Institute For Addressing Strangulation

Guidelines for clinical management of paediatric (under 16) non-fatal strangulation

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BASHH British Association for Sexual Health and HIV

british association for paediatric otorhinolaryngology

BSPR British Society of Paediatric Radiology

ENTUK

Royal College of Emergency Medicine

RCGP Royal College of General Practitioners

Royal College of Nursing

RCPCH Royal College of Paediatrics and Child Health *Leading the way in Children's Health*

Royal College of Paramedics

The Royal College of Pathologists Pathology: the science behind the cure

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

The Royal College of Radiologists

Royal College of Surgeons of England ADVANCING SURGICAL CARE

UNITED KINGDOM ASSOCIATION OF FORENSIC NURSES AND PARAMEDICS

The Faculty of Forensic & Legal Medicine

Aims of the guidelines

- To provide clinicians with guidance for investigation and management of suspected or confirmed strangulation in children and young people (CYP) under 16 years. This age range has been chosen to align with other clinical guidance, e.g. Major paediatric trauma radiology guidance.[1] For children aged 16 and 17 years old, separate guidance is available.[2]
- To emphasise the importance of a holistic approach including safeguarding, mental health and psychosocial considerations.
- The guidelines are aimed at clinicians in secondary care. For primary care clinicians, such as GPs, their role is to be aware of the issue, identify it and refer on as appropriate to an Emergency Department or paediatrics (depending on timing/severity) and then also do a safeguarding[3]/mental health referral (again depending on the circumstances).

These guidelines have been developed by a UK wide Intercollegiate Working Group, convened by the Institute For Addressing Strangulation (IFAS), in response to the increased understanding of the dangers and incidence of Non-Fatal- Strangulation (NFS), as well as the prevalence of long-term consequences, in CYP. The guidelines are based on the evidence base, where available, as well as expert opinion and consensus.[4] (See Appendix 1 for evidence base for imaging recommendations.)

These guidelines are new and as more evidence becomes available will be reviewed.

We welcome feedback on these guidelines via contact@ifas.org.uk.

Introduction

What is strangulation/non-fatal strangulation (NFS)?

Strangulation can be defined as a form of asphyxia caused by external pressure on the neck[5], which compresses blood vessels (such as carotid arteries/jugular veins) and/or airways (trachea/larynx), obstructing blood flow and/or breathing.

There are three main categories: hanging, ligature strangulation and manual strangulation[6], although pressure on the neck by other means, such as a knee, legs, etc. can also result in strangulation.

NFS is where the CYP has not died.

Alongside significant psychological harm, NFS can have serious physical health consequences for children including hypoxic ischaemic brain injury, pneumothorax, with case reports of intramuscular haematoma leading to airway obstruction.[7]

Incidence/prevalence

It is difficult to know the true incidence of NFS in CYP, or the prevalence of the consequences of it.

NFS may occur in different contexts for example: accidental injury, sporting activities, consensual sexual activity, self-inflicted/self-harm, physical abuse or sexual assault/abuse.

What is known:

- In one UK study of under 18-year-olds having a forensic medical examination following a report of rape or sexual assault/abuse, 5% reported also being strangled.[8]
- Home Office figures of the annual number of NFS and suffocation offences recorded by the police in England and Wales for victims under 18 were 2130 in the year 2022-2023, 3759 in 2023-2024[9] and 4888 in 2024-2025.[10]
- In England, between April 2019-March 2022 there were 42 child deaths as a result of accidental strangulation or suffocation, of which 9 were due to strangulation by blind/curtain cords or cables.[11]
- In England hanging/strangulation is the most common method of suicide for CYP, accounting for 69% of deaths in 2019-2020.[12]
- A UK study of 16 to 34-year-olds, looking at strangulation during consensual sex, reported that overall, 16% of the 16-17-year-old group of respondents had experience of being strangled during sex. When focusing only on those in the 16-17-year-old group who had prior sexual experiences, 43% reported being strangled during sex.[13]
- "Choking games" participated in by CYP fluctuate in popularity. One North American study reported that 7% of the school children surveyed (aged 9-18 years) admitted to having participated in asphyxia "games".[14]

