Institute For Addressing Strangulation

Non-fatal strangulation Workshop

Professor Catherine White

21st November 2023
Antwerp EFJCA

Faculty of Forensic & Legal Medicine Registered Charity No 1119599

Institute For Addressing Strangulation

- Established in 2022 following the introduction of new legislation on strangulation as a stand alone offence.
- Funded by the Home Office to develop best practice in responding to victims of strangulation with the overall aim to reduce the offence of strangulation and suffocation in the UK.
- Partnered with SafeLives and Bangor University to deliver the objectives

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Our objectives are to:

1. Increase awareness
2. Encourage data collection
3. Disseminate accessible resources
4. Improve policy and practice
5. Increase offender accountability and ultimately enhance victim safety
6. Co-ordinate and undertake related research and audits

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Our objectives today:

- 4 sessions with 3 breaks
- Cover topics
  - Anatomy
  - What happens during strangulation
  - Risks of strangulation
  - Clinical aspects
  - Risk assessment
  - Children
- Case studies

Who is here today & why?

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Have you had previous training on identification & management of strangulation?

1. **Yes**
2. **No**
3. **Not sure**

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Health warning

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What is strangulation?

What is strangulation?

Obstruction of blood vessels and/ or airflow in the neck resulting in asphyxia.

Non-fatal strangulation

- Section 75A(1)(a) SCA 2015 is the offence of non-fatal strangulation.
- The legislation does not provide a definition of 'strangulation' or 'strangles'. The word should be given its ordinary meaning which is the obstruction or compression of blood vessels and/or airways by external pressure to the neck impeding normal breathing or circulation of the blood. This offence applies where strangulation is non-fatal and does not result in death of the victim.
- Applying any form of pressure to the neck whether gently or with some force could obstruct or compress the airways or blood flow. Strangulation does not require a particular level of pressure or force within its ordinary meaning, and it does not require any injury.

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Case 1

- Unidentified male calls emergency services
- Unconscious female found on hotel room floor

- Carpet noted to be wet.

- Wet with what?

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Case 2

- Husband witnessed by neighbour strangling wife.
- Police & paramedics arrive.
- Woman unconscious.
- No forensic examination.
- Injuries captured on body worn video

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Case 2

- Retraction
- Says no assault
- Injuries due to love bites

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Case 3

5-year-old boy

When Dad is angry, he lifts him up.

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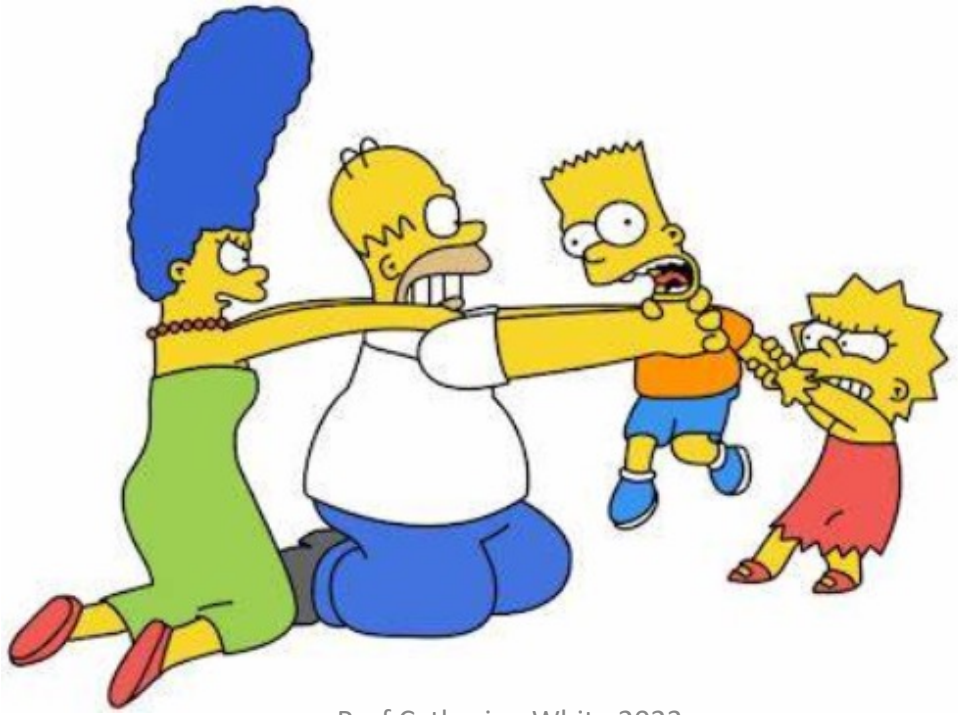
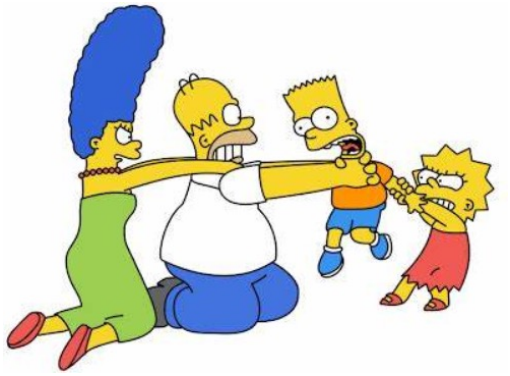


Institute For Addressing Strangulation



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Risks not restricted to women and girls

https://edition.cnn.com/2023/05/04/us/new-york-subway-chokehold-death/index.html

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NFS an important risk factor for homicide of women

Nancy Glass

***J Emerg Med* 2008 35(3)**

A History of NFS:

X 6 times risk of becoming a victim of attempted homicide

X 7 times risk of becoming a completed homicide

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What do we know?

- **1 in 4 women** accessing their community/refuge services reported having experienced strangulation or suffocation (**Women's Aid)**
- **32%** of cases accessing IDVA services had experienced strangulation (**SafeLives Insights IDVA dataset 2021-22)**.
- **19%** of adults attending **St Mary's Sexual Assault Referral Centre (SARC)** in Manchester reporting rape by a partner or ex-partner had experienced strangulation as part of the assault.
- A systematic review in 2014 reported the **lifetime prevalence of women** being strangled by an intimate partner to be between **3.0% and 9.7%.**

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Research Paper

'I thought he was going to kill me': Analysis of 204 case files of adults reporting non-fatal strangulation as part of a sexual assault over a 3 year period

Catherine White [a,*], Glen Martin [b], Alice Martha Schofield [a], Rabiya Majeed-Ariss [a]

[a] Saint Mary's Sexual Assault Referral Centre, Oxford Road, Manchester, M13 9WL, UK
[b] The University of Manchester, Vaughan House, Manchester, M13 9GB, UK

https://authors.elsevier.com/a/1ccS3,dssAKy-7

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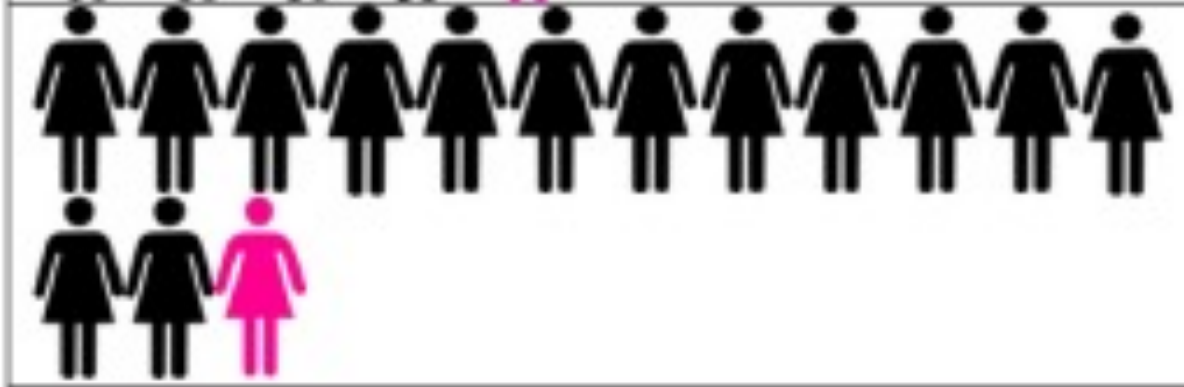
Strangulation in the Context of Sexual Violence

	1 in 11 for all adults
	1 in 5 where alleged perpetrator is a partner or ex-partner
	1 in 15 where alleged perpetrator is not a partner or ex-partner

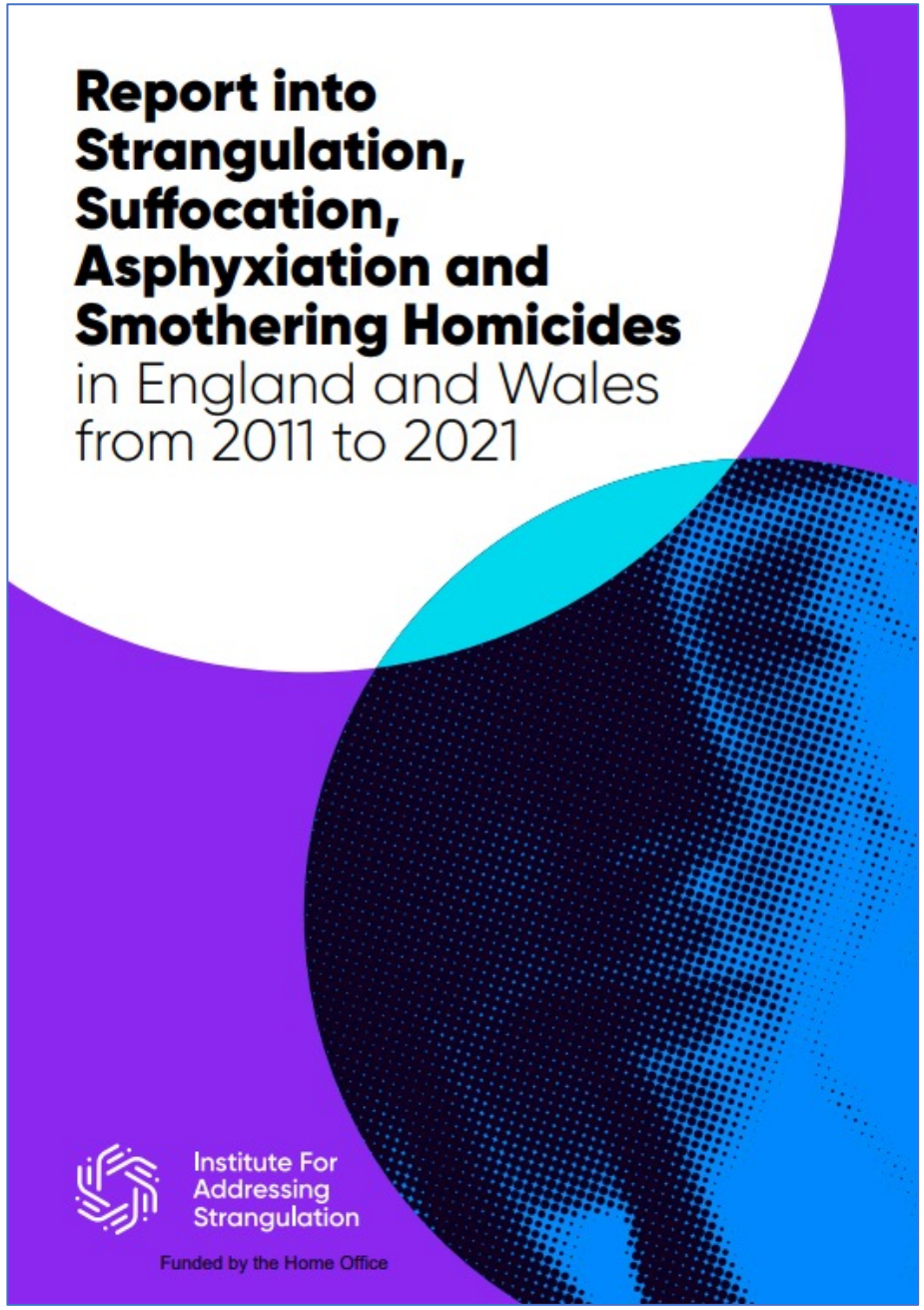
Sex

Complainants

96.6% Female

Alleged assailants

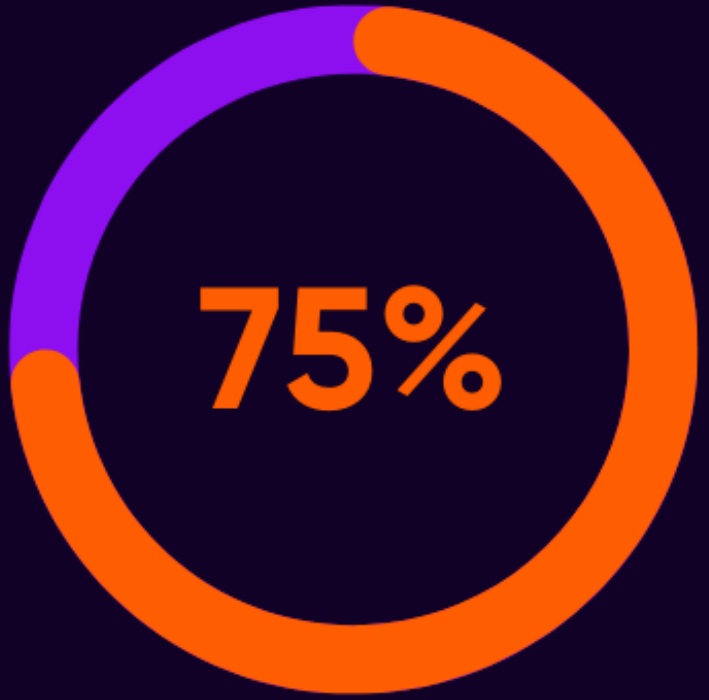
98% Male



https://ifas.org.uk/wp-content/uploads/2023/09/IFAS-final-ONS-1.pdf

352 strangulation and suffocation homicides

in England and Wales
from 2011- 2021



of victims were female.

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Most frequent place for a female to be fatally strangled was in a house.

