contents, or of the circulation.

Stridor: The harsh sound heard on inhalation caused by air passing through a constricted passage (rasphy breathing).

Subconjunctival: Situated or occurring beneath the conjunctiva which is a clear membrane that coats the inner aspect of te eyelids and the outer surface of the eye.

Subcutaneous: Under the skin

Subcutaneous emphysema: The presence of air in the subcutaneous tissue.

Thyroid cartilage: The largest cartilage of the larynx consisting of two laminae fusing anteriorly at an acute angle in the midline of the neck. The point of fusion forms a subcutaneous projection known as the adam's apple.

Trachea: The windpipe. A fibrocartilaginous tube lined with mucous membrane passing from the larynx to the bronchi.

Vein: Blood vessel that returns blood from the microvasculature to the heart, walls thinner and less elastic than those of artery.

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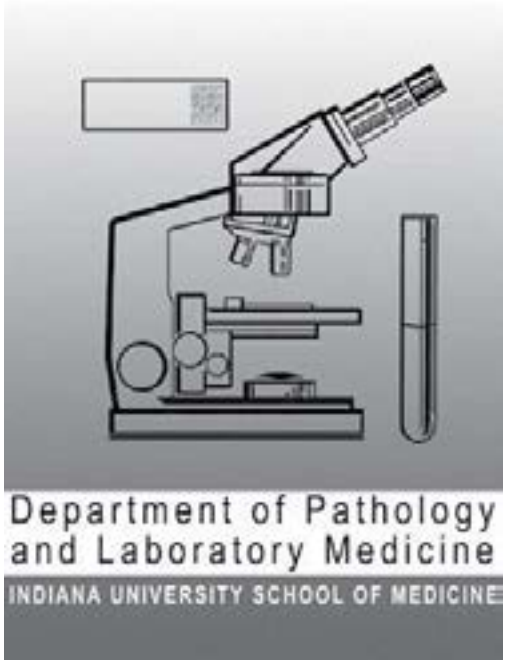
Injuries of Fatal and Non-fatal Suffocation in Family Violence Cases



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Suffocation is a mechanism of injury and death for children and adults, where the pattern of injuries may be very difficult to detect, and the injured victim is often not able to give a story about the injury. Suffocation also tends to occur in certain predictable relationships between the perpetrator and victim. Suffocation may be found as a simultaneous event during a strangulation assault, but for infants and frail dependant elders it is sometimes seen as the only mechanism of assault. Data has been collected on the frequency of this mechanism of injury. Cases will be reviewed for infants and at-risk elders, and there will be a discussion of the injury patterns seen when suffocation is used simultaneously with strangulation during an assault. Alaska, like many other states, has worked through the language of suffocation injury in developing specific state criminal statutes. This workshop will review the data and evidence behind suffocation assault cases, but also focus on suffocation as it occurs for infants and dependent elders.

OBJECTIVES:

1. Review the criminal statutes on suffocation in intimate partner relationships, and learn to recognize the medical evidence that may be found in these cases.

2. Learn to recognize some of the subtle medical findings that may indicate criminal suffocation assault as the mechanism of death for infants, dependant elders, and battered women, and learn the scene investigative clues that help distinguish a criminal suffocation assault, from an accidental suffocation.

INFANTS

Proof of child abuse, whether fatal or not, requires expert medical testimony. In the past, testimony from non-medical welfare or social workers, police officers, or school teachers has served in substitute for medical evidence. Now, proof of child abuse depends on expert medical opinion; and probably also requires physical evidence to include at least photographs of the injuries. Defense arguments often center on the potential for the injuries to have occurred accidentally, in falls or play-mishaps in the home.[1, 2, 3, 4, 5, 6] Comparison of blunt force injuries to alleged weapons is a standard procedure for proof or physical child abuse. Unfortunately, there are cases of serious -- even fatal -- child abuse where there is no external evidence of trauma. "Subtle child abuse," a term coined in 1980 by Zumwalt and Hirsch for these inconspicuous cases, now includes all of the following.[7]

1. **Nutritional abuse ("failure to thrive")**
2. **Suffocation (smothering)**
3. **Shaken infant syndrome**

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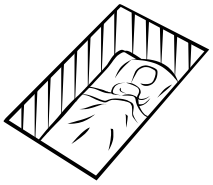
4. Munschausen's syndrome by proxy



Suffocation or smothering as a fatal assault is virtually indistinguishable from other natural (i.e. SIDS) and accidental (i.e. drowning, entrapment in bedding, aspiration of a toy or food) forms of asphyxial death.[8, 9, 10, 11, 12, 13] Although careful scene investigation may facilitate determining the mechanism of asphyxiation in some cases, the majority of asphyxial deaths remain undetermined.[14, 15, 16, 17] Passively ingested cocaine has been detected in otherwise completely normal-appearing dead infants.[18] Much public attention has been directed toward a 1992 statement by the American Academy of Pediatrics that Sudden Infant Death Syndrome may be caused by face-down sleeping posture of infants in cribs.[19, 20, 21, 22] Since 1993, maternity hospitals have taught new parents to place infants face-up in cribs, and there has been a dramatic decline in SIDS rates nationwide. Keep in mind that other obscure factors have also been alleged to cause sudden asphyxial death in infancy. Childhood vaccines--most recently hepatitis B vaccine--have been alleged to cause sudden asphyxial deaths, and this claim has been categorically disproved with scientific study.[23] Smothering by overlying when adults sleep with infants is a very real and frequent event. Intoxication and obesity increase the risk of overlying.[24]

Suffocation, by obstruction of breathing, can occur as a component of homicidal assault, and can also occur by accident. Covering the mouth and nose by hand, or using a pillow, plastic bag or other object, may result in death by anoxic encephalopathy. Homicidal suffocation is particularly implicated in cases where the victim is especially vulnerable, such as babies, the diseased elderly, or adults significantly impaired by intoxication with alcohol or drugs.[25, 26, 27, 28, 29, 30, 31, 32]

Battered Women

In domestic violence relationships, strangulation and suffocation assaults are a demonstration of the abuser's exercise of power and control .[34-42] Strangulation is an escalation of dangerous behavior, associated with increasing risk of serious injury or death.[43, 44, 45] New and evolving state penal statutes, and risk assessment screening tools, are targeting strangulation and suffocation behavior to better protect victims of domestic violence.[46, 47, 48, 49, 50] Most of the available data on the relationship between strangulation and domestic violence comes from studies that include victims of all ages. Data on suffocation, particularly in domestic violence situations, is extremely limited. This may be because the event is difficult to detect and even more difficult to prove. One state, Alaska, has incorporated "suffocation" into its criminal statutes.[50]

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As a general principle for suffocation assaults of battered women, these incidents commonly occur simultaneously with a strangulation assault. That is, both the suffocation and the strangulation are occurring at the same time, or at least as a component of the same interval of assault. The most typical scenario is for the victim to be on her back on the bed or floor, with the assailant sitting on top of her, while the assailant is strangling her. the pressure of his body down onto her chest or abdomen reduces her ability to expand her chest wall during inspiration thereby producing a "positional asphyxiation." Other variations of these combined contacts are possible, including using his hand to cover her mouth to prevent screaming, but in that act also obstructing her breathing. Duct tape over the mouth and/or nose, again sometimes to prevent the victim from screaming, is another type of suffocation.[51] In aggregate, the suffocation changes the typical injury pattern observed by the concomitant strangulation assault, in that the suffocation can induce petechiea in a pattern not expected from strangulation alone.[51] In singular strangualtion assault, the petechiae will be only above where the force was applied to the neck.[36, 44] In suffocation, the petechiae can be throughout the body, and especially over the visceral surfaces of the internal organs, like the epicardium of the heart and the pleura of the lungs, just like with children who suffocate.[19, 20, 32, 51] In one study of the effect of suffocation and strangulation on body temperature after death, Demierre et al reported that suffocation and strangulation can result in an unexpected postmortem hyperthermia, and this may be a useful indicator of the mechanism of death in cases were that mechanism might otherwise be undetected.[52]

Dependent Elders

Suffocation homicide of dependent elders is a topic that deserves special separate discussion, owing to the fact that these incidents are so difficult for field death investigators to detect. In general, elder abuse goes undetected. For every one case of elder abuse or neglect that is reported, five go unreported.[53] Safarik, et al pointed out that recognition of the types of offender behaviors can improve detection of crimes in which the victim's advanced age may mask the actual cause of death.[54] One purpose for separately discussing elder strangulation cases is to provide death scene investigators with information that may help direct decisions about whether an autopsy is warranted, when the scene investigation otherwise simply indicates advanced age, complex natural disease, and little or no external evidence of violent crime.

