DENVER COUNTY

STRANGULATION RESPONSE PROTOCOL

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This project was supported by Grant No.15JOVW-22-GG-01813-ICJR awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the U.S. Department of Justice.

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The Denver County Strangulation Response Protocol Committee created this document with input from law enforcement, prosecution, medical, and advocacy services. We appreciate their expertise, time, and dedication to enhancing Denver's policies and practices for providing the best response and care for survivors of domestic violence and sexual assault.

Prosecution Representatives:

Victoria Kelley, Domestic Violence Prosecution Specialist, Denver District Attorney's Office

Linda Loflin-Pettit, Manager of Community and Government Relations, Denver City Attorney's Office

Medical Representatives:

Dr. Kelly Finnegan, Child Abuse Pediatrician, Denver Health SAFE Center

Michelle Metz, R.N., Denver Health SANE Coordinator, Denver Health

Megan Whitehouse, FNP, Denver Health Rose Andom Center Clinic Practitioner, Denver Health

Denver Department of Safety Representatives:

Dr. Shea Gilliam, Medical Director, Denver Department of Safety Emergency Physician, Denver Health

Lt. Ricky Teter, EMS Training Representative, Denver Fire Department

Lindsey Dixon, Pretrial Services Manager, Community Corrections

Probation Representative:

Gail Prim, Supervisor, Denver Adult Probation Department

9-1-1 Emergency Communications Representatives:

Brian McGlawn, Dispatch Supervisor, Denver 911

Joe Nieto, Dispatch Supervisor

Dr. Jodi Slate, Dispatch Operations Manager

Law Enforcement Representatives:

Sgt. Anthony Montoya, DPD Sex Crimes Unit

Sgt. Mary Prestel, DPD Sex Crimes Unit

Chris Richardson, DPD Director, Crisis Services Bureau

Lt. Abel Salas, Denver Police Department

Sgt. Roger Torgeson, DPD Domestic Violence Unit

Sgt. Joseph Vasquez, DPD Homicide Cold Case Unit

Research Partner:

Anne DePrince, PhD, Associate Vice Provost of Public Good Strategy and Research, University of Denver

Community Advocacy Representatives:

Margaret Abrams, Retired Executive Director, Rose Andom Center

Natasha Adler, Program Director, Rose Andom Center

Angelica Hoyle, Director of Client Services, The Blue Bench

Francesca Lawrence, Former Director of Client Services, Rose Andom Center

Leanna Stoufer, Legal Advocacy Program Training Specialist, Project Safeguard

Whitney Woods, Executive Director, Rose Andom Center

In recognition of the severity that acts of non-fatal strangulation pose, the following departments and agencies agree to uphold the elements and practices identified in the attached protocol, to promote greater awareness of the incidence and potentially lethal risks regarding strangulation, and to help ensure effective intervention across disciplines in promoting survivor safety and responding to domestic violence and sexual assault cases.

John Walsh

John Walsh
Denver District Attorney

Chief Ron Thomas

Ron Thomas
Denver Police Chief

Cary Heck

Cary Heck, Ph.D.
Chief Probation Officer
Denver Adult Probation Department

Al Gardner

Al Gardner
Executive Director
Denver Department of Safety

W. Andrew Dameron

Andrew Dameron
Director
911 Communications Center

WW

Whitney Woods
Executive Director
Rose Andom Center

Jody Curl

Jody Curl
Executive Director
Project Safeguard

Marley Bordovsky

Marley Bordovsky
Director of Prosecution & Code Enforcement Section
Denver City Attorney's Office

Read G. Pierce

Read G. Pierce, MD
Chief Medical Officer
Denver Health

Greg Mauro

Greg Mauro
Director
Denver Community Corrections

Desmond J Fulton

Desmond Fulton
Chief
Denver Fire Department

Natasha Adler

Natasha Adler
Director of Survivor Services, (at time of authorship)
SafeHouse Denver

Rebecca Tiell-Krekeler

Becca Tiell-Krekeler
Executive Director
Blue Bench

Overview

A growing body of research consistently shows that non-fatal strangulation assaults by an intimate partner are more prevalent than previously thought. Survivors frequently do not have any visible injuries. Responders without specific training regarding strangulation may overlook the severity of the act, fail to ask key questions to appropriately document and intervene in the incident, and miss a critical opportunity to help educate the survivor on the risks and consequences of such an assault.

Research also clearly shows most survivors who experience strangulation are strangled multiple times, increasing the risk of death and serious health consequences each time. Early identification and intervention can reduce the number of strangulation incidents a survivor experiences.

Strangulation is one of the most lethal forms of assault, second only to gun violence. Non-fatal strangulation precedes intimate partner murder and attempted murder in almost half of cases. Identification of non-fatal strangulation can alter the approach taken by responders and flag increased risk to the survivor, which in turn may prevent future homicide.

45%

of the time, an intimate partner is the perpetrator of sexual assault and nearly all of these cases exhibit significant lethality risk factors.

There is significant overlap between domestic violence and sexual assault, with an intimate partner being the perpetrator of sexual assault approximately 45% of the time, and nearly all of these cases exhibit significant lethality risk factors.[6] The risks and need for appropriate identification, assessment, documentation, and intervention remains the same in both domestic violence and sexual assault, with the benefits of the strangulation response protocol applicable to survivors in both types of crimes.

Survivors are often unaware of the health consequences from being strangled despite many reporting it as a terrorizing experience resulting in fear of being killed during the assault. Symptoms can include but are not limited to difficulty swallowing, neck pain, and voice and/or vision changes. Severe cases can result in petechiae, injury to the arteries in their neck, loss of bladder or bowel control, and altered or loss of consciousness. Strangulation is increasingly associated with traumatic brain injuries, even when the strangulation does not cause other severe symptoms. Without information about the risks and consequences, survivors may minimize or dismiss the act, not disclosing the strangulation, especially if there were other, perhaps more visible outcomes from an assault. Therefore, it is critical for responders to ask every survivor about strangulation, to encourage medical assessment, to provide information about safety and health risks, and to treat every strangulation case as high risk.

Objective

Denver has a long history of upholding a coordinated, collaborative response to domestic violence and sexual assault, including multi-disciplinary teams such as the Collaborative Domestic Violence Response Team (CDVRT), the Sexual Assault Interagency Council (SAIC), one of the earliest domestic violence fatality review teams in the country, and Colorado's first family justice center. Collaborative, multi-disciplinary work has proven to reduce re-traumatization and lead to more effective interventions, both of which improve survivor safety, increase the use of victim services, and result in more cases appropriately charged as felonies.

The Denver County Strangulation Response Protocol (DCSRP) aims to promote greater awareness of the incidence of and risks regarding strangulation in domestic violence and sexual assault cases and establish consistent practices across disciplines to improve detection, documentation, and response. This protocol is intended for all public and private sector members providing services to survivors and those investigating and prosecuting cases. This protocol is intended neither to address every situation or potential issue, nor to substitute for individual discretion or departmental policies consistent with state law. The goal is for these best practices to inform and enhance each agency's operating procedures, leading to improved intervention and survivor safety.

The benefits of a multi-disciplinary, countywide protocol include:

- Development of a shared recognition and understanding across disciplines about the risk, prevalence, and lethality of strangulation to survivors of domestic violence and sexual assault.
- Creation of a shared commitment by professionals to appropriately screen, identify, document, and intervene in such cases within the scope of their discipline.
- Identification of each agency's role and expectations in a coordinated, community response.
- Establishment of training expectations and processes regarding strangulation across disciplines.
- Ensuring consistent messaging and information to survivors of strangulation regarding the seriousness, need for medical attention, and safety planning.
- Identifying the need to also inquire about and screen for the risk of strangulation of children in homes where domestic violence or sexual assault has occurred.
- Enhancing detection and intervention in order to provide lifesaving help to survivors and hold offenders accountable for these serious criminal acts.

