



Roll Call Training Bulletin

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Katherine Lester, Chief of Police
Volume 109

Documentation of Strangulation in Domestic Violence Cases

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Studies show that strangulation is an early indicator for domestic violence-related homicides. Statistically, people who have been victims of strangulation at the hands of an intimate partner are 750% more likely to be killed by the same perpetrator than other victims of domestic violence.

It is important that officers are aware of the importance of thoroughly documenting domestic violence strangulation incidents because they tend to show a sharp escalation in the severity of the violence within the relationship. Strangulation can also be a pre-indicator of violence against police officers.

During investigations, if officers are made aware that a victim was choked/strangled, they should treat the incident as a serious, violent attack and the fire department should be requested to medically examine the victim. Often there are no visible signs the victim was strangled, but there are many other indicators that should be investigated. Officers should ask and notate:

- Whether the victim's breathing changed or was affected.
- Whether it was hard for the victim to swallow.
- If the victim experienced dizziness, nausea, headaches, feeling disoriented or feeling faint / light-headed
- If the victim experienced coughing, urination, vomiting or dry heaving
- If the victim experienced any changes to their vision, such as "seeing stars" or experienced blurred vision.
- If the victim felt tingling in lips, arms, and legs.
- Whether the victim's voice is raspy or hoarse.

Visible signs of strangulation include:

- Petechiae, (can occur on the earlobes, eyelids, eyes, lips, cheeks, behind the ears, etc.) which may not be visible until hours after the attack.
- Visible contusions, abrasions, etc. on the neck/body.

It is important when attempting to discern the intent of the suspect what, if anything, they said before, during, and after the assault. Any statements made by the suspect can be invaluable to a prosecution.

In cases involving strangulation and/or other serious injury officers should consider whether to refer the victim to the BEAR Center for a Domestic Assault Forensic Exam, or DAFE (pronounced "Daffy"). This is a medical exam, similar to an evidentiary exam for sexual assault, conducted at the BEAR center. DAFE's are only appropriate for victims 12 years of age and over. These are available 24/7 at the BEAR Center and require supervisor approval.

Penal Code § 13730 mandates that domestic violence reports document if the victim was strangled. This includes whether any witness or victim reported any incident of strangulation or suffocation, whether any victims reported symptoms of strangulation or suffocation, or whether the officer observed any signs of



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strangulation or suffocation. To assist officers in this documentation a Strangulation Checklist (SPD 496) is attached and available on AMS.

Examples of injuries to the neck:



Petechiae



The Sacramento Police Department gratefully acknowledges Alliance for HOPE International for allowing us to reproduce the above photographs.



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SACRAMENTO POLICE DEPARTMENT STRANGULATION DOCUMENTATION WORKSHEET

VICTIM NAME (Last, First)	DATE OF BIRTH	M <input type="checkbox"/> F <input type="checkbox"/>	CASE #
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STRANGULATION EVENT QUESTIONS ASKED BY OFFICER _____

- What did suspect use to strangle you? Describe manner/method in detail in narrative.
 Left Hand Right Hand Two Hands Forearm Knee/Foot Chokehold Ligature Other Object Hanging Smothering
- Estimate how long strangulation lasted: ____ Minute(s) ____ Second(s) Multiple Times: Yes # ____ No
- Estimate the amount of force the suspect used to strangle you: _____
- Describe suspect's emotional demeanor while strangling you: _____
- Describe the suspect's face/expression while strangling you: _____
- What did suspect say while strangling you? _____
- What else did suspect do while strangling you? _____
- Was your head pounded against any object during the strangulation? If yes, what object? _____
- Were you shaken during the strangulation? _____
- Were you able to speak during the strangulation? Yes No If yes, what did you say? _____
- What did you think during the strangulation? _____
- Did you do anything to attempt to physically stop the strangulation? Yes No Describe: _____
- What made the suspect stop? _____
- Has suspect strangled you on other occasions? Yes No If yes, # of occasions: _____ When: _____