86%

of females fatally strangled

74%

of females fatally suffocated

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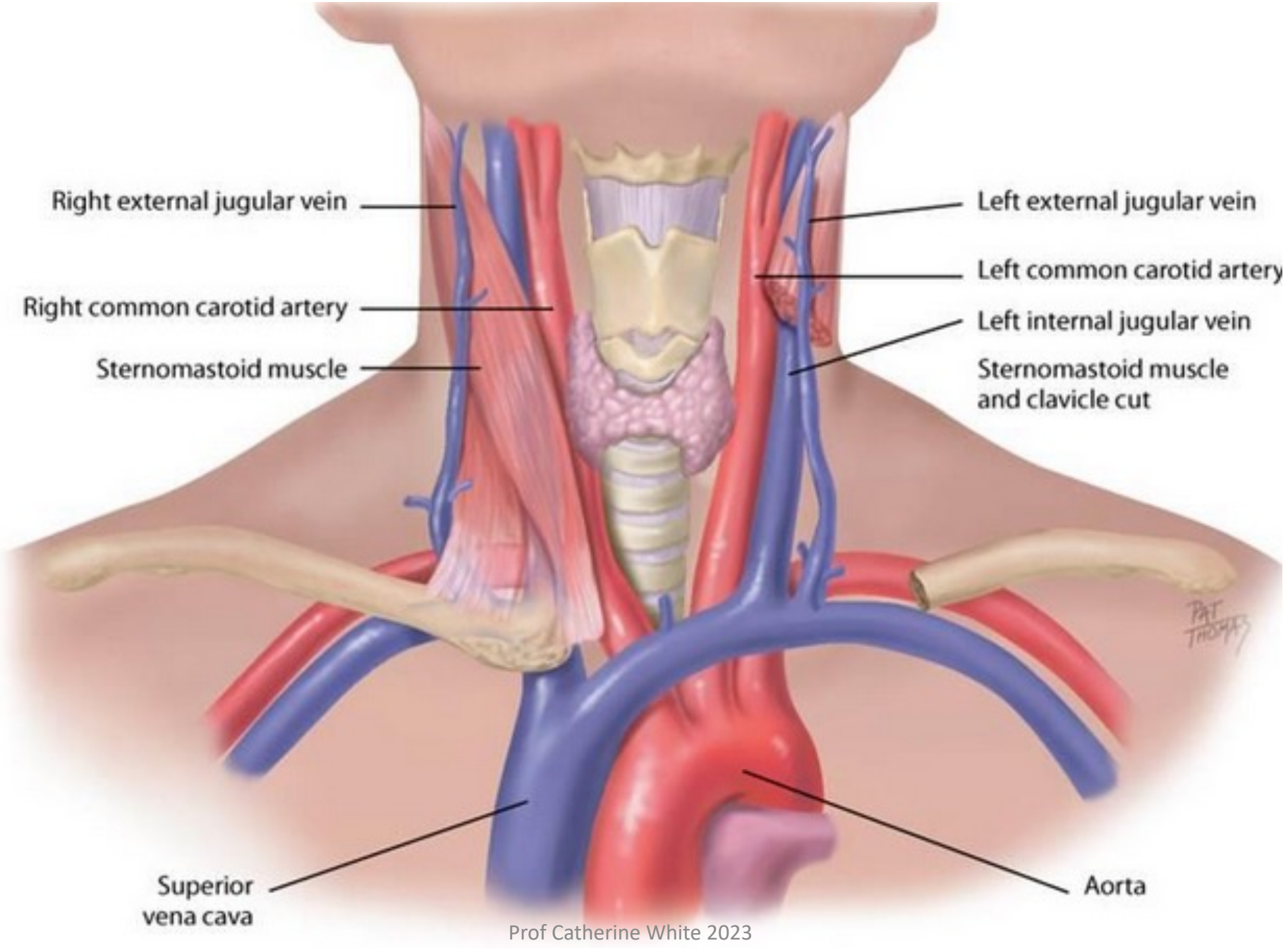
InstituteFAS
ifas.org.uk

Domestic Homicide Reviews


Right external jugular vein
Right common carotid artery
Sternomastoid muscle
Left external jugular vein
Left common carotid artery
Left internal jugular vein
Sternomastoid muscle and clavicle cut
Superior vena cava
Aorta

- **Carotid artery compression**

- **Carotid artery compression**
  - **Decreased blood flow to the brain**

- Carotid artery compression
  - Decreased blood flow to the brain
- **Jugular vein compression**

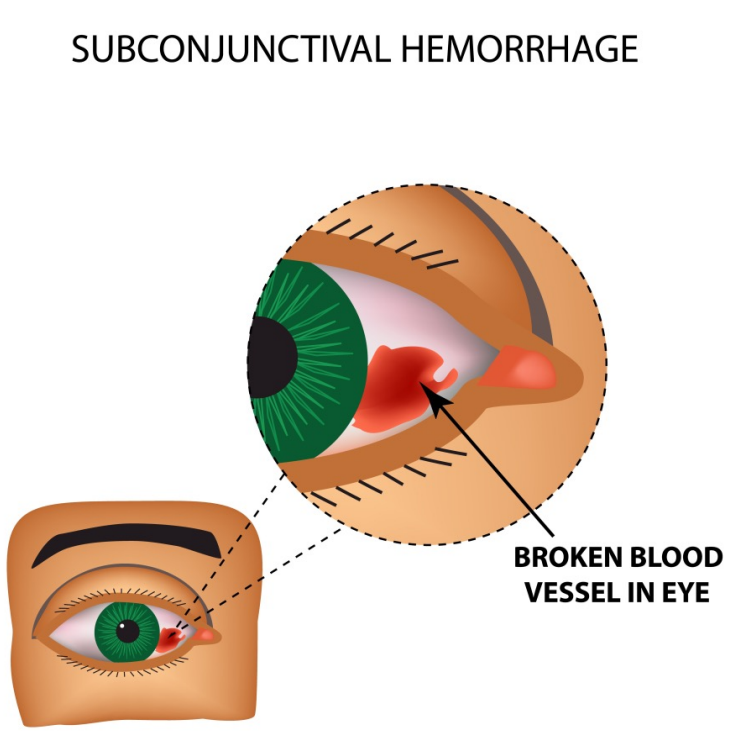
- Carotid artery compression
  - Decresed blood flow to the brain
- **Jugular vein compression**
  - **Stagnant hypoxia**

- Carotid artery compression
  - Decreased blood flow to the brain
- Jugular vein
  - Stagnant hypoxia
- **Compression +/- fracture of larynx or trachea**

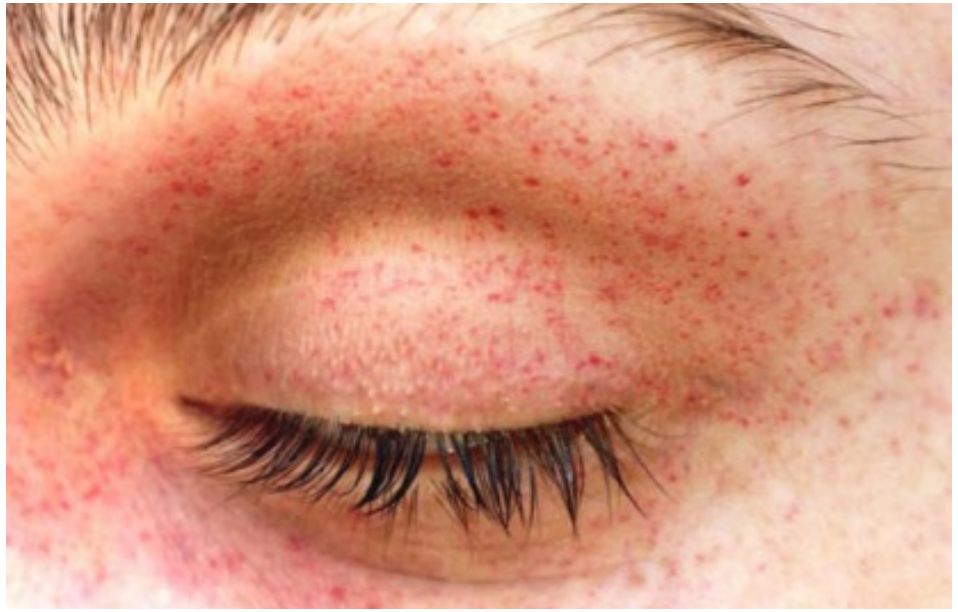
- Carotid artery compression
  - Decreased blood flow to the brain
- Jugular vein
  - Stagnant hypoxia
- **Compression +/- fracture of larynx or trachea**
  - **No oxygen intake**

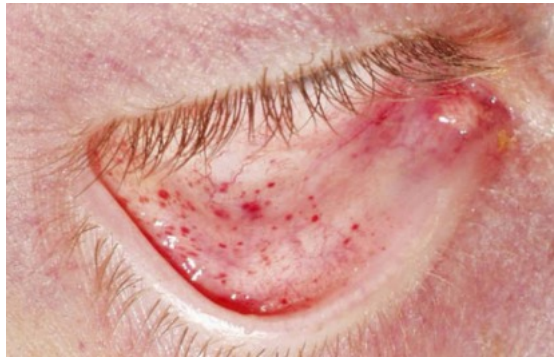
- Carotid artery compression
  - Decreased blood flow to the brain
- Compression +/- fracture of larynx or trachea
  - No oxygen intake
- Jugular vein
  - Stagnant hypoxia
- **Pressure on carotid bodies and baroreceptors**
  - **Bradycardia / asystole**

Subconjunctival haemorrhage



Petechial haemorrhage





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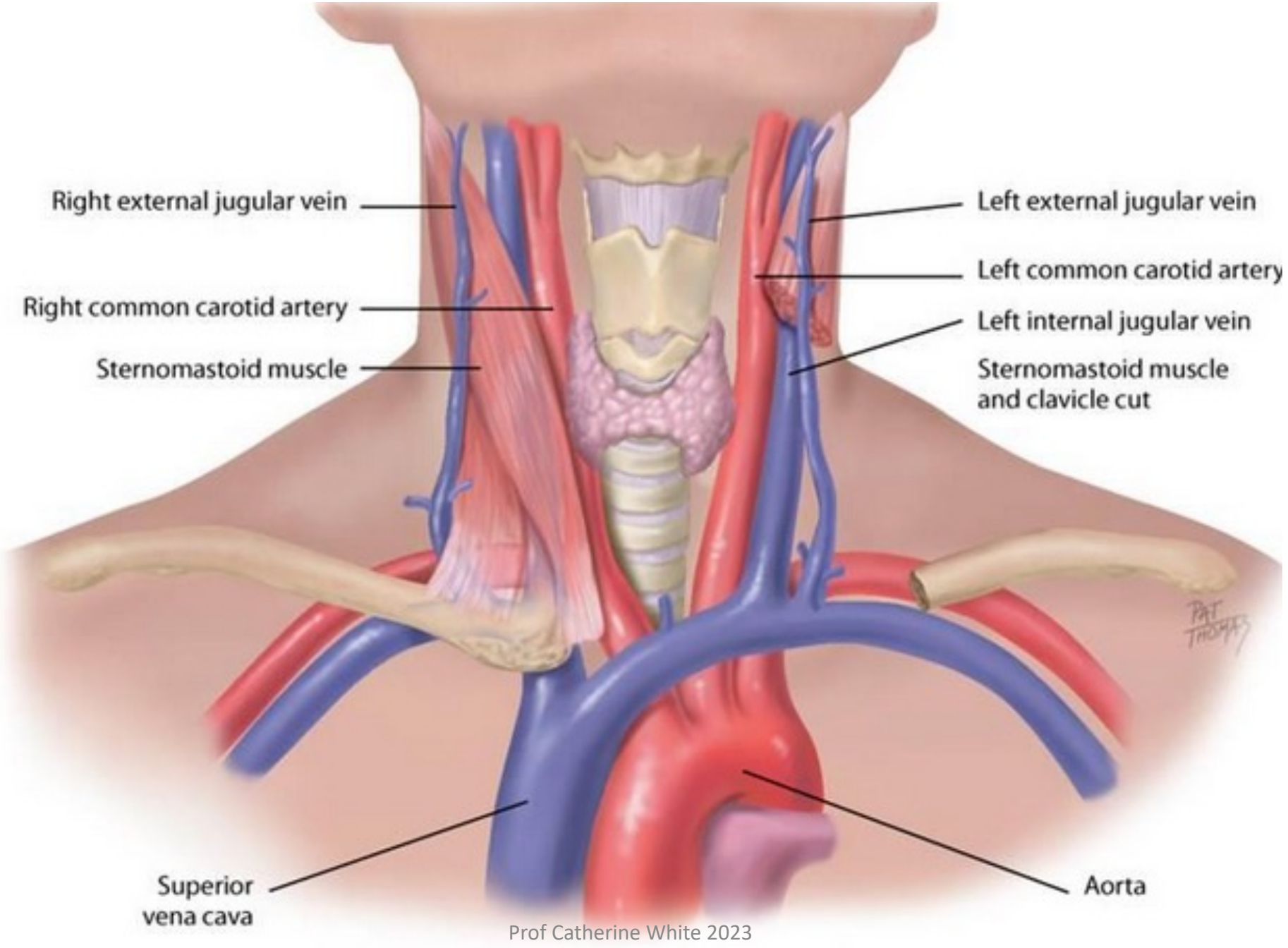
Language

- *He grabbed me.*
- He choked me
- He pinned me to the wall
- He held me down
- I'm not sure what happened


Break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Right common carotid artery
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Aorta

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Pressure on the neck in adults

Jugular vein	4psi,
Carotid artery	11psi,
Trachea	34 psi.
Opening a can of coke	20psi
Adult male hand shake	80-100psi

We don’t know the pressures required in children but most likely less.

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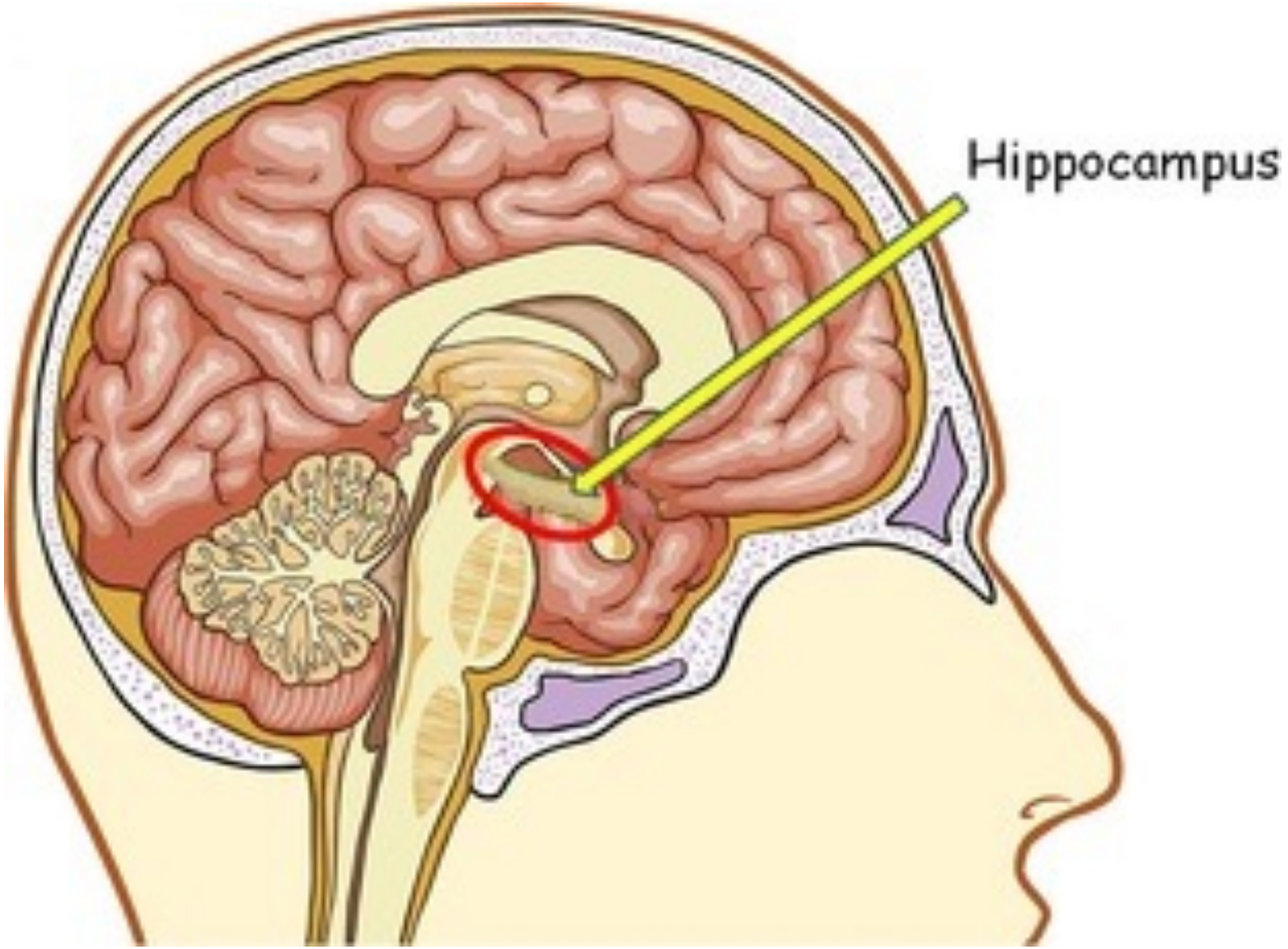
The Timeline

