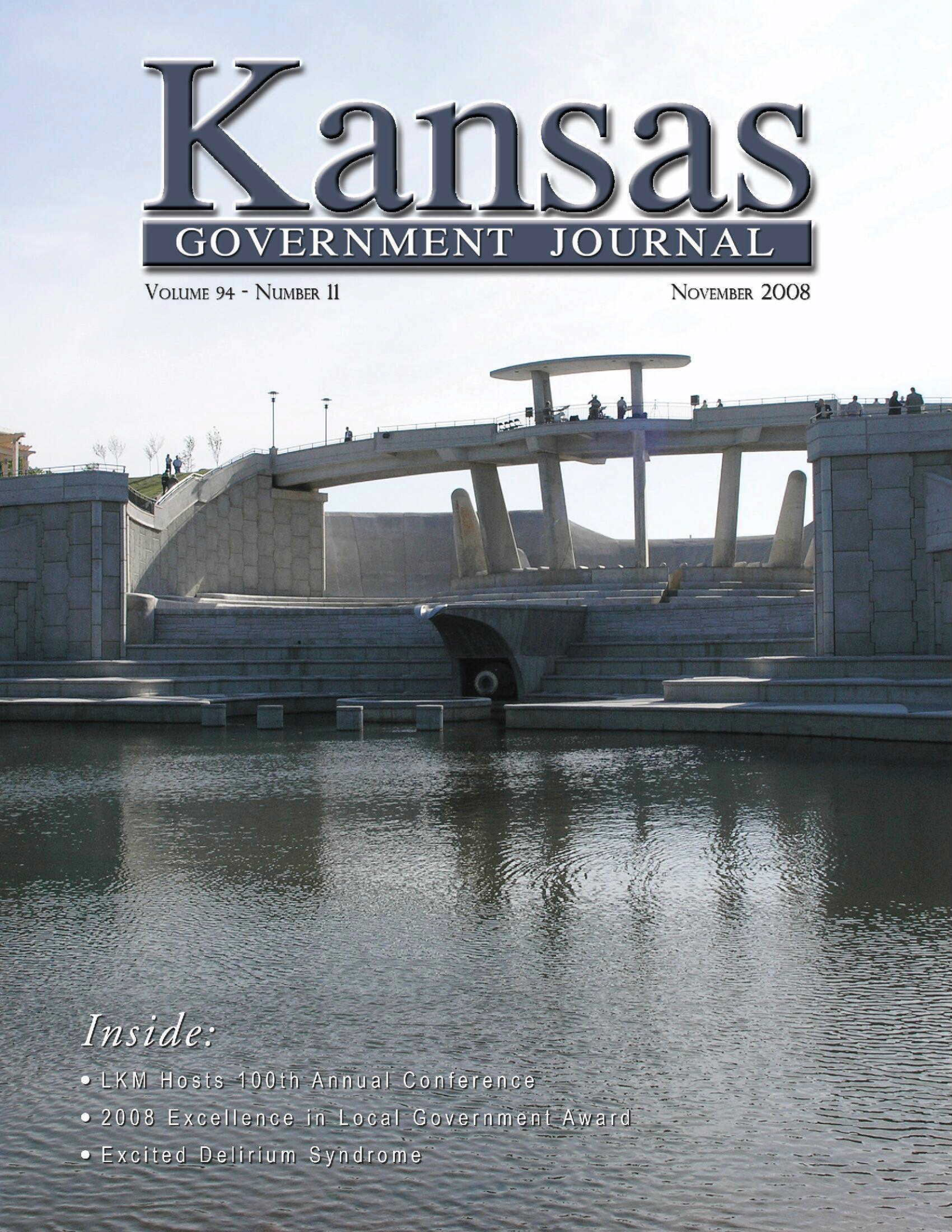
Kansas
GOVERNMENT JOURNAL

VOLUME 94 - NUMBER 11 NOVEMBER 2008



Inside:

- LKM Hosts 100th Annual Conference
- 2008 Excellence in Local Government Award
- Excited Delirium Syndrome

Excited Delirium Syndrome: Is Your Police Department Prepared?

By: James D. Hill

During a 15-month period in 2006–2007, four individuals in four different Kansas cities, ranging in size from small rural to large urban, died suddenly in custody after being restrained by police. All decedents had exhibited bizarre behavior which necessitated police intervention, and all arrests involved multiple officers, intense struggle, and the deployment of TASER electronic control devices. None of the post-mortem examinations revealed sufficient trauma or other evidence to explain the deaths.

