THE DOMESTIC VIOLENCE FORENSIC EXAM

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LEARNING OBJECTIVES

• Develop awareness and sensitivity to the barriers that inhibit effective interaction between battered persons and health care providers

• Identify the physical and behavioral signs and symptoms of domestic violence

• Utilize appropriate interview and intervention techniques once abuse is suspected

• Assess the patient’s level of risk for future violence

• Promote patient autonomy, confidentiality, and self-determination to the extent possible by law

• Understand and implement the legal duties and responsibilities of health care providers

• Outline the procedure for a domestic violence forensic exam

• Utilize resources and referral option available to health care providers and their patients
STUDIES SHOW THAT TALKING TO ALL OF YOUR PATIENTS ABOUT HEALTHY RELATIONSHIPS AND HOW UNHEALTHY RELATIONSHIPS AFFECT HEALTH, NOT SCREENING, IS WHAT IMPROVES HEALTH + SAFETY AND PREVENTS VIOLENCE.

- Survivors say they want health providers to:
  - Be nonjudgmental
  - Listen
  - Offer information and support
  - Not push for disclosure
CONFIDENTIALITY

• Always see patients alone for part of every visit so that you can bring up relationship violence safely.

• Know the mandatory reporting requirements and share any limits of confidentiality with your patients.

• Don’t rely on friends or family to interpret
MANDATORY REPORTING

- Cal. Penal Code §§11160 and 11161 require that any health practitioner employed in a health facility, clinic, physician’s office, local or state public health department, or clinic or other facility operated by a local or state public health department, is required to make a report to local law enforcement if he or she provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is suffering from any wound or other physical injury that is the result of assaultive or abusive conduct as defined, including sexual assault; or any person suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm.
UNIVERSAL EDUCATION AND SCREENING

• Give each patient two safety cards to start the conversation about relationships and how they affect health.

• Open the card and encourage them to take a look. Make sure patients know that you’re a safe person for them to talk to.

• Offering safety cards to all patients ensures that everyone gets access to information about relationships, not just those who choose to disclose experiences of violence.
SCREENING

- Cal. Health & Saf. Code § 1233.5 and § 1259.5 requires licensed clinics, general acute care hospitals, acute psychiatric hospitals, special hospitals, psychiatric health facilities, and chemical dependency recovery hospitals to establish written policies and procedures to screen patients routinely for the purpose of detecting spousal or partner abuse and provide education for appropriate hospital staff about the criteria for identifying, and the procedures for handling, patients whose injuries or illnesses are attributable to spousal or partner abuse.
SUPPORT

- Though disclosure of violence is not the goal—it will happen. Know how to support someone who discloses.

- Make a warm referral to your local domestic/sexual violence partner agency or national hotlines (on the back of all safety cards).

- Offer health promotion strategies and a care plan that takes surviving abuse into consideration.

- What resources are available in your area for survivors of domestic and sexual violence? How about for LGBTQ, immigrant, or youth survivors? Partnering with local resources makes all the difference.
PROTOCOLS FOR HEALTH PROFESSIONALS

- Cal. Health & Saf. Code § 1233.5 and § 1259.5 requires that policies and procedures adopted by clinic boards, general acute care hospitals, acute psychiatric hospitals, special hospitals, psychiatric health facilities, and chemical dependency recovery hospitals, include documenting in the medical record patient injuries or illnesses attributable to spousal or partner abuse, and providing to patients who exhibit signs of spousal or partner abuse a current referral list of private and public community agencies that provide, or arrange for, the evaluation, counseling, and care of persons experiencing spousal or partner abuse, including, but not limited to, hot lines, local battered women’s shelters, legal services, and information about temporary restraining orders.
• Cal Pen Code § 11161.2(b) requires the agency or agencies designated by the Director of Finance pursuant to § 13820, in cooperation with the State Department of Health Services, to establish medical forensic forms, instructions, and examination protocol for victims of domestic violence using as a model the form and guidelines developed pursuant to § 13823.5. The form should include a place for notation concerning taking a patient history of domestic violence, performance of the physical examination for evidence of domestic violence and a complete documentation of medical forensic exam findings.
WHAT IS A FORENSIC MEDICAL EXAM?