6.8 seconds	LOC
15 seconds	Bladder incontinence
30 seconds	Bowel incontinence


SPORTSCIENCE


SPORTSCIENCE


Hippocampus

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No oxygen = no memory

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Capacity & consent

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Management of NFS

- Helping victims to disclose
- History of NFS
- Documenting injuries
- Forensic samples
- On going medical management
- Patient information / education
- Safeguarding

Intercollegiate Working Group

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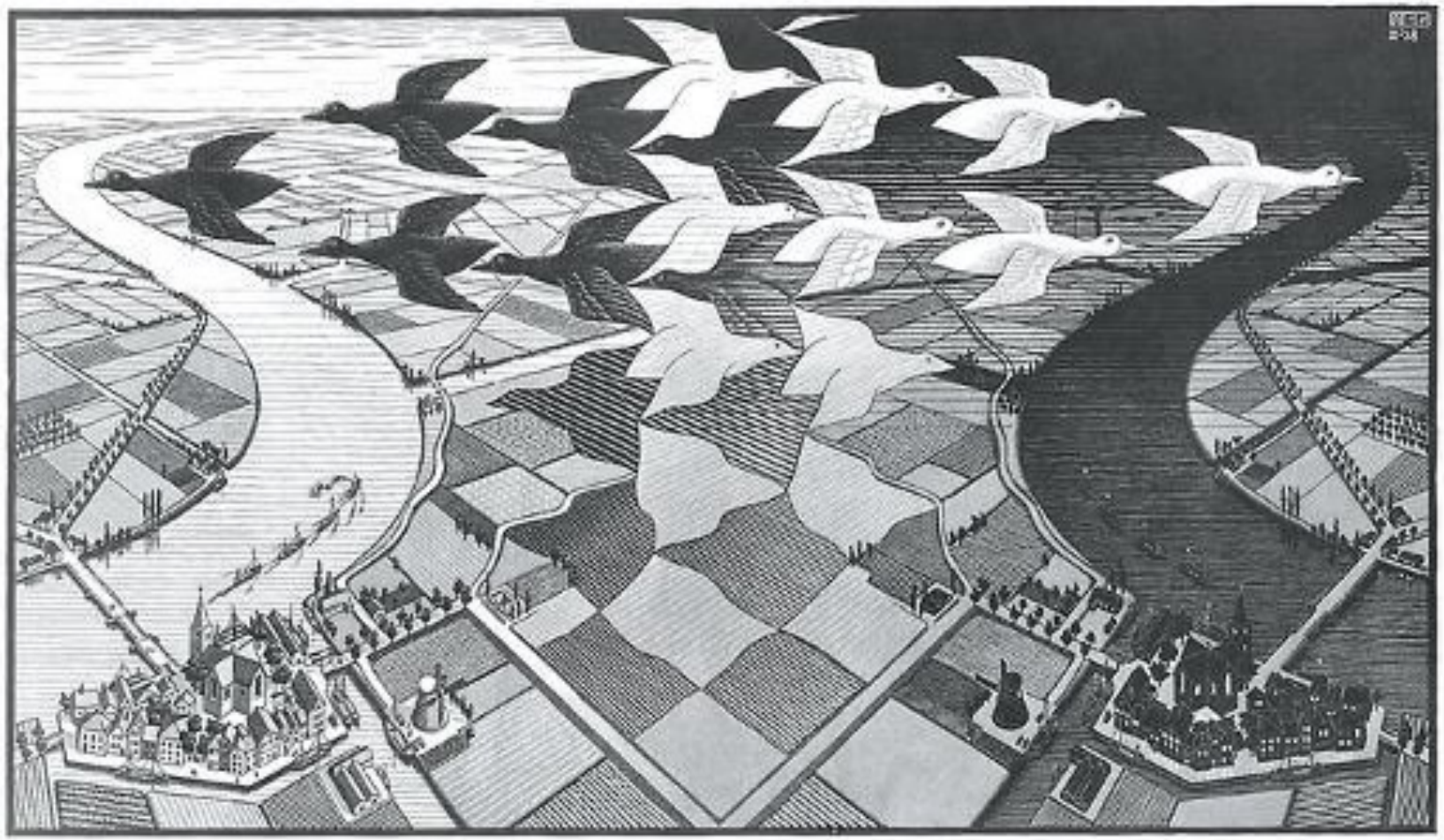
Non-partisan dual role of forensic clinician



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“I fell off a wall”

“My dad hits me when he is angry”

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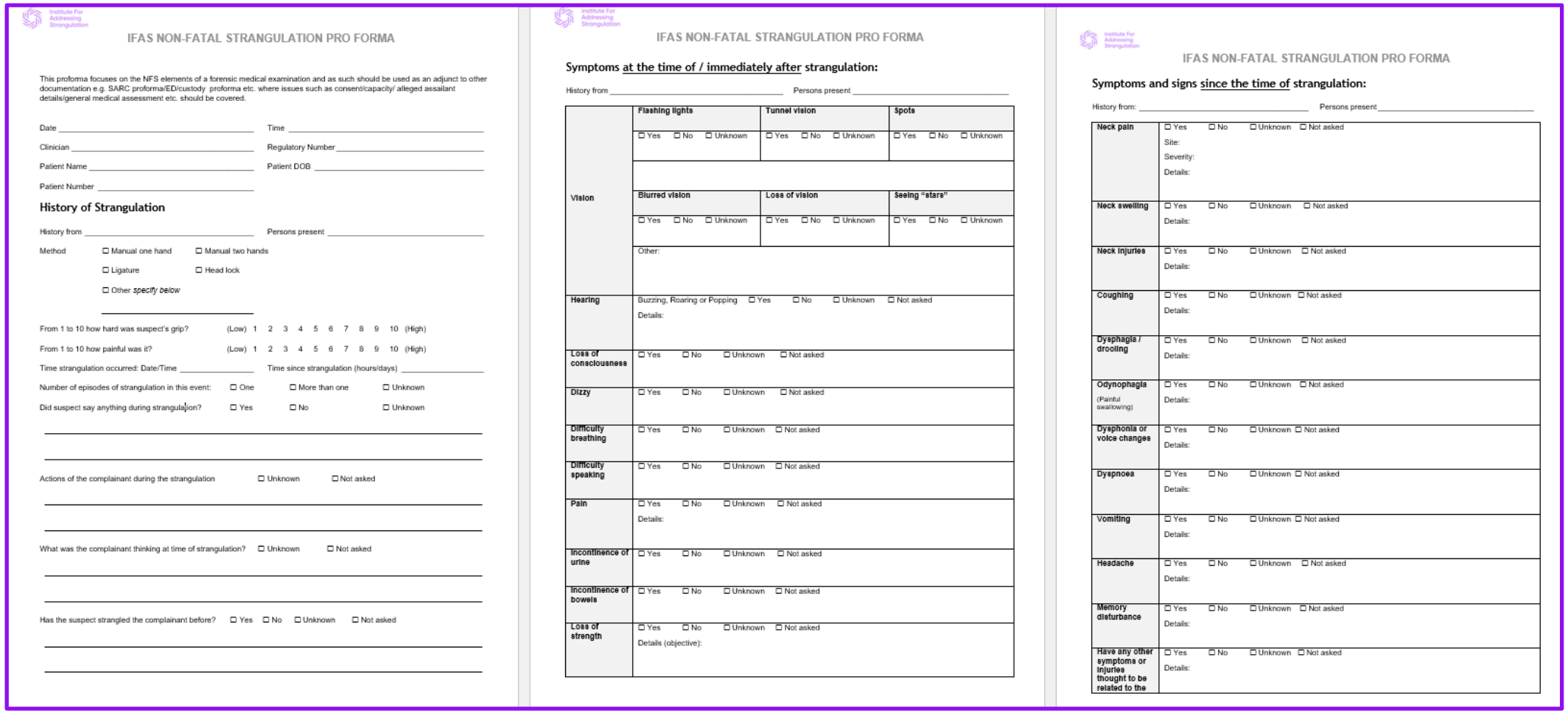
Use of a proforma



IFAS NON-FATAL STRANGULATION PRO FORMA

This proforma focuses on the NFS elements of a forensic medical examination and as such should be used as an adjunct to other documentation e.g. SARC proforma/ED/custody proforma etc. where issues such as consent/capacity/ alleged assailant details/general medical assessment etc. should be covered.

Date _____ Time _____

Clinician _____ Regulatory Number _____

Patient Name _____ Patient DOB _____

Patient Number _____

History of Strangulation

History from _____ Persons present _____

Method ☐ Manual one hand ☐ Manual two hands

☐ Ligature ☐ Head lock

☐ Other *specify below*

_____

From 1 to 10 how hard was 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)

Time strangulation occurred: Date/Time _____ Time since strangulation (hours/days) _____

Number of episodes of strangulation in this event: ☐ One ☐ More than one ☐ Unknown

Did suspect say anything during strangulation? ☐ Yes ☐ No ☐ Unknown

Actions of the complainant during the strangulation ☐ Unknown ☐ Not asked

What was the complainant thinking at time of strangulation? ☐ Unknown ☐ Not asked

Has the suspect strangled the complainant before? ☐ Yes ☐ No ☐ Unknown ☐ Not asked

IFAS NON-FATAL STRANGULATION PRO FORMA

Symptoms at the time of / immediately after strangulation:

History from _____ Persons present _____

Vision	**Flashing lights** ☐ Yes ☐ No ☐ Unknown	**Tunnel vision** ☐ Yes ☐ No ☐ Unknown	**Spots** ☐ Yes ☐ No ☐ Unknown
	Blurred vision ☐ Yes ☐ No ☐ Unknown	**Loss of vision** ☐ Yes ☐ No ☐ Unknown	**Seeing "stars"** ☐ Yes ☐ No ☐ Unknown
	Other:		
Hearing	Buzzing, Roaring or Popping ☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:		
Loss of consciousness	☐ Yes ☐ No ☐ Unknown ☐ Not asked		
Dizzy	☐ Yes ☐ No ☐ Unknown ☐ Not asked		
Difficulty breathing	☐ Yes ☐ No ☐ Unknown ☐ Not asked		
Difficulty speaking	☐ Yes ☐ No ☐ Unknown ☐ Not asked		
Pain	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:		
Incontinence of urine	☐ Yes ☐ No ☐ Unknown ☐ Not asked		
Incontinence of bowels	☐ Yes ☐ No ☐ Unknown ☐ Not asked		
Loss of strength	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details (objective):		

IFAS NON-FATAL STRANGULATION PRO FORMA

Symptoms and signs since the time of strangulation:

History from: _____ Persons present _____

Neck pain	☐ Yes ☐ No ☐ Unknown ☐ Not asked Site: Severity: Details:
Neck swelling	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:
Neck injuries	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:
Coughing	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:
Dysphagia / drooling	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:
Odynophagia (Painful swallowing)	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:
Dysphonia or voice changes	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:
Dyspnoea	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:
Vomiting	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:
Headache	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:
Memory disturbance	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:
Have any other symptoms or injuries thought to be related to the	☐ Yes ☐ No ☐ Unknown ☐ Not asked Details:

“I thought I was going to die”

36.6%

Psychological terror

- *He is going to kill me. At least if he kills me it will be over*
- *God please give me life, my children need me.*
- I actually thought he was going to kill me and the baby (20 weeks pregnant)
- *I'm going to die. He only stopped each time when I was losing consciousness. He strangled me like he wanted to kill me. He only stopped because he thought I was dead.*

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History of Strangulation

History from_____ Persons present_____

Method ☐ Manual one hand ☐ Manual two hands

☐ Ligature ☐ Head lock

☐ Other *specify below*

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_____

_____

Actions of the complainant during the strangulation ☐ Unknown ☐ Not asked

_____

_____

What was the complainant thinking at time of strangulation? ☐ Unknown ☐ Not asked

_____

_____

Has the suspect strangled the complainant before? ☐ Yes ☐ No ☐ Unknown ☐ Not asked

_____

_____

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History from _____ Persons present _____

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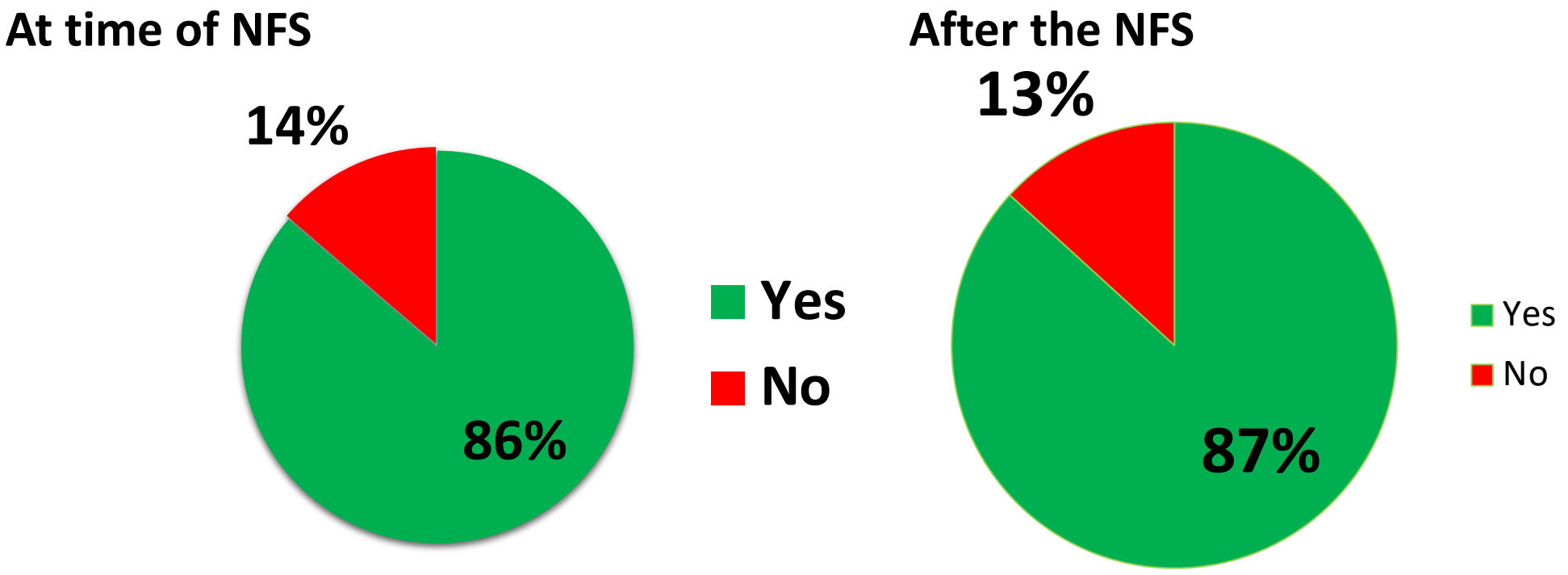
Symptoms of NFS