These cases bear a striking resemblance to a host of similar deaths reported by the media which have occurred around the country since the mid-1980s. These deaths were attributed to excited delirium (ED), a term used to describe a state of extreme mental and physiological excitement, characterized by extreme agitation, hyperthermia, hostility, exceptional strength, and endurance without apparent fatigue.[1]

Excited delirium is not a new phenomenon. Originally referred to as Bell's Mania, it was first noted in 1849 by Dr. Luther Bell's observation of psychiatric patients who developed onset of constant agitation and mania, in the presence of fever, and then suddenly died. It has been variously known as agitated delirium, excited delirium, and acute exhaustive mania.[2]

While neither the American Medical Association nor the American Psychological Association currently recognizes excited delirium as a medical or mental-health condition, it is recognized by the National Association of Medical Examiners, and it is listed as a cause of death on medical examiners' autopsy reports. It is also recognized by the many dedicated emergency room physicians nationwide who struggle to break its deadly grip.

Police Encounters

In the context of police encounters, ED is most often associated with illicit substance abuse and frequently involves chronic cocaine or methamphetamine users who engage in a binge of drug ingestion. ED presents a number of life-threatening physiological effects, to include: 1) hyperthermia; 2) metabolic acidosis, a change in the acidity of the blood; 3) electrolyte imbalance; and 4) rhabdomyolysis, a breakdown of muscle cells and leaching of cellular content into the bloodstream.

Due in large part to the cocaine and methamphetamine abuse epidemic, law enforcement officers are encountering ED more often, and they must be prepared to confront persons in the throes of this potentially fatal condition. This preparation requires an understanding of the syndrome, as well as sound department training and policy direction which will prepare officers to properly identify and effectively deal with the condition.

When a police executive is awakened by the telephone at zero-dark-30 hours, the news is normally not good. "Chief, we've had an in-custody death," the Watch Commander explains. "Officers were dispatched to the scene of a man running naked in the street. They encountered a bizarre acting, violent suspect, and in order to take him into custody, engaged in a protracted struggle. Shortly following his restraint, the suspect became tranquil and compliant. Officers then noticed that he quit breathing; they immediately initiated CPR, but all resuscitation attempts failed."

Revered for their meticulous planning and preparation for battle, the Spartans knew that the time to sharpen swords was not during the heat of battle. Likewise, as any police chief who has had to answer a telephone call similar to the one aforementioned will attest, early morning, immediately following a sudden in-custody death, is not the time for a police agency to learn about excited delirium.

There currently exists an alarming lack of law enforcement knowledge concerning the syndrome. At a recent training seminar, the presenter asked the 93 police executive attendees to "Please raise your hand if your department has experienced an excited delirium related incident." When no one responded, he asked if anyone in the audience was familiar with excited delirium syndrome and, again, received no response.

However, during the break following the first hour of training on the subject, members of the audience waited in line, and one police executive after another recounted incidents of violent encounters involving their officers and individuals displaying classic behavioral signs readily identified as ED by those trained to recognize the syndrome. Fortunately, none of the 93 police executives had yet experienced fatal excited delirium, which appears to consist of four clinically distinct, sequential phases: elevated temperature, agitated delirium, respiratory arrest, and death.[3]

There is no reliable national data available to determine 1) how frequently officers encounter ED on the street, or 2) the incidence of ED related death. It is believed that the majority of non-fatal incidents go unidentified, as responding officers commonly attribute the bizarre conduct observed to the subject being under the influence of an illicit drug.

It has been estimated that approximately 10% of cases of excited delirium result in death.[4] Fatal estimates range from a low of 125 to a high of 800 deaths a year in which ED may be a factor.[5] Nevertheless, while excited delirium related deaths may represent only a minuscule percentage of law enforcement's response to emotionally disturbed persons calls nationwide, fatal cases will result in significant controversy, protracted criminal and civil investigation, and, inevitably, costly litigation.

Deaths which occur shortly after a person is taken into police custody following a struggle are not unusual. However, when there is no apparent cause, charges that officials are using ED as a cover-up for what may be excessive use of force and inappropriate use of control techniques by officers are common. Often, the causes of these deaths are attributed by the media, the decedent's family, and special interest groups to a force technique (TASER electronic control device, pepper spray, lateral vascular neck restraint, physical restraint) used by police during the arrest. The proximity of the force technique to death makes a cause-and-effect correlation easy to accept and understand, even when the force options employed have been medically discounted as contributing to the cause of death.