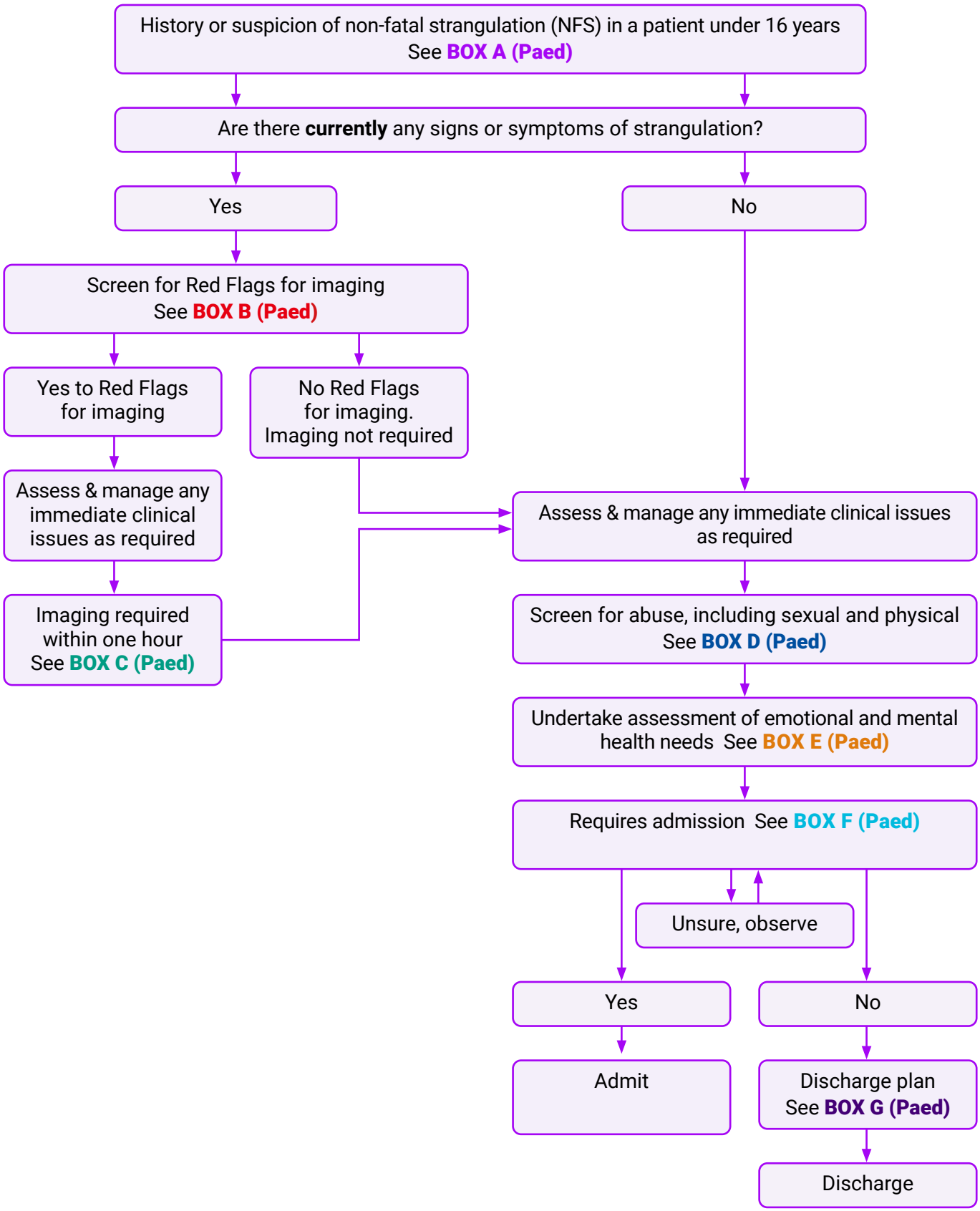
Examination

Where NFS is alleged or suspected clinicians should undertake a trauma-informed, comprehensive history & examination, taking into account the communication needs and developmental age of the CYP and the context that the strangulation is thought to have occurred.

