Non-fatal strangulation: origins, injuries, and challenges

By Rebecca McKnight
3PB Barristers

Introduction

The act of strangling or suffocating as part of an assault has long formed the part of allegations involving other offences such as battery and assaults resulting in actual harm (ABH) or serious harm. However as of 7th June 2022 section 70 of the Domestic Abuse Act 2021 has produced section 75A of the Serious Crime Act 2015, creating an offence of non-fatal strangulation or non-fatal suffocation. This article is focussed more on the former. It is becoming more commonplace both to see this offence charged and to advise on whether it should be charged. There has also been recent case law in the Court of Appeal concerning sentencing in these cases and Jonathan Underhill has written an article about this which goes hand in hand with this piece.

This article instead focuses on the earlier part of the process. It has been divided up as follows:

1. Background - looking what brought this new law into force.
2. Most of this piece is on injuries in cases of strangulation with a focus on the Criminal Bar Association (CBA) lecture from Dr Catherine White of the Institute for Addressing Strangulation (IFAS) (https://ifas.org.uk/).
3. A brief look at what this might mean for prosecuting and defending.
4. Finally, what the future holds in this area?

Dr Catherine White is one of the key experts in this area. This article draws upon information from a lecture she gave to the Criminal Bar Association on the 12th July 2023 entitled CBA Lecture: Non-Fatal Strangulation which can be accessed by CBA members. It also relies upon information provided by Dr White on the IFAS website. Any views expressed in this article are those of the author and not of Dr White.

Background

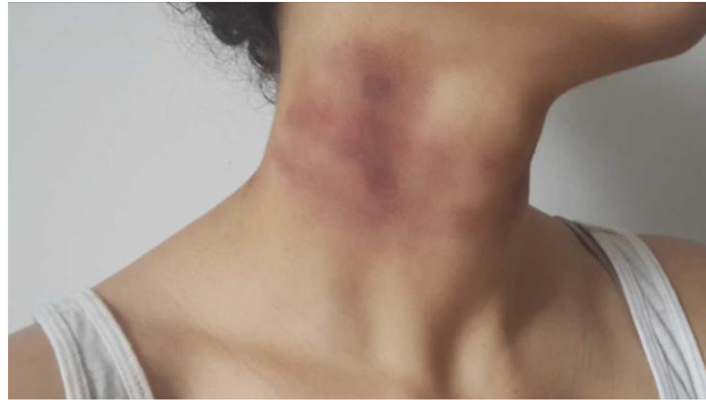
There appeared to be a contradiction between the way in which cases where strangulation was alleged were charged and being sentenced, when the seriousness of the act of strangulation is considered. This was certainly the view of groups such as the Centre for Women's Justice, who provided their views as part of a government policy paper. They pointed to alarming statistics in 2020 including that strangulation and asphyxiation are the second most common method of killing a female in homicides, 29% for the former and 17% for the latter, as compared to 3% where the homicide victim is male.[1] Yet the reality is that injuries are often not obvious or visible in these cases and that meant there was often a struggle even charging an ABH in these cases.

This created a situation where a complainant might be subject to repeated strangulation or suffocation where no injuries result, yet the perpetrator could end up being charged with the summary only offence of battery facing the maximum 6-month sentence. That does not seem logical where the act committed is a high-risk factor for homicide and can cause lasting injuries. There have been studies in the USA on strangulation as a risk factor, it is said that a victim who is strangled is 6 times more likely to become a victim of an attempted homicide and 7 times more likely to become a victim of homicide[2]. Dr White references similar research in Manchester in the CBA lecture and this research seems to reflect a similar picture to the finding in the USA. This means that strangulation is not just a sign of a risk of general violence but a sign of a risk of lethal violence.

Injuries in cases of strangulation

There is often no visible injury in a case involving strangulation or suffocation. There will of course be cases where there is bruising or fingerprints such as in the image below, but these cases will not be commonplace.