This document will provide for each involved agency a description of the agency's role in prevention and intervention; a description of involved professionals within the agency; training expectations for those professionals; a protocol for engaging with survivors, documentation, and agency-specific action items; and links or references to additional resources.

Definitions and Language

Definitions

Strangulation

Colorado law includes strangulation as a felony offense, with C.R.S. 18-3-203(1)(i) defining strangulation as *[with] the intent to cause bodily injury, he or she applies sufficient pressure to impede or restrict the breathing or circulation of the blood of another person by applying such pressure to the neck or by blocking the nose or mouth of the other person and thereby causes bodily injury.*

Relevant crimes that include strangulation are:

i. Assault in the First Degree – C.R.S. 18-3-202(1)(g)
ii. Assault in the Second Degree – C.R.S. 18-3-203(1)(i)
iii. Attempted Murder – C.R.S. 18-3-102(1)(a), 18-2-101

For the purposes of this document, strangulation can include:

- Manual strangulation (by use of hands, forearms, or other extremity). This is the most common form.
- Ligature strangulation (use of some cord-like object without suspension).
- Strangulation by hanging (use of cord-like object with suspension).
- Suffocation or smothering (mechanical obstruction of air flow into the nose or mouth, as might occur by covering with a hand, pillow, gag object, or plastic bag).
- Positional asphyxia (caused by compression to face, neck, chest, and/or abdomen sufficient to make it difficult or impossible to breathe).

Domestic Violence

In Colorado law, CRS§18-6-800.3 defines "domestic violence" as *an act or threatened act of violence upon a person with whom the actor is or has been involved in an intimate relationship. "Domestic violence" also includes any other crime against a person, or against property, including an animal, or any municipal ordinance violation against a person, or against property, including an animal, when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.*

Intimate Relationship

In Colorado law, CRS§18-6-800.3 defines "Intimate relationship" as *a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time.*

Systems-Based Advocate

This document uses the term "advocate" to refer to many individuals, however there are key differences between system- or criminal legal-based advocates and community-based advocates. This document may refer to these advocates as system-based, law enforcement advocates, or police advocates.

- Systems-based advocates employed by law enforcement agencies do not have privilege and information shared with them may not be confidential.
- Systems-based advocates are also mandatory reporters and are required to report instances of child abuse or neglect.
- Systems-based advocates are always to work within the operations protocol for their jurisdiction and position.
- These advocates are typically the first point of contact for a survivor who engages with the criminal legal system.
- Systems-based advocates work with survivors who have reported a crime, serving as a liaison and guide throughout the process to help ensure survivors are informed and aware of their rights. This includes status of potential charges, upcoming court hearings, opportunities for bond and other input, mandatory protection orders, and other rights delineated in the Victim Rights Act, available under Appendix B.
- Although systems-based advocates are not confidential they may be able to provide similar support in the form of safety planning and resourcing

Community-Based Advocate

Community-Based advocates are advocates have undergone at least 15 hours of training as a victim advocate (or at least 30 hours if assisting sexual assault survivors).

- Community advocates work in a community-based program such as an emergency shelter, resource center, or crisis hotline.
- Community-Based advocates can provide privileged and confidential communication and support to survivors (C.R.S. 13-90-107), regardless of their choice to report the crime to law enforcement. Changes to Colorado statute in 2025 also preclude community-based advocates from being mandatory reporters. Colorado statute explicitly excludes advocates employed by law enforcement agencies from the category of privileged advocates.
- Community advocates have the primary function of rendering advice, counsel, or assistance to survivors of domestic violence or sexual assault.
- Community-Based advocates can provide on-going comprehensive support and services, independent of the presence or length of criminal case proceedings.

Language

Survivor

This protocol is written from a survivor-centered and trauma-informed focus. Thus, the term "survivor" is used throughout the document. Exceptions include when the term "victim" is used with regard to cases of homicide, when referring to 'victim advocates', a broadly used term, and the Victim's Rights Act (VRA).

"Choking" vs. Strangulation

Survivors often refer to the experience of strangulation as 'being choked'. However, "choking" technically refers to a physical obstruction of the windpipe, such as food or other object, that results in a blockage of normal air flow. Strangulation is most often an intentional act *due to external pressure* applied to the neck, mouth, nose, or chest that prevents normal flow of oxygen or blood. It can be important to differentiate between the terms in certain settings to emphasize intentionality.

Domestic Violence (DV) vs. Intimate Partner Violence (IPV)

Domestic violence and intimate partner violence may be used synonymously. However, due to Colorado law defining and using the term 'domestic violence' in statute, this document will primarily refer to domestic violence.

Know The Facts

- **Strangulation is common in intimate partner abuse.** Approximately 8 in 10 victims in police-reported domestic violence incidents disclosed histories of being strangled by their intimate partners. One third of those victims had been strangled multiple times.[1] Studies involving survivors identified that 38% of victims were strangled multiple times by the same abuser, an average of five times.[2]

- **Strangulation happens in sexual assault.** More than 1 in 10 sexual assault forensic exams documented strangulation.[3] A study published in The Journal of Emergency Medicine found that non-fatal strangulation was reported in 12% of sexual assault cases.[4]

- **Strangulation is increasingly common during sexual activity.** Nearly a quarter of women (21%) and 1 in 10 men report having been "choked" during sex. The prevalence is higher among young people: among sexually active college students, a majority of women (64%) and gender-diverse people (56%), as well as a sizable minority of men (29%), report having been "choked" during sex.[5]

- **Strangulation can mean danger for other family members.** When one person in the household experienced strangulation, the risk of a child in the home also being strangled more than doubles (2.3×).

Strangulation can be difficult to detect from external injuries. Strangulation does not necessarily result in visible external injuries such as bruising or marks around the neck.[6] In more than half of cases where survivors reported strangulation, police did not detect visible external injuries.[7] Up to 40% of fatal strangulations had no visible external injuries.[8] Beyond marks to the neck, facial petechiae (red spots) and neck swelling can be visible.[9]

- **Survivors commonly describe a range of strangulation symptoms.** Strangulation frequently results in loss of or altered consciousness, though survivors may not remember losing consciousness or may not understand questions about passing or blacking out.[10] Survivors also report symptoms including changes in vision, headache, breathing difficulty, facial or limb paralysis, urinary or bowel incontinence, changes in sensation, lightheadedness or dizziness, limb weakness, difficulty swallowing, ringing in the ears, spasms, tremors, shaking, seizures, facial droop, confusion, nausea, and vomiting.[11]

- **Strangulation can be lethal.** Strangulation restricts blood flow to and from the brain, can cut off airflow to the lungs, and can severely damage the thyroid, all of which can result in death.[12] In Colorado, 10% of 227 homicides involved perpetrators who used strangulation or asphyxiation, according to Colorado Domestic Violence Fatality Review data.[13]

- **Strangulation predicts homicide.** When intimate partners strangle victims, there is a six-fold increase in the likelihood they will later attempt to kill their victims and a more than 7.5-fold increase in the likelihood they will murder their victims.[14]

- **Suspicious deaths may be hidden strangulation homicides.** The term hidden homicides recognizes the need to better identify suspicious deaths when there has been a history of domestic violence and the death initially appears to be a suicide or accident.[15]

- **Training matters for improving strangulation detection and response.** Because strangulation does not necessarily result in visible external injuries, it can be overlooked without training. Seventeen percent of police reports failed to explicitly identify strangulation despite describing assault characteristics and injuries consistent with strangulation.[15] Lack of training and fear of not knowing how to respond are key barriers to effective strangulation response.[16]

Key Agencies and Responders

9-1-1 Communications Center

9-1-1 call takers may be the first person a survivor speaks to following a domestic violence incident. It is vital that they be prepared to ask appropriate questions to identify if strangulation was involved, send information to dispatch for appropriate first responders, and aid in documentation.