Remember:

- Urgent ENT referral if concerns for stridor/objective signs of airway obstruction.[15]
- There may be other injuries and/or medical conditions and /or intoxication alongside strangulation.
- Bruising from NFS may occur on the scalp, in the mouth, and/or behind the ears.
- Eye examination – consider referral to ophthalmology if child abuse is suspected.
- Document any injuries accurately and consider using body maps and photo-documentation (there may be criminal justice/family court proceedings).[16]

Algorithm for clinical management of paediatric (under 16) non-fatal strangulation



BOX A (Paediatric under 16)

- There may not be a clear disclosure of NFS.
- Take a comprehensive history of the mechanism and circumstances where possible.[17]
- A trauma informed approach in line with Advanced Paediatric Life Support guidance[18], is required, including, where appropriate, seeing the patient on their own when taking a history to ensure safety & privacy.
- Consider NFS:
  - Where child physical or sexual abuse is suspected.
  - Some CYP may be reluctant to disclose NFS as it may have been part of consensual activity including sexual activity*, self-harm, experimentation or play. Some CYP may not appreciate the potential dangers of NFS, for some it may have become normalized behaviour.
- Language such as "grabbed, held by the neck, choked, pinned down, breath play" may be used.
- NICE guidance provides a summary of clinical features associated with child maltreatment. Child maltreatment: when to suspect maltreatment in under 18s (NICE CG89)
- Many child victims of manual NFS will not have visible external injury to the head or neck.[8]
- Given the potential seriousness (clinically, legally, psychosocial, safeguarding etc.) SENIOR clinical decision maker[19] input is required with NFS patients.

***Sexual activity/Age of consent**

The age of consent for sexual activity is 16 years old in all UK nations. Sexual activity involving a child under the age of 16 should be considered a potential safeguarding concern. Professionals who are aware of sexual activity involving a child aged under 16, should follow their organisational, local, and national procedures when deciding whether to make a safeguarding referral. Sexual activity involving a child under the age of 13 should always result in a child protection referral.[20, 21]

BOX B (Paediatric under 16): Red Flags indications for imaging related to the strangulation

Determine if the CYP currently has any of the following	
Airway	Possible airway compromise such as stridor / objective signs of airway obstruction
Breathing	• Dyspnoea • Objective signs of breathing compromise such as pallor, cyanosis, altered respiratory rate, increased work of breathing, reduced oxygenation, altered heart rate, altered BP [22] • Subcutaneous emphysema
Circulation	*Assess for haemodynamic stability and refer to trauma guidelines[23, 24]
(C-Spine)	Clinical suspicion of cervical spine injury. See NICE guidance[25]

Disability	• Paediatric Glasgow Coma Scale[26] (GCS) less than 13
	• New onset neurological signs
	  • Seizure
	  • Stroke

Exposure	Subcutaneous emphysema

- In the available evidence base literature there were no specific circulation markers related to NFS to indicate imaging is required.
- Clinical suspicion of head injury see NICE guidance[27]

BOX C (Paediatric under 16): Imaging

Should be done within 1 hour of request with urgent report as per trauma guidelines[1,28]

Clinical Signs	Recommended Imaging
Stridor/ Airway Obstruction	CT Neck with Contrast*
Dyspnoea/ Subcutaneous Emphysema	Chest X-Ray PA or AP as appropriate – ideally erect
Clinical suspicion of C-Spine Injury	CT Cervical Spine- as per NICE guidance[27]
GCS <13 or new onset neurological signs • Seizure • Stroke	Volumetric Unenhanced CT Head

* CT neck angiogram is not recommended in children in this context. CT neck with contrast (images acquired around 30 seconds after contrast injection) is typically preferred.