The finding that strangulation (as the cause of death) increases in frequency with the victim's age was reported by Safarik, et al, in their study of elder sexual assault homicides.[54] This finding is surprising given that strangulation actually becomes more difficult to detect in elder death investigations.[54, 55] Strangulation and suffocation, which also occur at a greater frequency in domestic violence relationships [3], may be fatal without external evidence of injury

on the body [4, 12], and cases of strangulation or suffocation occurring in medically-disabled elders will be missed unless investigators develop suspicion at the scene.[21, 54]

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Forensic Medical Findings in Fatal and Non-fatal Intimate Partner Strangulation Assaults

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Autopsy examination in cases of fatal strangulation is a procedure that has probably not changed very much in the last few decades. In fact, perhaps the best medical scientific paper ever written about examination of strangulation victims was published by Gonzales in 1933, relying on European references from the 19th century.[1] The process of strangulation, whether by hand (manual), or by ligature, results in blunt force injury of the tissues of the neck. The pattern of these injuries allows us to recognize strangulation as a mechanism, and to distinguish strangulation from other blunt injuries including hanging, traumatic blows to the neck, and artifacts of decomposition. [2, 3, 4, 5, 6, 7, 8, 9, 10] Strangulation is not always fatal, it does produce medical signs and symptoms for survivors, and the non-fatal assaults are very typical of domestic violence.[11, 12, 13, 14]

It is no coincidence that the best medical evidence of strangulation is derived from post mortem examination (autopsy) of the body, but even in living survivors of strangulation assaults it may be possible to recognize a pattern of injury distinctive for strangulation. At autopsy we can exam all of the tissues of the neck, superficial and deep, and track the force vector that produced the injuries. In living people, we are left with superficial examination of the skin, and two-dimensional shadows by radiography.[15, 16] Oftentimes, even in fatal cases, there is no external evidence of injury[17]. While patterned abrasions and contusions of the skin of the anterior neck are typical of strangulations cases, some cases have no externally evident injury whatsoever. The injuries that may occur include patterned contusions and abrasions caused by fingernails, finger touch pads, ligatures, or clothing. These injuries are then prone to change over time, with the healing process. Injuries not at all apparent on the day of death may actually become visible by the next day, as the skin begins to dry and become more transparent. Strangulation injury may be observed by a dentist during routine dental examination.[18

Much medical research has been published on the findings of strangulation, owing to a no-longer promoted practice by police agencies wherein “choke holds” were trained and practiced as a way for officers to subdue suspects.[19, 20, 21, 22] The summary experience with choking for control of suspects -- also called the “carotid restraint hold” ,“shime waza”, or “the sleeper hold” -- is that death can ensue without the intent of the officer, and without leaving external marks on the body. The likelihood of death during neck compression increases if there is advanced age, coronary artery disease of the heart, intoxication with stimulant drugs, or prior brain injury.[19] To quote Drs. Reay and Eisele, “Use of neck holds (by police officers) must be viewed in the same way as firearms; the potential for a fatal outcome is present each time a neck hold is applied and each time

a firearm is drawn from its holster. The neck hold differs in that its fatal consequence can be totally unpredictable."[19]

In addition to the blunt force injuries of the neck, strangulation produces evidence of regional venous obstruction in the neck, recognized as pinpoint hemorrhages (petechiae) in the skin, conjunctiva of the eyes, and deep internal organs of the head and neck, geographically located above the point of constriction in the neck.[23, 24] Ear bleeding has been reported as an infrequent finding in fatal strangulation, related to the mechanism of petechiae.[25] A localized geographic distribution of petechiae develops because the veins are obstructed at the level of the stranglehold, but the arteries are still open, allowing the distal capillaries and venules to over-fill with blood, and rupture. If a medical blood pressure cuff is placed around the left upper arm, and inflated to a pressure that is high enough to obstruct the veins, but that pressure is sustained low enough to leave the arterial flow open, then there develops a regional, geographic distribution of petechiae in the left hand, and left forearm. This happens promptly, and it will not be associated with petechiae anywhere else in the body. The petechiae are confined to the geographic distribution of blood vessels distal to the point of application of force.

The necessary event for creating a localized geographic distribution of petechiae in the head is a pressure high enough to obstruct venous return, but low enough to allow continued arterial filling, and then sustaining that pressure long enough so that the local capillaries and venules over-fill, and rupture under arterial pressure. If the pressure is so great as to obstruct the arterial flow, then there may not be geographic petechiae, but there could still be death. If the pressure is not sustained for long enough to over-fill the blood vessels, then there may not be petechiae, but there could still be death by cardiac arrhythmia, as discussed later.

In addition to the localized, geographic distribution of petechiae sometimes observed with strangulation, one may also have generalized petechiae. Generalized petechiae are a non-specific finding, not specifically related to strangulation by sometimes found in strangulation assault as well as a myriad of other complex circumstances and illnesses. Generalized petechiae can develop from any cause of elevated central venous pressure including, but not limited to, suffocation by pressure on the chest or abdomen. Generalized petechiae in this context are the result of centrally-elevated venous pressure in the chest, rather than a focal or regional venous compression such as a strangulation or a blood pressure cuff on the arm. The causation of increased venous pressure by physical force applied to the chest and abdomen can be a deliberate inflicted injury of suffocation, such as the assailant sitting on the victim's chest or abdomen during an assault, or it can occur by accident such as entrapment beneath a motor vehicle when a mechanic is working on the

underside of the car and the jack fails. In a medical context, suffocation resulting in elevated central venous pressure and generalized petechiae can happen when medical patients attempt to climb out of hospital beds, and become entrapped in bed rails. Smothering by obstruction of the mouth and nose, (a variant of which is the "sudden infant death syndrome" by face-down sleeping posture for infants), aspiration of gastric contents, profound depressant drug intoxication, and some natural diseases with congestive heart failure can also result in generalized petechiae by increased intra-thoracic negative pressure. In these cases the petechiae do not arise as a result of the asphyxiation alone, but via the elevation in central venous pressure. Drowning and suffocation within an inflated plastic bag (oxygen-deprived atmosphere) are less likely to produce generalized petechiae because the mechanism for increased central venous pressure is absent.[26] Further, generalized petechiae can occur from disorders of blood coagulation, like leukemia, some bacterial infections, excess levels of anticoagulant medications, and other medical circumstances completely unrelated in increased central venous pressure. By these combined mechanisms, simultaneous strangulation and suffocation, when the assailant is sitting on top of the victim while strangling, can result in both geographic and the generalized petechiae. The presence of petechiae does not prove strangulation, and the absence of petechiae does not disprove strangulation.[27] In addition to petechiae, one may also (rarely) find interstitial free air in the lung or mediastinum.[28, 29]

Fingernail marks are superficially incised curvilinear abrasions, occurring singly or in sets. In rare cases, all four fingers will mark the skin in a single pattern.

Fingernail marks are rarely associated with the assailant's hands, but commonly associated with the victim's own fingers, as she struggles to pry the assailant's grasp off her neck. Finger touch pad contusions are caused by the assailant's grasp. The thumb generates more pressure than the other fingers, so singular thumb impression contusions are found more often than contusions showing the complete hand grasp. Ligature abrasions follow a predictable pattern of horizontal circumscription about the neck; distinguishable from the marks left by suicidal hanging, where a suspension point causes the ligature furrow to rise toward one ear.

A common scenario for homicidal strangulation is that the individual is found dead, often reported by the assailant, with a vague history of substance abuse or depression. There being no externally-evident injury, the body is taken for autopsy with a suspicion of drug overdose, and the injury of strangulation is not found until the neck dissection is carried out at autopsy, ordinarily at the end of the case. Therefore, photographs and trace evidence collections are not made.

The scene investigation may be useful in identifying strangulation assaults, based on blood spatter and ligatures.[30] Rarely, the latent fingerprints of the assailant may be recovered from the skin of the victim's neck.[31, 32, 33] Of research interest, it may be possible to actually recover the assailant's skin cells from the victim's injured neck, and DNA-type the recovered cells to the suspect.[34, 35]

Ultimately, a medical opinion of strangulation as the mechanism of neck injury will be based on a complete examination of the patient's neck, either at autopsy or by radiography, to detect superficial and deep injuries fitting a pattern that supports the diagnosis. A common cited injury is fracture of the hyoid bone, actually only found in a minority (no more than one third) of all fatal strangulations.[36, 37, 38, 39, 40, 41, 42] One must keep in mind that the seriousness of the internal injury may take a few hours to be appreciated, and delayed death has been reported.[43, 44]

Autopsy examination of the neck includes complete dissection with removal of the larynx including the hyoid bone, and preferably with the tongue attached. The superficial and deep musculature must be individually examined for contusion hemorrhage. The laryngeal skeleton is then exposed to examine for cartilage fracture. Finally, the cervical spine may be opened and examined for injury.

There is considerable folklore about the neck injury in judicial hanging, including the notion that radical displaced fractures occur. So, common misconception allows that there will be fractures or some sort of internal neck injury in people who hang themselves. In fact, in suicidal hanging there is rarely any internal evidence of neck injury at all. Suicidal hanging is usually affected with very little force. Although there is evidence in the medical literature that neck injury occurs during alleged suicide hangings in Serbia, such injuries are rarely encountered in cases in North America.[45, 46] There are different physiologic mechanisms involved in suicidal hanging, depending on the forces provided by the mechanism as constructed by the decedent.[47] Suicidal hanging is usually painless, and can be accomplished even when lying down in bed. External injury including the dramatic "rope burns" or ligature abrasion only occurs after the body has been suspended for several hours after death.[48] If the ligature is released at the moment of death, there will be no mark in the skin. Leave the body hang suspended by the ligature for a few hours, and a very dramatic furrow and ligature abrasion will develop post-mortem.