9-1-1 Response Procedure

- All domestic violence incidents involving a physical altercation will require the Emergency Call Taker (ECT) to ask if the survivor(s) were strangled or "choked"
- The ECT can use direct questioning or an open-ended phrase such as: **Was anything placed on or against the person's neck or face by any means?**
- In situations where an individual was strangled, the ECT will utilize the mandatory shorthand command/STR which translates to <<Possible strangulation involved>>, to aid in documentation that strangulation was reported as part of the incident.

Key Agencies and Responders

Medical Provider Response

1. A Brief Overview of the Agency
2. A Description of the Agency's Role in Prevention and Intervention
3. Description of Involved Professionals Within the Agency
4. Training Expectations for Responders Within Agency
5. Protocol for Responders
6. Links and References to Further Resources

Emergency Medical Services

EMS is frequently the first and only medical professionals that a survivor of strangulation may interact with. That interaction can set the stage for a patient's understanding of the seriousness of strangulation and its potential complications.

All EMS providers should receive basic education on strangulation. If a real-time education opportunity is not available, the Training Institute on Strangulation Prevention has a recorded webinar that can be accessed at EMS and Paramedic Response to Strangulation Webinar, also linked in Appendix D.

When assessing a patient disclosing domestic violence, the patient should be examined and questioned separately from others. Frequently, survivors of domestic violence will begin to minimize the incident once providers arrive. It is also necessary to ask specifically if there was pressure applied to the neck as many patients may not understand what strangulation is. If a patient discloses strangulation they should be encouraged to go to the emergency department for further evaluation. Other questions to ask during assessment include whether they are or have experienced:

- Difficulty breathing
- Vomiting
- Loss of consciousness or memory loss
- Changes in vision or hearing
- Voice changes or difficulty swallowing
- Loss of bladder or bowel control

When selecting a facility for transport, it is in the best interest of the patient to be transported to a facility with a 24/7 FNE program to avoid subsequent transfer whenever possible. A list of resource locations, including where SANE exams can be obtained, are linked in Appendix A.

A patient may not be aware of loss of consciousness, however, alterations in vision and/or hearing may be indicative that they did lose consciousness, which is a strong indicator for imaging. Patients will frequently decline transportation to the hospital. In instances where they decline it is important to educate about the potential dangers of strangulation including delayed swelling and symptoms of stroke. They should be encouraged to seek medical care on their own, especially if they experience further symptoms.

For patients who are transported, documentation should include:

- Manner of strangulation;
- Associated symptoms;
- Visible physical injuries such as petechiae;
- Appearance of mouth, eyes, around ears;
- Possible abrasions under chin or around neck;
- Any statements made by the patient, verbatim, utilizing quotations.

Of note, if there were children in the home during the altercation a report to Law Enforcement and Denver Human Services (DHS) should be made as exposure to intimate partner violence is a form of child abuse. Children in the home may also be at risk of experiencing strangulation — refer to the following section on Pediatric Strangulation for further information regarding key screening points with children or infants.

Medical Service Providers

Strangulation can have serious and life-altering sequelae including arterial injuries, anoxic brain injury, stroke, vocal cord damage, tracheal fractures, other soft tissue injuries, psychological trauma, and death. Sequalae from vascular injury, including stroke, can occur up to one year from incident, and other consequences may be long-term. See Signs and Symptoms in Appendix B. Survivors of strangulation presenting with long-term sequelae and/or brain injury may benefit from referrals to behavioral health, occupational therapy, neurology, or neuropsychology, depending on symptoms.

Therefore, it is critically important that health care providers ask every patient who discloses a history of domestic violence about strangulation:

- “Has anyone strangled you or applied any pressure to your neck?”
- “Has anyone done anything that made it hard for you to breathe?”

Note that survivors will often refer to “being choked”. It is okay to use their language but recognize that choking is distinctly different from being strangled.

The physiological consequences of strangulation occur in a predictable timeline. It is important to be aware of this timeline when inquiring about symptoms. See Physiological Consequences of Strangulation Seconds to Minute Timeline, also linked in **Appendix D**.

Forensic Exams

If strangulation has occurred within 5 days, encourage a forensic exam and facilitate access to appropriate resources. As of the publishing of this protocol, three emergency departments in the Denver Metro Area offer this resource, though it is best practice to call ahead to confirm availability. (Refer to Appendix A for contact information.)

- A forensic exam is performed by a medical provider who has been specially trained to care for patients impacted by violence, frequently a registered nurse. Forensic exams are performed with the consent of the patient and include a detailed history, forensic photography, and potentially evidence collection. Forensic Nurses are also specially trained to testify in court proceedings.
- Thorough documentation of internal and external images including verbatim quotes of subjective complains and about the experience of the assault are useful for prosecution even when serious medical complications are not present or if the individual presents longer than 5 days after the assault.
- Nurses and Providers can find further resources linked in Appendix D.

Patient History

If a history of strangulation is disclosed, complete history and physical exam. A detailed history is important as external signs on physical exam are often absent. Appropriate imaging and exams may vary based on the timeline:

- History of strangulation within the last year may require imaging (follow *Imaging Protocol* below).
- Imaging for a history of strangulation that occurred over one year ago would not routinely be recommended as positive findings become less likely with time. However, imaging should be considered if individual is experiencing persistent symptoms following a strangulation event or any potential symptoms of sequalae from blunt cerebrovascular injury such as stroke.[16]
- History of strangulation within the last five days may be appropriate for a forensic examination.
- When a survivor presents with a history of past strangulation over one year ago, it is important to inquire about symptoms of brain injury that may manifest as headaches, dizziness, sleep disruption, anxiety, depression, and cognitive changes and refer to appropriate resources for further evaluation.

Helpful questions while taking a patient history may include:

- How was pressure applied? Hands, arm, other
- Were your feet ever off the ground, such as being held up by the neck similar to hanging?
- How hard was pressure 0 to 10?
- What were they saying to you as you were strangled?
- What did you think was going to happen?
- What did you see/hear?

History should include presence of the following, both during and after the event:

- Hearing changes i.e.: whooshing in the ears
- Visual changes during and after the incident — seeing stars, seeing spots
- Loss of consciousness or "gaps" in memory
- Presence of facial, intra-oral, conjunctival petechiae after event
- Presence of neck bruising, erythema, or ligature marks
- Swelling or tenderness to neck
- Incontinence
- Presence of other neurological symptoms (seizure, amnesia, weakness)
- Dysphagia
- Dysphonia
- Dyspnea
- Incidence of prior strangulation

Physical Exam

- Neurological exam
  - Include cranial nerve testing, orientation, speech
- Neck exam
  - Inspect skin for bruising, erythema, ligature marks.
    - Take into account that signs of bruising, soft tissue injury, inflammation, anoxia, and detection of petechiae will appear differently on patients with darker skin tones and cannot be reliably detected by visual assessment alone.
    - In individuals with melanated skin, the presentation of bruises can vary, appearing as shades of black, purple, blue, brown, or yellow, influenced by the depth of melanin pigmentation. See Skin Assessment in Patients with Dark Skin Tone and Bruises on dark skin: Symptoms and Treatment in Appendix D below.
  - Palpation for tenderness, swelling
  - Auscultation for carotid bruit
- HEENT (Head, Eyes, Ears, Nose, and Throat)
  - Eye exam, presence of subconjunctival hemorrhage
  - Evaluation of tympanic membrane for hemotympanum
  - Intra-oral exam for petechiae, lacerations
- Respiratory exam
- Consider more complete musculoskeletal and skin exam based on history

Imaging Protocol

Neck imaging should be ordered as appropriate per Imaging guidelines, typically CTA. Detailed protocol can be found in Recommendations for the Medical/Radiographic Evaluation of Acute Adult Non/Near Fatal Strangulation, also linked in **Appendix D**.