- Consider C-Spine X rays as per NICE guidance[27] if CT C-spine criteria not met.
- Skeletal survey decisions to be made as part of safeguarding assessments, as per relevant guidance.[29]
- ENT assessment should be considered in addition to imaging.[15]

BOX D (Paediatric under 16): Safeguarding All cases

- Safeguarding assessment and refer for child protection medical assessment where appropriate. For non-mobile babies and children see relevant guidelines.[30]
- Although the term CYP has been used, it is important to remember that legally these patients are children and there are consequential responsibilities and considerations for clinicians.[31]
- Sexual activity/sexual assault/rape cases (see Sexual Activity/Age of Consent):

  All the above plus:

  a. Assess need for:
  - Emergency contraception
  - HIV & Hep B post exposure prophylaxis
  - Signpost for window period for STI screening

  b. Consider referral/seek advice from local Sexual Assault Referral Centre (SARC) as a self or police referral.
  - Forensic medical examination
  - Independent Sexual Violence Advisor (ISVA) support
  - Counselling

To find nearest SARC go to:

England:
NHS Find a rape and sexual assault referral centre

Wales:
WSAS NHS Wales Performance and Improvement

Scotland:
www.nhsinform If you're under 16

Northern Ireland:
nidirect The Rowan - Sexual Assault Referral Centre (SARC)

Box E (Paediatric under 16): Assessment of Emotional and Mental Health Needs

- All CYP need a developmentally appropriate assessment of their immediate emotional and mental health needs.[32]
- Psychosocial screening tools such as a HEEADSSS assessment or Not Just a Thought…assessment should be considered.[32, 33, 34]
- Where NFS is in the context of self-harm or suspected suicide attempt, these CYP require a face to face developmentally appropriate biopsychosocial assessment of their emotional and mental health needs undertaken by a mental health professional experienced in carrying out such an assessment.
- Do not delay the psychosocial assessment until after medical treatment (see NICE Self-harm guidance[35]).
- Where there is significant concern for the state of the CYP 's mental health or following the face-to-face assessment by the mental health practitioner, the patient may require further specialist input and local processes should be followed.

Coercive control considerations (adolescent interpersonal violence IPV)

Where NFS has occurred in the context of an intimate or peer relationship, screen for wider coercive and controlling behaviours: monitoring, isolation, threats, sexual coercion, escalation patterns. Strangulation is a recognised marker of escalating violence in adult IPV literature[36]; the same risk profile is increasingly recognised in adolescent relationships. Liaise with safeguarding and consider MARAC referral pathways where applicable.

Brain injury/mental health interface

Where neuropsychological symptoms emerge or persist (see Appendix 2), maintain awareness that:

- Acute behavioural, emotional or cognitive change post-NFS may reflect hypoxic brain injury rather than primary psychiatric pathology
- Pre-existing neurodiverse conditions may both increase vulnerability to NFS and complicate post-event assessment
- Joint working between CAMHS, paediatrics and neuropsychology may be required

Box F (Paediatric under 16): Admission Considerations

Admission may be required either for the management of injury, for social/safeguarding reasons, or both.

A senior clinical decision maker[19] should be involved.

Local pathways to appropriate clinical specialty for admission should be followed.

Considerations for admission:

- Concern about airway.
- Clinical condition.
- History of significant blunt force/pressure to neck or head[27]
- Significant findings on imaging.
- Unsafe discharge setting – where it is deemed unsafe from a safeguarding perspective to discharge a CYP back to their usual home setting, refer to children's social care for a suitable place of safety.
- Immediate mental health-related risks.
- Safeguarding requirement.

If the CYP has presented very soon after the strangulation, consider a period of observation. Delayed airway difficulties are rare and likely to occur within the first 6 hours post assault, dependent on factors such as type/extent of injury etc.

Box G (Paediatric under 16) : Discharge planning

1. Safeguarding

- Is the CYP safe to go home?
- Where the NFS has occurred in the context of self-harm, has the CYP been reviewed by a mental health practitioner as per NICE guidance?[35] See Box E (Paed).
- Have all relevant safeguarding checks and referrals been made?
- Where necessary, has a child protection medical assessment, full documentation of injuries and photo-documentation been undertaken or arranged?

