In the wake of the New York "choking" case that was so heavily publicized, it is perhaps time to again look at the phenomena of Excited Delirium. One of our newest LETB Master Instructors, Sergeant Andrew Watts, Brownsburg Police Department, recently wrote on this subject. ML

"Excited Delirium"
by Sergeant Andrew Watts, Brownsburg Police Department

Introduction

The *sudden death* of an individual is not a new phenomenon, in fact, upon researching this topic one will find numerous writings ranging from the 1830's to present day describing many of the same observations with the eventual outcome being death of the subject. One early writer Dr. Luther Bell is credited with writing one of the earliest medical articles on sudden death in the *American Journal of Insanity* in 1849.

Dr. Bell ran an insane asylum in Massachusetts and began observing and researching sudden deaths in 1836. Dr. Bell had the following descriptions of his observations: Some of the patients appeared "confused…no tolerance to light…low mutterings…and having a dull apprehension of impending danger" (Bell, 1849). Dr. Bell further described subjects as "struggling with the utmost desperation, irrespective of the numbers or strength of those who may be endeavoring to restrain him" (Bell, 1849). Finally, he noted that the patient had "no disposition to yield to an overpowering force, noticeable in some degree in the blindest fury of the most intense forms"(Bell, 1849). Dr. Bell appeared to be describing behavior that would later be referred to as *excited delirium*.

In early 1985 an interesting, yet disturbing phenomenon began to be noticed in the Miami area. Several cases of seemingly healthy subjects were encountering police, exhibiting strange irrational behavior, and when restrained, they were dying. The Miami medical examiner's office coined and began to utilize the term *excited delirium* (ExDS) to classify the

deaths of these subjects (Peters, 2006). At the time, no real justification could be placed on any one cause that would explain the rapidly growing number of individuals allegedly dying in police custody. One of the few similarities observed among the deceased was the frequent presence of cocaine in the bloodstream. As more and more incidents began to immerge throughout the United States it was clear to agencies nationwide that a cause and a solution were desperately needed. Law Enforcement began questioning their officers training, use of force, and even the specific tools officers were using to assist in subduing subjects.

Medical View of Excited Delirium

The question now becomes: *Is there a clear concise definition of excited delirium?* Unfortunately, that is a simple answer…*No*. Currently, the medical view of excited delirium (ExDS) is split among the medical associations. The overall consensus is that ExDS is a syndrome in the very least (Hall, et al., 2009). The National Association of Medical Examiners (NAME) and the American College of American Physicians (ACEP) among others, consider ExDS an "altered mental state inside the continuum of delirium" (Hall, 2011). The American Medical Association (AMA) and American Psychiatric Association (APA) have no official position in regard to the classification of ExDS. In addition, the lack of consistency among the medical experts nationwide allow for an even more liberal interpretation by others. For instance, Amnesty International and its medical experts agree that some sort of extreme behavior occurs, but that police response to the subject is the cause of most deaths later classified as ExDS.

Causes for the syndrome are clearly not well understood, however they are believed to be linked with drug use, mental illness, and some metabolic disorders. Generally, the existence of a single *cause* listed above may not be sufficient to create the symptoms associated with ExDS. A blend or what has been described as a *perfect storm* of all three of the above *causes*

would create what we have historically described as ExDS. This poses the question of why the medical view of excited delirium has not been more widely accepted by medical experts. Some likely causes for the lack of acceptance might be the sporadic nature of ExDS events, current policing and medical record systems in the United States, unavailability of information due to lawsuits and Hippa rules, and finally the lack of precise findings at autopsies (WPSTC, 2011).

Two additional factors that have not been discussed that contribute to the lack of recognition by such bodies as the American Psychiatric Association (APA) include the Thirty Year Gap in Occurrences (1950's-1980's) and the decline in mental institutions across the United States. The period from 1800's to 1950's appeared to have a drastic decline in reported cases. This occurrence seems to be linked directly to the advent of antipsychotic pharmaceutical therapies in patients with severe behavior issues.

In the 1980's a dramatic increase in the number of ExDS deaths across the United States appeared to be linked to the increasing illicit use of cocaine based drugs in North America. Secondly, a consequence of closing state mental institutions has been the direct introduction of many mentally ill patients into the state and local prison systems. Persons once treated in long term care facilities are placed into communities and issued antipsychotic medications with the hope that they successfully self medicate.

Dr. Christine Hall a world renown expert in the area of ExDS and an acting Canadian emergency medical physician specifically states that ExDS is "very real…and is a unique syndrome…characterized by the acute onset of agitation, aggression, distress, and possibly sudden death" (Hall, et al., 2009).