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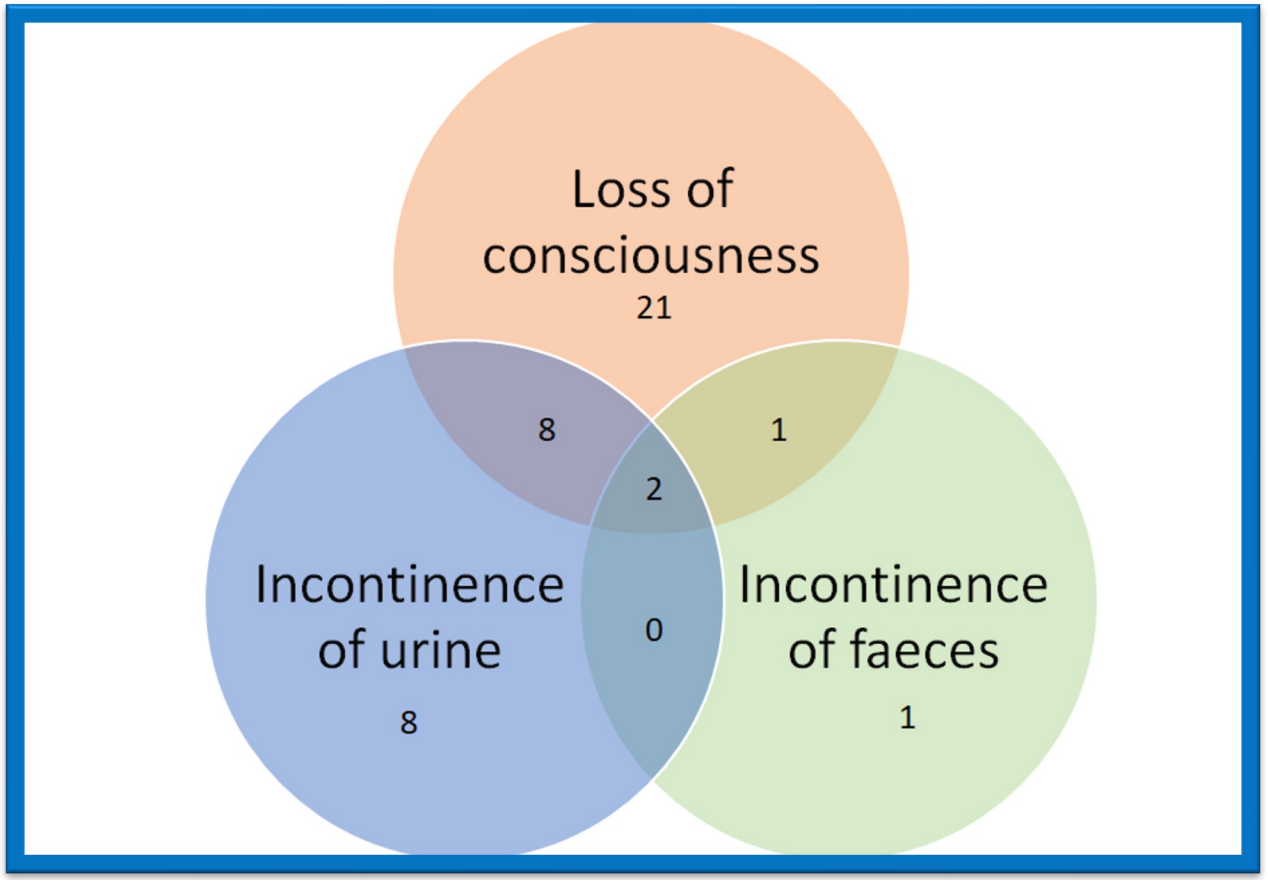
Saint Mary's Adult NFS cases

St Mary's Centre
Sexual Assault Referral Centre



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Capacity & consent

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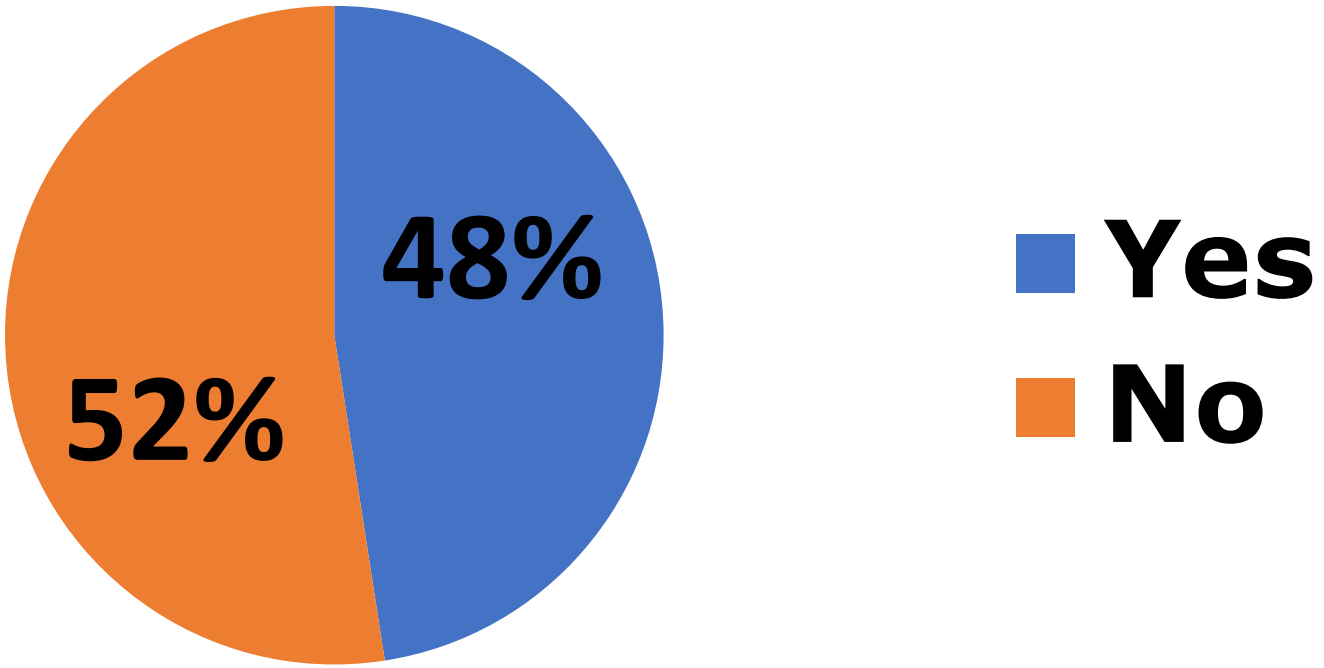
Neck & Head Injuries

Saint Mary's NFS cases 2017-2019

n=204



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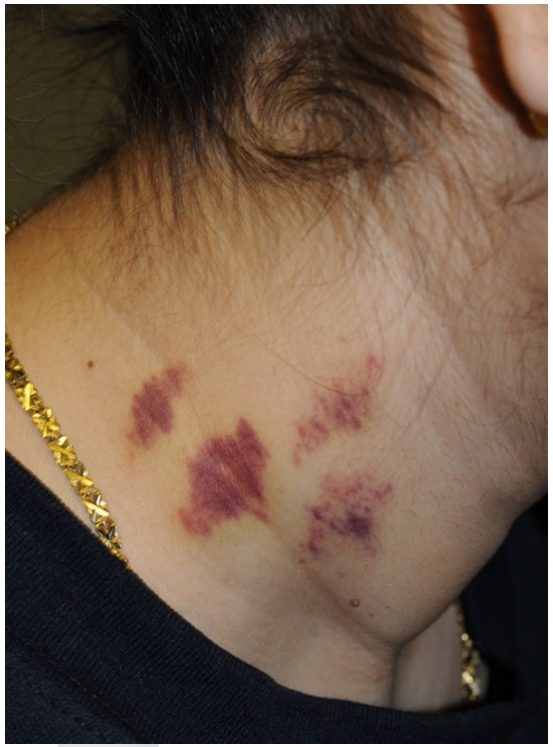
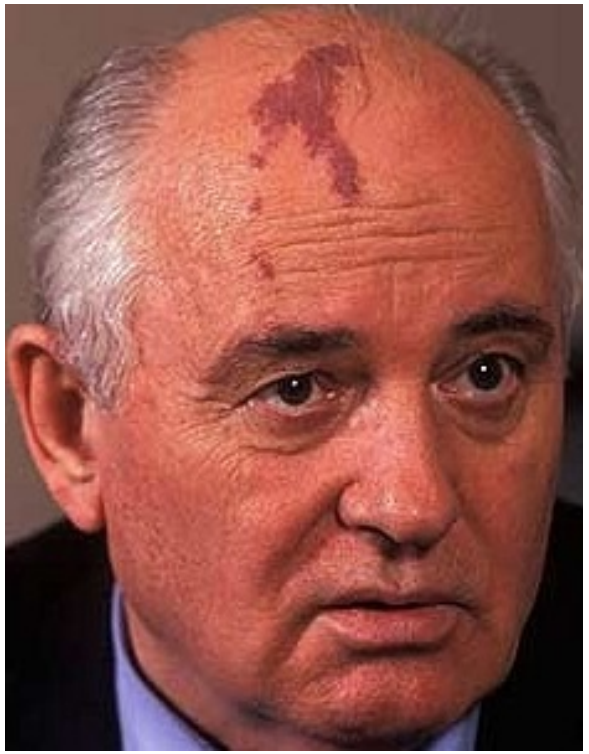
What's a red mark?





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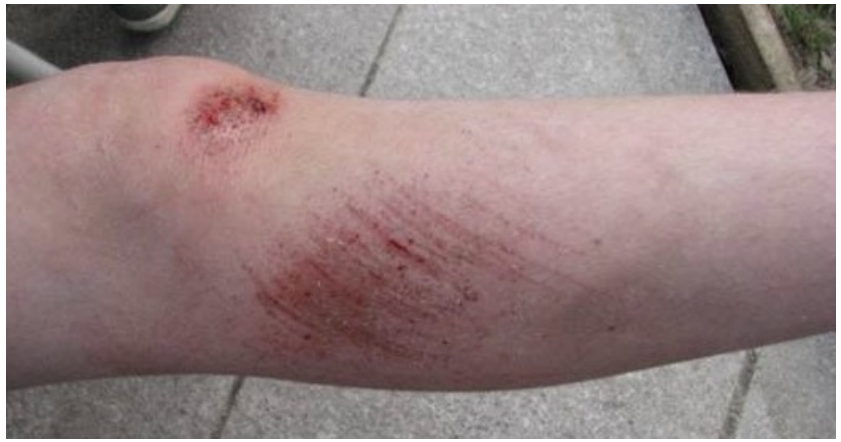
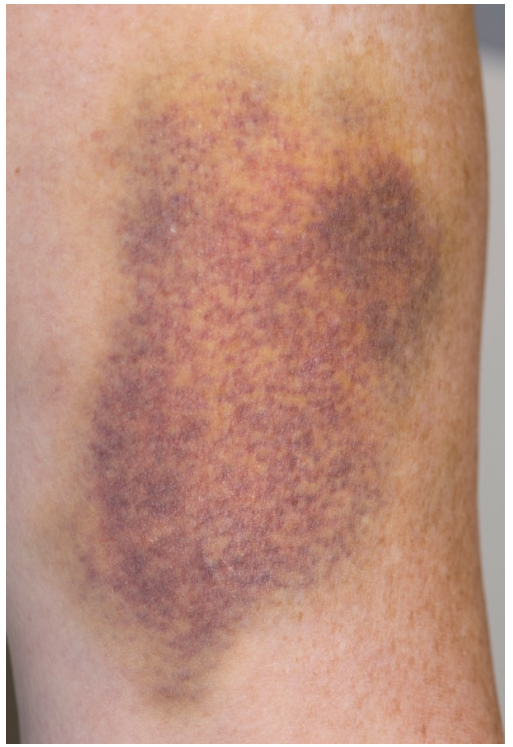
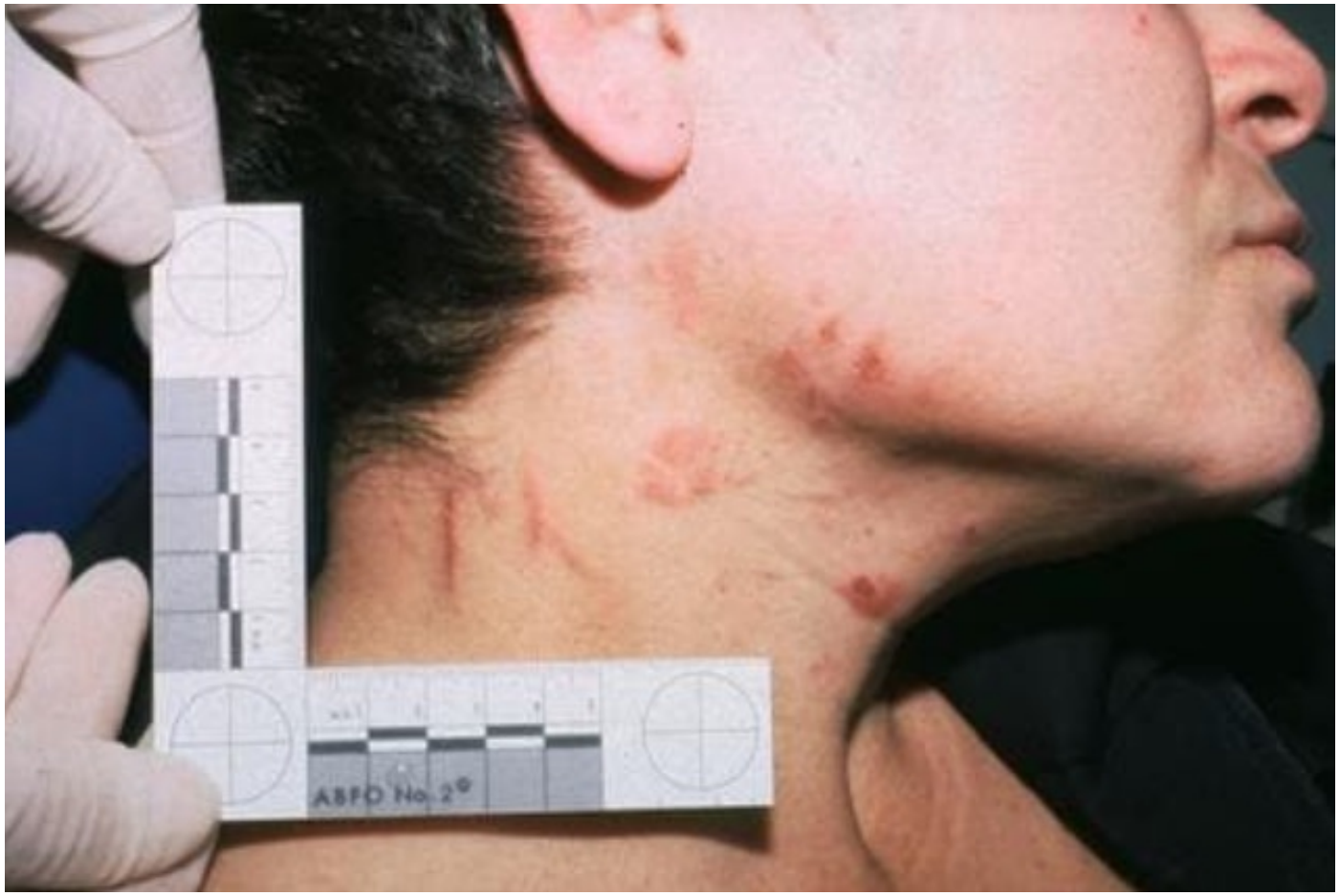
Document injuries accurately





Neck bruises



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Fitzpatrick Skin Colour Scale

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FFLM Forensic sample guidelines

https://fflm.ac.uk/resources/publications/recommendations-for-the-collection-of-forensic-specimens-from-complainants-and-suspects

Cellmark Forensic Services College of Policing Key Forensic Services Ltd Eurofins Forensic Services National Police Chiefs' Council
Scottish Police Authority The UK Association of Forensic Nurses and Paramedics Analytical Services International

Faculty of Forensic & Legal Medicine

Recommendations for the collection of forensic specimens from complainants and suspects

Jul 2023 Review date Jan 2024 – check www.fflm.ac.uk for latest update

The medico-legal guidelines and recommendations published by FFLM are for general information only. Appropriate specific advice should be sought from your medical defence organisation or professional association. FFLM has one or more senior persons from each of the three medical defence organisations on its Board, but for the avoidance of doubt, endorsement of the medico-legal guidelines or recommendations published by FFLM has not been sought from any of the medical defence organisations.