Immediate death from hanging or strangulation can progress from one of four mechanisms:

1. **cardiac arrhythmia may be provoked by pressure on the carotid artery nerve ganglion (carotid body reflex) causing cardiac arrest**

2. **pressure obstruction of the carotid arteries prevents blood flow to the brain**
3. **pressure on the jugular veins prevents venous blood return from the brain, gradually backing up blood in the brain resulting in unconsciousness, depressed respiration, and asphyxia**
4. **pressure obstruction of the larynx cuts off air flow to the lungs, producing asphyxia**

Item number 1(carotid body reflex arrhythmia) must be very uncommon. The reflex cardiac arrhythmia can be reproducibly demonstrated in humans, but force must be applied over a very localized and specific anatomic area.[19, 20, 21] Item number 2 (carotid artery occlusion) must also be very uncommon in suicidal hangings, but may be more frequent in homicidal strangulations. Quite a bit of pressure is required to obstruct arterial flow in the carotids, and that amount of force would typically be associated with obvious soft tissue injury locally within the neck muscles or soft tissue planes. Physiologic study has disclosed the forces, location and timing for development of cerebral hypoxia and loss of consciousness with carotid compression by strangulation.[49] When the force is promptly sufficient to obstruct carotid arterial flow, petechiae will not develop.[24] Blunt force injury of the carotid arteries is oftentimes fatal due to arterial thrombosis, stroke, or dissection of the arteries.[50, 51, 52] Carotid artery injury by non-fatal strangulation may also result in delayed stroke with visual defect.[53] Item number 3 is probably the usual route for death by suicidal hanging.[5, 6, 7] Suicidal hanging is often accomplished by standing, sitting or lying with the neck supported by a suspended ligature, so that escape is possible by just standing up or sitting upright. Jumping into the ligature, from a ladder or tree limb is less common. Testing of the ligature, experimenting with the apparatus or checking out the pain threshold is accomplished with slight and completely voluntary pressure applied against the ligature. This pressure fully or at least partially obstructs venous return in the jugular veins, gradually causing passive congestion of blood in the vessels within the brain. This diminishes oxygen delivery to the brain, eventually resulting in loss of consciousness. The type of pressure required is slight, but prolonged. Unconsciousness probably doesn't occur for several minutes, but the overall process is completely painless. Once unconscious, the full weight of the suspended part of the body becomes supported by the ligature, and death ensues. In the practice of autoerotic sexual asphyxia – a behavior of intentional ligature hanging – the asphyxia is alleged to be associated with sexual arousal.[54] Autoerotic asphyxia (discussed in more detail below) is occasionally seen resulting in accidental death in males. But to quote Byard, "autoerotic asphyxial activity by women is a rarely described phenomenon."[55] In cases of suicidal hanging, eventually the individual becomes unconscious, then Item 4 takes over. With the person unconscious, the full weight of the suspended part of the body falls against the ligature, creating enough pressure to restrict air flow through the trachea. Then, irreversible asphyxiation follows in just a few minutes. In a review article posted on

the medical internet service "UpToDate" accessed in November 2012, Ulrich and Goodkin wrote a dissertation titled, "The Choking Game and Other Strangulation Activities in Children and Adults," wherein they reviewed prior scientific measurements of the timing for loss of consciousness, permanent brain damage, and death during strangulation and suffocation:

> **Cerebral hypoxia and hypoperfusion** — Several elements of strangulation activity may result in cerebral hypoxia. These include breath holding, external limitation of chest wall expansion, and compression of the carotid arteries.* Compression of the carotid sinuses further reduces cerebral oxygenation through reflex bradycardia and vasodilation.*
>
> Acute severe hypoxia can cause loss of consciousness in 10 to 20 seconds, permanent brain damage in three minutes, and death in four to five minutes.** Hypoxia that is less severe can cause impaired judgment, drowsiness, dulled pain sensation, excitement, disorientation, and headache.** Other symptoms and signs of hypoxia include anorexia, nausea, vomiting, tachycardia, and tachypnea; hypertension occurs when hypoxia is severe.
>
> The effects of arrest of cerebral circulation were evaluated in a study that was performed before the Belmont Report (which outlines ethical principles and guidelines for the protection of human subjects).*** Complete arrest of cerebral circulation for 5 to 10 seconds resulted in a rapidly reversible loss of consciousness and convulsive syncope that was preceded by an aura of visual blurring and constriction.
>
> *Ullrich NJ, Bergin AM, Goodkin HP. "The choking game": self-induced hypoxia presenting as recurrent seizurelike events. Epilepsy Behav 2008; 12:486.
>
> **McPhee SJ, Ganong WF. Respiratory adjustments in health and disease. In: Pathophysiology of Disease: An Introduction to Clinical Medicine, 5th ed, McGraw-Hill, New York 2005
>
> ***Rossen R, Kabat H, Anderson JP. Acute arrest of cerebral circulation in man. Arch Neurol Psychiatry 1943; 50:510.

A determination of whether a neck assault has caused "serious bodily injury," or whether that assault resulted in "a significant risk of serious bodily injury," is a dilemma for medical experts. Such an opinion could easily "invade the province of the jury," in a criminal matter, and may actually be a burden of proof or element in a criminal case, rather than language that should be used by a medical expert in offering an opinion about injury risk. A study by Plattner, et al attempted to define this risk, based on the temporal relationship of skin injury, deep muscle injury, petechiae, and loss of consciousness; though the authors admitted that 29% of their population of fair-complexioned Swiss women failed to follow this progression. Plattner, et al did provide a scheme of "light, moderate, or severe life-threatening" strangulation assaults, but were only able to fit 71% of their cases into this scheme.[56] A subjective division of "life-threatening," and "non-life threatening" for internal MRI

image determination of strangulation injuries was offered by Christe, et al, followed by a discussion of the usefulness of MRI for survivors in determining "danger to life."[57, 58] One shortcoming of the data from Switzerland using MRI to detect internal injuries that are not externally evident is that these studies do not account for causations of injury other than the strangulation event. There is no mention in these papers of blunt force injuries, or injuries that could have been produced by co-occurring suffocation or positional asphyxia such as sitting on the chest or abdomen during the assault, so it is possible that the data reflect a composite of other modalities of injury during an assault. Notwithstanding the drawbacks, data coming out of Europe on intimate partner strangulation suggests a compelling argument in favor of a broad utilization of patient history, symptoms, clinical signs, and radiologic tests as a means of determining that an assault posed a significant risk of death for the victim. These studies also validate the earlier works suggesting hoarseness of voice, pain on swallowing, and breathing difficulty as cardinal clinical signs of strangulation, while also proving that loss of consciousness, urinary or fecal incontinence, and petechiae are strong indicators of a near-lethal experience for the patient. Non-fatal strangulation is a recognized risk factor for subsequent intimate partner homicide, whether by a repeat strangulation assault, or by some other violent act such as stabbing or gunshot.[59, 60]

Suffocation, by obstruction of breathing, can occur as a component of homicidal assault, and can also occur by accident. Covering the mouth and nose by hand, or using a pillow, plastic bag or other object, may result in death by anoxic encephalopathy. Homicidal suffocation is particularly implicated in cases where the victim is especially vulnerable, such as babies, the diseased elderly, or adults significantly impaired by intoxication with alcohol or drugs.[61, 62, 63. 64, 65, 66, 67,68]

In strangulation and suffocation cases, and some suicidal hangings where the individual is "saved" before death, there may be a prolonged period of survival with obvious brain damage, followed by death. This delay is the effect of loss of blood flow to the brain, with partial asphyxiation of the brain. The presence of asphyxial brain damage does not imply a specific mechanism, and there are many ways for asphyxiation to occur involving natural diseases, accidents, suicidal injury, and assaults. A study of the human gene regulatory response to strangulation, suffocation, and natural disease showed prompt and reaction for RNA transcription up-regulation in individuals who were killed by suffocation.[69] The vocabulary for the mechanisms of various asphyxia events is not consistently used in the medical literature; so it is even possible to find medical articles where "strangulation" is used to describe a suicidal hanging death. There has been a proposal for a unified classification scheme for the medical use of the vocabulary of asphyxial trauma; but there are authors and research investigators who have also pointed out definite

shortcomings to the dogmatic use of certain terms, like "traumatic asphyxia," and "compressional asphyxia."[70, 71]

A decrease in blood flow to the brain will produce a pathologic change called *anoxic encephalopathy*. Brain cells are not all equally sensitive to loss of blood flow. Some cells die soon, while others survive for days and eventually succumb to the delayed effect of oxygen deprivation. Nerve cell death may be patchy in the brain.[72] Certain localized parts of the brain are more susceptible to anoxia, and other areas are more resistant to anoxia. Fatal anoxic encephalopathy results in clinical "brain death" where the functions of the heart and internal organs can be maintained by medical life support, but all hope of meaningful recovery is lost. Complications may include persistent vegetative coma, cerebral edema (brain swelling), and herniation of the brain. For patients who do recover consciousness, lifelong brain damage may be observed. The damaged nerve cells have been shown to express a gene product, c-fos, which may be found within anoxically-damaged nerve cells.[73]

Quantitation of the actual forces applied to the neck is not a meaningful argument. The amount of force required to compress the jugular vein is less than the force to compress the carotid, and that in turn is less than the force required to constrict the airway. However, absolute values -- measured as foot-pounds of force -- must vary tremendously from one person to the next depending on development of neck musculature, and the surface area for the application of force. If the force were applied over a very narrow surface area -- a clothesline ligature as opposed to a broad belt for example -- then much less force would be necessary. Four variables are working simultaneously:

1. The quantity of applied force or pressure
2. The duration of time that the force is applied
3. The surface area over which the force is distributed
4. The exact specific anatomic location of the applied force

For the same amount of pressure, if you decrease the surface area, or increase the duration of the force, you increase the likelihood that the force will be fatal. Further, if even a small force is applied in just the right anatomic area, the force may obviate the normal anatomic protections of the neck musculature and skeleton. A small woman can easily strangle a large man. The U.S. Army trains "close-range combatives" to use strangulation as a mechanism of lethal force.[74]

Medical resuscitation, and organ procurement procedures, work against the pathologist's ability to detect fatal homicidal neck injury.[23] An oxygen mask can leave abrasions on the mouth and nasal bridge. During resuscitation, an airway tube is placed into the mouth or nose, and inserted into the esophagus or trachea, to establish a path through which air can be forced under pressure to the lungs. The usual airway

device is an oral endotracheal tube, but many varieties of hardware exist. The skill of the rescue staff, and the size and rigidity of the victim, dictate how much injury occurs during this intubation procedure. Traumatic intubations result in internal injuries of the deep musculature of the larynx, often completely mimicking the injuries of strangulation.[75] Ulceration of the larynx may develop from pressure produced by the inflatable cuff on the tube. The mechanical ventilation can produce barotrauma in the lungs, with air dissecting up to the skin of the neck. In cases where the rescue staff is unable to intubate the patient, they might attempt a surgical cricothyroidotomy or tracheostomy procedure to establish an airway. This would completely obliterate all signs of manual strangulation. Further, intravenous needles are sometimes placed into the jugular veins, leaving tracks of hemorrhage that can obscure physical injuries. If resuscitation is successful, the patient may linger on mechanical ventilation for hours or days, resulting in healing of soft tissue injuries in the neck that would have been recognizable if examined earlier. Toxicology is meaningless in patients who survive a few days in the hospital, so disproving a defense theory that the asphyxial death was caused by overdose of prescribed or abused drugs becomes impossible.