- **Negative/Reassuring Findings:** Educate patient on risks, to watch for signs and symptoms of stroke and blunt cerebrovascular injury (BCVI)
- **Positive Findings:** Consider neurosurgery, Ear, Nose, and Throat (ENT) consults as appropriate based on specific findings

Mandated Reporting of Adult Domestic Violence and Serious Bodily Injuries

Colorado law requires healthcare professionals to report certain injuries involved in a criminal act (including domestic violence) under Colorado Revised Statute 12-240-139. Of note, only MDs, DOs, Pas, and AAs are included in the definition of "licensee" in this statute.

For adults over age 18, the following **should be** reported to law enforcement in the jurisdiction where the medical provider is located:

- All gunshot wounds, accidental or intentional
- Intentional stab wounds involved in a criminal act
- Injuries that meet the definition of "serious bodily injury"
  - Under Colorado Revised Statute 18-1-901, **"Serious bodily injury"** means bodily injury that, either at the time of the actual injury or at a later time, involves a substantial risk of death; a substantial risk of serious permanent disfigurement; a substantial risk of protracted loss or impairment of the function of any part or organ of the body; or breaks, fractures, a penetrating knife or penetrating gunshot wound, or burns of the second or third degree.

It is the opinion of the protocol committee that strangulation should, in many cases, be considered serious bodily injury (SBI) due to the act's intrinsic lethality that is highlighted throughout this document and reporting should be discussed with the patient. Ultimately, the determination of SBI remains at the discretion of the provider, and mandatory reporting should be disclosed to the patient. At a minimum, providers should educate these patients on the danger of these injuries, the link to future homicide, and the possible delayed sequelae including arterial injury and stroke.

Reporting of injuries is **not required** in the following instances:

- An adult survivor of domestic violence indicates their preference that the injury not be reported. The provider should clearly document this request in the medical record.
- The injury is not a serious bodily injury (see above).
- The injury is not otherwise required to be reported (see above).

If a provider intends to report an injury, effort should be made to advise the survivor/patient of this intent and account for reasonable safety planning. The provider should also refer the survivor to a domestic violence advocate.

It is important to note mandatory reporting guidelines differ significantly for children and at-risk adults. For further guidance on mandatory reporting of incidents involving children under 18 see the Pediatric Strangulation section of this protocol below. For further guidance on mandatory reporting of incidents involving an at-risk adults see C.R.S. 18-6.5-103 — Crimes against at-risk persons.

Pediatric Strangulation

When there is a history of domestic violence in the home, ask the caregiver, child, and siblings about child abuse and strangulation. When appropriate, speak to the child alone.

As a medical provider or medical responder, the goal is to identify potential injury and harm, not to determine all the details of who, when, why, and how of a strangulation or abuse concern. Asking about mechanism and symptoms is appropriate, as is obtaining information that will help assess for injury, medical needs, or need for further testing. Please note that young children have difficulty with timing and frequency (when something happened and how many times something has happened). Keep questions open-ended whenever possible.

Children who disclose recent or ongoing physical abuse will benefit from a forensic interview through a Child Advocacy Center.

Helpful phrases for assessing verbal children for abuse include showing child an injury on their body and asking:

- "What happened?"
- "Tell me more about that."

Survivors (especially children) will often refer to "being choked." It is appropriate to use their language and reflect how they describe the event. Children may have different words to describe events, actions, or feelings. When unsure, use phrases such as, "tell me more about that" rather than guessing what they mean.

Ask the child (can adapt for development/age):

- "Has a grownup ever put their hands or anything else around your neck? Your face?"
- "Has a grownup ever done anything that made it hard for you to breathe?"
- "Has a grownup ever hurt your body?"
- "What happens when [mommy/daddy/etc.] gets mad?"
- Ask the child(ren) about their siblings.
- "What happens when [sibling] gets in trouble?"

Ask the caregiver :

- "Have you ever been worried that someone hurt your child?" or
- "What would [partner] do when they were upset at [child]?"

If a history of strangulation (or other form of child abuse) is disclosed, the medical provider should:

- Complete mandated reporting to DHS and Law Enforcement if not already done. **1-844-CO-4-KIDS**
  Safety Note: Reporting to DHS or Law Enforcement can create safety risks for the adult survivor/ caregiver and possibly the child. Discuss your reporting requirements with the adult parent/ survivor and identify safety concerns. Refer to and/or coordinate with confidential victim advocacy services to develop safety plans with the adult survivor, and, as age-appropriate, with the child.
- Complete history and physical exam
  - See **Appendix D** for detailed information regarding pediatric exam and history in Symptoms (ONLY) of Pediatric Strangulation – Baby HOPE
- Triage the need for urgent medical care and screening
- Refer child to the Emergency Department immediately if:
  - Strangulation has occurred within the past 24 hours, regardless of findings on exam
  - There are any ongoing symptoms secondary to strangulation
  - ANY time an infant or child under 2 years old is involved in an instance of IPV (being held during the time of the incident, being tugged or fought over, etc.) they should be seen in the Emergency Department for medical workup and occult injury screening
  - ANY time there is a concerning bruise or mark on a young child, they should be seen in the Emergency Department
  - Extensive bruising, patterned bruising, or bruising in abnormal locations (ears, neck, torso)
  - Petechia to face, neck or palate, or the presence of subconjunctival hemorrhage
  - There are physical findings on exam that could be documented by a forensic nurse

Documentation of Pediatric Strangulation should include:

- Who was present when you obtain the history from caregiver or patient
- Who is providing the information
- Direct quotes whenever possible
- If asking about an injury during an exam, document the child's response for each specific injury

Key Agencies and Responders

Law Enforcement Response: Denver Police Department

Responding Patrol Officer

Patrol officers serve a vital front-line role in the identification, initial response, and documentation of strangulation-related crimes. Their actions are critical to both survivor safety and the integrity of the investigation.

Response and Survivor Safety

- Immediately separate involved parties and prioritize the safety of the survivor.
- Request Emergency Medical Services (EMS) when strangulation is alleged — regardless of visible injuries or refusal of medical attention.
- Strongly encourage a SANE (Sexual Assault Nurse Examiner) examination, also known as an "FNE" Forensic Nurse Examination, which is an essential part of the evidence-gathering process for strangulation cases. The SANE exam can be conducted at Denver Health Medical Center or University Hospital, where SANE nurses are available 24/7 or on call.

Assessment and Documentation

- Conduct a Lethality Assessment using the DPD Intimate Partner Case Summary and screen for strangulation-specific symptoms such as raspy or hoarse voice, confusion, memory loss, difficulty swallowing, lightheadedness, or visual changes.
- Document all reported and observed signs and symptoms, including any statements made by the survivor. Be thorough even if no injuries are visible — many strangulation injuries are internal or delayed.
- Note any involuntary bodily functions, behavioral changes, or disorientation as possible indicators of neurological trauma.