Although the excited delirium debate continues without sign of abatement, the disconnect between the rhetoric and the reality is alarming. Ask any police officer who has confronted and attempted to control a bizarre acting, extremely agitated, naked man running in the street, screaming as he flees from invisible demons, if the phenomenon is real. In all probability, the officer will recount engaging a subject who exhibited phenomenal strength, extreme endurance, and imperviousness to pain, while effectively resisting the attempts of multiple officers to control him.

While our officers frequently deal with emotionally disturbed persons (EDP), the difference between controlling an EDP and an ED subject may be likened to the difference between attempting to contain a stray cat and a starved tiger. In attempting to physically control an ED subject, officers going hands on will quickly realize that there is no subtlety whatsoever about his intensity, energy, and physical prowess. During the desperate struggle, the subject's phenomenal strength, stamina, and unwillingness to yield to overwhelming force will alarm even those officers familiar with and trained in ED.

The striking similarities between the deaths experienced in Salina, Liberal, Iola, Kansas City, and in countless other cities across the nation provide law enforcement and other first responders with classic and foreboding warning signs. Agencies must heed these signs and provide officers with proper training, as well as develop sound policies, procedures, and risk management strategies to deal with such events.

Indicators of Excited Delirium

ED presents as a cluster of psychological and behavioral symptoms, that may include, but are not limited to, the following:

- Confusion/Disorientation/Inability to respond appropriately to reason;
- Bizarre and/or violent behavior;
- Extreme aggression;

- Paranoia;
- Exceptional physical strength and endurance;
- Very high pain threshold/Impervious to pain;
- Ability to effectively physically resist multiple police officers;
- Hyperthermia;
- Profuse sweating;
- Shedding of clothing/Partial or full nudity;
- Hallucinations; and
- Incoherent shouting and/or nonsensical speech.

An ED subject is, in effect, in a continual "fight-or-flight" response mode, and, in all probability, the subject will already be in medical crisis before officers arrive on scene. As there can be no medical treatment without physical control, responding officers will have to physically restrain the ED subject. The intense struggle will increase body temperature and the levels of circulating epinephrine, which will further stress the heart. Once finally restrained, the ED subject may lapse into a phase of calm listlessness, a tranquil, foreboding state which police officers often mistake as compliance. Cessation of struggle should be regarded as a life-threatening event.

It is not a matter of whether your officers will encounter ED in the field; it's how they are trained to respond when they encounter this extremely dangerous, potentially fatal condition. While much is yet to be learned about ED, and there are currently no nationally recognized "best practices" for response, certain steps can be taken which will improve the odds of the subject's survival, enhance public and officer safety, and decrease the likelihood of litigation.

Contemporary training is available from several excellent sources, to include the annual Sudden Death, Excited Delirium, and In-Custody Death conference presented by the Institute for the Prevention of In-Custody Deaths (IPICD). Attendees will glean state-of-the-art information presented by world-class medical researchers, medical examiners, lawyers, and law enforcement and medical practitioners, which will enable their respective agencies to promulgate sound training and policy directives.