[1] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/strangulation-and-suffocation
[2] Nancy Glass J Emerg Med 2008 35(3) https://www.criminalbar.com/resources/cpd-accredited-films/

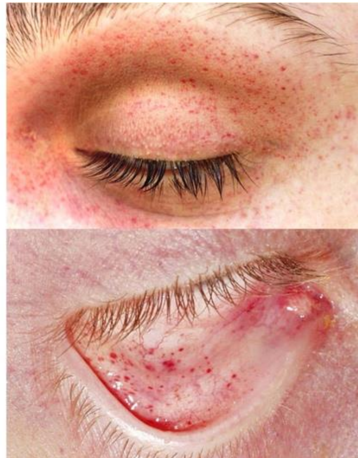


The act of strangulation is referred to as obstruction of blood vessels and/or air flow in the neck which then results in asphyxia. It should be noted that asphyxia, a state of oxygen deprivation, is not a pre-requisite for the offence, but the result of an act of strangulation can cause this which can lead to the victim losing consciousness, dying, or being suffocated. Dr White also highlights some words to look out for in determining whether there is an allegation of strangulation, such as being **choked, grabbed, pinned**. She suggests that when police are taking statements, without leading the complainant, that where these terms are used, the issue is further explored to determine whether a non-fatal strangulation charge is appropriate.

The legal position is that strangulation should be 'given its ordinary meaning, obstruction or compression of blood vessels and/or airways by external pressure to the neck impeding normal breathing or circulation of the blood'[3].

Dr White describes how your arteries in the neck and chest area must work against gravity in pumping blood to the brain, working alongside veins which are returning blood from the brain to the rest of the body. The arteries are found deeper within the neck than the veins and therefore it is common in these cases that the veins will be restricted by an act of strangulation even if very short lived. The result if the veins are compressed is that blood will be unable to leave the brain, this can result in redness to the eyes, little pinprick dots called petechial (see below). However, where both the arteries and veins are compressed rather than being unable to leave the blood will not flow to the brain. There have been cases where someone has died as a result of strangulation but there are no physical injuries outside, and a post-mortem is necessary to show neck compression leading to death.

[3] https://www.cps.gov.uk/legal-guidance/non-fatal-strangulation-or-non-fatal-suffocation#:~:text=The%20word%20should%20be%20given,in%20death%20of%20the%20victim.



There is then not long between that initial strangling, grabbing, choking to potential death. At around 15 seconds victims can suffer from bladder incontinence, at 30 seconds bowel incontinence, 2-3 minutes cell death and at 4-5 minutes brain death. A factor such as a history of someone urinating themselves during an assault might indicate a history of being strangled. My understanding is that the seconds it takes to get to each stage reduce with a higher amount of pressure being applied.

Dr White is clear that there can of course be physical injuries, a complainant might have abrasions to their neck, marks where they have tried to get someone off, or DNA under their fingernails. She also makes the point that skin tone can greatly impact how visible an injury is with the basic rule being that the darker the skin tone the harder it is to see red marks and bruising.

The IFAS has a helpful paper written by Dr White which expands upon this topic[4], for prosecution and defence counsel purposes, the signs to look for, symptoms and what to expect from a physical examination are particularly useful. At the time of an incident of strangulation the complainant might report, although not limited to, visual disturbances, auditory disturbances, faecal or urinary incontinence, loss of consciousness, or a lack of awareness or memory as to what has happened. During the CBA lecture Dr White played short clip of a man allowing himself to be choked, within seconds he had lost consciousness temporarily but what was disturbing about this clip was he did not recall what had happened. This can of course present difficulties, particularly prosecuting, as one may be dealing with a confused witness who cannot remember exactly what happened because they were in fact strangled.

[4] https://ifas.org.uk/wp-content/uploads/2023/05/Non-fatal-strangulation-in-physical-and-sexual-assault-Dr-C-White-Jan-2023.pdf

The report further expands upon symptoms in the aftermath. A complainant might have respiratory problems such as laboured breathing, speech problems, a cough, a hoarse voice, or inability to speak. They can often report problems around the airway such as difficulty swallowing or pain, dribbling or drooping, oedema or swelling, or vomiting. There can be neurological issues like seizures, dizziness, headaches, motor weakness, sensory weakness, or memory loss. In terms of what might be physically indicative of strangulation, you might see swelling, bleeding, bruising, small purple or red dots, subconjunctival haemorrhages (see below). This is not limited to the neck area and is around the general facial area, mouth, eyes, ears. On the neck there might be tenderness, swelling, bruising, abrasions, marks if a ligature has been used. It is important that attempts are made for complainants to be physically examined where possible, of course by the point a case comes to us that opportunity may have been missed. A physical examination may show a number of these factors, there might also be damage to the larynx or thyroid cartilage and of course there may be no injury at all.