Postmortem changes in the body, during the fixation of livor mortis and beginning putrefactive changes, can produce alterations in the tissues of the neck and skin of the body that resemble strangulation injuries. Prinsloo and Gordon described hemorrhages in the neck due to decomposition.[9] Bockholdt, Maxeiner and Hegenbarth described "postmortem hypostatic hemorrhages," resembling petechiae, that develop during the late postmortem interval, sometimes even in the conjunctivae of the eyes, and are associated with a face-down postmortem position of the body and morbid obesity.[76] Pollanen, et al devised an actual cadaver model for the production of postmortem hypostatic hemorrhages into the neck muscles, even finding a false appearance of inflammation in the hemorrhages, but the "rig" used to suspend the decomposing bodies required a radical inclination from toe-to-head, and even then they failed to produce postmortem hemorrhages in about half the tested cadavers.[77] Putrefaction in the neck muscles may also resemble contusions of strangulation assault. In some cases, it may not be possible to discern the presence of strangulation in decomposing bodies. Drowning has also been claimed as a mechanism for hemorrhage in the connective tissue fascia between neck muscles, as opposed to crush injury within the muscle fibers.[78] The dilemma for the medical examiner is much worse if there is a history of domestic violence, and also a history of drug or alcohol abuse or withdrawal; additional reasons to be found dead, decomposing, with potentially-factitious hemorrhages in the neck, an otherwise negative autopsy, and sub-lethal toxicology.

In some communities, organ procurement procedures are routinely performed, regardless of the circumstances of death. A dissection for heart donation can totally obliterate all evidence of injury by manual strangulation. Donation of corneas will

obscure observation of petechiae in the eyes. The prosecutor is then dependent on the organ procurement team to recognize subtle injuries before they are obscured by the procedure. Few organ procurement technicians or physicians will have any experience whatsoever testifying in murder trials. In the autopsy investigation of strangulation in domestic assault cases, every injury on the body becomes significant. Contusions of the chest wall, abdomen, and extremities become valuable evidence to establish a pattern of abuse. Like child abuse cases, the autopsy strives to illuminate a big picture, not just focus singularly on the neck examination. Each and every bruise and scrape is important. These peripheral injuries can be jeopardized by organ and tissue donation procedures.[79]

Asphyxiation in the pursuit of sexual arousal has been cited as a cause of "accidental" death in strangulation cases. A point well-taken is that sexual behavior is a common component of homicidal asphyxial deaths -- Di Maio determined rape in 66% of women strangled by ligature, and 52% of women manually strangled.[62] Autoerotic sexual asphyxia occurs in men (these combined studies include 241 men, no women) who were alone (not with someone else), engaged in a paraphilia with sexual arousal, and who died accidentally.[80,81, 82,83,84] Asphyxial death during paraphilia has been reported in eight women, but four of those eight cases had circumstances described by the authors as "equivocal" or "atypical" or "none," and the authors summarized their findings as "rarely reported in women".[55] Shields, et al reported one female in a series of eleven "atypical autoerotic deaths," and then further characterized that case as actually being a homicide perpetrated by an intimate partner, completely defying the definition of "autoerotic".[85] Gosink cites a male:female ratio of "greater than 50:1" for autoerotic asphyxiation.[86] The medical literature therefore indicates that the combined findings of strangulation and sexual assault in a woman means that homicidal behavior is likely, and accidental paraphilic behavior is extremely unlikely. In an article based only upon a review of the published litererature, Sauvageau, et al reported a 21:7 male:female ratio, but this review includes the cases previously reported by Byard [55] where those cases were described in the original work as "atypical" and "equivocal."[87] Byard subsequently (2012) published a 7-year retrospective review of cases in Australia and Sweden citing a total of 53 cases, with two of those occurring in women; which would be a ratio of men:women as 27:1. [88]

Suicide by self-strangulation has been reported as a very rare event.[89, 90] Circumstances of death would need to be very carefully examined to come to the unlikely conclusion that a strangulation death was self-inflicted. Much more common than this issue of "self-strangulation is the alleged defense of suicidal hanging in the context of suspected strangulation homicide. There are usually multiple pathologic findings that allow determination of ligature strangulation (pressure applied to the neck), where these findings also help exclude hanging (ligature suspension of the head

and neck). As already discussed, the determination of direction of applied force from the ligature mark, where gravity causes a downward force, is the most helpful. Additional support for a theory of strangulation may be found if other injuries elsewhere on the body suggest defensive injuries; whereas support for a theory of suicidal hanging may include contusions of the extremities due to body contact from dropping, swinging, or thrashing during hanging.[91]

Asphyxiation or "asphyxial game play" behavior reported in the media as "the choking game" has been reported among children.[92, 93, 94] Published tables of undocumented cases suggests that there are occasionally female child participants in this behavior.[95] A study from India where strangulation is more frequently a mechanism of homicide, reports an increasing frequency of strangulation homicide deaths of male and female children under the age of 12 years.[96]

Intimate partner strangulation homicide can be complicated by the post-mortem finding of blood levels of drugs or intoxicants that might appear to offer an elegant defense theory, that the death occurred by deliberate suicidal intoxication or overdose after the strangulation injury, so that the assailant "merely" committed a physical assault, or even a consensual "asphyxophilic sexual injury" and then the victim later committed suicide. Just such a circumstance was reported by Dettling, et al.[97] This paper addresses the technical toxicology interpretation issues for post-mortem redistribution of an anti-depressant drug, but it does not offer a conclusion or adjudication of the case, which is an alleged intimate partner strangulation homicide.

A training videotape has been produced by the office of the San Diego City Attorney, for teaching information about strangulation in domestic violence assault. This video would be useful to domestic violence instructors involved in training law enforcement first responders, domestic violence detectives, dispatch operators, prosecutors, judges, advocates, and medical and nursing specialists. The video is available as:

"*Strangulation: Never Let a Victim Die in Vain*." A video production of IMO Productions, Inez Odom, Producer. 2 hrs, VHS, with companion workbook and resource materials. An educational documentary film in"Violence Against Women, The Series," IMO Productions, 5276 Caminito Cachorro, San Diego, CA 92105. See at http://www.imoproductions.com. November, 2001

Criminal Statutes Specific for Strangulation Assault

Many states have statutes that specifically address criminal behavior of strangulation and/or suffocation in domestic violence (intimate partner violence) assaults. There have been limited studies of the effectiveness of domestic violence

felony strangulation laws, in promoting victim safety, and improving offender accountability.[98, 99, 100,101]

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National Strangulation Training Institute

Sample Medical Report

Sharp Healthcare
Grossmont Hospital
5555 Grossmont Center Drive, La Mesa, CA 91942

Emergency Service Report

Date: Saturday, November 11, 2000 at 2:13 PM

Patient: Victim

Author: Dr. George McClane

Primary Care Physician: Unknown

Chief complaint: Dyspnea, chest pain and odynophagia.

History of present illness:

The patient is a very pleasant 36 year old Hispanic female with dyspnea and chest pain for the last hour, describes it as substernal, worse with palpation. No radiation. No diaphoresis, nausea or vomiting, but it has made her somewhat short of breath because it is painful to take a deep breath. No fevers or chills. No recent coughs. She is under a lot of stress. The patient also complains of persistent odynophagia since being strangled one month ago by her intimate partner.

Past Medical History: Morbid obesity, weighs 200 pounds, asthma.

Medications: Asthma inhalers.

Allergies: None.

Family History: Noncontributory.

Review of Systems:

Constitutional: No recent history of fever, night sweats or weight loss.

Lymph: No enlarged painful nodes.

National Strangulation Training Institute

Eyes: No eye pain or acuity change or discharge.

Ears: No ear pain or hearing loss.

Neurological: No recent history of syncope or headache that would be suggestive of an acute onset of neurological disease.

Gastrointestinal: No recent history of pain or bleeding that would be suggestive of the acute onset of gastrointestinal disease.

Genitourinary: No recent history of pain or bleeding that would be suggestive of an acute onset of musculoskeletal disease.

Integument: No recent history of generalized rash that would be suggestive of an acute onset of integumentary disease.

Immunologic: No recent infections that would be suggestive of an immune disorder.

Social History:

The patient lives locally. Does not currently smoke cigarettes.

Physical Examination:

Vital signs: Temperature 98.3, pulse 76, respiratory rate 15, blood pressure 127/73.

General Appearance:

The patient is a very pleasant, morbidly obese female sitting quietly on the stretcher. She is anxious but does not appear to be dyspneic. Oxygen saturation was 99% on room air. EKG sinus arrhythmia. Monitor sinus arrhythmia.