Instructions for use – PLEASE READ BEFORE REFERRING TO TABLE

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Forensic samples

- Nails
  - Broken / missing / length
  - Forensic samples
- Skin swabs

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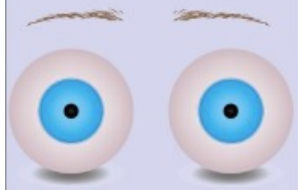
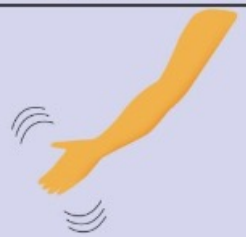
Glasgow Coma Scale

Behaviour	Response
 Eye Opening Response	4. Spontaneously 3. To speech 2. To pain 1. No response
 Verbal Response	5. Oriented to time, person and place 4. Confused 3. Inappropriate words 2. Incomprehensible sounds 1. No response
 Motor Response	6. Obeys command 5. Moves to localised pain 4. Flex to withdraw from pain 3. Abnormal flexion 2. Abnormal extension 1. No response

Mild 13-15

Moderate 9-12

Severe 3-8

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	NFS + sexual assault	NFS but no sexual assault
Specialist secure victim focussed centre	✓	✗
Forensic clinician assessment	✓	✗
Crisis worker	✓	✗
Colposcopic images	✓	✗
Forensic samples	✓	✗
ENT Radiology pathway	✓	✗
Forensic report	✓	✗
Shower & clothing	✓	✗
Expert report	✓	✗
Advocacy	✓	✗
Quality assurance & peer review	✓	✗


Break

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Internal injuries

- Brain
- Neck structures
  - Haemorrhage into muscles
  - Vocal cords
  - Nerves
  - Thyroid
  - Hyoid
- Blood vessels
  - Carotid artery dissection

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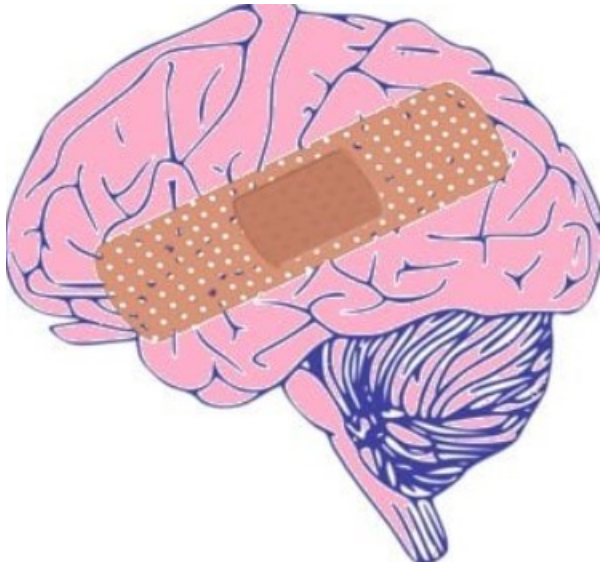
Acquired Brain Injury



Advice regarding seeking brain injury assessment

should be provided if there is history of prolonged

and/or repeated strangulations and/or deficits

suggestive of hypoxic brain injury that persist in the

months following the incident

(Australian ED Guidance)

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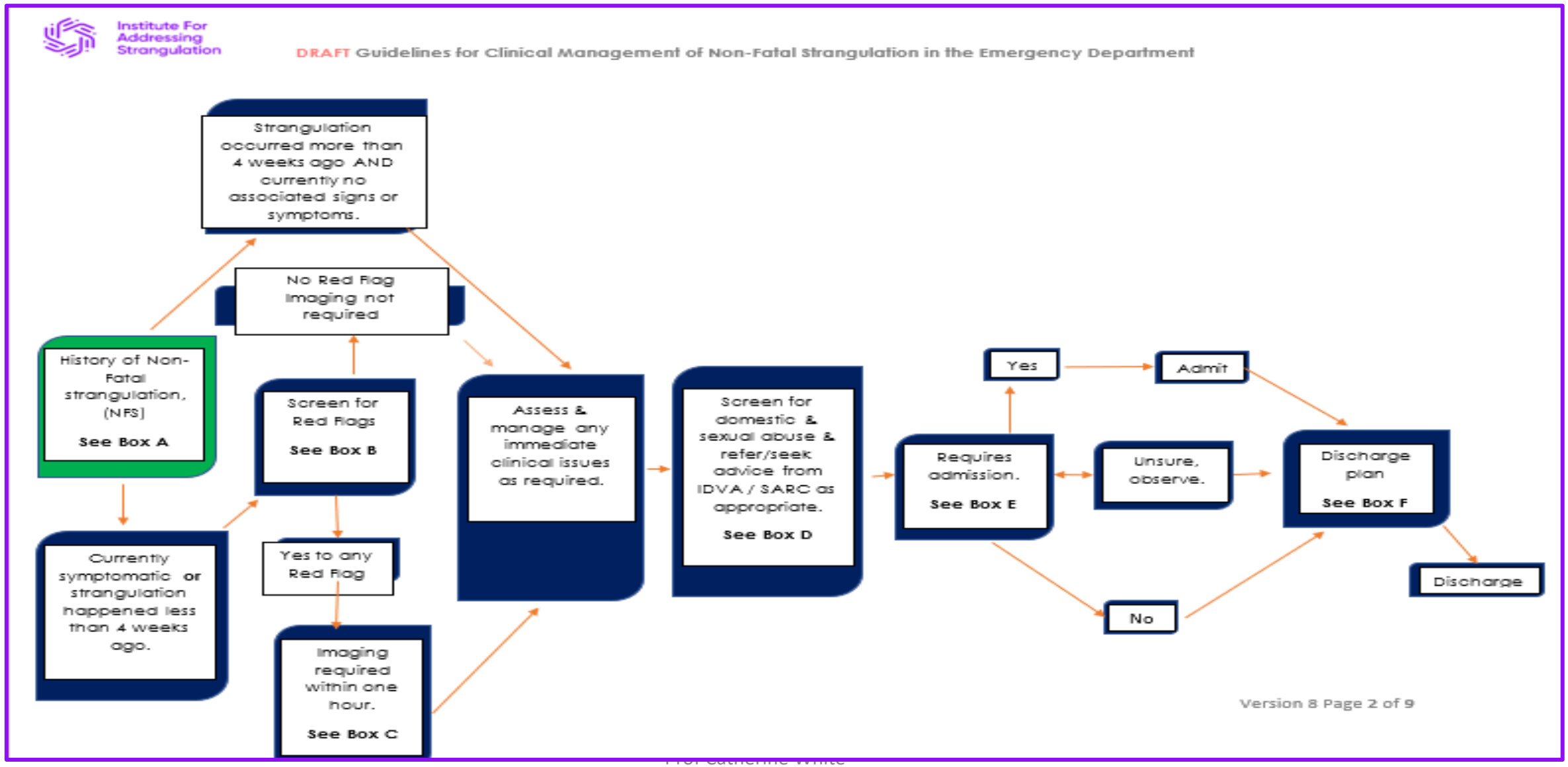

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Box B: Red Flags related to the strangulation.(draft document)

Neck

Mechanism concerning for cervical spine injury
Dysphagia or odynophagia (painful swallowing)
Voice changes, dysphonia (difficulty speaking)
Bruising to neck or ligature marks
Carotid bruits
Neck swelling or tenderness of larynx, trachea, carotid arteries

Chest

- Dyspnoea (objective signs and symptoms[10])
- Subcutaneous emphysema

Head/neurological

- Amnesia or altered mental status (dizzy/confused/loss of memory or awareness)
- Incontinence (bladder and/or bowels)
- History of head injury/stroke
- Loss or near loss of consciousness
- Mechanism of significant pressure applied to the neck.
- Neurological symptoms or signs (seizures, stroke-like symptoms, severe headache, tinnitus, decreased hearing, focal numbness)
- Visual symptoms (flashing lights/ spots /stars/tunnel vision)
- Petechial hemorrhages (neck/face/oral/conjunctival)

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Imaging

Box C (draft)

Imaging (should be done within 1 hour)

- CT angiography of the neck and intracranial vessels[a]
- +/- CT head[b]
- +/- CT chest

(a). Arterial phase study with bone reconstructions of the cervical spine recommended.

(b). Initial non-contrast CT head scan if clinical indicators present (GCS <14, witnessed seizure, history of incontinence, focal neurology, concerning blunt trauma to head evident clinically).

Ultrasound/carotid doppler ultrasound and plain X-rays are NOT RECOMMENDED for evaluation of the vascular or soft tissue structures in this setting.

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Box D: All Cases

- Safeguarding assessment including any children or vulnerable adults that may be at risk.
- Discuss with patient options of reporting to police taking into consideration capacity, confidentiality & best interest[11].
- Undertake suicide risk/ self-harm assessment. Self-harm by hanging/strangulation often indicates a very high suicide intent[12].

Domestic Abuse with no report of sexual violence

- All of the above plus:
- Complete DASH assessment (note NFS in itself would warrant a MARAC referral, regardless of overall DASH score) Dash risk checklist quick start guidance FINAL.pdf (safelives.org.uk)
- Independent Domestic Violence Advisor (IDVA) referral

Sexual Assault/Rape Cases (Including sexual assault/rape in the context of domestic abuse)

- All of the above plus:
- Consider referral / seek advice from local Sexual Assault Referral Centre (SARC) as a self or police referral.

England https://www.nhs.uk/service-search/other-health-services/rape-and-sexual-assault-referral-centres
Wales https://executive.nhs.wales/networks/programmes/welsh-sexual-assault-services-programme/sexual-assault-referral-centres-sarcs/
Scotland https://www.nhsinform.scot/turn-to-sarcs/7-days-and-under/about-the-sexual-assault-self-referral-phone-service
Northern Ireland https://www.nidirect.gov.uk/articles/rowan-sexual-assault-referral-centre-sarc

  - For forensic medical examination
  - Independent Sexual Violence Advisor (ISVA) support
  - Counselling

- Assess for
  - Emergency contraception
  - HIV & Hep B post exposure prophylaxis.
  - Signpost for window period for STI screening

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Requires hospital admission (draft)

Box E: Requires Admission

Admission may be required either for the management of injury, or for social/safeguarding reasons or both. Involve senior decision maker as required. Local pathways to appropriate clinical specialty for admission should be followed.

Considerations for admission:

- Concern about airway
- Clinical condition
- History of significant blunt force/pressure to neck or head[13]
- Significant findings on imaging
- Unsafe discharge setting
- Vulnerable population (e.g., children, elderly, pregnant, homeless) and/or safeguarding requirement including self-harm risk.

Consider observation if very acute presentation. Delayed airway difficulties are rare and likely to occur within the first 6 hours post assault, dependent on factors such as type/extent of injury etc.

(NOTE: "Observation only" has NO role in a suspected vascular injury and appropriate imaging is required)

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Discharge planning (draft)

Box F: Discharge Planning

1. **Safeguarding**
   a. Is the patient safe to go home?
   b. Have all relevant safeguarding referrals been made?

2. **Safety netting**
   a. Provide patient / carer with information regarding strangulation including signs and symptoms to watch out for that would need urgent medical assessment https://ifas.org.uk/wp-content/uploads/2023/05/IFAS-01-Patient-Information.pdf

3. **Imaging**
   a. For those not seen within 4 weeks of the strangulation and who were not currently symptomatic and have therefore not been scanned, they may still be at risk of vascular problems such as carotid artery dissection due to the blunt neck trauma. Those who screen positive for any Red Flag (see Box B) will require outpatient imaging arranged directly or via GP dependent upon local arrangement.
   b. Consider antiplatelet treatment for those being referred for outpatient imaging.

4. **Acquired brain injury assessment.**
   Strangulation may result in acquired brain injury[14] (hypoxic-ischaemic), and this may lead to neuropsychological difficulties such as:
   - Disorders of language
   - Emotional dysregulation, personality changes and behaviour disturbance including aggression.
   - Cognitive decline

   An assessment by a neuropsychologist, or similar, should be undertaken 3 months post the strangulation, with the referral organized by the GP or direct referral dependent upon local arrangement.

5. **GP letter**
   Following standard local consent to share information processes, include details of strangulation and requested GP actions such as any required referrals in a clear timely fashion, remembering that victims of strangulation are likely to require psychological support. Consider confidentiality / risk issues regarding access to information in patient records.

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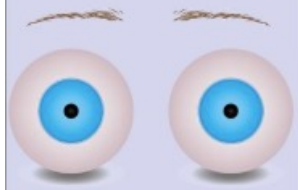
Glasgow Coma Scale

Behaviour	Response
 Eye Opening Response	4. Spontaneously 3. To speech 2. To pain 1. No response
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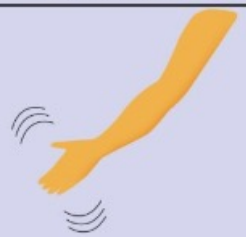 Motor Response	6. Obeys command 5. Moves to localised pain 4. Flex to withdraw from pain 3. Abnormal flexion 2. Abnormal extension 1. No response

Mild 13-15

Moderate 9-12

Severe 3-8

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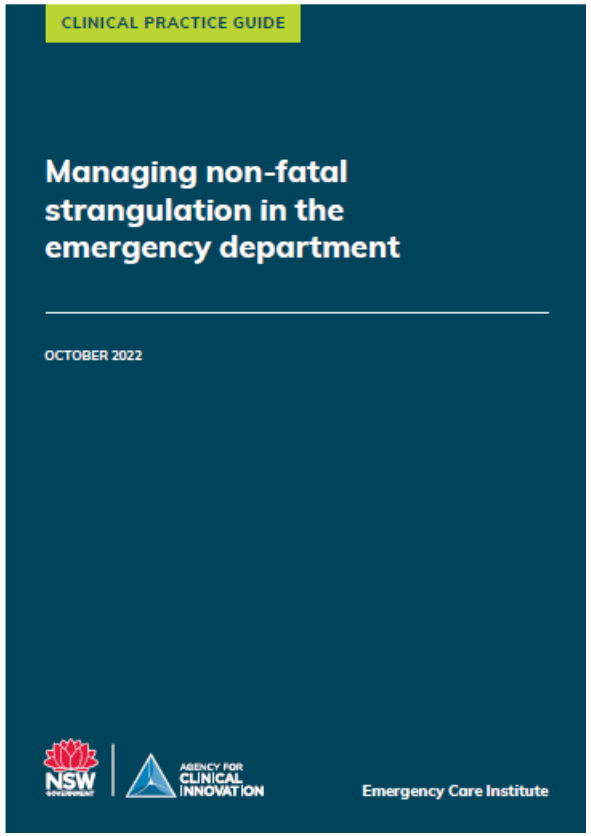
Australian Guidance 2022



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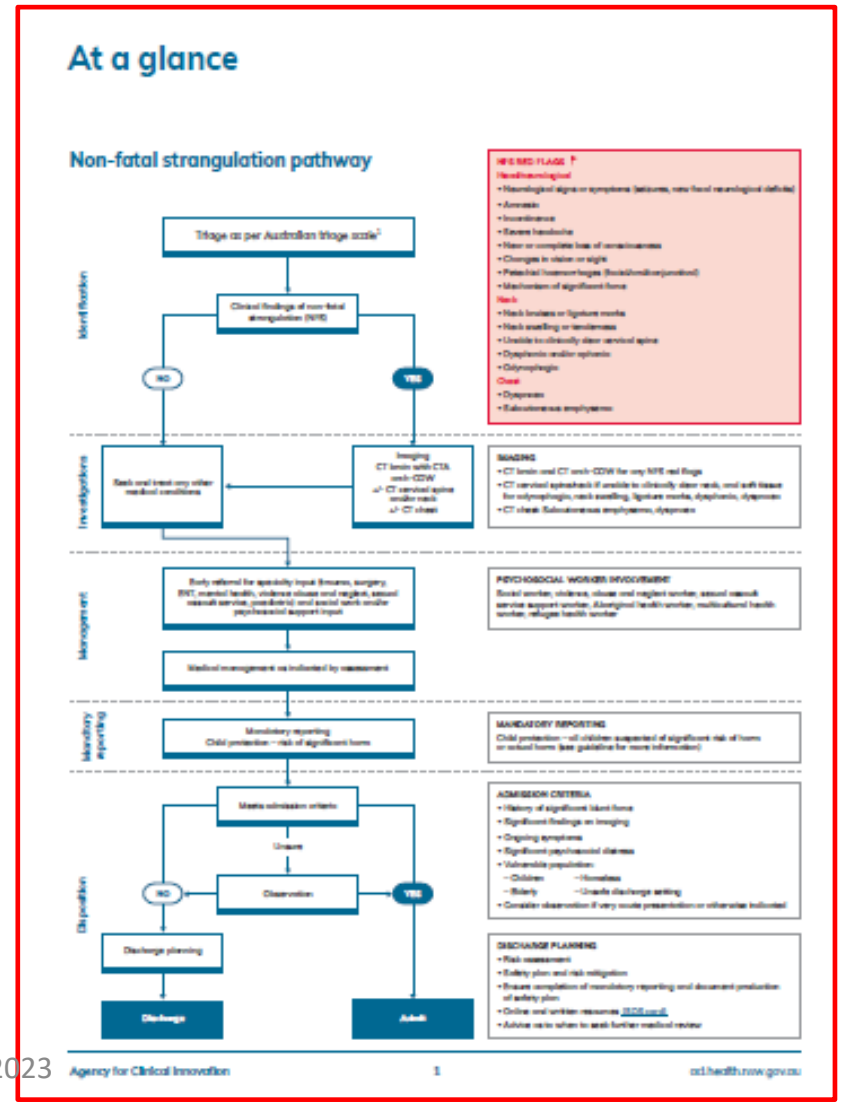

