Recognising and responding to non-fatal strangulation in domestic abuse

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Abstract
Victims/survivors (the authors use this term throughout the article but acknowledge that individuals may use various terms to describe their experiences) of non-fatal strangulation associated with domestic abuse are at risk of further serious harm or death, but often do not disclose the assault. In addition, some of the signs and symptoms are not immediately apparent or obvious. Nurses have a professional responsibility to respond to suspicions about and/or disclosure of any type of domestic abuse by initiating safeguarding and protection procedures and must provide effective care. This article discusses non-fatal strangulation in domestic abuse, including the presenting signs and symptoms and barriers to disclosure, and describes the role of the nurse. The authors include a fictional case study to demonstrate the type of situation nurses may experience when they encounter a victim/survivor of non-fatal strangulation.

Keywords
clinical, domestic abuse, health promotion, professional, professional issues, responsibility, safeguarding

Non-fatal strangulation in domestic abuse
Non-fatal strangulation as a form of domestic abuse may not occur in isolation and may reflect years of abuse or occur early in an intimate partner relationship (Vella et al 2017). It is a dangerous, potentially fatal and pervasive form of abuse with many victims/survivors and nurses unaware of the complications and risks (Vella et al 2017). Non-fatal strangulation has been compared with ‘waterboarding’, a form of torture that simulates drowning and near death (Joshi et al 2012), leaving victims/survivors feeling helpless and fearful they will die and resulting in development of post-traumatic stress disorder and/or depression and/or suicide (Sorenson et al 2014).

Legislation
In June 2022, non-fatal strangulation became an offence under the Domestic Abuse Act 2021 in England and Wales and is punishable by up to five years’ imprisonment (Crown Prosecution Service 2021).
Non-fatal strangulation is a dangerous, potentially fatal and pervasive form of abuse, with many victims/survivors and nurses unaware of the complications and risks.

Victims/survivors of non-fatal strangulation may present with a range of physical signs and symptoms, which they may not report and are not always immediately obvious.

It is important that all nurses can recognise the signs or symptoms of non-fatal strangulation, understand and enact their safeguarding and protection responsibilities and know how to provide effective nursing care.

**Key points**

- Non-fatal strangulation is a dangerous, potentially fatal and pervasive form of abuse, with many victims/survivors and nurses unaware of the complications and risks.
- Victims/survivors of non-fatal strangulation may present with a range of physical signs and symptoms, which they may not report and are not always immediately obvious.
- It is important that all nurses can recognise the signs or symptoms of non-fatal strangulation, understand and enact their safeguarding and protection responsibilities and know how to provide effective nursing care.

**Barriers to disclosure**

Many victims/survivors do not present to a healthcare setting.

**Signs and symptoms**

Victims/survivors may present with a range of physical signs and symptoms (Figure 2, Box 1), which they may not report and are not always immediately obvious. For example, redness or ligature marks may fade quickly, bruising may develop over time (Monahan et al 2020) and conjunctival petechiae (haemorrhages in capillaries that cause tiny ‘red dots’ in the conjunctiva, the thin membrane that lines the inside of the eyelids and covers the whites of the eye) can be very subtle. It is important to note that in the UK the lack of visible injury does not undermine a prosecution (CPS 2023b).

**Control**

Non-fatal strangulation in domestic abuse is used by the perpetrator to assert, regain or maintain control over the victim/survivor (Monahan et al 2020). A marker of this control is that some victims/survivors do not resist, despite feeling like they are going to die (Joshi et al 2012). This lack of resistance, which may be misinterpreted as passivity, can constitute what has been termed ‘strategic compliance’, a survival strategy where the victim calculates that resistance could provoke greater violence and harm (Coates et al 2003). By complying, the person is exercising agency, deliberately choosing to preserve their life when confronted with immediate danger.

This type of abuse is also a mechanism for coercive control – which uses threats, humiliation and intimidation to harm, punish, frighten and isolate individuals (CPS 2023a). Perpetrators who use non-fatal strangulation within a pattern of controlling behaviour are eight times more likely to murder their victim (Monckton-Smith 2020). Monckton-Smith (2019) developed the Homicide Timeline, a framework for tracking homicide risk in cases of coercive control and stalking, which can be accessed at: homicidetimeline.co.uk/what-is-the-homicide-timeline.php Victims/survivors of non-fatal strangulation are also at risk of brain damage, stroke and miscarriage (Joshi et al 2012, De Boos 2019, Monahan et al 2020, Bichard et al 2022).