Evidence Collection

- Photograph the survivor and suspect as soon as possible, including any injuries or defensive wounds. Use ALS (Alternate Light Source) equipment if available.
- Secure and preserve any physical evidence (e.g., torn or soiled clothing, bedding, objects used to strangle).
- Encourage the survivor to change into fresh clothing only after evidence is secured.

Notifications and Referrals

- Notify the Domestic Violence or Sexual Assault Unit when strangulation results in serious bodily injury, loss of consciousness, or other high-risk indicators.
- Provide the survivor with their Victim Rights Notification and immediate referral to the Crisis Services Victim Advocate Unit (CSVAU).
- Inquire if children are present or impacted and document accordingly so the Domestic Violence Unit or City Attorney's Office can initiate appropriate reporting to Child Protective Services.
- Strongly encourage a SANE (Sexual Assault Nurse Examiner) examination, also known as an "FNE" Forensic Nurse Examination, which is an essential part of the evidence-gathering process for strangulation cases. A list of resource locations, including where SANE exams can be obtained, can be found in Appendix A.

The Sexual Assault Nurse Examiner (SANE) exam is not exclusive to sexual assault investigations; it is also used to assess other forms of trauma including strangulation. SANE nurses are specially trained with a focus on the meticulous documentation of injuries and evidence collection. In cases of strangulation, a SANE exam is particularly valuable as it involves a comprehensive head-to-toe assessment, identifying both visible and non-visible injuries. This specialized examination ensures that critical evidence is preserved, supporting both the survivor's medical care and the investigative process.

Due to the frequent lack of visible external injuries, Denver Police Department (DPD) officers should focus on collecting supporting evidence and conducting thorough symptom-based questioning when completing the Intimate Partner Case Summary (IPV). All reported strangulation cases require an EMS response, regardless of the presence of visible injuries or refusal of medical attention, due to the risk of internal injury and potentially life-threatening complications.

Survivors of strangulation may exhibit a wide range of trauma responses, which officers should recognize and document as part of their investigation. While some survivors may appear calm or disoriented, others may display heightened agitation, fear, or emotional distress due to oxygen deprivation, brain trauma, or the psychological impact of near-fatal violence. Officers should be aware that memory loss, confusion, headaches, or difficulty speaking can be signs of underlying neurological damage. Additionally, survivors may experience difficulty breathing, difficulty swallowing, or extreme anxiety, which can sometimes be misinterpreted as uncooperativeness. Survivors in crisis may struggle to articulate their experience and officers should approach these cases with patience, trauma-informed questioning, and a survivor-centered approach, ensuring they document both physical and behavioral symptoms while requesting EMS for a full medical evaluation, regardless of visible injuries.

Crisis Services Victim Advocate Unit (CSVAU)

Crime Services Victim Advocates, also referred to as Police Victim Advocates, provide essential support to survivors during and after police intervention, ensuring access to services and helping the survivor to make informed decisions. Police Victim Advocates are referred to the survivor on the date the incident occurs and continue to support survivors until the case passes the investigative stage and is accepted for filing with the District Attorney's Office or City Attorney's Office.

Initial Response and Risk Education

- After receiving a referral from DPD, make timely contact with the survivor—ideally within 24 hours of the incident.
- Use trauma-informed communication to assess for ongoing danger and create a customized safety plan.
- Educate the survivor about the medical and psychological risks of strangulation, including delayed symptoms and long-term health impacts.

Support Services and Navigation

- Offer referrals to emergency shelter, civil protection orders, counseling, and medical and legal services.
- Explain the survivor's rights under the Colorado Victim Rights Act.
- Assist in navigating the criminal justice system and informed consent protocols.

Collaborative Support

- Coordinate with detectives, prosecutors, medical personnel, and community partners to ensure a wraparound response while maintaining the survivor's autonomy and safety.
- Assist the Domestic Violence or Sex Crimes Units in disrupting threats and mitigating risks by emergency placement, issuance of cell phones, and safety planning.

Investigating Detective – Domestic Violence & Sex Crimes Units

The DVU detective or SAU detective leads the follow-up investigation, ensuring the strangulation case is fully and thoroughly investigated with survivor safety and offender accountability in mind.

Investigation and Interviewing

- Conduct trauma-informed interviews with the survivor, witnesses, and suspect.
- Record all survivor statements to document changes in vocal quality or memory over time.
- Prioritize interviewing the first non-law enforcement person the survivor contacted following the incident. Gather their observations of the survivor's symptoms and demeanor.

Evidence Collection and Medical Coordination

- Ensure the crime scene is processed thoroughly:
  - Collect relevant objects used in the assault.
  - Photograph the survivor, suspect, and scene.
- Request and review medical records, including FNE documentation and EMS run sheets.
- Encourage the survivor to undergo a medical evaluation if not already completed.

Follow-Up and Risk Management

- Schedule follow-up photographs within 24–48 hours to document delayed bruising or petechiae.
- Where ALS was used initially, repeat ALS photography if additional bruising becomes visible.
- Note in case files if a survivor declines follow-up photos or examination.
- Use the Strangulation Supplement within DPD's case management system to ensure standardized reporting.

Risk Identification

- Flag cases involving coercive control, prior strangulation, or escalating violence.
- Collaborate with prosecutors for consideration of 404(b) prior acts or expert testimony on non-visible injury.

Homicide/Cold Case Detective – Suspicious Deaths

When a suspicious death occurs in a domestic violence context, especially with prior strangulation reports, Homicide and Cold Case Detectives play a key role in uncovering and documenting the lethality trajectory.

The following 10 factors should be considered during an investigation of an individual when there has been a history of domestic violence:[1]

1. Survivor dies prematurely/unexpectedly.
2. Appears to be a suicide or accident scene.
3. One partner wanted to end the relationship.
4. Prior history of domestic violence (or coercive control).
5. Victim found dead in home or place of residence.
6. Victim found by current or previous partner.
7. Prior history of strangulation/suffocation by partner (including prior relationships).
8. Partner is the last to see the victim alive.
9. Partner has control of the crime scene before the police arrive.
10. Crime scene altered in some way.

Background Review

- Immediately review all prior law enforcement contacts, DV reports, and known history of strangulation involving the parties.
- Examine the scene and body for indicators of fatal or non-fatal strangulation (e.g., petechiae, hyoid bone fractures).

Collaborative Investigation

- Coordinate with the Medical Examiner to determine the cause and manner of death.
- If appropriate, consult with DVU detectives and PVAs to understand the history and high-risk factors in the relationship.
- Collaborate with the District Attorney's Office to pursue relevant expert witnesses or prior acts evidence that establishes a pattern of violence and control.

Training and Education

Denver Police Department (DPD) personnel — including patrol officers, detectives, evidence technicians, and Crisis Services Victim Advocates (PVAs)— should receive specialized training in the identification, investigation, evidence collection and prosecution of non-fatal strangulation. DPD should provide training opportunities and annual refresher training incorporated into in-service schedules to maintain operational excellence in strangulation response. Online training resources for DPD personnel are linked in Appendix C of this document.

Community Services Response

Denver offers victim services through both the criminal legal system and community-based organizations. Both types of advocates provide necessary and beneficial support to survivors, with services that often complement each other. Survivors may navigate both criminal and civil legal systems, which can be complex and challenging. See the Definitions section of this document or Types of Advocates in Appendix F. Community-based advocates play a crucial role in helping survivors navigate and understand the differences between these systems, including the distinction between various advocacy roles and confidentiality mandates.