NECK: Supple, full range of motion. No adenopathy. No bruises. She does have tenderness over the left anterolateral aspect of the neck. There is no crepitance noted.

HEENT: Oropharynx pink and moist. The posterior oropharynx is somewhat erythematous. No viral plaque. No petechiae seen or subconjunctival hemorrages. PERRL. EOMI.

CHEST: Clear. Breath sounds equal bilaterally. She does have some tenderness to palpation over the costosternal junctions. No crepitance noted.

National Strangulation Training Institute

Emergency Department Course and Procedures:

One mg of Ativan IM markedly improved the patient's symptoms.

The patient described further her strangulation episode of a month ago. She states that her intimate partner at that time strangled her several times before but a month ago it was worse. She was strangled twice for about a minute with the assailant strangling her from the front using two hands. She states that she could barely swallow for three days and she was very sore. She states that now even a month later she is still having some odynophagia but is not nearly as bad. It is more over the left side of her neck. She states that she also had pain over the back of her head after the strangulation. Describing the assailant during strangulation, she stated that "he looked like death, as if he wanted me to stop breathing with big, evil eyes. His eyes were crazy, they were big, they were open and wobbling back and forth."

When asked what the assailant was saying at the time, the patient quoted him as saying: "Fuck-off and die you ugly bitch. You make me sick!"

The patient said the assailant later apologized. She stated that she found out that her assailant was an intravenous drug user of crystal. She never made a police report.

Another time, around the same time, the assailant grabbed her from behind with two hands. The patient was able to roll over and get away. She states at that time it appeared that the assailant "wanted to kill me."

The patient finally was able to muster up her courage and evict the assailant out of her apartment after the assailant began bringing questionable persons into the apartment and the patient believes there was drug involvement in that.

Medical Decision Making:

As noted with the above discussion, this patient probably is still suffering from some post-traumatic stress syndrome and is having hyperventilation and anxiety attacks but she may also have a component of costochondritis as well. Her neck and oropharyngeal pain is probably related to her vigorous strangulation attempts done by intimate partner. This also may represent simple pleurisy as well.

Assessment:

Acute pleuritic chest pain with acute anxiety attack. Protracted neck and oropharyngeal pain

secondary to recent strangulation attempt. History of recent intimate partner violence. History of morbid obesity, weights 200 pounds. History of asthma. The patient was seen by psych/social worker and given referrals, 800-799-SAFE was also given to the patient and she was given Ativan 1 mg. p.o. q4 hours p.r.n. #20 prescription.

Discharge Instructions:

The patient appears to be stable at the time of reevaluation and discharge. Extensive verbal and written instructions were given to the patient with an emphasis on followup. Patient was told to return to the emergency room immediately if there were any new or worsening symptoms, with specific potential symptoms being individually discussed and described. The patient appears to understand the aftercare instructions and plan for further medical workup. The diagnostic studies were discussed and the rationale leading to the tentative diagnosis was explained by this examiner and there were no further questions on discharge. Follow-up at the CMS Clinic as well in the next couple of days.

Admitted: No.

Please note – unless specifically stated, all procedures mentioned, tests done and medications given were performed/interpreted by the emergency physician or were under the direct supervision of th emergency physician.

Dr. George McClane
Dictated: 10-31-00, 11:32
Transcribed: 10-31-00, 20:50

End of report

Monitor Your Signs and/or Symptoms

Date and Time:	Journal Your *Signs*	Journal Your *Symptoms*	Journal Any Other Sensation

Signs of Strangulation

- **Face**- red or flushed, pinpoint red spots (petichiae), scratch marks
- **Eyes and eyelids**- petichiae to the left or right eyeball, blood shot eyes
- **Nose** – bloody nose, broken nose, petichiae
- **Finger tips-** bruises are circular and oval and often faint
- **Ear-** petichiae (external and/or ear canal), bleeding from ear canal
- **Mouth-** bruising, swollen tongue, swollen lips, cuts/ abrasions
- **Under the chin-** redness, scratch marks, bruise(s), abrasions
- **Chest-** redness, scratch marks, bruise(s), abrasions
- **Shoulders-** redness, scratch marks, bruise(s), abrasions
- **Neck-** redness, scratch marks, finger nail impressions, bruise(s), swelling, ligature mark
- **Head-** petichiae (on the scalp)
- **Other-** hair pulled, bump(s), skull fracture, concussion

Symptoms of Strangulation

- **Voice changes**
  - Raspy voice
  - Hoarse voice
  - Coughing
  - Unable to speak
  - Complete loss of voice
- **Swallowing changes**
  - Trouble swallowing
  - Painful to swallow
  - Neck pain
  - Nausea/ Vomiting
  - Drooling
- **Breathing Changes**
  - Difficulty breathing
  - Hyperventilation
  - Unable to breath
- **Behavioral changes**
  - Restlessness or combativeness
  - Problems concentrating, amnesia
  - Agitation
  - Post-traumatic Stress Syndrome
  - Hallucinations
- **Memory Loss**
- **Unconsciousness**
- **Dizziness/ headaches**
- **Involuntary urination or defecation**

San Diego Family Justice Center
707 Broadway, 2nd Floor
San Diego, CA 92101

Call us Toll-Free: (619) 533-6000
http://www.familyjusticecenter.org

FJC Legal Network

Seeking Hope and Justice for All Our Clients

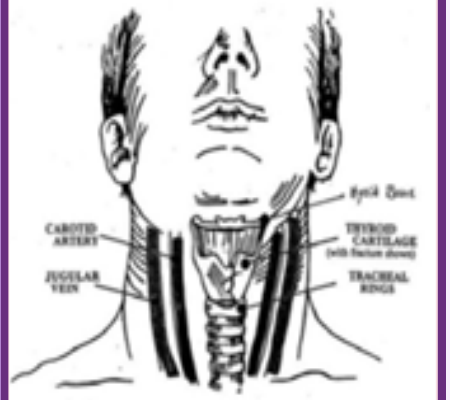
Facts Victims of Choking (Strangulation) Need to Know!

Strangulation

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

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

Important Parts of the Neck



Strangulation (Cont.)

Losing Consciousness

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

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

Observing Changes

Observation of the changes in these signs over time can greatly facilitate determination of the nature and scope of internal damage produced during the assault, and lend credibility to witness accounts of the force and duration of the assault.

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

Victims should also seek medical attention if they experience difficulty breathing, speaking, swallowing or experience nausea, vomiting, light headedness, headache, involuntary urination and/or defecation.

Although most victims may *suffer no visible injuries* whatsoever and many fully recover from being strangled, *all victims, especially pregnant victims, should be encouraged to seek immediate medical attention.* A medical evaluation may be crucial in detecting internal injuries and saving a life.

Use the face and neck diagram to mark visible injuries:

Advocacy Tips for Victims of Strangulation

Developed at BWJP Strangulation Workshop in Boise, Idaho in collaboration

with Det. Mike Agnew, Dr. Dean Hawley, Rhonda Martinson, JD, and Gael Strack, JD.

August 2008

Educate the Victim:

- About serious of strangulation, signs and sypmptoms
- Ask for help in getting the documentation and documentation
    - History of Medical Documentation
    - Copy of EMS report
    - Copy of medical records
- Give victims a copy of the strangulation brochure & log (translate it in various language)
- Give them information about their rights
- Give them information about the system
- Give them information about their resources
- Find out if they have medical insurance. If not, provide information on how to obtain medical insurance.

Support through:

- Risk assessment
- Safety planning
- Follow up
- Consent to share & sharing with law enforcement
- Victim Impact Statement
- Restitution at criminal court, victim restitution or civil cour
- PTSD information
- Counseling or support group

- Validation

Educate the Community & Develop relationships with:

- Police
- Prosecutors
- Judges
- Medical Community
- Teens
- Public Health
- Adult and Child Protective Services

Continuing Education for Professionals:

- Continue to learn
- Know the facts about Confidentiality and information sharing
- Advise victims of your role – community based or system-based advocacy

Resources:

- A free, previously recorded, Risk Assessment Webinar provided by Dr. Jackie Campbell can be viewed at www.familyjusticecenter.org.
- Sample Advocacy Protocols are posted on www.familyjusticecenter.org, go to library.

Your Victim Impact Statement...

Your Victim Impact Statement

Judges and juries care about what you have been through. It hasn't always been that way.

Victim advocate Jo Kolanda describes a sentencing hearing she attended in the 1970's:

I went to court for the sentencing of a defendant who had been convicted of homicide by intoxicated use of a vehicle. With me were the mom and dad of the young woman he killed. The offender's parents, friends, and pastor told the court what a wonderful guy he was. The victim's parents asked the assistant district attorney to ask the judge if they could tell the court about their daughter. The judge said they could not because it would be inflammatory. Then he added that he couldn't understand why this simple traffic case was cluttering up his court calendar in the first place.

Judges today are compelled by law to give victims and their family members an opportunity to address the court. Every state guarantees the right to present a written or oral statement in court addressing the impact of crime on the people most affected. Victim Impact Statements are not presented during the first part of a trial. The focus of the first part of a trial is to determine the factual events surrounding the alleged crime in an effort to determine guilt or innocence. It is not intended to draw out the feelings of the victims or their family members. The Victim Impact Statement is presented after a defendant has been found guilty of a crime and the court has moved into the sentencing phase of a trial. The right to present a statement – your right – is guaranteed by your state law or constitution. That right did not come easily.