2. Safety netting

Provide the CYP/parent/carer with age-appropriate information regarding strangulation, including signs and symptoms to watch out for that would need urgent medical assessment. See (for example) Information after a medical assessment for strangulation. Be mindful that victims of strangulation are likely to require psychological support.

3. Acquired brain injury assessment

Strangulation may result in acquired brain injury[37] (hypoxic-schaemic), with neuropsychological difficulties. Referrals for neuropsychological assessment and community neurorehabilitation on discharge should be considered; this may be via neurology or paediatrics dependent upon local provision. See Appendix 2: Acquired brain injury

4. Information sharing

- Ensure "strangulation" is clearly recorded in the clinical notes and relevant communication. See Appendix 2: Acquired brain injury
- Follow standard, local, consent to share information processes, include details of strangulation, any investigations, mental health assessments, results, any referrals and follow up plans.
- Make clear any suggested GP actions, remembering that victims of strangulation are likely to require psychological support.
- Consider information sharing with other key healthcare professionals already involved with the CYP, e.g. psychiatrist, health visitor, school nurse etc. Ensure discussion about information sharing has been documented. The Children's Wellbeing and Schools Act 2026 sets out the duties of professionals regarding information sharing[38] (applicable for England). For further guidance re information sharing see the Child protection decision tool - GMC.
- Whilst recent changes to practice allowing patients online access to their health records, have many benefits, there may be associated disadvantages. A patient may be at ongoing risk of abuse and vulnerable to coercion to share record access and subsequently be at increased risk of harm if sensitive communication is accessible. Consideration should be given to redacting or preventing information being visible to patients with online access to medical records.[39] Ideally this should be done in collaboration with the patient.
- It is also important to remember that redacted information and redaction flags may be visible on-screen during consultations and may be seen by the patient or anyone accompanying the patient in a consultation.[40,41]

Vicarious trauma

Dealing with people with a history of strangulation may put clinicians at risk of developing vicarious trauma (secondary trauma or secondary trauma stress). This is when exposure to someone else's trauma can have a significant mental health impact. Resources which highlight the common signs of vicarious trauma, ideas for strategies to reduce risk and support the well-being and retention of staff delivering services are available.[42,43]

Clinical coding

Coding should be as "strangulation".

ICD-11 codes[44]

PB02 Unintentional threat to breathing by strangulation

PE62 Assault by threat to breathing by strangulation

NF05 Asphyxiation by strangulation

PH22 Threat to breathing by strangulation with undetermined intent

PC72 Intentional self-harm by hanging, strangulation or suffocation.

For General Practice

See RCGP guidance on recording of domestic violence updated Jan 2021.

Further reading/viewing

1. NICE. Child maltreatment: when to suspect maltreatment in under 18s. Clinical guideline CG89. Last updated December 2025.
2. NICE. Head injury: assessment and early management. NG232 Published 18 May 2023
3. Royal College of Opthalmologists Clinical Guideline January 2024 Abusive Head Trauma and the Eye, Executive Summary 2024.
4. The radiological investigation of suspected physical abuse in children. Revised first edition. Nov 2018
5. Stroke in childhood. Clinical guidelines for diagnosis, management and rehabilitation. 2017. RCPCH.
6. RCGP Safeguarding toolkit: Part 4: Documenting safeguarding concerns and information. RCGP Learning.
7. Intercollegiate document (2025) Safeguarding children and young people & children and young people in care: Competencies for health care staff.

Audit standards

There is currently no national audit standard for paediatric NFS.

Local audit looking at different aspects of these guidelines is recommended.

Research recommendations

- The incidence of NFS in different contexts should be established together with the prevalence of long-term consequences.
- Outcomes of clinical investigations (including imaging) in the context of presenting signs and symptoms.
- Long term neuropsychological impact of NFS (isolated and repeated events)
- The implementation and effectiveness of multi-agency pathways for NFS.