SYMPTOMS EXPERIENCED BY VICTIM

SYMPTOM	DURING	AFTER	SYMPTOM	DURING	AFTER	SYMPTOM	DURING	AFTER
Vision Changes: Tunnel	<input type="checkbox"/>	<input type="checkbox"/>	Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>	Hoarse Voice	<input type="checkbox"/>	<input type="checkbox"/>
Vision Changes: Spots	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Voice	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss/Changes	<input type="checkbox"/>	<input type="checkbox"/>	Vomit/Dry Heaving	<input type="checkbox"/>	<input type="checkbox"/>	Whisper Voice	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain/Tender	<input type="checkbox"/>	<input type="checkbox"/>
Unable to Breathe	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Feel Faint	<input type="checkbox"/>	<input type="checkbox"/>	Pain Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Disorientation	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Pain While Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Urinate	<input type="checkbox"/>	<input type="checkbox"/>
Shallow Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Painful to Speak	<input type="checkbox"/>	<input type="checkbox"/>	Defecate	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	Raspy Voice	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

OFFICER CHECKLIST

- | | |
|--|---|
| <input type="checkbox"/> If strangulation was done with an object, photo and collect the object
<input type="checkbox"/> Determine if jewelry (neck, wrist, hand) was worn by either party during the incident; look for pattern injuries; photo and seize item(s)
<input type="checkbox"/> If defecation or urination in clothing, collect the clothing as evidence | <input type="checkbox"/> If victim vomited, take photos of the vomit
<input type="checkbox"/> Strongly encourage victim to seek medical attention regardless of DAFE; medical records will be some of the best evidence
<input type="checkbox"/> Give strangulation pamphlet to victim; if possible, arrange a DAFE |
|--|---|

APPROXIMATELY _____ HRS. ____ / ____ / 20____, OFFICER _____ OBSERVED THE FOLLOWING INJURIES:

FACE	EYES	NOSE	MOUTH
<input type="checkbox"/> Skin Red/Flushed <input type="checkbox"/> Red Spots (e.g. petechiae) <input type="checkbox"/> Scratches or Abrasions <input type="checkbox"/> Swelling <input type="checkbox"/> Bruising <input type="checkbox"/> Other:	<input type="checkbox"/> Red Eye <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Red Spots in Eye <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Red Spots on Eyelid <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Blood in Eyeball <input type="checkbox"/> Eyelid(s) drooping <input type="checkbox"/> Other:	<input type="checkbox"/> Redness <input type="checkbox"/> Red Spots (i.e. petechiae) <input type="checkbox"/> Scratches or Abrasions <input type="checkbox"/> Swelling <input type="checkbox"/> Bleeding <input type="checkbox"/> Other:	<input type="checkbox"/> Swollen Lips <input type="checkbox"/> Swollen Tongue <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Scratches or Abrasions <input type="checkbox"/> Red Spots in Palate or Gums <input type="checkbox"/> Other:
EARS	UNDER CHIN	NECK	SHOULDERS
<input type="checkbox"/> Redness <input type="checkbox"/> Red spots (i.e. petechiae) <input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising or Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Red Spots Behind Ear(s) <input type="checkbox"/> Bruising Behind Ear(s) <input type="checkbox"/> Other:	<input type="checkbox"/> Redness <input type="checkbox"/> Scratches or Abrasions <input type="checkbox"/> Lacerations <input type="checkbox"/> Bruises <input type="checkbox"/> Linear Marks (e.g. fingernail marks) <input type="checkbox"/> Other:	<input type="checkbox"/> Redness <input type="checkbox"/> Scratches or Abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Linear Marks (e.g. fingernail marks) <input type="checkbox"/> Ligature Marks <input type="checkbox"/> Red Spots (e.g. petechiae) <input type="checkbox"/> Swelling <input type="checkbox"/> Other:	<input type="checkbox"/> Redness <input type="checkbox"/> Scratches or Abrasions <input type="checkbox"/> Lacerations <input type="checkbox"/> Bruises <input type="checkbox"/> Other:
HANDS, FINGERS, ARMS	HEAD	CHEST	
<input type="checkbox"/> Redness <input type="checkbox"/> Bruising <input type="checkbox"/> Swelling <input type="checkbox"/> Scratches or Abrasions <input type="checkbox"/> Broken Fingernails <input type="checkbox"/> Other:	<input type="checkbox"/> Lumps/Bumps <input type="checkbox"/> Lacerations <input type="checkbox"/> Scratches or Abrasions <input type="checkbox"/> Hair missing <input type="checkbox"/> Red Spots on Scalp (e.g. petechiae) <input type="checkbox"/> Other:	<input type="checkbox"/> Redness <input type="checkbox"/> Scratches or Abrasions <input type="checkbox"/> Lacerations <input type="checkbox"/> Bruises <input type="checkbox"/> Linear Marks (e.g. fingernail marks) <input type="checkbox"/> Other:	