**Recognising non-fatal strangulation**

Several structures within the neck are vulnerable to damage caused by applied pressure (Figure 1) which can, in isolation or in combination, occlude blood vessels, occlude the trachea and stimulate the carotid sinus (De Boos 2019). Occlusion of these structures decreases blood and/or oxygen levels to the brain, potentially resulting in unconsciousness within 5-10 seconds and death within minutes (Taliaferro et al 2009). Stimulation of the carotid sinus, a neurovascular structure that appears as a natural swelling at the bifurcation of the common carotid artery and the start of the internal carotid artery, can induce instantaneous syncope or asystole, leading to death (De Boos 2019).

**Signs and symptoms**

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following non-fatal strangulation and of those who do, only a small proportion disclose this assault (Joshi et al 2012, De Boos 2019, Monahan et al 2020, Richard et al 2022). There are many barriers to disclosure, which can be categorised as internal and external (Othman et al 2013, Heron and Eisma 2021) (Table 1).

Nurses can help to address these barriers by, for example, expressing to the individual that they are open to discussing domestic abuse and reassuring them that they know who to refer them to for support and how this should be arranged. The nurse should also ensure confidentiality and maintain the person’s autonomy regarding when and how much they might disclose, which may increase the likelihood of disclosure (Othman et al 2013). In addition, as victims/survivors may use a range of terms to describe non-fatal strangulation (Zilkens et al 2016) (Box 2), nurses should pay attention to the language used by the person to describe what has happened to them.

**Role of the nurse**

Nurses have a professional responsibility to safeguard and protect patients they believe to be at risk. For example, the Nursing and Midwifery Council (2018) ‘preserve safety’ professional standard states that the nurse must ‘raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection’.

The NHS England (2016) ‘pocket principles of protection’ (www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/04/1085-nhs-leaflet-accessible-copy.pdf) sets out nurses’ and other healthcare professionals’ responsibilities in relation to preventing harm and reporting abuse, which includes discussing concerns with a colleague and making a safeguarding referral. A safeguarding referral should be made to the organisation’s safeguarding lead in line with local policy (this may be via a telephone call or via the local risk management information system, such as Datix). Most local authority areas have a multi-agency safeguarding hub, which co-locates health, local authority and policing to facilitate making and referrals for adults and children (Home Office 2014). The Training Institute on Strangulation Prevention (2020) recommends asking the person directly if pressure has been applied to their neck. When doing so, the nurse should adopt a non-judgemental and trauma-informed approach (Monahan et al 2020) and frame the conversation something like this: ‘As violence and abuse in the home are so common, we now routinely ask… are you in a relationship with someone who hurts, threatens or abuses you? Did

<table>
<thead>
<tr>
<th>Table I. Barriers to disclosure of domestic abuse including non-fatal strangulation</th>
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<tbody>
<tr>
<td><strong>Internal barriers</strong></td>
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<tr>
<td>A belief that domestic abuse is a private matter and should not be disclosed</td>
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<td>Embarrassment</td>
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<td>Self-blame</td>
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<td>Fear of being judged</td>
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<td>Pressure to maintain the public perception of the perpetrator</td>
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<td>Normalisation of abuse</td>
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<td>Pressure to maintain the family unit (especially women)</td>
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<td>Belief that the abuse is temporary</td>
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(Adapted from Zilkens et al 2016)

**Box 1. Examples of physical signs and symptoms of non-fatal strangulation**

- Neck or throat pain
- Neck tenderness
- Difficulty and/or pain on swallowing
- Vocal changes
- Shortness of breath
- Loss of consciousness
- Feeling dizzy or faint
- Blurred vision
- Urinary or faecal incontinence
- Difficulty talking

(Adapted from Zilkens et al 2016)

**Box 2. Terms used by victims/survivors to describe non-fatal strangulation**

- Strangled
- Sleeper hold
- Chokehold
- Headlock
- Ligature
- Hanging
- Choking, choked
- Throttled

(Zilkens et al 2016)
someone cause these injuries?'

Any patient reporting or suspected of being a victim/survivor of any type of domestic abuse should be asked about a history of pressure applied to the neck (Carlson 2014). The nurse may need to make several gentle attempts before the person discloses the abuse.