Glossary of terms

ADHD	Attention-Deficit/Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BP	Blood Pressure
CAMHS	Child and Adolescent Mental Health Services
CT	Computerised tomography
CYP	Child and Young People
ED	Emergency Department
ENT	Ear, Nose and Throat
GCS	Glasgow Coma Scale
GP	General Practice/General Practitioner
Hep B	Hepatitis B
HIV	Human Immunodeficiency Virus
ISVA	Independent Sexual Violence Advisor/Advocate
MARAC	Multi-agency Risk Assessment Conference
NFS	Non-fatal strangulation
NICE	National Institute for Health and Care Excellence
SARC	Sexual Assault Referral Centre
STI	Sexually Transmitted Infection

Appendix 1

Evidence base for imaging recommendations

A review of the literature was undertaken when considering the evidence base for these guidelines. The publications (see below) demonstrated that vascular injuries were rarely being detected with CT angiograms. Hypoxic-ischaemic encephalopathy and pulmonary injury such as pneumothorax were more common and associated with increased mortality.

In addition, UK data was informally collected from 30 hospitals over a period of 3 months during the development of these guidelines. Of the 106 consecutive CYP (17 years and under) presenting with history of NFS, mostly in the last 4 years, having undergone CT neck angiography, **none** were found to have a cervical vascular injury or cervical bony fracture. In this cohort, 66/106 had CT head imaging and 10/66 had imaging features of hypoxic/anoxic brain injury (all 10 of them had low GCS in the range of 3-5 and had cardiac arrest at the time of strangulation). 2/10 patients with brain injury died a few days later secondary to the hypoxic brain damage from the strangulation event" – Kapadia et al (under review).

Publication	Numbers included	Age range	Findings
Gorski JK, Smith CM, Ramgopal S. **Injury patterns and mortality associated with near-hanging in children**. Am J Emerg Med. 2024 Jan;75:83-86. doi: 10.1016/j.ajem.2023.10.039. Epub 2023 Oct 26. PMID: 37924732.	1929	<17 years	• 38.7% underwent neck angiography • BCVI noted in 0.9%
Swendiman RA, Scaife JH, Barnes KL, Bell TM, Roach CM, Iyer RR, Brockmeyer DL, Russell KW. **Hanging and Strangulation Injuries: An Institutional Review From a Level 1 Pediatric Trauma Center**. J Pediatr Surg. 2023 Oct;58(10):1995-1999. doi: 10.1016/j.jpedsurg.2023.02.056. Epub 2023 Feb 28. PMID: 37002058.	128	<19 years	• 53/54 CTAs normal. In one the finding deemed not clinically significant
Kline-Fath, B.M., Seman, J.M., Zhang, B. et al. **Pediatric hanging and strangulation: is vascular injury a true risk?** Pediatr Radiol 51, 1889–1894 (2021). https://doi.org/10.1007/s00247-021-05056-1	66	1-18	• No cervical arterial injury detected

Appendix 2

Acquired brain injury

Strangulation may result in acquired brain injury[37] (hypoxic-ischaemic), leading to neuropsychological difficulties:

- Cognitive deficits such as attention, memory, and executive dysfunction.
- Speech and language difficulties
- Changes in emotional regulation, personality or behaviour

If these difficulties are not resolving, consider referral for neuropsychological assessment and neurorehabilitation. Access to these services will differ dependent upon local arrangements, and may require going through Paediatrics or Neurology, or asking for advice and guidance in the first instance.

For all CYP, regardless of imaging, and whether brain injury is diagnosed, it is vital strangulation is recorded clearly within clinical notes – and possibly shared with schools - not least because of the 'sleeper effect'[45]. Childhood brain injury, often 'silent' at the time, can impact later neuroanatomical development. Frontal lobe injury may not manifest until adolescence and increased academic and social demands. If a possible brain injury from strangulation is not recorded, CYP's difficulties may not be appropriately assessed, or be misattributed to neurodevelopmental conditions such as ADHD, ASD, or to mental health, meaning they do not receive the correct intervention, or the appropriate educational access arrangement.

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Conflicts of interest was a standing agenda item at all Working Group meetings. None were raised.

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Other organisations were invited to the group but were unable to/decided not to send representatives.

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