- Forensic medical and evidentiary based exam performed by specialized forensic examiners
  - Focused medical assessment
  - Obtain history
  - Identify and document injuries
  - Evaluate and refer for treatment of injuries
WHAT IS A FORENSIC MEDICAL EXAM?

- Focused medical assessment
- Detailed forensic report
- Collection of forensic evidence
- Forensic photography
- Crisis intervention
- If applicable STI and pregnancy prophylaxis treatment
- Referrals for follow up care

➢ All provided in patient-centered, trauma-informed manner
WHY THE NEED FOR FORENSIC EXAMS IN IPV?

- IAFN White Paper
- Pilot study performed in Maricopa County in Arizona
San Diego County

- Began pilot for Domestic Abuse Forensic Exams in 2017
  - Medical forensic exam
  - Evidence collection
  - Photographs
  - Documentation on state form
San Diego County results (18 months)

- 33 → 73% felony filing rate
- 10 → 40% plea rate

✓ Decrease in DV homicide rate during same time frame
ALAMEDA COUNTY

- Implemented medical forensic exams for DV/IPV in 2014
- 59% of victims served scored in the severe to extreme risk categories according to their lethality assessment scores
- Developed and piloted electronic form
  - Domestic Violence Report and Referral (DVRR)
  - Increased victim access to medical care
  - Increased number of victims connected to services
    - 70% consented to referral to Family Justice Center
Intimate Partner Violence Exam Pilot

District Attorney’s Office

Santa Clara County Sheriff’s Office

Santa Clara County VMC SAFE Program
WHAT HAPPENS IN A MEDICAL FORENSIC EXAM?

- Meet forensic nurse
- Meet or connected with medical social worker
- Meet or connected with domestic violence advocate, who can provide support during the interview/exam, assist with aftercare needs
- 2-3 hours long
- Opportunity to shower after, replacement clothes, snacks
- Discharge information includes Medical follow-up
- Resources regarding investigation and safety needs.
PATIENT CONSENT

- Family Code 6930 minor consent for IPV (AB 3189 2018) allows minors (12-17 years old) to consent for themselves
- Patient consent to conduct the forensic exam obtained before the exam
- The exam is voluntary
- Patient has the right to decline any portion of the exam or stop the exam at any time.
- All information collected remains confidential within the multidisciplinary team
THE MEDICAL FORENSIC EXAM
DANGER ASSESSMENT
ALTERNATIVE LIGHT SOURCE (ALS)
COLPOSCOPY
COLPOSCOPY
INJURY IDENTIFICATION AND POTENTIAL MECHANISM

- Blunt Force (Abrasions, contusions and lacerations)
- Sharp Force
- Burns
- Bite Injuries
- Strangulation Injury

➢ ALWAYS ASSESSING FOR MEDICAL AND EVIDENCE NEEDS
NON-FATAL STRANGULATION

Strangulation:

A form of asphyxia characterized by the intentional closure of blood vessels and/or air passages of the neck as a result of external pressure applied to the neck sufficient to cause

- disruption of blood flow to or from the brain
- disruption of air exchange

resulting in a lack of adequate oxygen delivery to the brain

2017 San Diego County Strangulation Protocol
Complete loss of consciousness is not required
NON-FATAL STRANGULATION

**Asphyxia:**

- *Condition arising when the body is deprived of oxygen, causing unconsciousness and untimely death*

**Anoxia**

**Hypoxia**
Complete loss of consciousness is not required
NON-FATAL STRANGULATION

Types of strangulation:

- **Manual**: use of fingers or other extremity
- **Ligature**: use of some form of cord-like object around the neck without suspension
- **Hanging**: use of some form of cord-like object around the neck with suspension
**NON-FATAL STRANGULATION**

**Suffocation:**

Mechanical obstruction of airflow into the mouth and/or nostrils

- Hand
- Pillow
- Gag object
- Plastic bag

✓ May be partial or complete, depending on patient’s ability to inhale some (but not enough) air

✓ In general, asphyxia due to suffocation requires at least partial obstruction of both nasal cavities and the mouth
NON-FATAL STRANGULATION

Positional Asphyxiation:

Caused by compression of the face, neck, chest, and/or abdomen sufficient to making it difficult or impossible to breathe

Example – sitting on victim’s chest
NON-FATAL STRANGULATION

When strangulation and suffocation are combined, damage to the brain is accelerated, increasing the chance of fatality.
PHYSIOLOGICAL CONSEQUENCES OF STRANGULATION
Occlusion of Arterial Blood Flow: Seconds to Minutes Timeline

Created by: Ruth Carter, Bill Smock, MD; Gael Strack, JD; Yesenia Aceves, BA; Marisol Martinez, MA; and Ashley Peck

0 seconds
PRESSURE APPLIED
Occlusion of carotid arteries

6.8 sec.
(5-10 sec. range)
TIME TO RENDER UNCONSCIOUS
≈ 6.8 seconds
Adult Male

14 sec.
(11-17 sec. range)
ANoxic SEIZURE

15 sec.
(minimum)
LOSS OF BLADDER CONTROL

30 sec.
(minimum)
LOSS OF BOWEL CONTROL

1 minute
DEATH/RESPIRATION CEASES
Beginning Time
(First patient, 1/14 dead at 62 seconds)

62 sec.
DEATH/RESPIRATION CEASES
Ending Time
(All patients, 14/14 dead between 62 and 152 seconds)

152 sec.

REFERENCES AND RESOURCES

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2 Anny Sauvagneau, MD, MSc; Romano LaHarpe, MD; David King, MD; Graeme Dowling, MD; Sam Andrews, MD; Sean Kelly, MD; Corinne Ambrosi, MD; Jean-Pierre Guay, PhD; and Vernon J. Geberth, MS; MPS for the Working Group on Human Asphyxia, Forensic Med Pathol 2011;32: 104 – 107.

3 Training Institute on Strangulation Prevention: strangulationtraininginstitute.com

strangulationtraininginstitute.com
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Vessels: arteries & veins

- Carotid Artery
- Jugular Vein
- Hyoid Bone
- Thyroid Cartilage (with fracture shown)
- Tracheal Rings
NON-FATAL STRANGULATION

Psychological Symptoms

- Nightmares
- Insomnia
- Depression
- Anxiety
- PTSD
- Suicidal ideation
NON-FATAL STRANGULATION

Potential Complications

- Neck swelling/airway obstruction/swallowing issues
- Pulmonary edema
- Aspiration pneumonitis
- Pneumonia
- Stroke
  - Carotid dissection
  - Jugular vein thrombosis
- Ptosis, palsy, L or R sided weakness
- Cerebral hypoxic injury
- Miscarriage
- Death from event
  - Immediate
  - Future (increased risk >700%, especially if guns in home)
Survivor considerations

- Fight, flight, or freeze
- Near death experience
- “Thought I was going to die”
- Memory storage and recall

Non-fatal v. fatal strangulation
NON-FATAL STRANGULATION

Photos
%injury
NEXT STEPS

• Complete DV Medical Protocol
• Strangulation protocol
• Imaging vs. surveillance recommendations
• Implement IPV pilot with data collection
• Report and disseminate findings
Health Professionals have an unprecedented opportunity to provide universal education on healthy relationships, assess for IPV and intervene if abuse is identified.

This can improve health and decrease risk of violence.

—*Futures without Violence*
REFERENCES


THANK YOU

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