Sample "Excited Delirium" Directive

PROCEDURE

1. **Communications Responsibilities**
   - 1.1. Upon receipt of a call for service that may lead the dispatcher to believe that a person is exhibiting signs of Excited Delirium, as described above, a minimum of four officers will be dispatched, if practical, and the Watch Commander will be notified.
   - 1.2. Dispatchers shall also request emergency medical services (EMS) when the original nature of the call dictates or when requested by officers on the scene. EMS personnel shall be advised to stage at a location a safe distance from the scene until notified by officers that the scene is secured.
2. **Responding Patrol Officer(s) Responsibilities**
   - 2.1. Responding officers shall assess the situation to determine if the person is suffering from ED. The determination must necessarily be based on a rapid assessment of the overall scenario and behavior of the subject. If ED is suspected (err on the side of caution if unsure), immediately request EMS and the Watch Commander if they have not been initially dispatched.
   - 2.2. If the ED subject is armed and/or combative or otherwise poses a threat that requires immediate intervention, officers shall employ reasonable and necessary force to protect themselves and others and take the person into custody.
   - 2.3. If the ED subject is unarmed and presents no immediate threat to self or others, officers shall, if practical, contain the subject while maintaining a safe distance and remove others who might be harmed.
   - 2.4. Officers shall formulate a custody plan prior to making physical contact with the subject, if possible. There can be no medical intervention without custody. The object of the plan is to de-escalate the situation, calm the individual, and gain control of the person so that he/she may be medically cared for. If practical, attempt to gain the ED subject's voluntary compliance with these tactics:
     - 2.4.1. One officer should attempt to engage the subject in conversation. Remain calm, speak in a conversational, non-confrontational manner, and reassure the subject that you are trying to help.
     - 2.4.2. Attempt to have the individual sit down, which may have a calming effect. Also, refrain from making constant eye contact, which may be interpreted as threatening.
     - 2.4.3. Because of the subject's mental state, statements and questions may need to be repeated several times. The subject may be extremely fearful and confused, so be patient and reassuring, as it may take some time for him/her to calm down.
   - 2.5. Once sufficient officers are present and if the determination is made that physical force is necessary, the custody plan must be executed quickly and with overwhelming force, to minimize the intensity and duration of any resistance and to avoid a prolonged struggle, which may increase the risk of sudden death. If possible, officers should ensure medical personnel are staged nearby prior to executing the custody plan.
   - 2.6. Officers shall take into consideration all available force options and control techniques, with the realization that ED subjects often demonstrate unusual strength, resistance to pain, as well as instinctive resistance to the use of force. Primary consideration should be given to proper application of the TASER, which has proven effective, as it temporarily overrides the central nervous system, providing officers with a window of opportunity to safely control and restrain the subject. Immediately upon TASER application, a multi-officer take-down team, using a coordinated group tactic, should swarm the subject, gain physical control, and handcuff him/her while he/she is incapacitated by the TASER.
   - 2.7. Once the subject is in custody and the scene is

secured, immediately summon EMS personnel. Until primary responsibility for the care of the subject is transferred to EMS personnel, officers must keep the restrained subject under constant observation. Place the individual in a supine position or on his/her side, and continually monitor and assess vital signs. Be especially vigilant if he/she suddenly stops resisting and becomes tranquil. Initiate CPR as indicated.

2.8. Officers shall coordinate with on-scene EMS personnel and transfer custody of the subject to them, assisting in any way to avoid delay in the transportation of the individual to a medical facility. An officer shall be assigned to accompany EMS personnel during the ambulance transport.

2.8.1. Upon arrival at the emergency room, ensure that the subject's core body temperature is recorded.

3. **Supervisor Responsibilities**

3.1. The Watch Commander shall respond to all and assume command of all ED calls.

3.2. The Watch Commander shall ensure that all necessary forms and reports are completed as required, to include as much of the following information as possible:

3.2.1. Description and duration of subject's behavior prior to and after police contact, to include subject utterances and actions, e.g., running, shouting, pacing furiously, etc.

3.2.2. Type and duration of resistance.

3.2.3. Number and identity of officers involved.

3.2.4. Method of subject transport, to include time transport begins and ends.

3.2.5. Struggle against restraints during transport.

3.2.6. Presence or absence of sweating by subject.

3.2.7. Air temperature/humidity at scene of incident

3.2.8. Describe resuscitation efforts, number of times attempt was made, and by whom.

3.2.9. Note subject's body temperature at scene, if available, at arrival at medical facility, and, if applicable, upon death.[6]

Prompt Recognition and Early Intervention

Prompt recognition and early intervention are vital in order to reduce the incidence of ED associated death, as evidenced on August 15, 2007, when Saline County (Kansas) sheriff's deputies responded to a report of an out-of-control, violent subject, known to be a chronic abuser of methamphetamine. Upon arrival, they found a partially clothed, extremely agitated suspect who was shouting incoherently. He was sweating profusely and displayed numerous other signs indicative of excited delirium. Recognizing the behavioral cues, EMS was summoned, and the subject was contained until an appropriate number of back-up officers arrived. A TASER electronic control device was deployed to immobilize the subject, providing officers with a window of opportunity to safely restrain him. Immediately following restraint, deputies carried the ED subject into the shade on a 100° day and continually doused him with cold water in an attempt to control his body temperature until the ambulance arrived. EMS personnel treated and transported the individual, using their ED protocol. The individual spent several days in the ICU but lived, thanks in large part to the response of trained law enforcement officers and EMS personnel.