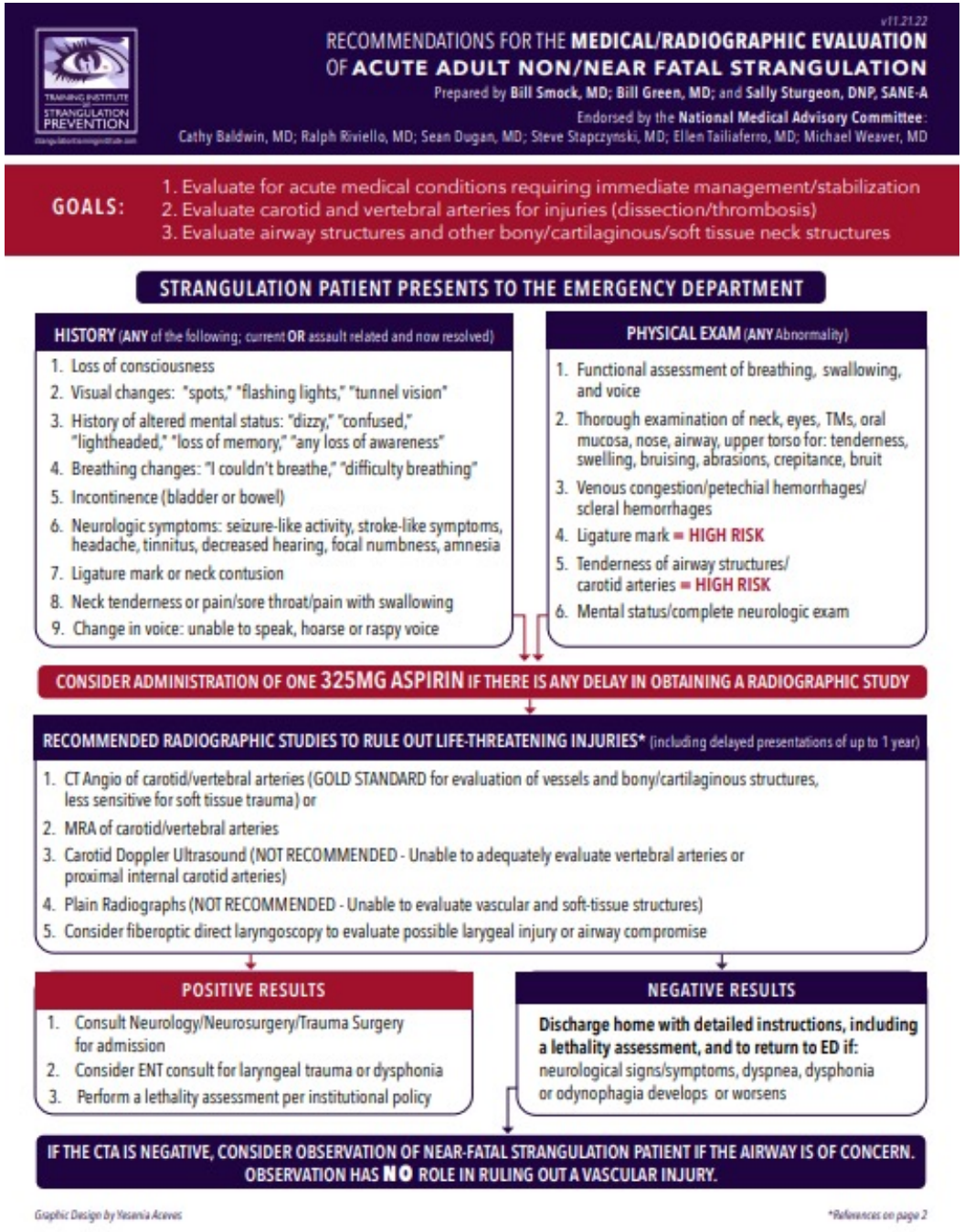

Training Institute On Strangulation Prevention

https://www.familyjusticecenter.org/resources/recommendations-for-the-medical-radiographic-evaluation-of-acute-adult-adolescent-non-near-fatal-strangulation/

October 2022

Institute For Addressing Strangulation

Forensic samples

- Nails
  - Broken / missing / length
  - Forensic samples
- Skin swabs

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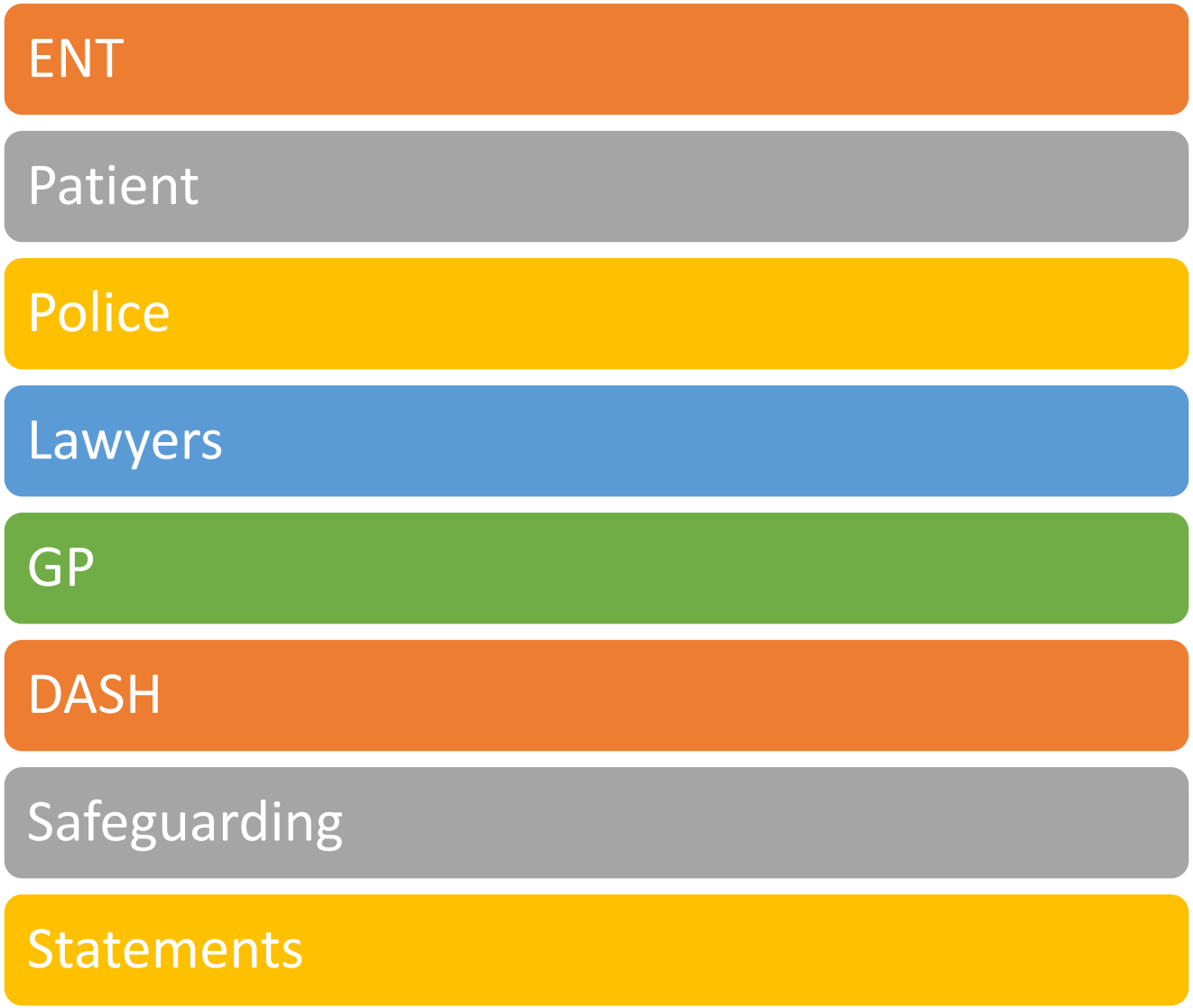
Information sharing



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	NFS + sexual assault	NFS but no sexual assault
Specialist secure victim focussed centre	✓	✗
Forensic clinician assessment	✓	✗
Crisis worker	✓	✗
Colposcopic images	✓	✗
Forensic samples	✓	✗
ENT Radiology pathway	✓	✗
Forensic report	✓	✗
Shower & clothing	✓	✗
Expert report	✓	✗
Advocacy	✓	✗
Quality assurance & peer review	✓	✗

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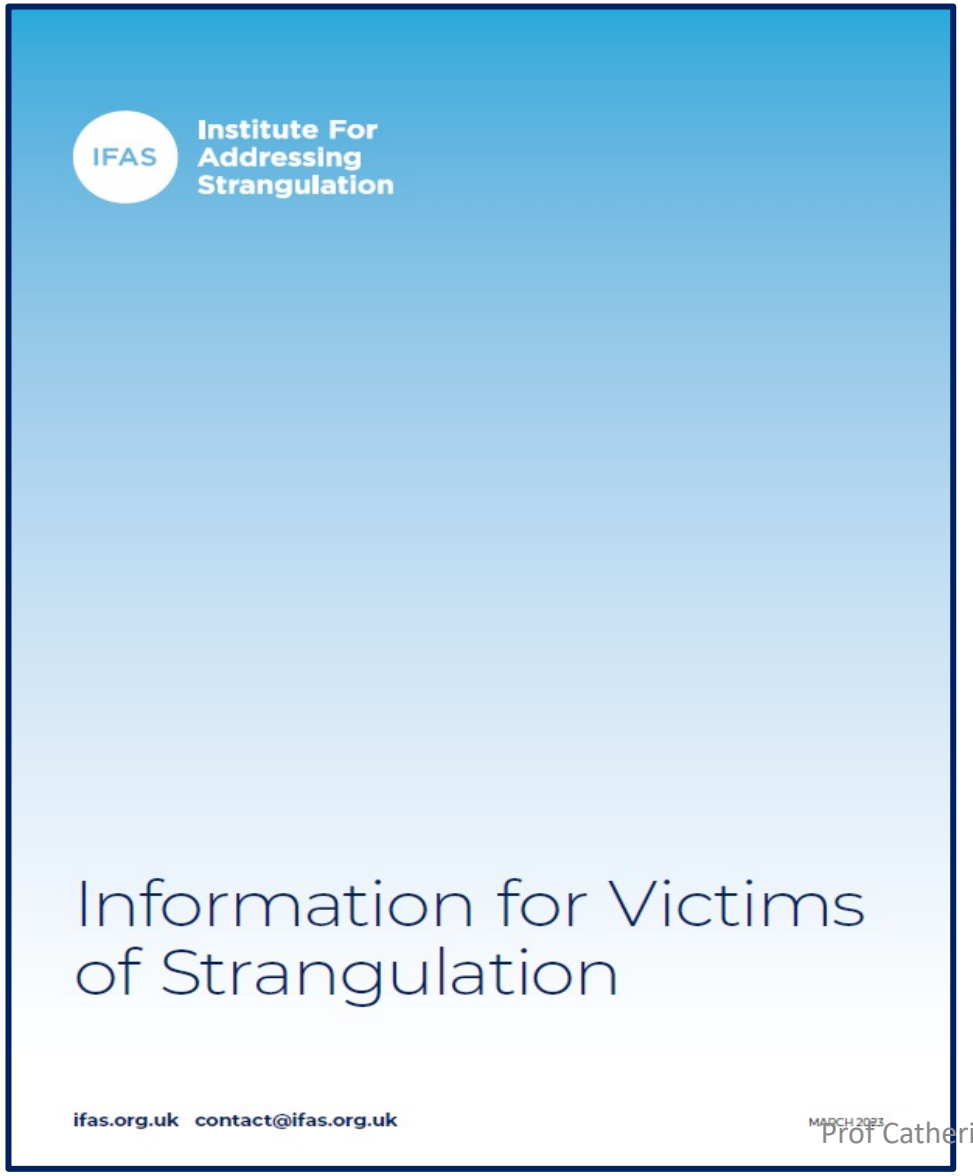

Risks of not knowing the risks

https://static1.squarespace.com/static/63bd7ef0794e9f154bdce4ce/t/64131368ee0266496d81dde8/1678971753356/IFAS+01+-+Patient+Information+v5.pdf

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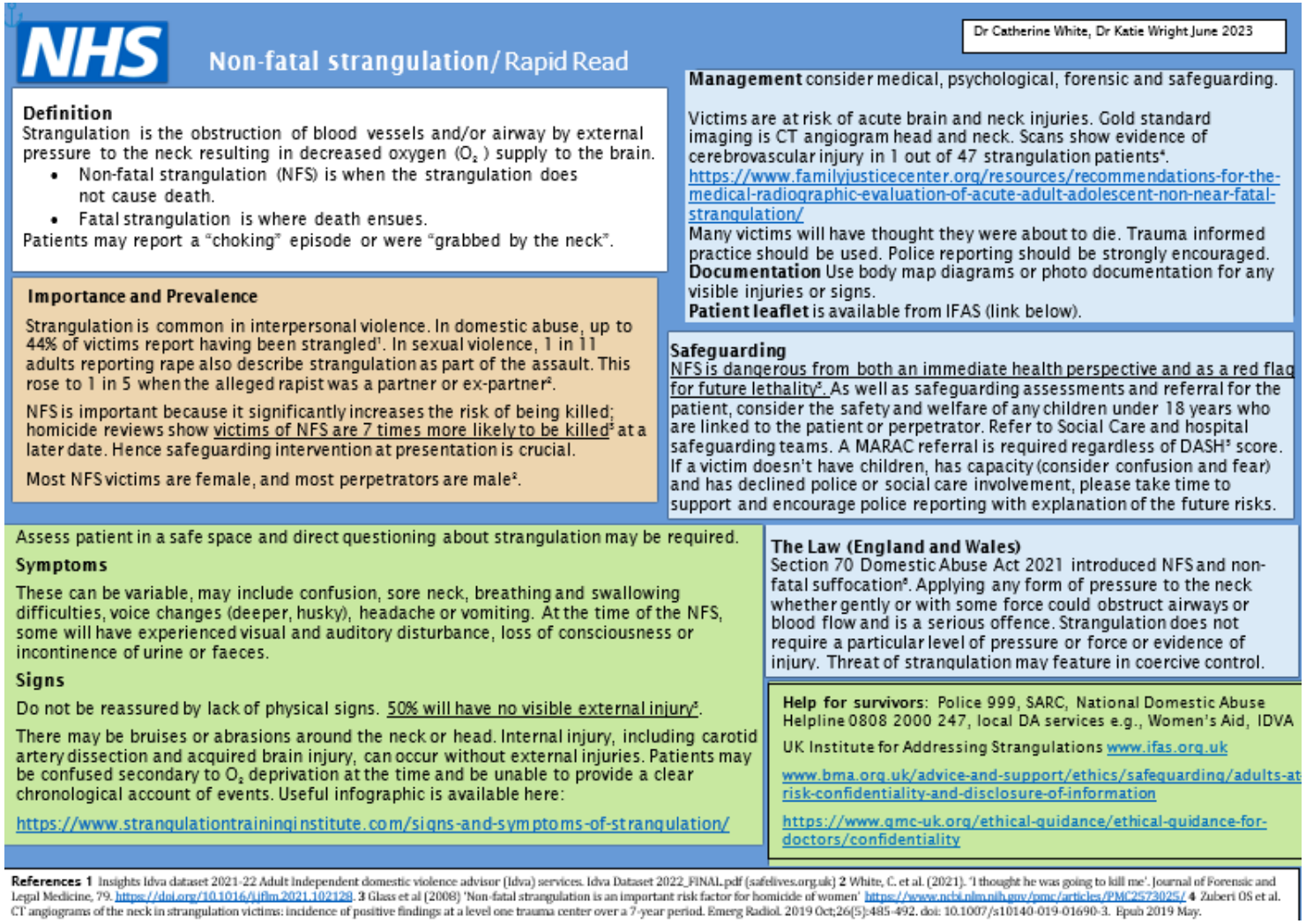
NHS England Rapid Read



NHS Non-fatal strangulation/ Rapid Read

Dr Catherine White, Dr Katie Wright June 2023

Definition
Strangulation is the obstruction of blood vessels and/or airway by external pressure to the neck resulting in decreased oxygen (O_2) supply to the brain.