Dr White quotes numbers from the study in Manchester as suggesting in around 52% of cases there will not be a head or neck injury.

What does this mean for prosecuting and defending cases involving non-fatal strangulation?

The short answer is that when prosecuting it will often not be as straightforward as pointing to an exhibit photograph of injuries. If there has been an assessment done at hospital, the complainant went to their GP, or they rang 111 these will be important parts of the evidence. There will be cases where an assessment has been conducted and there are signs that the individual may have been strangled. They may have at least reported symptoms via 111 such as hoarseness in the voice or difficulty swallowing for example.

There will, however, frequently be cases where there has been no medical intervention even by way of a report. In those situations, an additional statement might be taken where the complainant outlines anything they recall happening at the time of the act or afterwards. This might produce an account of memory loss, or a change in their voice for example which would assist in demonstrating that this individual was a victim of strangulation. Dr White says that often these complainants can be dazed and confused when police arrive so look at the BWV and see if that assists. If they ring 999 or speak to police, can you notice a change in their voice?

Dr White suggests that there should not be a suggestion that no injury means strangulation has not taken place. From a defence perspective I have some difficulty in that, it is clear there are some cases of strangulation where there are injuries, and a lack of injury might therefore indicate it did not happen. If there is limited medical evidence and no injury it strikes me that it is a point which must be made, the Crown can make the perfectly valid point that a lack of injury doesn't mean it did not happen.

The defence should also be aware these complainants might not recall everything and that although that could indicate strangulation it also means that where there is little other evidence surely a jury cannot be sure? The list of various common signs and symptoms is useful to defence, it may be the witness statement of a complainant does not list any of these factors. The information about the seconds it takes could assist defence, it is not uncommon for a complainant to suggest they were held down and strangled for ages, such as minutes, which clearly would not be the case if they are alive. If the complainant says they were strangled for 30 seconds yet remained conscious that could indicate a lack of authenticity.

There are clearly areas that require exploration from both sides and the document provided on the IFAS website is helpful in explaining what to look out for in more detail.

What does the future hold on this topic?

There was discussion within the lecture on other areas in which strangulation can feature and can present some difficulties, for example in sexual offences. Dr White referenced the Manchester findings again which indicate around 1/11 of those reporting a rape/sexual assault allegation described strangulation as part of that. There are of course questions around capacity and consent if someone is strangled and then loses consciousness as a result and/or loses their memory. This area could be the subject of a whole separate article, but it shows

the ways in which this new research might impact areas outside of offences against the person.

Many of the findings and knowledge here are from subject matter experts and there are not many experts who specialise in this area, in fact Dr White appears to be one of the few. There are problems with non-fatal strangulation that may require expert input that goes beyond a simple hospital report, and it will be interesting to see if this becomes a more common feature in these trials. Certainly, my limited experienced of defending or prosecuting these cases at trial is that juries may require some further direction and assistance – for example asking about the lack of injuries for strangulation and whether someone must stop breathing.

Dr White had given her lecture to a group of judges, and it seems her continued input into providing guidance in this area is likely. She talked about providing a standard statement which would seek to dispel various myths and misunderstandings about strangulation so watch this space, there may be more change to come in this relatively new area.

Conclusions

This is a serious and important topic, a crime that overwhelmingly involves female complainants and male assailants and with statistics quoted by Dr White suggesting some 36.6% of complainants thought they were going to die when strangled.

When you are dealing with non-fatal strangulation cases the normal approach to assaults and injuries simply does not seem to work. Most of these cases will involve thinking a bit more broadly in terms of the impact on a complainant and require careful consideration from a defence perspective. What is clear is that further guidance is needed for this ‘new’ offence, and it seems likely that a myth dispelling standard direction to juries may become part of these trials in the future.

For more information on the sentencing aspect of non-fatal strangulation please see the article from Jonathan Underhill.

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Rebecca McKnight

Barrister
3pb

01962 868 884
Rebecca.mcknight@3pb.co.uk

3pb.co.uk