Law Enforcement View of Excited Delirium

ExDS is commonly observed and hopefully identified initially by either police, EMS personnel, or citizens. Therefore the immediate indication by most would include some or all of the following signs/symptoms

- Unfounded Fear and panic
- Shouting/nonsensical speech
- Bizarre behavior (hallucinations/paranoia)
- Hyperactivity and thrashing (especially after being restrained)
- Unexplained strength/endurance
- Nudity (due to increased body temperature)
- Profuse sweating (regardless of outside temperature)

(Seattle Police Department, 2007)

The ability of law enforcement to readily identify any of the above symptoms and make appropriate notification to other medical personnel is vital toward the successful outcome of any ExDS incident. In other words, the incident needs to be treated as a medical crisis and not just a criminal encounter (Parent, 2006).

Historically, a law enforcement response would include verbal guidance by law enforcement followed by an escalation in force including the application of hands to the subject exhibiting the bizarre behavior. As discussed earlier, the subjects will generally exhibit extreme strength and most likely will not respond to law enforcement efforts in the area of *pain compliance* techniques. Law enforcement will commonly identify these behaviors as an attempt to defeat their efforts for a safe apprehension of the subject. Eventually, a greater number of law enforcement personnel or a successful application of a CEW (Taser) will most likely allow for an apprehension. Routinely, the subject might remain in the prone position or be secured in a transport vehicle for a few minutes while law enforcement continues gathering information for report purposes. In most ExDS incidents, during transport or during the restraint process the individual will suddenly become calm, unconscious, or go into respiratory distress/cardiac arrest.

The failure of law enforcement to recognize this progression is detrimental to the successful outcome of any incident.

Training for Excited Delirium Incidents

Many progressive jurisdictions nationwide have identified and implemented training for law enforcement, EMS, and hospital personnel in the recognition and combined response to ExDS incidents. For instance, in Las Vegas, Seattle, San Jose, and Lenexa, Kansas the law enforcement protocols include direct applications involving trained EMS personnel utilizing sedatives when safe to do so.

Certain protocols have been published and discussed as early as 2009 in *White Papers Report on Excited Delirium Syndrome by the American College of Emergency Physicians (ACEP, et al., 2009)*. Many of the protocols in place in the above mentioned cities are based upon findings from the 2009 report. Most importantly the report identified ExDS as a "Coordinated and Cooperative Effort" between police and EMS personnel focused on the successful but safe ending to an ExDS incident (ACEP, et al., 2009). The differences between agencies protocols in regard to ExDS response are minimal and seem to all focus on the following objectives

- Clear Identification of ExDS cases based upon common signs and symptoms of the syndrome
- Rapid control of the individual with appropriate number of personnel
- Sedation by trained EMS personnel immediately after being restrained
- Transport of the subject to medical facility immediately for evaluation and documentation

The identification portion of the protocol recommendations include training for first responding law enforcement officers as well as dispatchers asking the correct questions of callers prior to officers arrival. The correct questions being asked will allow EMS personnel to be dispatched simultaneously and prevent additional delays.

The control portion of the protocol recommendations include ensuring adequate numbers of personnel are present prior to engaging the subject if at all possible. In addition, officers must gain rapid control of the person exhibiting the symptoms of ExDS. The quicker and more effective the control is brought on the person the less likelihood of a negative outcome for the subject involved. Finally, ensuring efficient breathing of the subject while they are in custody is a requirement. Officers must be aware of any unnecessary weight being placed on the subject that might impair breathing.

The sedation of the subject immediately upon restraint is one of the most preventative steps of the protocol recommendations presented. This allows the subject to relax and not continue fighting the restraints or the officers on the scene. Obviously, the EMS personnel must be trained to respond to the scene and be prepared to be involved in the sedation process not waiting for law enforcement to have all aspects of the control complete. Dosages or specific medications involved in the sedation process must be in accordance with local emergency physician's orders and acceptance. However, it should be noted that the 2009 White papers report acknowledged the immediate sedation of the individual as an integral part of the process (ACEP, et al., 2009).

Finally, the rapid and successful transport of the subject involved in the ExDS incident must be accomplished not only for initial continued treatment, but to adequately provide documentation for the ExDS case itself. A few of the issues that the *2009 White Report*

identified for hospitals to consider was the possible presence of *acidosis*, *hyperthermia, and Rhabdomyolysis* in the subject (ACEP et al., 2009). If identified early upon reception to the medical facility these issues can be dealt with successfully. One additional portion of the hospital transportation and treatment process is the documentation of the ExDS subject's case. This will aid in understanding the syndrome itself and improving responses while also providing some litigation management for all involved.

Conclusion

Clearly, the nation as a whole remains behind in regard to the identification and training for ExDS incidents. The Canadian government and police have moved far more progressively in the research and training realm of ExDS. However, as many larger law enforcement jurisdictions begin to recognize the need for advanced training in the ExDS area their personnel are becoming more aware of the varied tactics necessary for successful outcomes. In addition, hospitals and EMS workers also are seeking a more thorough understanding of the syndrome which commonly involves combined training and response with local law enforcement officers.

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