Collaborating Community-Based Advocates

Community-based advocates may be the first point of contact to identify when non-fatal strangulation has occurred, providing survivors with critical information regarding the associated safety and health risks and developing safety planning based on individual circumstances. Many survivors of domestic violence and sexual assault do not report their abuse to police or choose not to engage with the criminal legal system even if reported. Therefore, community-based advocates should be prepared to provide survivors with critical information regarding the associated safety and health risks and develop safety plans based on individual circumstances.

Community-based advocates play a crucial role in providing confidential crisis intervention, on-going support, and linkage to other resources, regardless of a survivor's choice to participate in the criminal legal system.

Training

The following practices should be incorporated into community-based organizations serving survivors who have experienced domestic violence or sexual assault:

- All advocates should receive basic training regarding strangulation and the associated lethality, safety, and health risks to survivors.
- Basic training should be included as part of orientation for all interns or volunteers that provide client contact.
- Community organizations should encourage and provide additional training on strangulation through local or national resources to help ensure advocates have a full understanding of the risks and consequences and are capable of screening and assessing for strangulation, providing information to survivors regarding risk, and connecting them with appropriate services.

Intake Process

The intake process at community-based organizations serving survivors should include questions regarding the experience of strangulation with ALL new clients. Survivors may minimize strangulation, not recognize it as a form of abuse, or not think about disclosing it in light of other forms of abuse they have experienced. Given the high lethality of strangulation, it is critical that advocates actively inquire, using specific language to identify if strangulation has occurred. There are several assessment tools that can be used, (refer to Appendix F) but at a minimum, all new clients should be asked:

- Did anyone apply any pressure to your neck in any way? This may have been during an assault and/or during consensual or non-consensual sexual activity.
- Did anyone apply anything to your face, neck, nose and/or mouth that made it difficult to breathe? This may have been during an assault and/or during consensual or non-consensual sexual activity.
- Did it happen more than once?
- While being strangled, did you lose any bodily functions, such as urinating or losing control of your bowels?
- Did you lose consciousness or have 'gaps' in memory?
- Have you received any medical attention?

When strangulation is identified, advocates will encourage survivors to access medical care, providing general information about possible health impacts and the benefits of being seen by a health care provider *with knowledge about strangulation*. Health care locations with trained personnel can be found in Appendix A. Offer to share the TISP brochure on strangulation and the imaging protocol, also available in Appendix F, so that survivors can feel more confident in sharing their needs & concerns with their medical provider.

- Example conversation about strangulation screening:

> We know that strangulation or suffocation can be very dangerous, and people who use these behaviors may also be extremely dangerous, posing risks to your safety. I have some concerns about your health given that you have experienced this. Human necks have a lot of nerves and blood vessels, and sometimes there may be injuries that don't show up immediately after an assault and can be serious even when there is no visible injury. This is true regardless of the context of the strangulation — if it was during an assault, or as part of consensual or nonconsensual sexual activity. Injuries can also occur due to a lack of oxygen getting to the brain."

- In keeping with trauma-informed practices, ask the survivor:

> Is it okay if we talk a little about some of the effects, and some of the possible options for following up? If today is not the best time, I'd still like to provide you with some basic information, and we can revisit this in more detail the next time we talk."

- Explore loss of consciousness (LOC), while also reminding survivors that they may not realize that they have lost consciousness but may have a 'gap' in their memory. Information about strangulation/ suffocation and blows to the head can cause injury even without LOC.
- Symptom log: (See Strangulation Symptom Log in Appendix F) Whether or not a survivor declines medical attention, helping them be aware of possible physical and/or psychological signs and symptoms that they may experience in the days following can be helpful. Signs and Symptoms of Strangulation can be found in Appendix F and can be helpful to share with survivors to aid in their understanding of possible health risks.
- Help survivors be aware that symptoms and injuries may become more apparent over time and tracking them may be important information for healthcare providers or prosecutors. Survivors can note appearance of bruises, change in color or size, increase in pain, voice changes, swelling, increased confusion and other unexplained symptoms that may appear days later.
- Symptoms can be serious and life-threatening, and survivors should always be encouraged to seek medical care and be aware of when to seek emergency medical care, especially if they experience:
  - Hearing and/or vision loss or changes
  - Trouble swallowing, swelling to throat, neck or tongue
  - Dizziness, weakness, possible stroke symptoms
  - Headaches; possible brain injury
  - For more complete list of symptoms, refer to resources in Appendix B and Appendix D

Reducing Barriers

Advocates play an important role in addressing barriers to medical care such as transportation, childcare, financial concerns, lack of health insurance, fear of losing their job due to time missed from work, fear, minimization, or other safety concerns.

There may be additional identity-specific considerations that impact a survivor's ability or trust in seeking medical treatment. Advocates can help explore these barriers, address concerns, and help direct to appropriate services and resources from providers who have specific training on strangulation assessment. (See Skin Assessment in Patients with Dark Skin Tone in Appendix D for resource information and links).

Crime Victim Compensation (CVC) may be a resource to pay for strangulation assessment exams regardless of a survivor's choice to report to law enforcement. Advocates should be familiar with this resource, help inform survivors, and assist with the application process as needed (C.R.S. 24-4.1-108 and OVP: Crime Victim Compensation | Division of Criminal Justice)

Trauma-Informed Care

Advocates should work from a trauma-and violence-informed response, with an underlying understanding that traumatic experiences impact the way individuals respond and react. Trauma-informed care is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety .... and that creates opportunities for survivors to rebuild a sense of control and empowerment."[17] A violence-informed approach adds considerations of systemic violence, generational violence, institutional & cultural violence that a person may have experienced in addition to specific traumatic incidents.

Common trauma responses that survivors may experience include sadness, crying, trembling, anger, distrust, agitation, a strong startle response, confusion, trouble concentrating, losing track of the conversation, or silence. Advocates should also keep in mind possible physical or cognitive barriers or considerations.

Guiding principles of Trauma-Informed Care include:[2]

- Creating a sense of **safety, trustworthiness/honesty, and transparency** as much as possible. Using active listening to help the survivor feel heard, taking the time to ensure you understand what they are saying.
- **Empowerment-based,** giving options and clear information (related to engagement with or without legal systems, medical care, resources) for survivors to make informed decisions that are best for them.
- **Withholding judgment,** providing support and information to help survivors increase their safety. Acknowledging the complex reasons for staying or leaving and offering resources so survivors can make informed decisions based on their own expertise about their situation.
- **Validation,** avoiding minimizing the danger and risks, while also reminding the survivor that they survived.
- **Violence-informed care,** expanding these concepts through bringing consideration that generational violence may make trusting agencies, law enforcement, and service providers more difficult; poverty, disability, childcare, or other factors may make transportation and scheduling extremely difficult. Family history of poor outcomes with health or legal systems affect survivors' choices in safety planning, etc.
- **Cultural, historical and gender considerations** being factored into every aspect of services and trauma-informed care, with an awareness of how cultural barriers and identity potentially informs seeking access to medical care, leaving the home, what support looks like, access to resources, etc.

Safety Planning

Advocates should work to develop a safety plan specific to the risks and needs of each survivor, including options regarding leaving and/or staying in the relationship, seeking medical care, legal options, etc. Safety planning resources can be found in Appendix F.

- Documentation: survivors may be advised to keep their own evidence/documentation, even if they have provided photos, screenshots, text messages, voicemail, etc. to law enforcement. It may be difficult to retrieve copies of evidence for use in civil legal or other processes.
- Phone applications to safely store documentation and photos include:
  - Victims Voice
    - Not a free service
  - Bright Sky US
    - Free, has evidence documentation feature that saves to an email address
- Clients can back up evidence to a new/safe email or send files to a trusted friend or family member for safekeeping.
- Photos of injuries can be cropped so the photo is unrecognizable and is less likely to be deleted if the abuser is monitoring phone/photos. Then when needed, the photo can be "reverted to original" to show the injury/damage.