- Non-fatal strangulation (NFS) is when the strangulation does not cause death.
- Fatal strangulation is where death ensues.

Patients may report a "choking" episode or were "grabbed by the neck".

Importance and Prevalence

Strangulation is common in interpersonal violence. In domestic abuse, up to 44% of victims report having been strangled[1]. In sexual violence, 1 in 11 adults reporting rape also describe strangulation as part of the assault. This rose to 1 in 5 when the alleged rapist was a partner or ex-partner[2].

NFS is important because it significantly increases the risk of being killed; homicide reviews show victims of NFS are 7 times more likely to be killed[3] at a later date. Hence safeguarding intervention at presentation is crucial.

Most NFS victims are female, and most perpetrators are male[2].

Management consider medical, psychological, forensic and safeguarding.

Victims are at risk of acute brain and neck injuries. Gold standard imaging is CT angiogram head and neck. Scans show evidence of cerebrovascular injury in 1 out of 47 strangulation patients[4].
https://www.familyjusticecenter.org/resources/recommendations-for-the-medical-radiographic-evaluation-of-acute-adult-adolescent-non-near-fatal-strangulation/
Many victims will have thought they were about to die. Trauma informed practice should be used. Police reporting should be strongly encouraged.
Documentation Use body map diagrams or photo documentation for any visible injuries or signs.
Patient leaflet is available from IFAS (link below).

Safeguarding
NFS is dangerous from both an immediate health perspective and as a red flag for future lethality[5]. As well as safeguarding assessments and referral for the patient, consider the safety and welfare of any children under 18 years who are linked to the patient or perpetrator. Refer to Social Care and hospital safeguarding teams. A MARAC referral is required regardless of DASH[5] score. If a victim doesn't have children, has capacity (consider confusion and fear) and has declined police or social care involvement, please take time to support and encourage police reporting with explanation of the future risks.

Assess patient in a safe space and direct questioning about strangulation may be required.

Symptoms

These can be variable, may include confusion, sore neck, breathing and swallowing difficulties, voice changes (deeper, husky), headache or vomiting. At the time of the NFS, some will have experienced visual and auditory disturbance, loss of consciousness or incontinence of urine or faeces.

Signs

Do not be reassured by lack of physical signs. 50% will have no visible external injury[5].

There may be bruises or abrasions around the neck or head. Internal injury, including carotid artery dissection and acquired brain injury, can occur without external injuries. Patients may be confused secondary to O_2 deprivation at the time and be unable to provide a clear chronological account of events. Useful infographic is available here:

https://www.strangulationtraininginstitute.com/signs-and-symptoms-of-strangulation/

The Law (England and Wales)
Section 70 Domestic Abuse Act 2021 introduced NFS and non-fatal suffocation[6]. Applying any form of pressure to the neck whether gently or with some force could obstruct airways or blood flow and is a serious offence. Strangulation does not require a particular level of pressure or force or evidence of injury. Threat of strangulation may feature in coercive control.

Help for survivors: Police 999, SARC, National Domestic Abuse Helpline 0808 2000 247, local DA services e.g., Women's Aid, IDVA

UK Institute for Addressing Strangulations www.ifas.org.uk

www.bma.org.uk/advice-and-support/ethics/safeguarding/adults-at-risk-confidentiality-and-disclosure-of-information

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality

References 1 Insights Idva dataset 2021-22 Adult Independent domestic violence advisor (Idva) services. Idva Dataset 2022_FINAL.pdf (safelives.org.uk) 2 White, C. et al. (2021). 'I thought he was going to kill me'. Journal of Forensic and Legal Medicine, 79. https://doi.org/10.1016/j.jflm.2021.102128. 3 Glass et al (2008) 'Non-fatal strangulation is an important risk factor for homicide of women' https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2573025/ 4 Zuberi OS et al. CT angiograms of the neck in strangulation victims: incidence of positive findings at a level one trauma center over a 7-year period. Emerg Radiol. 2019 Oct;26(5):485-492. doi: 10.1007/s10140-019-01690-3. Epub 2019 May.

Consensual??

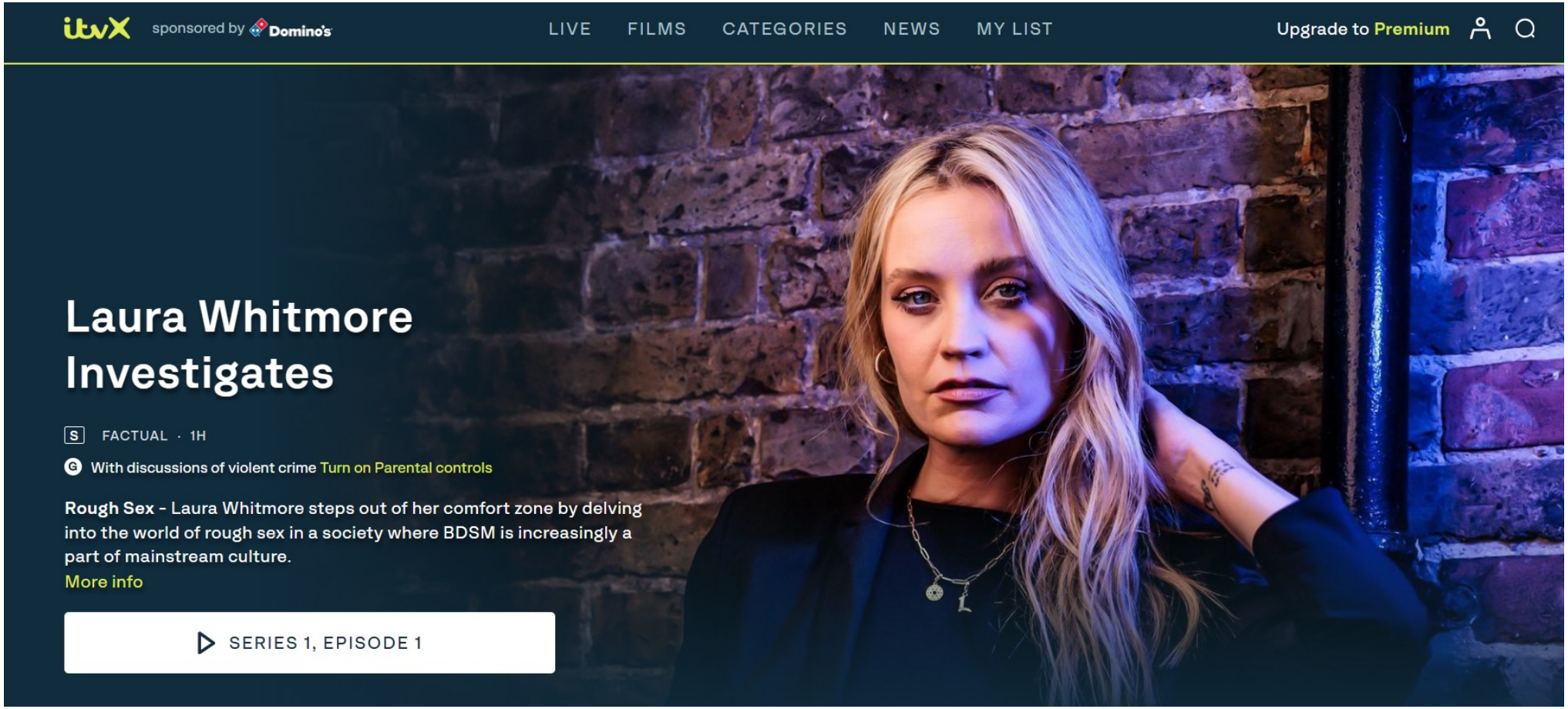
112 of the 224 cases a DASH was completed.

Dash –average score 15

Consensual strangulation

- https://publichealth.indiana.edu/research/faculty-directory/profile.html?user=debby
- Herbenick, D., Fu, T., Svetina Valdivia, D., Patterson, C., Rosenstock Gonzalez, Y., Guerra-Reyes, L., Eastman-Mueller, H., Beckmeyer, J., & Rosenberg, M. (2021). What is rough sex, who does it, and who likes it? Findings from a probability survey of U.S. undergraduate students. *Archives of Sexual Behavior*, 50(3), 1183-1195.
- Herbenick, D., Fu, T., Patterson, C., & Fortenberry, J.D. (In press). Exercise-induced orgasm and its association with sleep orgasms and orgasms during partnered sex: Findings from a U.S. probability survey. *Archives of Sexual Behavior*.
- Herbenick, D., Fu, T., Patterson, C., Rosenstock Gonzalez, Y.R., Luetke, M., Svetina Valdivia, D., Eastman-Mueller, H., Guerra-Reyes, L., & Rosenberg, M. (In press). Prevalence and characteristics of choking/strangulation during sex: Findings from a probability survey of undergraduate students. *Journal of American College Health*.

“There is no safe way to strangle”



Children witnessing NFS

- Saint Mary's 2021 study
  - 40% strangled in their own home
  - 30% had children living at home
- San Diego Paper 1
  - Children witnessed the NFS in at least 41% of cases
- CPS Dec 2022
  - Children present in more than a third of NFS offences, according to analysis of a sample of cases by CPS
  - www.cps.gov.uk/cps/news/children-are-often-present-during-non-fatal-strangulation-cps-analysis-shows

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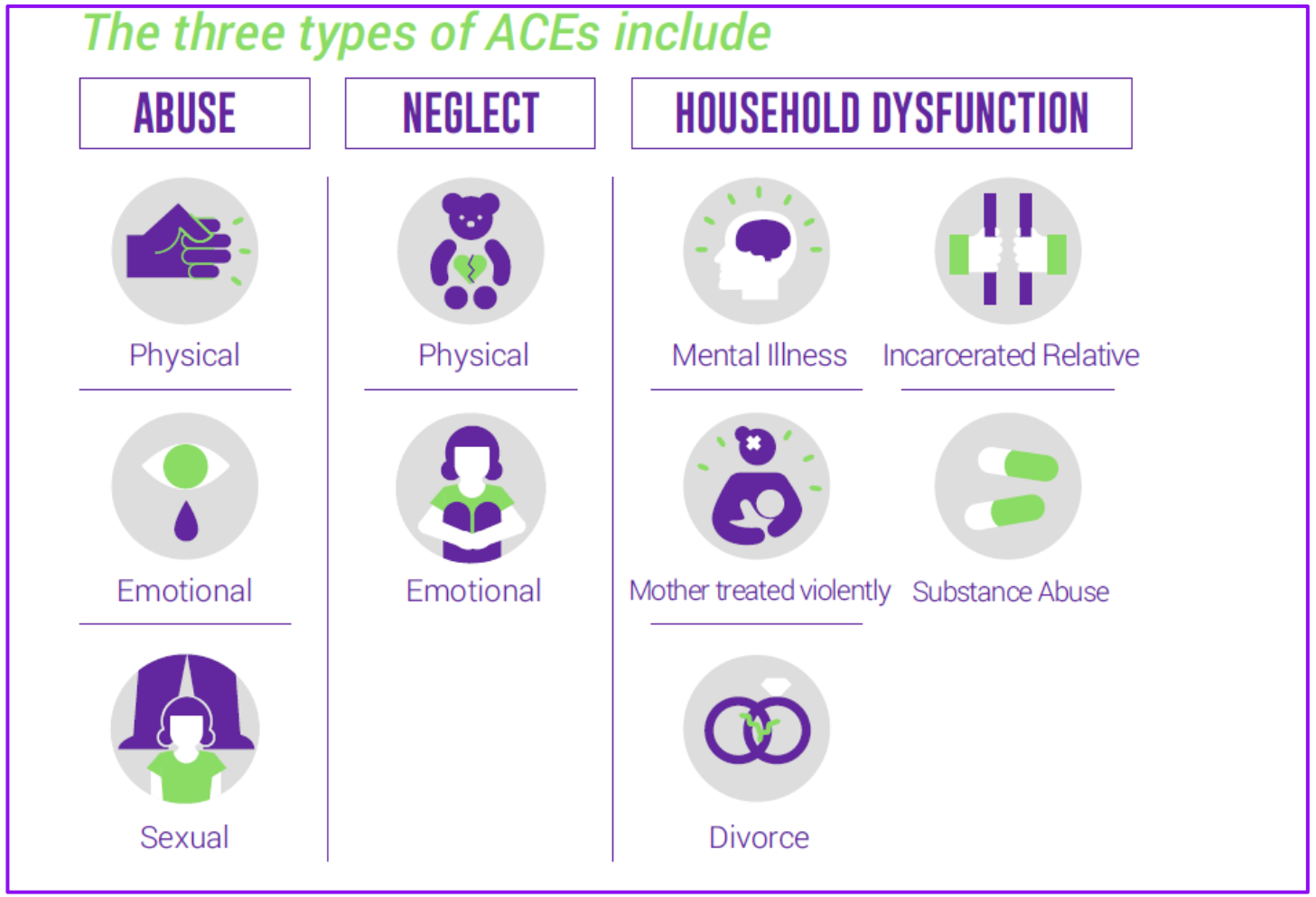
Adverse Childhood Experiences



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Children as victims of strangulation

- Not mini adults
- Underestimated, little in the literature
- Anatomical differences
- Less able to report
- Incontinence?
- Deaths , cerebral asphyxia from carotid occlusion