Acknowledgments

Thank you to James Rowland, founder of the Victim Impact Statement; Anne Seymour of Justice Solutions in Washington, D.C.; Bob Wells, a senior instructor with the Behavioral Science Division of the Federal Law Enforcement Training Center; and the Honorable Ted Todd of the Fifth Judicial District of Indiana for their contributions. Some of the material in this workbook has been adapted from *Victim Impact: A*

Victim's Right to Speak, a Nation's Responsibility to Listen*, written in 1994 by Ellen K. Alexander and Janice Harris Lord with the support of the U.S. Department of Justice, Office for Victims of Crime, and later published by the National Victim Center and Mothers Against Drunk Driving.

By Janice Harris Lord, ACSW-LMSW/LPC
For Mothers Against Drunk Driving

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The Beginning

Every new idea begins as a seed in someone's mind. Victim Impact Statements were the idea of James Rowland, chief probation officer in Fresno County, California. Rowland believed it was unjust that convicted offenders could use every means possible to cast themselves in a more favorable light before sentencing, while victims and their families were gagged with silence. Rowland's opinion spread and became widely accepted. In 1982, President Ronald Reagan's Task Force on Victims of Crime filed its Final Report. Among the report's many recommendations was a proposal calling for legislation that would "require Victim Impact Statements at sentencing." That same year, the Federal Omnibus Victim and Witness Protection Act required Victim Impact Statements be considered in federal criminal cases. Individual states also began passing Victim Impact Statement laws.

That was only the beginning, however. Judicial debate followed on whether Victim Impact Statements violated the rights of offenders. The most heated debates involved death penalty cases where offenders had the most at risk. The debate reached the U.S. Supreme Court in 1987 when the court agreed to hear the case of *Booth v. Maryland*. Convicted offender John Booth had been found guilty of two counts of first-degree murder and other charges. In the Supreme Court hearing, Booth's attorneys argued that their client's Eighth Amendment rights had been violated by the Victim Impact Statements given by family members of the deceased at his trial. The court agreed. In his summation, Supreme Court Justice Lewis Powell stated, "…The admission of these emotionally-charged opinions as to what conclusions the jury should draw from the evidence is inconsistent with the reasoned decision-making we require in capital cases." The U.S. Supreme Court addressed the issue two more times, before finally concluding in the case of *Payne v. Tennessee* (1997):

The States remain free, in capital cases, as well as others, to devise new procedures and new remedies to meet felt needs. Victim Impact evidence is simply another form or method of informing the sentencing authority about the specific harm caused by the crime in question, evidence of a general type long considered by sentencing authorities… Victim Impact evidence serves entirely legitimate purposes.

To Give or Not to Give a Statement

Your right to tell the court how the crime committed against you or your loved one has affected you has been nobly won. Now it is up to you to determine if you want to exercise the right. The purpose of a Victim Impact Statement is to assure a balanced picture of both offender *and* victim in determining the most appropriate sentence for the convicted offender. It is your chance to tell the court and the offender what your life has been like since the crime. It may be the only opportunity you will have to communicate with the offender.

You retain the right, however, *not* to prepare a written statement and *not* to speak or read a statement in court. Victims choose to forego this right for several reasons. Some may have cultural or spiritual concerns. Others believe their statements won't matter, are afraid they lack the necessary writing or speaking skills, or fear retaliation from the offender. These are reasonable concerns, but all require additional reflection. *Cultural or Spiritual Concerns:* In the Buddhist faith, words spoken against someone are believed to result in bad karma. Therefore, some Buddhists choose not to participate in the criminal or civil justice systems, or may avoid speaking about the impact of the crime. Other faiths or cultures that seek peace or peacemaking as their ultimate goal, including many Native American tribes, may also avoid involvement in criminal procedures. If this is an issue for you, explain it to your victim assistance provider or prosecutor. They likely will pursue the case in traditional fashion, but may grant your request to avoid active involvement.

It won't matter: It is possible that the judge or jury will have decided how to sentence the offender before your statement is considered. While judges claim to endorse Victim Impact Statements, research has yet to determine the degree to which reading or hearing statements actually makes a difference at sentencing. Research *has* shown that judges use the financial information in statements when ordering the offender to pay restitution for all or some of the expenses related to the crime. A restitution order does not guarantee the offender will pay the amount ordered by the court, but it can be grounds for revoking probation or parole.

Considering the issue more broadly, every victim's physical, emotional, and financial reaction is unique. The court often is bound by predetermined guidelines at sentencing. If discretion is allowed, however, it is important that the judge have access to as much information as you can provide about how your life has been negatively impacted by the offense committed against you or your loved one. If you choose not to provide this information, the balance of information could be weighted in favor of the defendant. Members of the media often have substantial interest in crime victims. Victim Impact Statements and the stories they generate may help educate the public about the effects of

crime. Therefore, the public could become more sensitive to victims even if your statement does not influence the court.

I'm not a polished writer or speaker: Most attorneys are skilled at presenting eloquent statements. That's not your job. The goal of your Victim Impact Statement is to help the judge or jury identify with your loss. Your statement helps present you as an ordinary member of the community who did not deserve to be victimized by crime. One research project determined judges were more likely to read handwritten statements than those typewritten on a form. Wouldn't you? A handwritten statement is more personal. If you misspell words or your grammar is incorrect, it doesn't detract from the important points you make about your loss or pain. Judges and juries make some of the same writing errors and are not likely to hold it against you.

The offender may retaliate: That may be a reasonable concern, but it carries less weight

when you limit what you say to your personal reaction. You will not be repeating evidence already presented in the fact-finding phase of the trial. You will simply state how the crime has affected you. No one can take issue with that perspective. Your Victim Impact Statement will become an official part of the court record if it is written, and an oral statement will be transcribed into the record in most states. Those with access to the file include the judge, prosecutor, defense attorney, prison officials, probation officers, and parole officers. In fact, the official court record is public information and can be accessed by anyone unless sealed by the judge for a specific reason. However, your address and phone number are not required on statements. If you are concerned about the offender's ability to retaliate, discuss your fears with your victim assistance provider or prosecutor. Together you can decide if it is wise to prepare a statement.

What You Need to Know About Your Rights

States differ regarding the form of impact statements that may be presented. All states allow presentation of a written statement. Some states provide a form for your Victim Impact Statement, although you are not required to use it in most states. Many forms do not allow enough space for you to fully express yourself. Some instructions may be confusing. If you have been given a Victim Impact Statement form, ask your victim assistance provider if you are required to use it or if you may write your statement without using the form.

Use the form below to guide you when asking questions about your Victim Impact Statement. Check the correct answers so that you can refresh your memory as the trial date approaches.

Question
Yes
No

1. Will I be allowed to read or speak my impact statement at the sentencing of the convicted offender?
2. Will I be allowed to put my statement on video, audio, or film rather than appearing in court to present my statement?
3. Will I be able to discuss the physical impact of the crime on my life?
4. Will I be able to discuss the mental and emotional impact of the crime on my life?
5. Will I be able to discuss the financial impact of the crime on my life?
6. Will I be able to ask that the offender pay for the financial costs of the crime (restitution payments)?
7. Will I be able to offer my opinion about what should happen to the offender?
8. If the case is plea-bargained, will I be able to present my statement?
9. If the offender goes to prison, will my written statement be placed in the offender's prison records?
10. Will I be informed and afforded the right to prepare a revised statement when the offender comes up for parole or probation?

In addition to the questions above, ask your victim assistance provider and prosecutor if they have other information about Victim Impact Statements to share with you.

Let's Get Started!

If you have decided to prepare a Victim Impact Statement, you will want to give it substantial thought before presenting your final product. Whether presented in written or oral form, you probably will want to tell the court much more than court time will allow. But begin by writing *everything* that comes to mind. You can come back later and choose the most important parts. Remember not to repeat evidence that has or will be *presented in court. Your job is to tell the court how those facts affect you now.*

Following are a few *Dos and Don'ts* about Victim Impact Statements.

Do:

- Do write simply and descriptively. Your goal is to help the court feel your loss. While no one can understand exactly what you are feeling, you can help others identify with your loss by using words that evoke feeling. Your words will help others in the court understand your experience. For example, which of the following statements give you more understanding?

    1. Every morning when I wake up, I think about my daughter.
    2. *Every morning when I wake up, I remember that (name of daughter) will not be in her chair at the breakfast table and that I no longer will need to buy Fruit Loops, her favorite cereal. My heart skips a beat every time I pass the Fruit Loops in the grocery store and I say a quick prayer that she doesn't miss me as much as I miss her.*

The second sentence goes beyond sentiment to convey a word picture. It will be more effective in an attempt to invoke understanding by members of the court.

- Do write in short sentences and short paragraphs. Leave space between paragraphs.

- Do ask someone to check your draft for spelling and grammar before you write your final statement.

Don't:

- Don't vent your anger toward the court or the offender. Your goal is to express your hurt and your pain, not to blame. Assessing blame is the court's job. You must always show respect to the court. Unsuitable language will diminish the effectiveness of your statement.

- Don't describe what you want to happen to the offender while in prison. If your state law allows you to express your wishes for the sentence, do so – but don't get descriptive about harm you wish imposed.

- Don't ask for a confession from the offender. The offender's attorneys will advise their client not to confess to the crime, even if they are found guilty. If you have an interest in meeting with the offender, it may be possible to arrange a meeting at a later time.

- Don't write anything that is not true. In most states, the defendant, through his or her attorney, can question or object to statements not believed to be factual. In a few states, the defense attorney can cross-examine the victim about what has been said in the statement. Ask your victim assistance provider if this is allowed in your state.

As you consider how the crime has changed your life, you may use the following questions to guide you. Remembering and writing about something so painful may be difficult for you. Pace yourself and don't feel that you have to complete your draft in one sitting. Be gentle with yourself and take as many breaks as you need.

The Physical Impact of the Crime

When you or your loved one are injured

If your or your family member(s) was (were) injured, describe your treatment and recovery process. What preparations had to be made for your immediate care and your aftercare? Remember to include those injuries that may have healed.