Pediatric Strangulation

As noted in the Pediatric Strangulation section of this protocol, pediatric strangulation is emerging as a co-occurring issue with domestic violence strangulation and is important to consider when working with survivors who have children. Advocates can help inform survivors about this information and provide resources for screening and safety planning.

Although confidential domestic violence and/or sexual assault advocates are no longer mandatory reporters of child abuse, this does not prevent an advocate from making a report if the survivor chooses to sign an appropriate Release of Information. It is important to share this option with survivors as well as letting them know that they can make a direct report to the appropriate law enforcement or Dept. of Human Services location. Many survivors may wish to have a report made.

For advocates or providers working with survivors who may not fall within the defined categories in C.R.S.13-90-107 (or who are mandatory reporters under C.R.S. 19-3-304), clarity and transparency about mandatory reporting of child abuse is important. The safety of child(ren) is a priority, and reporting may impact both the survivor's safety as well as that of the children. Transparency about the process, along with informing the survivor of the requirements of each provider, allows the survivor the opportunity to do additional safety planning with respect to their specific situation. In addition, this can promote trust and better engagement with the process.

Prosecution Response

Prosecutors

Prosecutors should have a foundational understanding of non-fatal strangulation, its traumatic impact, and best practices in evidence collection in order to effectively prosecute cases and hold offenders accountable. Prosecutors need to understand the realities of non-fatal strangulation — its warning signs, the serious risks it poses, and how to gather the right evidence to support prosecution.

Prosecutors should receive training on the dangers, signs, and symptoms of strangulation, staying up to date with advanced strangulation training, prosecution strategies, and best practices. This should include training on evidence-based strategies, understanding witness forfeiture, and how to prove a case without a survivor. Additionally, prosecutors should have a strong understanding of domestic violence dynamics, including the complexities of survivor behavior, coercive control, and the impact of trauma on memory and reporting. Recommended training resources are included in Appendix G.

Prosecutors should be well-versed in applicable charges and, when legally appropriate, pursue felony strangulation charges. Relevant felony statutes include:

- Assault in the First Degree – C.R.S. 18-3-202(1)(g)
- Assault in the Second Degree – C.R.S. 18-3-203(1)(i)
- Attempted Murder – C.R.S. 18-3-102(1)(a), 18-2-101

The Denver City Attorney's Office's (CAO) protocol is to review all domestic violence cases and, when strangulation is noted in the police report, to staff that case with the District Attorney's Office (DAO) for consideration of an up-file to a state-charged case. If accepted, the case will go to the District Attorney's Office for prosecution. If rejected for a misdemeanor or felony filing, the CAO will prosecute the case and handle it as a high-risk situation.

Follow-up investigations are critical in strangulation cases. Prosecutors and District Attorney Investigators should:

- Inquire about and document injuries that develop after the initial incident.
- Encourage survivors to seek medical care if not yet received.
- If the survivor has seen medical professionals, obtain medical records, including imaging.
- Utilize jail calls, when applicable.
- Conduct follow-up discussions regarding the survivor's prior history of violence, including prior acts of strangulation.
- Identify outcry witnesses and obtain statements.
- Collect any available digital media to corroborate the incident.

Whenever possible, prosecutors should consult medical professionals and utilize their testimony in court to demonstrate the medical risks associated with strangulation.

Given the high lethality risk of these assaults, prosecutors should approach plea negotiations and sentencing with a heightened awareness of the danger posed by these offenders. When supported by the evidence, prosecutors should pursue meaningful plea offers. Sentences should also reflect the seriousness of the offense, the risk to the survivor, and the potential for escalation.

Advocates

District or City Attorney Victim Advocate (System-based)

Prosecution-based advocates differ from police advocates in that they work with a survivor once their case has been referred for prosecution. The City Attorney's Office or District Attorney's Office will prompt an advocate to outreach to a survivor once the case has reached the prosecution stage. A District or City Attorney's Office victim advocate will complete outreach to a survivor after a case has been accepted for filing. These advocates provide initial court date information, safety planning resources, and connections to community resources.

Court Advocates

Court Advocates provide essential support to survivors during and after police intervention, ensuring access to services and empowering survivors to make informed decisions. Court advocates can maintain a presence in the court room to support a survivor, notify a survivor of upcoming court dates, and let them know about critical stages of their case related to the Victims' Rights Act (available in Appendix B).

All prosecution-based advocates should receive training on the dynamics of domestic violence and sexual assault, including the reasons survivors may recant, the impact of trauma, and the significant dangers of non-fatal strangulation. Advocates should encourage and facilitate medical screening and treatment for survivors of non-fatal strangulation to address potential delayed or hidden injuries.

Advocates should provide ongoing support to survivors following the incident and throughout court proceedings in accordance with their obligations under the Victims' Rights Act and relevant statutes. Advocates should provide information on how a survivor's information may be shared within the criminal legal system, and when referral to a confidential community-based advocate may be of benefit. Relevant statutes include:

1. D.R.M.C. Chapter 14, Article VIII
2. Colo. Const. Art. II, Section 16a
3. C.R.S. 24-4.1-300.1
4. C.R.S. 24-4.1-301
5. C.R.S. 24-4.1-302
6. C.R.S. 24-4.1-302.5
7. C.R.S. 24-4.1-303
8. C.R.S. 24-4.1-304

Safety planning should be revisited regularly with each survivor, and all strangulation cases should be treated as high-risk situations. Safety planning resources can be found in Appendix F. Advocates should make every effort to provide survivors with information on available resources, including shelters, hotlines, medical and civil legal assistance, community support services, the legal system process, safety planning, and their rights as victims.

Collaboration Between Victim Advocates and Prosecutors

System-based advocates and prosecutors should work closely to ensure a survivor-centered approach to prosecution. This includes regular communication regarding survivor safety, case updates, and any concerns the survivor may have throughout the legal process. Advocates can provide valuable insight into survivor behavior and trauma responses to help maintain survivor engagement, which can assist prosecutors in effectively presenting their cases. As needed, and with appropriate consent, collaboration with confidential community-based resources may help support the survivor throughout the process, increasing safety and engagement.

Community Supervision Response: Pretrial and Probation Services

Pretrial Services Response

With the exception of non-domestic violence municipal charges, Pretrial Services is engaged if a defendant is arrested for a strangulation offense, regardless of case outcome.

Assessment of defendant includes the following steps:

- Pretrial should conduct a domestic violence risk assessment which includes high risk factors. These assessments provide a score which correlates with an assigned supervision level, which is then included in a report with recommendations on bond conditions and provided to the Court. Currently these assessments do not contain a strangulation specific component.
- Denver Pretrial uses the ODARA risk assessment for domestic violence offenses, available in Appendix H.
  - DPD officers complete the IPV form at the time of their response to a domestic violence incident which includes the answers to the ODARA questions that require survivor input.
  - If the form is not completed on scene, Pre-trial Victim Advocates will attempt to contact the survivor to get those questions answered.
  - The ODARA is then scored by Denver Pretrial Staff and included on the bond report to the Court. Defendants can score low, medium, or high risk to reoffend against an intimate partner in the 20 months post offense. The score dictates what supervision level is recommended; however, pretrial staff may override the recommendation based on various factors, and the Judge has the ultimate say in what is ordered.
- In cases where domestic violence is not alleged, defendants are evaluated for the pretrial risk assessment which assesses the likelihood of committing a new offense or failing to appear for court during the pretrial phase. This should be completed on most Victim's Rights Act (VRA) cases and is included on the bond report to the court. The court has ultimate say in what bond conditions are ordered.