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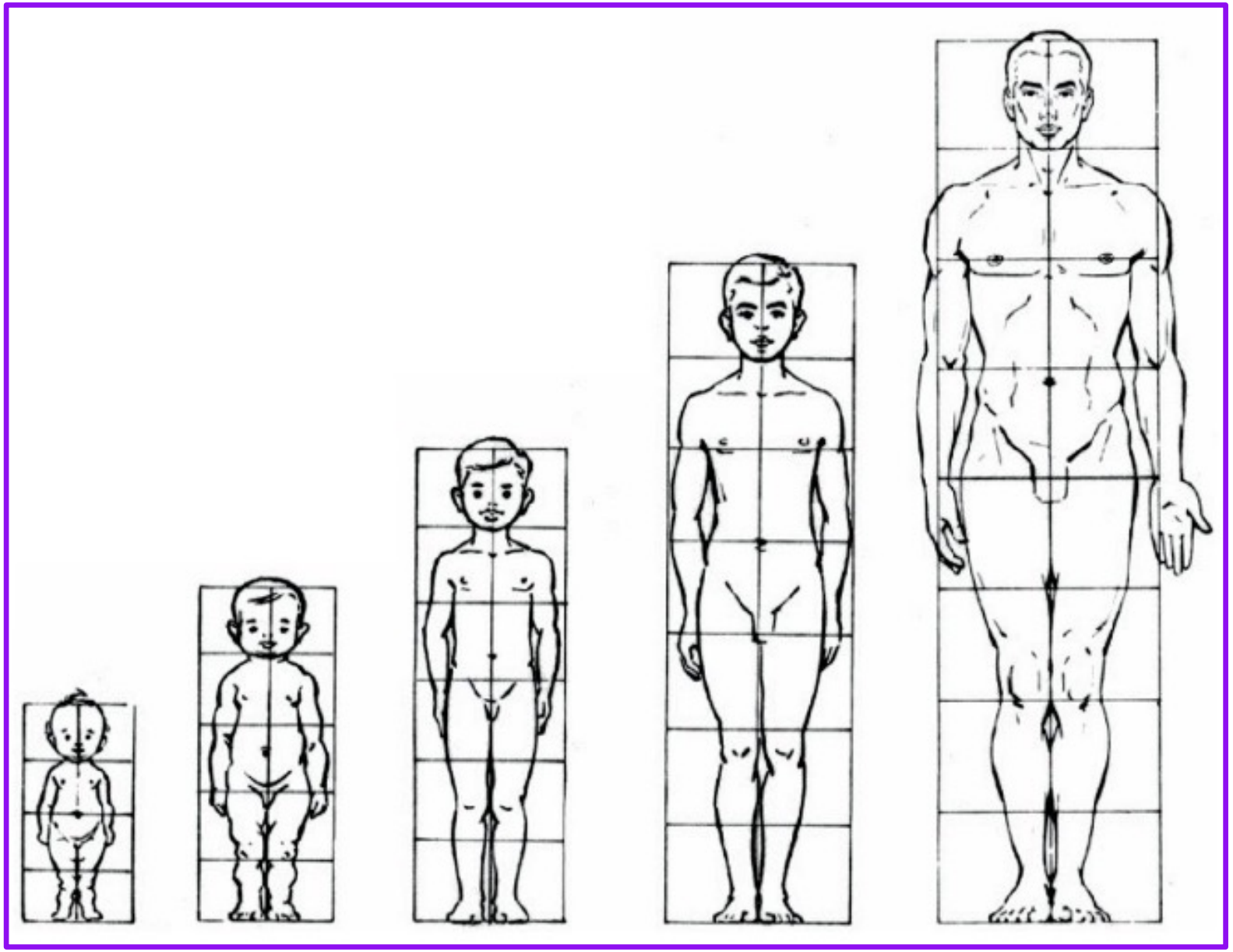

Prof Catherine White

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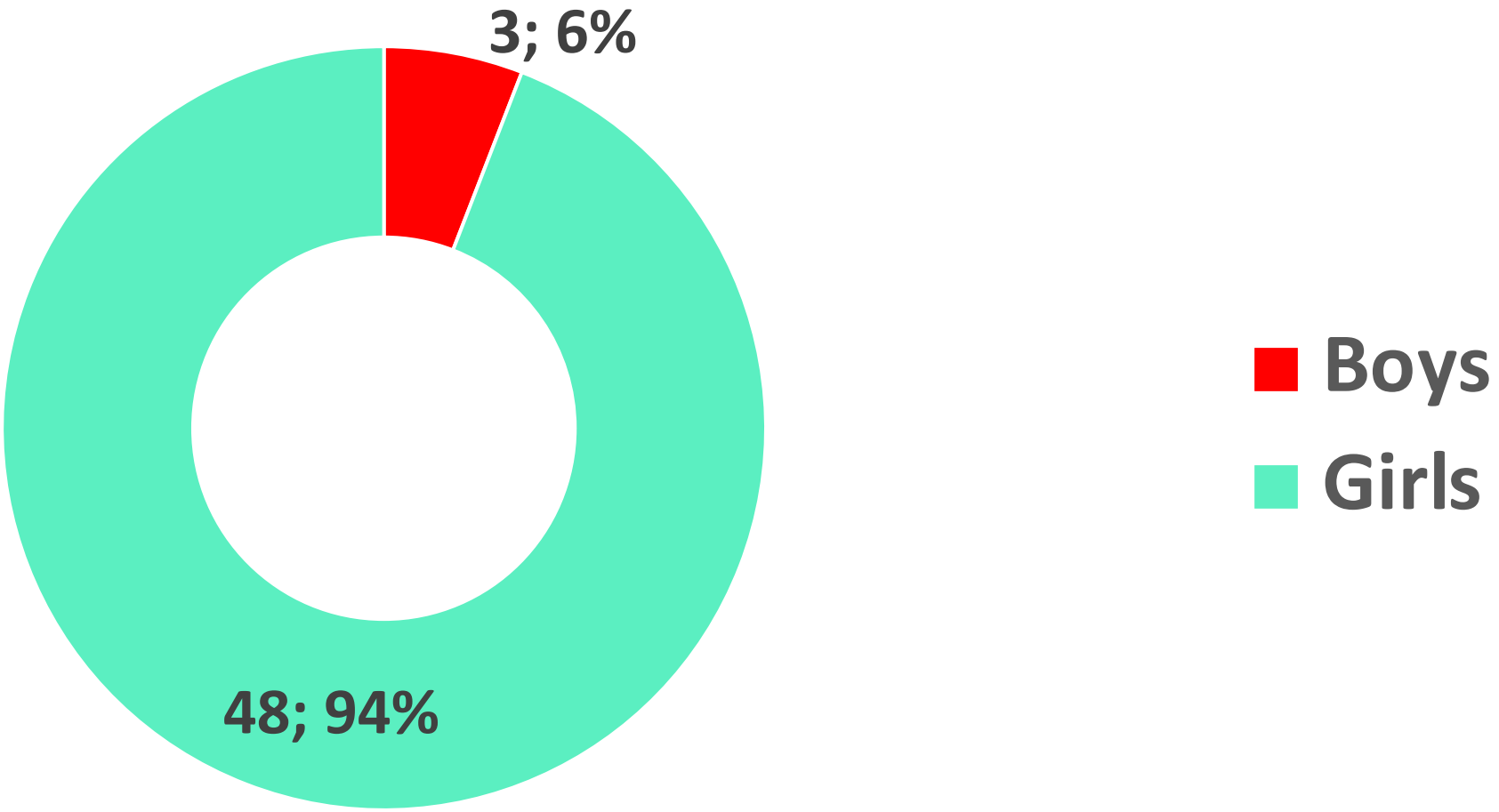
St Mary's Centre
Sexual Assault Referral Centre

Sex of 51 children reporting NFS



Review

Abuse, neglect and neurodevelopment across the life course: what can paediatricians and child psychiatrists do about this together? The Rees-Illingworth keynote lecture 2023

Helen Minnis

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Accepted 25 August 2023

ABSTRACT
Paediatricians and child psychiatrists share complex cases, often associated with abuse, neglect and other 'Adverse Childhood Experiences (ACEs)'. ACEs are associated in a dose-response relationship with both mental and physical health problems across the life span. We found that 9-year-old children who had been abused and neglected were much more likely to also have symptoms of heritable neurodevelopmental conditions (NDCs) such as ADHD, autism and intellectual disabilities. To our surprise, these were not caused by the abuse and neglect. Instead, both the NDCs and the abuse and neglect were being caused by additional genetic factors. We also found that children who have experienced abuse and neglect, and who also have NDCs, are at twice the risk of developing symptoms of severe mental illness in adolescence. This has caused us to develop our 'Double Jeopardy' hypothesis—that experiencing both abuse and neglect and NDCs in childhood might double the risk of a range of physical and mental health problems across the life span.
Both paediatricians and child psychiatrists will be faced with children who have complex problems, and they will sometimes need to work together to solve these—whether or not abuse or neglect is in the mix.
Dr Corinne Rees's words were prescient: 'The truth that psychological issues and behaviour are integral to all illness indicates the necessity for every doctor to feel competent in considering their relevance'. As paediatricians and child psychiatrists, let's move forward together to overcome the mind-body dichotomy for the benefit of our patients.

Most paediatricians would agree that there is no hard divide between the mind and the body. Some paediatricians take this understanding to another level, clarifying what is needed in a way that supports their colleagues in working with families and moves the field forward. This paper is written in memory of Corinne Illingworth-Rees, who was one such paediatrician—practising in a Bristol general community paediatric clinic and specialising in recovery from neglect and abuse. She believed in reassessing accepted practice and asked paediatricians to consider how to involve Child And Adolescent Mental Health Services (CAMHS) colleagues in overcoming the 'mind-body dichotomy'.[1]

However, we are all busy, and I suspect paediatricians and psychiatrists usually only call on each other if we feel stuck because cases are particularly complex. Often these complex cases are children who either have a history of severe early adversity, or who have the kinds of complex developmental problems that involve both mental and physical problems. We all know that severe early adversities, such as abuse and neglect, are major risk factors for problems that affect both the mind and the body.[2] What we have also known for decades, but often forget, is that developmental disabilities—from cerebral palsy to Autism—increase a child's risk of experiencing abuse and neglect.[2] Unfortunately, with these complex cases, paediatricians are often left 'holding the baby'. CAMHS are in crisis.[3] Since National Health Service workforce data show that there are six times as many paediatricians (4484 wte consultants) as child psychiatrists (748 wte consultants) (https://digital.nhs.uk/; https://www.nes.scot.nhs.uk/; https://statswales.gov.wales/), some children will have their complex mind-body difficulties addressed solely in paediatric clinics, even when a child psychiatrist could have offered useful insights or treatment if only such a clinician had been available to help.

Referrals to CAMHS have increased dramatically in the last few years, likely, at least in part, due to the impact of the COVID-19 pandemic: for example the follow-up of England's Mental Health of Children and Young People Survey showed that the incidence of mental health problems in children aged 5–16 years rose from 10·8% in 2017 to 16·0% in 2020 across all age, gender and ethnic groups[4–6]—an upward trend undoubtedly reflected in other countries across the world.[7–9] The postpandemic cost of living crisis is also undoubtedly playing a role[8] in the increased prevalence of child mental health problems, since there is a well-known association between child psychopathology and poverty.[9] Alongside the tsunami of child mental health referrals, there is an international shortage of child and adolescent psychiatrists,[5 10 11] and this can lead to workforce crises where colleagues leave the profession or are too daunted to join it in the first place. For example, in the UK, more than 14% of child and adolescent psychiatry posts are unfilled.[12 13] This means that, when paediatricians are seeing a child with complex mental and physical health problems, they might struggle to get access to child and adolescent psychiatric support. A recent international consensus statement on 'shaping the future

Check for updates

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https://adc.bmj.com/content/early/2023/10/03/archdischild-2023-325942

England's Mental Health of CYP survey:

Incidence of mental health problems in children aged 5-16 years

2017 10.8%

2020 16%

Catherine White

Institute For Addressing Strangulation

St Mary's Centre
Sexual Assault Referral Centre

Did he say anything?

"Now you are going to die"

"If you tell anyone I'll come find you"

*"F***ing stay still!"*

What were you thinking?

"I'm going to die"

"I'd better do what he wants"

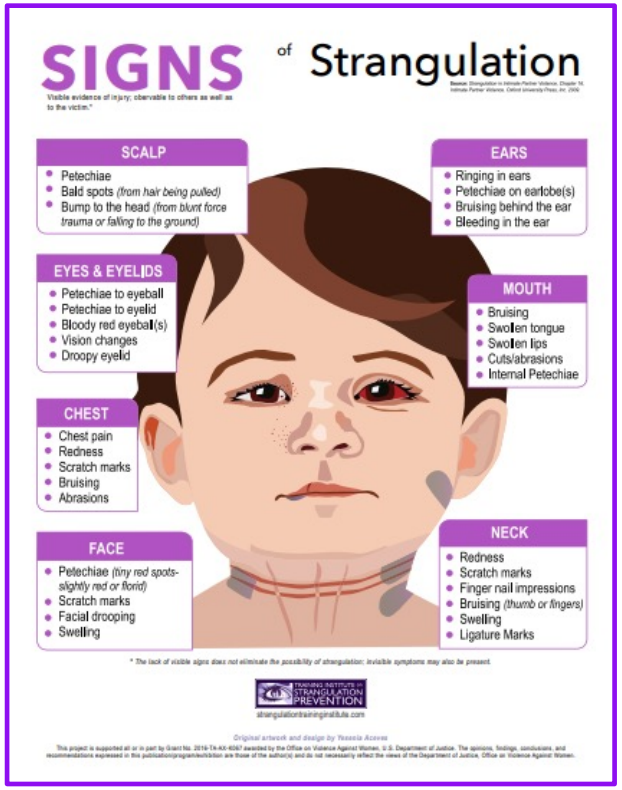
"Am I going to make it out alive?"

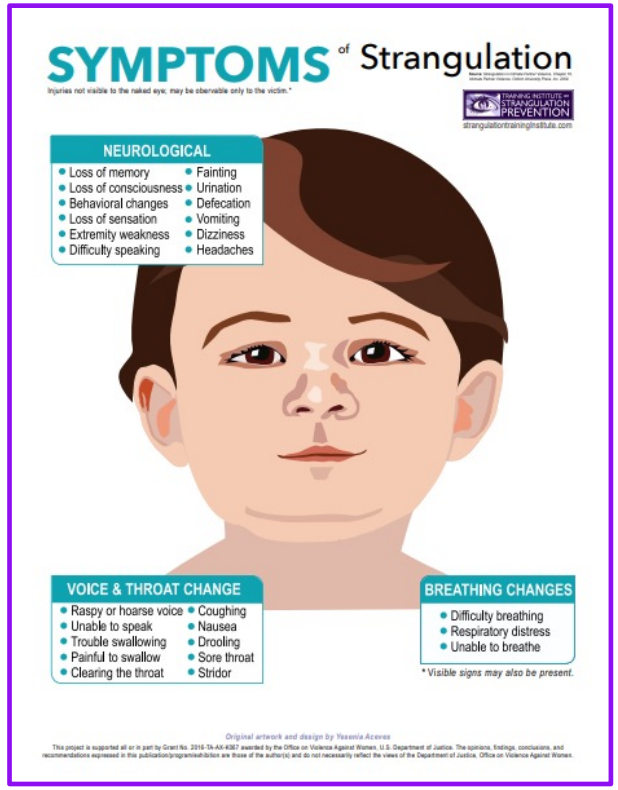
"I wanted to punch him but I couldn't"

Institute For Addressing Strangulation

TRAINING INSTITUTE on STRANGULATION PREVENTION

www.strangulationtraininginstitute.com





Dr Catherine White

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Abuse tends to hunt in packs

- Physical
- Sexual
- Neglect
- Emotional
- Financial


Break

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Case 1

- Unidentified male calls emergency services
- Unconscious female found on hotel room floor
- Carpet noted to be wet.
- Wet with what?

Case 1

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Lancashire Police officer admits attempted murder of woman

7 November

- https://www.bbc.co.uk/news/uk-england-manchester-67346591

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Case 2

- Husband witnessed by neighbour strangling wife.
- Police & paramedics arrive.
- Woman unconscious.
- No forensic examination.
- Injuries captured on body worn video

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Case 2

- Retraction
- Says no assault
- Injuries due to love bites

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Case 3

5-year-old boy

When Dad is angry, he lifts him up.

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Case 3 The Darth Vadar Lift

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The Institute for Addressing Strangulation: One Year On

Tuesday 28th November
On-line event
contact@ifas.org.uk

Institute For Addressing Strangulation

Thank You & Stay Connected

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