What physical limitations do you live with now? Describe the physical pain involved in getting around, in getting to the courthouse. How much do the physical injuries affect your energy level? How permanent are your injuries? How have your injuries affected your ability to work and your ability to enjoy life? List things you can no longer do.

The Physical Impact

When a loved one is killed

If your loved one was killed, how has this affected you physically? Do you experience more frequent headaches? Have you gained or lost significant weight? Have you developed stress-related illnesses since the death? Have you visited a doctor more frequently? Do you experience pain that you did not suffer before the death?

The Emotional Impact

How do you feel emotionally when you wake up in the morning? What do you think about? How often do you cry? Describe the last time you cried. What do you think about when you go to bed at night? How difficult is it for you to sleep? How long do you sleep? Do you have nightmares? About how much of every day do you feel sad? Do you feel more tired than you did before the crime? Have you been diagnosed with depression, anxiety, post-traumatic stress disorder, or any other stress-related illness since the crime? Are you on any medications for those conditions? Have you considered suicide since the crime? Have you had difficulties with relationships since the crime? How has it affected your family life? Has your view of the world as a safe and fair place changed since the crime? Has your spirituality changed since the crime?

The Financial Impact

On the next page, you will find a chart that can be used to help tally up the financial aspects of the crime committed against you or your loved one. This information will be helpful to the court if the offender is ordered to pay restitution. For now, however, it will be helpful to record some general statements about the financial impact of the crime on your family and/or you. List expenses you have incurred that have not been reimbursed by insurance, Crime Victims Compensation programs, or other financial resources. List the amount you have spent on medical care, prescriptions, gas, automobile upkeep for trips to the doctor, rehabilitation, and counseling. Did you have funeral or burial costs that were not reimbursed? Have you lost income as a result of the crime? Have you had to change households because the crime was so upsetting?

The court can order the offender to pay you for crime-related expenses. This money is called *restitution.* While some judges are reluctant to order restitution, especially when the offender is going to prison and may have limited opportunity to earn money, most state law requires a judge to listen to your request and to consider restitution if your request is reasonable. The worksheet below may help determine the amount ordered. Remember to include only expenses for which you have not been reimbursed. You will need to provide proof of major expenses.

Expense	**Amount**	**Expected Amount to Date**	**Future Amount**
Emergency transportation to the hospital			
Hospital expenses			
Physician expenses			
Prescriptions			
Physical or occupational therapy Medical supplies (Wheelchairs, ramps, special beds, over-the-counter medications, and treatment supplies)			
Replacement of personal health items destroyed, such as eyeglasses, contact lenses, hearing aids			
Vehicular damage			
Replacement of items in damaged vehicle (luggage, etc.)			
Replacement of clothing and personal items			
Counseling expenses			
Lost wages while you were attended to by doctors, dentists, rehab, or other counselors			
Travel expenses to doctors, dentists, rehab, or other counselors			
Lost wages to attend court-related meetings, hearings, the trial			
Crime scene clean-up			
Replacement of damage to the home during the crime			
Postage and long-distance phone calls to handle			
Crime-related business			
Crime-related child care			
Crime-related elder care			
Crime-related disability care			
Photocopying of necessary documents			
Notarizing of necessary documents			
Anticipated future physical health care			
Anticipated future mental/emotional health care			
Anticipated future rehab or other therapy			
Anticipated loss of wages for future care			
Anticipated travel expenses for future care			
Other			
TOTAL			

Sentencing Recommendations

If your state allows you to recommend conditions of the sentence for the offender, what do you want to happen?

If you want the offender to go to prison, ask the victim assistance provider or prosecutor for the range of years that corresponds with each conviction. You will need to recommend a number of years within that range. In addition, you may request that the court order the offender to do certain things in prison or while on *probation* (monitored by a community program *rather than* going to prison) or *parole* (monitored by a community program *after being released* from prison). Violation of the conditions of probation or parole can result in the offender going to, or back to prison.

Following are some things to consider:

- no alcohol or other drug use
- submit to random alcohol or other drug testing
- alcohol or other drug treatment
- pay for mandatory urinalysis
- participate in Victim Awareness Classes in prison (if available)
- attend Victim Impact Panels or classes if returned to the community (if available)
- have no contact with the victim or the victim's family
- pay full or partial restitution (Some victims require only a small amount paid every week to remind the offender of the crime.)
- place the victim's photo in the prison cell (Judges may not order this unless the victim requests.)
- restrictions on where the offender can live in the community
- perform community service and/or make a donation to an agency that relates to the crime, such as Mothers Against Drunk Driving (In these cases, however, both the victim and the agency must agree to the community service placement before it is ordered.)
- electronic monitoring
- installation of breathalyzer on automobiles
- meet with the victim if both desire a meeting and after both have been
- professionally prepared
- write weekly letters from prison describing prison life (to the victim's family or to the offender's own family or children); and
- no Internet access.

Relationship with the Offender

Do you have any fears about the offender attempting to intimidate, harass, or cause you future harm? If so, what is the basis of your fear? What would you like the court to do to help you feel safer when the offender returns to the community?

Remember: Charges should be filed against any person making a threat against you.

Call your prosecutor or the law enforcement agency where the crime was reported. Steps can be taken to prevent any future threats or violence. This may include getting a protective order against the offender.

Refining Your Statement

That was a lot of work, wasn't it? It was probably not only physically taxing, but emotionally draining as well. Attempting to write about the impact of crime can bring it all back again, and it is usually difficult to find adequate words to describe what has happened to you.

Nonetheless, words are all you have at this point, so try to make the best of them. Your Victim Impact Statement should take no more than 10 minutes of reading or listening time to make the greatest impression. So here comes the hard part. Go over what you have drafted and underline or highlight the parts of each section that you think are most important in order to understand what you are going through. You do not need to shorten the Restitution Chart.

Now let's write a new draft with a few guidelines.

Your Honor:

- *Write a couple of sentences about how difficult it is to prepare this statement and why.*
- Write about the physical impact of the crime.
- Write about the emotional impact of the crime.
- Write about the financial impact of the crime. Don't repeat what you have checked on the Restitution Chart. You can staple it to your statement. State the general categories of your most significant expenses and give the total amount.
- If allowed in your state, write about the sentence you think would be most appropriate for the offender. Do not describe specific harm, however.
- Look over what you have written and make changes that you believe will make things more clear and descriptive. When you are satisfied with your statement and it can be read or heard in 10 minutes or less, copy it on some of your own stationery, typing paper, or notebook paper.
- *Call your prosecutor or victim assistance provider. Ask where you should take or mail your statement, and when it is due. Be sure to make a few copies for yourself in the event your original gets lost or you need extras.*

Victim Impact Statements and Children

Following are some guidelines for writing about the impact of crime on children in your family. Use this space to draft a statement as you did previously, and then revise it until you have it ready to present.

Physical Impact

Was your child injured or hurt as a result of this crime? Write about the type of injuries, medical treatment received, how long the injuries lasted, and, where applicable, how long the injuries are expected to continue.

Emotional Impact

How has your child been emotionally impacted by this crime? Has your child regressed developmentally as a result of this crime? How has your child's school performance changed? How has your child's relationship with family members and friends changed? Has your child required counseling? If so, how has it helped? If not, why not?

Victim Impact Statement for the Pre-School Child

Parents: If your child is unable to read, help him or her with the blanks at the top of the page and read the instructions out loud to your child. However, please do not tell the child what to choose or draw. Remember that your child should do this only if he or she indicates an interest. What is your name? _____ How old are you? _____ Do you go to pre-school? If so, what is the name of your school or mothers-day-out program? _____ How do you feel about what happened to you?

You can circle as many as you like.
What do you think should happen to the person who caused this crime?
You can circle as many as you like.

Go to jail.

Pay money to my family.

Get some help for his or her behavior.

Nothing.

Other ideas?

If you would like to draw a picture for the judge, you can do so.

If you don't want to draw a picture, that's OK too.

Victim Impact Statement for the School-Aged Child

What is your name?_____ How old are you?_____ What grade are you in?_____ Please write or draw anything you would like the judge to know about how you feel about what happened in your family. It can be a story, poem, picture, or anything you would like to convey to the judge. If you would like to do more than one, just ask for more paper.

Presenting Your Statement Orally

You may be given the opportunity to present your Victim Impact Statement orally at the sentencing of the offender which is sometimes referred to as Allocution. If you are not comfortable doing so or are unable to attend the sentencing, ask your prosecutor or victim assistance provider if your statement may be recorded on audiotape or videotape, or if someone else can read it on your behalf.

Here are a few things to think about if you are appearing in court or preparing a tape.

Courtroom attire should reflect the seriousness of the business that transpires there. While it is not necessary to wear a business suit, clean, well-pressed clothing is expected. Women should wear a dress or a skirt that is not too short and a blouse that is not designed with a low-cut neckline. Pant suits are also acceptable if they are not too informal. Men should wear long pants and a solid color shirt. Soft colors are more effective than vivid colors. When in doubt, choose a conservative outfit. Avoid jewelry that could detract from your face. Hair should be clean. Men should be clean-shaven. Your goal is to have the members of the court focus on your face, not your attire. If you choose to audiotape or videotape your Victim Impact Statement, be aware that it will be less effective than your physical presence in the courtroom. Your goal on tape should be to make yourself appear as sincere as possible to the court. It is crucial that the tape be of excellent quality. Look through the Yellow Pages for professional audio or videotaping studios and call to inquire about prices. Your product should not be long (no more than 5 to10 minutes), and you should not have it edited. You may decide to record it several times before deciding on a final version, which will require additional studio time. If the cost is prohibitive, call the journalism or radio and television department of a local college to inquire about a student-made tape. Perhaps your prosecutor has audio or videotape equipment in the office. Remember, however, that quality lighting and skilled recording will make your product more effective.