Training & Education for Pretrial Staff

All pretrial officers should receive initial and ongoing training on strangulation dynamics, including its role as a high-lethality factor in domestic violence cases, the risks of non-visible injuries, and appropriate response. This training will help them better manage their defendants who have perpetrated this crime, as well as recognize those who may have been victimized.

Pretrial Supervision

If a defendant posts bond any time after their arrest, they will be subject to Pre-trial Supervision requirements if ordered by the court as a condition of bond. These conditions could include GPS monitoring, home detention, curfew, monitored sobriety, and phone, virtual, or in person check ins with a Pre-trial Officer.

Denver pretrial domestic violence cases which include strangulation allegations should be assigned to a DV specific supervision officer who has received domestic violence specific training. Statutory conditions of bond are ordered by the court, and additional supervision conditions may include electronic monitoring, monitored sobriety, and/or movement restrictions. Pretrial officers should consider offense information, individual defendant risk/needs and barriers, to determine the individual supervision plan. Non-compliance and compliance should be reported to the court. High-risk cases involving strangulation may require an after-hours coordinated response with law enforcement for GPS violations, particularly when the violation indicates proximity to the survivor or other escalating behaviors as identified by pretrial staff.

If the supervising pretrial/probation officer identifies a defendant under their supervision who may be a victim of recent strangulation or threats of strangulation, they should refer to the appropriate law enforcement, medical, prosecutorial, and/or advocacy/support agencies. An immediate referral or direct contact with a partner from the supervision officer may be needed depending on the severity of the circumstances. They may also provide education to the survivor on the dangers and effects of strangulation. Officers should document any observed indicators of strangulation injuries.

Pretrial Victim Services and Advocacy

Denver Pretrial Services has domestic violence pretrial-specific victim advocates which are responsible for educating survivors on the court process, bond conditions, pretrial supervision levels, and bond process. Pre-trial staff will work with pre-trial advocates to prompt advocate outreach to survivors engaged in the pre-trial process. DV pre-trial advocates monitor the offender if they have been assigned any pretrial conditions such as an ankle bracelet, etc.

These advocates or a pretrial staff member should notify survivors of specific GPS alerts at the time of the notification and may dispatch law enforcement. Advocates may provide resources and safety planning to survivors at any stage in the pretrial phase of a case. They may make connections and communicate to the prosecution and community partner advocates. Pretrial officers may occasionally speak with survivors of defendants on pretrial supervision but should generally refer them back to law enforcement, system and community-based advocates, or attorneys.

Probation

Colorado Probation is committed to public safety, survivor and community reparation through offender accountability, skill and competency development, and provision of services to the communities of Colorado.

Denver Adult Probation (District Court) supervises felony and/or misdemeanor probation supervision in Denver County.

- The Probation Department completes a Pre-Sentence Investigation Report (PSIR) when ordered by the court. A PSIR includes information about the offense, victim impact statement, offender's criminal history, family background, education/employment history, and assessment of risk and needs.
- If the defendant has committed a sexual offense, the defendant will also need to complete an Offense Specific Evaluation (OSE) by a Sex Offender Management Board approved provider. For additional information on sexual offense specific cases, please reference the City & County of Denver Adult Sexual Assault Response Protocol.
- If a PSIR was not completed prior to being sentenced to Probation, the defendant will be interviewed and standardized assessments used to assess the client's risk, needs, and responsivity.
- The PSIR, OSE, and City & County of Denver Adult Sexual Assault Response Protocol can be found in Appendix H.

Training & Education for Probation Staff

Probation staff are provided with ongoing training through the Division of Probation Services, and other community agencies such as The Office of Domestic Violence and Sex Offender Management.

Supervision

Standards for Probation in Colorado provide consistent expectations for probation practices and services. The probation officer monitors the defendant's compliance with the terms and conditions ordered by the Court.

For supervision of Sex Offenders, when the Court has ordered the Additional Conditions of Supervision for Sex Offenders, the defendant must complete Offense Specific Treatment with a Sex Offender Management Board approved provider. The Community Supervision Team includes, at a minimum, the treatment provider, the evaluator, the polygraph examiner, and the supervising officer who collaborate to make decisions about offender treatment.

For supervision of Domestic Violence Offenders, when the Court has established an underlying factual basis to include an act of Domestic Violence, the defendant will be required to complete a Domestic Violence Evaluation and any recommended treatment with a Domestic Violence Offender Management Board (DVOMB) approved provider. The Multi-Disciplinary Team includes, at a minimum, the treatment provider, a victim advocate, and the supervising officer, who collaborate and coordinate offender treatment.

The Victim Services Officer provides information regarding a Victim's Rights Act (VRA)-eligible survivor, or the survivor-designee, with the right to be notified of critical stages as it relates to probation supervision and community corrections. VRA-eligible survivors must opt in to the Victim Notification program (VNOT) to receive the notifications required by the VRA. If the defendant absconds from probation supervision, the victim services officer must attempt to notify a VRA-eligible survivor even if they did not opt into the victim notification program.

Appendix A

Community-Based Service Agencies

The following Denver Metro agencies provide a variety of survivor services. It is always best practice to confirm their availability and scope of services before referring. With appropriate survivor consent, facilitating a warm-handoff or introduction to the service provider can also help ensure an effective connection.

1. **Brain Injury Association Colorado:** Support. Guidance. Connection.
2. **The Blue Bench:** Metro Denver's only comprehensive sexual assault prevention and client services organization.
3. **Denver Child Advocacy Center**
4. **PorchLight:** A Family Justice Center | Domestic Violence | Colorado
5. **Project PAVE**
6. **Project Safeguard**
7. **Rose Andom Center:** One Place. Immeasurable Hope.
8. **SafeHouse Denver**: Domestic Violence Services
9. **Servicios de la Raza**
10. **Cultural Development & Wellness Center:** Aurora Mental Health & Recovery
11. **The Initiative**

SANE/ Forensic Nurse Resources

1. **Denver Health**
   777 Bannock St., Pavilion A, 1st Floor
   303.602.3007
   Sexual Assault Nurse Examiners | Denver Health
2. **St. Anthony's North Hospital**
   303.430.2648
   720-321-4103
   St. Anthony North Hospital SANE
3. **UC Health**
   Colorado Sexual Assault Forensic Examiner Program | UCHealth

Appendix A

Pediatric Resources

Two hospitals in the Denver Metro Area with a Pediatric SANE Program and affiliated Child Abuse Pediatricians, with SANE on-call 24/7:

1. **Denver Health Medical Center**
   Call the Emergency Department at 303-602-3007.
   777 Bannock St., 1st Floor Pavilion A, Denver, CO 80204
   Has on-call Child Abuse Pediatricians 24/7

2. **Children's Colorado Hospital**
   Call the Emergency Department at 720-777-3999.

3. **Anschutz Medical Campus**
   13123 E. 16th Ave. B251 Aurora, CO 80045
   Has on-call Child Abuse Pediatricians 8am-5pm daily

Endnotes

[1] Messing et al., 2018

[2] Study of survivor self-reports (see Messing et al., 2018)

[3] McQuown et al., 2016

[4] *Journal of Emergency Medicine* study on sexual assault–related strangulation

[5] Herbenick, Patterson, et al., 2023

[6] Brady et al., 2023

[7] Strack et al., 2001

[8] De Boos, 2019

[9] Armstrong & Strack, 2016

[10] Bichard et al., 2022

[11] Colorado Domestic Violence Fatality Review data; email from Joanne Belknap, PhD (May 29, 2025)

[12] Glass et al., 2008

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