Document
The nurse should document all interactions with the person, including assessment and any treatment and advice provided. However, details should not be recorded in a user-held record, which the perpetrator may have access to (Dheensa 2020). The nurse should also detail the person’s injuries and mark these on a body diagram (Reckdenwald et al 2022). As some signs of physical injuries may be absent initially, prosecutions often rely on victim/survivor statements (CPS 2023b), therefore the nurse must document the person’s description of their injuries and the assault verbatim wherever possible (White et al 2021).

Observe
It is important to use the best available lighting to examine the person for signs and symptoms of strangulation. Additionally, the nurse should observe for non-verbal signs of domestic abuse, such as limited eye contact, apparent lack of emotion or heightened emotion, agitation, defensive body language, evasiveness and apparent unwillingness to commit to further appointments (Usta and Taleb 2014).

Medical management
Any victim/survivor who presents within four weeks of a strangulation incident, or longer if they are symptomatic, must be screened for ‘red flag’ signs and symptoms (Table 2) and referred to the emergency department (ED) for further assessment and management (IFAS 2024). If red flag signs and symptoms are present, the person should be referred for an urgent computed tomography angiography of the neck and intracranial vessels (IFAS 2024). Hospital admission may be required for further management of the injury and/or for social/safeguarding reasons; IFAS (2024) criteria for admission to hospital are shown in Box 3. Strangulation can result in acquired brain injury therefore the person should be followed up at three months post-injury to assess for signs and symptoms of this (IFAS 2024).

Offer support
The nurse should offer the person support by providing them with information about their rights and options (Royal College of Nursing 2020), such as making a complaint to the police (at the time or later), and about supportive organisations, such as Women’s Aid (www.womensaid.org.uk/information-support), and how to access such support. It may not be safe to provide the person with a printed leaflet that could be seen by the perpetrator, therefore the nurse could ask the person to memorise a phone number or website address or provide them with a small card they could keep discretely.

Many hospitals employ, or have access to, an independent domestic violence adviser (IDVA) or medical social worker who works with high-risk victims/survivors of domestic abuse to prepare safety plans, complete risk assessments and empower the person to act (Eley et al 2022, SafeLives 2024). Community IDVAs can also be accessed through domestic abuse charities, so nurses should familiarise themselves with local services (Safer Futures 2024).

Risk assessment and refer
A DASH risk assessment should be undertaken, by a front-line professional trained in its use, to determine the person’s risk level; a referral should be made to the MARAC if the assessment identifies that the person is at high risk (Richards 2009). The DASH risk checklist can be accessed online at: www.dashriskchecklist.com

Education
Victims/survivors should be advised about red flag signs and symptoms (Table 2) that indicate they should attend the ED (Smock and Sturgeon 2023). They may also require counselling regarding the long-term adverse physical and psychological effects of the injury (Carlson 2014) and should be warned about their increased risk of becoming a victim of homicide (Monckton-Smith 2019, Monahan et al 2020).

Training
NICE (2016) recommends that front-line staff, including nurses, should be trained and be able to respond to disclosures of domestic violence and abuse to a level appropriate to their role. Providing nurses with training in domestic abuse, including coercive control and non-fatal strangulation, could enhance their ability to recognise the signs and symptoms of this assault and respond appropriately. Such training should incorporate

| Table 2. Red flag signs and symptoms related to non-fatal strangulation |
|-------------------------|----------------------------------|
| **Body area**          | **Signs and symptoms (reported or apparent)** |
| Head                   | Amnesia or altered mental status |
|                        | Incontinence                      |
|                        | History of head injury/stroke     |
|                        | Loss or near loss of consciousness|
|                        | Significant pressure applied to the neck |
|                        | Neurological symptoms or signs    |
|                        | Visual symptoms                   |
|                        | Petechial haemorrhage             |
| Neck                   | Cervical spine concerns           |
|                        | Difficulty swallowing             |
|                        | Voice changes                     |
|                        | Bruising to neck or ligature marks|
|                        | Carotid bruits (a ‘whooshing’ sound usually heard with a stethoscope over the carotid artery that may indicate turbulent blood flow due to a narrowing of the artery) |
|                        | Neck swelling or tenderness of airway structures/carotid arteries |
| Chest                  | Dyspnoea                          |
|                        | Subcutaneous emphysema            |