If you choose to make a statement on videotape and your physical appearance has changed since the crime, you may want to hold a photo of yourself as you looked before the crime. If your loved one was killed, you may want to hold his or her photo as you are recorded. The predominant image on the video, however, should be your face. This will enhance the ability of the court to witness the sincerity of your statement. Follow the same rules for dress and makeup as noted above. Women who wear make-up may want to wear slightly more colorful lipstick and blush to accommodate for bright lights.

Community Victim Impact Statements

Communities and neighborhoods, as well as individuals, can be victims of crime. A known drunk driver with a reputation for unsafe driving can frighten an entire neighborhood. A neighborhood that prides itself on peace, safety, and quality of life for adults and children is violated by the anxiety caused by a drunk driver. Concerned citizens may wish to band together to form a community watch in an effort to determine the offender's driving schedule. Knowing the habits of a drunk driver provides residents with information that may help keep their children and property safe. In these cases, prosecutors are adopting the notion of community prosecution that involves neighborhood or community Victim Impact Statements. In Milwaukee, WI, a victim assistance provider works with individuals and neighborhood associations to gather information for impact statements that are presented at the sentencing hearing. Residents are sent information regarding the offender's length of incarceration after sentencing. According to the United States Attorney's Office in the Eastern District of Wisconsin, benefits of Community or Neighborhood Victim Impact Statements include:

- Obtaining information from the neighborhood about the impact of drunk driving on the community, providing valuable information to the court.
- Providing information to the community about incarceration of drunk drivers, increasing awareness of law enforcement efforts.
- Encouraging community residents to become involved because they recognize that what they do makes a difference.

A Community Impact Statement can be prepared several ways. Citizens can come together to draft a statement; individuals can write statements that can be edited and combined into one statement signed by all; or many residents can write short impact statements that are stapled together and presented to the court as a packet.

Victim Impact Statements at Parole Hearings

Most states allow Victim Impact Statements at parole hearings of offenders. Your original statement may not always be included in the convicted offender's corrections file even though the law states it should be. You will want to be sure it is filed, but you may also want to present an updated Victim Impact Statement when the offender comes up for parole. To assure that you will be notified, keep the parole board updated with your current contact information. Call the victim assistance provider in your prosecutor's office or ask your MADD advocate how to assure that you will be informed when the offender is eligible for parole. Your revised statement should include new physical, emotional, or financial consequences of the crime since sentencing was imposed. It should also include any evidence of unwanted communication you have received from the offender or the offender's representatives. If parole hearings are conducted a long geographical distance from where you live, a video or audiotaped statement may be prepared if allowed by state law.

Tips to Remember

- Prepare early to avoid the stress of last minute writing after the conviction.
- Focus on what the crime means to you physically, emotionally, financially and spiritually.
- Write and speak from the heart about your pain.
- Don't repeat evidence presented in the trial.
- The statement should take no longer than 5 to 10 minutes to read.
- Shorter and simpler is always more powerful.
- A legible, hand-written statement is acceptable.
- Consider including a photograph as part of your statement.
- You may ask your victim assistance provider for sample Victim Impact Statements, for example from *MADDvocate.* However, someone else's story is not your story. Don't use someone else's words rather than your own. Reading other statements can give you a general idea of what a good statement is like, however.

Endnotes

* Alexander, Ellen and Janice Harris Lord, *Impact Statements – A Victim's Right to Speak…A Nation's Responsibility to Listen,* Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, 1994.

** Office for Victims of Crime, *President's Task Force on Victims of Crime: Final Report,* Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, 1982, 77.

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American Bar Association, 1987.

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January 1, 2006

Victim Impact Statement
State of Washington vs. John. A. Doe
Grant County Cause No: 06-1-00123-4

Honorable Judge,

The actions of Mr. Doe have greatly affected my life. Since he committed this crime, I have been unable to sleep at night. I am constantly afraid that someone will break into my home and injure me again. I am no longer able to trust people like I did before. My children are also afraid. They do not want to go out in the yard to play because they fear that Mr. Doe or someone will try to hurt them. The used to play with other children in the neighborhood, but now will not even go to the bus stop without me.

Mr. Doe's crime has also had a deep financial impact on our family. As we do not have insurance, we have been unable to replace the items broken when he broke into our home. Although Crime Victims Compensation has been covering our medical bills, the healing process is taking a long time. I had to miss six weeks of work, using all of my sick and vacation leave. Prior to this incident, I had rarely missed a day at work.

People should not be able to commit crimes like this and get away with it. The emotional and financial impact will be felt for years to come. I believe Mr. Doe needs to spend at least 5 years in prison for this crime. I know this is not the first time he has committed a felony, and it's time that he be held accountable for his actions.

Very truly yours,

Jane A. Smith

VENTURA COUNTY DISTRICT ATTORNEY
CRIME VICTIMS' ASSISTANCE UNIT
VICTIM INTAKE FORM

(PLEASE PRINT CLEARLY)

DATE: _____

Name: First: _____ Middle: _____ Last: _____

Other Names Used (maiden, etc):_____

Date of Birth: _____ Age:_____ Sex: M___ F____

African-American ___ Filipino ___ Asian _____
Caucasian ___ Hispanic/Latino ___ Other _____

Address: _____City:_____ State: _____ Zip:_____

Phone Numbers: (Home)_____ (Work)_____ (Cell) _____
Is it okay to call you at these numbers? Yes ____ No____

In case of emergency, who can we call: _____ Phone # _____
Relationship to you _____

Did you sustain injuries resulting from the crime? Yes ____ No____

Do you have children in common with the offender? Yes ____ No____

YOUR RELATIONSHIP TO THE OFFENDER: _____

OFFENDER:
Name: First:_____ Middle:_____ Last:_____

Other Names Used (maiden, etc):_____

Date of Birth: _____ Age:_____ Sex: M___ F____

African-American ___ Filipino ___ Asian ___
Caucasian ___ Hispanic/Latino ___ Other _____

Address: _____City:_____Zip: _____

Phone Numbers: (Home)_____ (Work)_____ (Cell) _____

Height _____ Weight _____ Hair Color _____ Eye Color _____

Person to be protected

Have the police responded to a domestic violence incident?	**Yes**____ **No**____
Have **you** ever been cited or arrested for domestic violence?	**Yes**____ **No**____
Do **you** have any pending criminal cases?	**Yes**____ **No**____
Are **you** currently on probation?	**Yes** ____**No**____

Person to be restrained

Have they ever been cited or arrested for domestic violence?	**Yes**____ **No**____ **Don't Know** _____
Are they currently in custody?	**Yes**____ **No**____ **Don't Know** _____
If yes, jail _____or prison_____?	
Are they on probation?	**Yes**____ **No**____ **Don't Know** _____

Family Law Case Info

Do you have an attorney for a family law matter?	**Yes**____ **No**____
Is there a current restraining order?	**Yes**____ **No**____
If yes, what county or state _____	

Please describe the conduct of the person to be restrained

Depressed	Yes____	No____
Obsessed with you	Yes____	No____
Believes s/he cannot live without you, or is entitled to you	Yes____	No____
Abuses alcohol	Yes____	No____
Abuses drugs	Yes____	No____
Has been abusive to animals or pets	Yes____	No____
Has access to you or household members needing protection	Yes____	No____

Pulled phone from wall	Yes____ No____	Date/Location _____
Broke the phone	Yes____ No____	Date/Location _____
Prevented you from leaving	Yes____ No____	Date/Location _____
Refused to leave your property	Yes____ No____	Date/Location _____
Destroyed your property	Yes____ No____	Date/Location _____
Threw objects	Yes____ No____	Date/Location _____
Forced entry into your home	Yes____ No____	Date/Location _____
Placed harassing phone calls	Yes____ No____	Date/# of calls _____
Sent harassing texts/emails	Yes____ No____	Date/# of them_____
Pushed, shoved, slapped	Yes____ No____	Date/Location _____
Hit, punched	Yes____ No____	Date/Location _____

Bruised	Yes____ No____	Date/Location _____
Gripped your arms	Yes____ No____	Date/Location _____
Scratched, kicked, bit you	Yes____ No____	Date/Location _____
Pulled your hair, cut your hair	Yes____ No____	Date/Location _____
Choked/smothered you	Yes____ No____	Date/Location _____
Burned you or your child	Yes____ No____	Date/Location _____
Kidnapped or stalked you	Yes____ No____	Date/Location _____
Forced you to have sex	Yes____ No____	Date/Location _____
Demanded sex with threats	Yes____ No____	Date/Location _____
Molested your child/ren	Yes____ No____	Date/Location _____
Threatened to kill you	Yes____ No____	Date/Location _____
Threatened to kill themselves	Yes____ No____	Date/Location _____
Stated how s/he would kill	Yes____ No____	Date/Location _____
Threatened to use a weapon	Yes____ No____	Date/Location _____
Brandished a knife or gun	Yes____ No____	Date/Location _____
Assaulted you with a weapon	Yes____ No____	Date/Location _____

Type of weapon/s used _____

1. Have you reported any incidents of abuse to the police? Yes____ No____

   If so, please list the date the incident was reported, the police department that took the report, and the crime report number, if known.

Date _____ Police Agency _____ Report/Event/Incident # _____

Date _____ Police Agency _____ Report/Event/Incident # _____

2. Have there been any incidents of abuse that have **not** been reported to the police? Yes____ No____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Petitioner Signature: _____ DATE: _____