Fatal Excited Delirium

Despite the best efforts of law enforcement and other emergency responders, the ED subject may die. While every agency must have a plan in place on how to manage the aftermath of a suspected ED death, the investigation that follows is beyond the scope of this paper. Suffice it to say, however, that the death should be investigated as a homicide.

A determination that the death involves excited delirium must be based on the totality of the circumstances and the observed behavior of the ED subject. Although not always present, it should be noted that hyperthermia (core body temperature >103°) is considered strong supportive evidence for the diagnosis of ED. In one of the Kansas deaths, the decedent's core body temperature, obtained 56 minutes after he was pronounced dead by the attending physician, was 105.1°. Anecdotally, hyperthermia is regarded as a harbinger of inevitable death, as survivors of the syndrome don't exhibit the markedly elevated core temperature.[7]

Harvesting the brain for examination during the forensic autopsy is critically important, as excited delirium is often triggered following a one- or two-day drug binge, and blood levels for cocaine or

FULL SERVICE MAINTENANCE PROGRAMS
GASB 34 Compliant
Interior and Exterior Painting, Repairs, Safety Accessories
Inspections, Washouts, Disinfections

WIRELESS COMMUNICATIONS SERVICES
Antenna Site Management • Antenna Installations
Design Reviews/Project Management

TAX EXEMPT FINANCING
Asset Acquisition and Infrastructure Growth
Extremely Competitive Rates
No "Red Tape"

NEW TANK SALES
Expedited Delivery
Any Style, Design, Capacity

Utility Service Co.
INCORPORATED

TOM STECHMANN, Representative
11414 Wil Mar Drive
Liberty, MO 64068
Phone: 314-420-4912
Fax: 816-628-6487
tstechmann@utilityservice.com

CORPORATE OFFICE
P.O. Box 1350
Perry, GA 31069
Phone: 800-223-3695
Fax: 478-987-2991
www.utilityservice.com

methamphetamine may be low or not even detectable following the episode. Within 12–18 hours after death, certain sections of the brain of the decedent must be harvested by the Medical Examiner, frozen, and sent to a specialized laboratory which can identify changes in brain chemistry characteristic of excited delirium.

Dr. Deborah C. Mash, of the University of Miami School of Medicine, Departments of Neurology and Molecular and Cellular Pharmacology, is one of the foremost researchers in this area. Dr. Mash may be reached at 1-800-UM-BRAIN for specific procedural information relative to submitting specimens for neurochemical pathology examination.

The Bottom Line

Excited delirium has few, if any, boundaries, and it will be experienced by both large and small agencies. Due to the inexplicable, bizarre, and oftentimes violent behavior demonstrated by ED subjects, police intervention is inevitable. We must ensure that our officers are prepared to respond to one of the most volatile, life-threatening (to officers as well as suspects) scenarios in law enforcement today.

Police administrators can, and must, orchestrate a paradigm shift in police response to calls involving emotionally disturbed persons by 1) providing officers with proper training to recognize and identify excited delirium syndrome, its symptoms, causes, and dangers; 2) forming partnerships and promulgating directives which will ensure an appropriate, coordinated response (by communications, law enforcement, EMS, receiving hospital ER) to subjects in the throes of excited delirium; and 3) instilling an organizational recognition that, upon taking the subject into custody, the syndrome is to be regarded and managed first and foremost as a life-threatening medical emergency.

We must act, and act now. Lives, careers, and reputations, as well as the public trust, depend on it.

[1] Morrison A, Sadler D. Death of a psychiatric patient during physical restraint. Excited delirium – a case report. Med Sci Law 41:46–50, 2001.

[2] Ross DL. Factors associated with excited delirium deaths in police custody. Mod Pathol 11:1127-1137, 1998

[3] Wetli CV, Mash D, Karch SB. Cocaine-associated agitated delirium and the neurplectic malignant syndrome. Am J Emerg Med 14: 425-428, 1996

[4] Stratton ST, Rogers C, Brickett K, Gruzinski G. Factors associated with sudden death of individuals requiring restraint for excited delirium. Am J Emerg Med 19:187-191, 2001.

[5] Sudden Death, Excited Delirium & In-Custody Death Conference, IPICD, 2006

[6] Salina Police Department Operations Manual, General Order O2306 1-3, 2007

[7] Sudden Death, Excited Delirium & In-Custody Death Conference, IPICD, 2007

James D. Hill is the Chief of Police for the Salina Police Department. He can be reached at jim.hill@salina.org or (785) 826-7221.