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<th>Box 3. Criteria for hospital admission</th>
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<tr>
<td>History of significant blunt force/pressure to neck or head</td>
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<tr>
<td>Significant findings on imaging</td>
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<tr>
<td>Clinical condition</td>
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<tr>
<td>Airway concerns</td>
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<td>Unsafe discharge setting</td>
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<td>Vulnerable population (for example children, older people, pregnant, homeless) and/or safeguarding requirement</td>
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<tr>
<td>Very acute presentation</td>
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<td>Pregnancy</td>
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(Adapted from Institute For Addressing Strangulation 2024)
the effects of non-fatal strangulation on a person’s mental health, which can include post-traumatic stress disorder, depression, anxiety and suicidality (Bichard et al 2022). Nurses also require information and training about their professional responsibilities regarding safeguarding and protecting patients, how to complete a DASH risk assessment, the role of the IDVA and local referral pathways and services.

Case study
The fictional case study (Case study 1) describing Sheila’s story demonstrates the type of situation nurses may experience when they encounter a victim/survivor of non-fatal strangulation. Figure 3 provides a summary of the nursing response to suspicion of non-fatal strangulation in the form of a flow chart.

Case study 1. Sheila’s story
Sheila, a 45-year-old woman, presents to the emergency department (ED) with a laceration to her temple and is accompanied by her male partner, Phil. The triage nurse, Jack, notices that Sheila appears subdued. Phil explains that Sheila tripped and fell down the stairs. Sheila nods and says she is ‘clumsy’. Phil appears to be helpful and often on Sheila’s behalf, which he explains is because of ‘her anxiety’. Jack feels reassured by this explanation. Sheila is seen by the doctor, her wound is sutured and she is discharged home. Three weeks later, Sheila re-presents with a deliberately incised wound to her wrist. She is again seen by Jack, who notes that she appears nervous. Jack explains how he would like Sheila to be seen by a mental health nurse before she leaves the ED. Sheila appears to be unhappy about this suggestion and says she wants the wound closed and to be discharged without any fuss. She tells Jack she needs to get home before Phil who, she says, will be ‘very worried’ if he arrives home to find she is not there.

Jack notices some petechial bruising around Sheila’s eyes and bruising to her neck. When he mentions this, Sheila says she fell and that her eyes are red because of hay fever, before quickly repeating that she must leave. However, Jack persuades her to wait in the ED while he speaks to the nurse in charge. Jack explains to the nurse in charge that he thinks his patient has been strangled but that she is, for the moment, reluctant to disclose this. Jack and the nurse in charge discuss how Sheila may be in more danger if she arrives home after her partner than if she leaves the ED now, however Jack is also aware of his professional responsibilities in terms of safeguarding and protecting his patients. The nurse in charge suggests Jack uses the ASK and DO MORE acronym.

Jack finds a safe space in which he tries to encourage Sheila to disclose the suspected abuse by displayed genuine interest and communicating with empathy. When it is safe and appropriate to do so, Jack asks Sheila directly about non-fatal strangulation, observes for non-verbal cues in her response and attends to the language she uses to describe what happened to her. Sheila eventually discloses that she has been a victim of non-fatal strangulation. Jack then follows the DO MORE acronym to ensure he adheres to safeguarding and protection procedures and provides Sheila with effective care. With support from the nurse in charge, Jack completes a domestic abuse, stalking and honour-based violence (DASH) risk assessment that identifies Sheila is at high risk, therefore a referral is made to the multi-agency risk assessment conference (MARAC) with Sheila’s consent. Jack also contacts Sheila’s GP and arranges for her to meet with the independent domestic violence adviser that same day, again with her consent.

Conclusion
Non-fatal strangulation in the context of domestic abuse has short and long-term physical and psychological consequences. In addition, victims/survivors are at risk of experiencing further serious harm or death. The signs and symptoms of non-fatal strangulation are not always apparent, and...
victims/survivors are sometimes reluctant to disclose this assault. Nurses must therefore be vigilant for non-verbal cues and act on their suspicions to safeguard and protect their patients. Nurses can use the ASK and DO MORE acronym to ensure they provide comprehensive and effective care. In addition, nurses should be provided with training in recognising and responding to patients who may be victims/survivors of domestic abuse.

References


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