In-Custody Deaths: Excited Delirium

A worst case scenario before you are even dispatched

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The dispatch call may be for a disturbance or for a mentally ill subject. There will probably be several reporting parties. A man is yelling and screaming downtown; he has smashed in several stores' windows; he is nude. When you arrive you find you cannot communicate with him. He is grossly incoherent, obviously hallucinating. The subject is either acutely mentally ill, under the influence of drugs, or both. He advances towards citizens who have stopped for the show. It is time to contain and control him. He needs to go somewhere--jail or a mental health facility. As you approach he immediately initiates a fight with apparent superhuman strength. You may have already employed a less-lethal weapon to little or no effect. Other officers respond and six of you engage in a protracted physical encounter. You finally get him handcuffed, and apply leg restraints. Paramedics have been called to the scene. While you wait, the subject still fights the restraints. Suddenly he stops struggling, and you realize he has also stopped breathing and has no pulse. Attempts by officers and paramedics to resuscitate him are futile. The subject is pronounced dead at the hospital. On autopsy, the coroner cannot find sufficient evidence to establish a cause of death.

It is estimated that there are between 50 and 125 in-custody deaths in the United States that correlate with excited delirium symptoms every year. Similar deaths also occur in psychiatric and geriatric care facilities.

Three groups of subjects are more prone to the sudden and unexpected death associated with excited delirium: people with a mental illness, (bipolar disorder or schizophrenia), chronic illicit stimulant (cocaine, methamphetamine) abusers and ecstasy, marijuana, or alcohol abusers, or a combination of mental illness and substance abuse. Other causes of excited delirium include infection, head trauma, and adverse reactions to medication. Most subjects the police will encounter with excited delirium are males between the ages of 30 and 40. It is rarely seen in females.

The Excited Delirium Syndrome

There is no medical or psychiatric diagnosis of excited delirium. The International Association of Chiefs of Police has not acknowledged the syndrome, either. It is the subject's behavior that indicates the syndrome. However, annually, excited delirium is increasingly determined to be the cause of in-custody deaths.

Any person experiencing delirium requires prompt medical attention as it is a result of life threatening medical conditions. Delirium is characterized by an insidious disturbance in the level of consciousness and a change in mental status. People in delirium will likely manifest acute behavior problems, including becoming oppositional, defiant, angry, paranoid and aggressive. Attempts to calm or contain them will

result in further aggression and violence. Control techniques can be difficult because subjects often demonstrate unusual strength and insensitivity to pain, as well as instinctive resistance to the use of force.

Signs and Symptoms of Excited Delirium

Excited Delirium presents as a cluster of physiologic and behavioral symptoms which include:

1. Bizarre and violent behavior
2. Hyperactivity
3. Shedding clothes or nudity
4. Aggression
5. Attraction to glass (smashing glass is common)
6. Foaming at the mouth
7. Drooling
8. Sweating
9. Dilated pupils
10. Incoherent shouting or nonsensical speech
11. Grunting or animal-like sounds while struggling with officers
12. Unbelievable strength
13. Imperviousness to pain
14. Ability to offer effective resistance against multiple officers over an extended period of time
15. Hyperthermia (temperatures can spike to between 105-113°F)

Symptoms of Excited Delirium

1. Extreme paranoia
2. Hallucinations
3. Confusion or disorientation

Excited delirium is a medical emergency that requires acute medical care. Excited delirium causes a person's sympathetic nervous system to shift into overdrive. The sympathetic nervous system is responsible for the up or down regulation of most of the body's homeostatic functions, including the release of adrenalin, heart rate, body temperature, and pain perception. Physical restraint compounds these effects on the sympathetic nervous system. The subject was already in a medical crisis before you arrived on scene. It is likely he is near complete exhaustion, despite how he presents. Excited delirium is associated with a number of dangerous physical effects including hyperthermia, changes in blood acidity, electrolyte imbalances, a breakdown of muscle cells, cardiac arrhythmias and ventricular fibrillation. The typical excited delirium death involves the subject slipping into a state of sudden tranquility, either during or after the struggle and restraint, followed by cardiac arrest. It is essential that law enforcement officers recognize the symptoms of excited delirium and sudden death so that

appropriate emergency medical care is initiated early. If you are not sure if someone is exhibiting excited delirium behavior, err on the side of caution.

Ten Suggestions for Law Enforcement Officers and Agencies

1. **Protocol:** Law enforcement agencies must establish a protocol in advance for dealing with subjects in excited delirium.
2. **Dispatch:** Dispatchers should be trained to recognize indicators of excited delirium and ask the reporting party follow-up questions. If excited delirium is suspected, the dispatcher should alert officers for their safety. They should notify paramedics to be on standby.
3. **Backup:** If the first officer on scene believes that he/she is dealing with an individual experiencing excited delirium, they should call for backup (several officers if possible) immediately. Advanced life support paramedics should be called to stand by. If feasible, wait for paramedics to stage before attempting to control the subject.
4. **Containment:** The first officers on scene should focus on containing the subject, making sure he cannot hurt any other individuals. Unless there is an immediate public safety threat, officers should not approach the individual until substantial law enforcement backup has arrived and paramedics are nearby.
5. **Control:** The quicker control can be established, the better. The longer the physical confrontation goes on with an excited delirium suspect, the higher the risk of an in-custody death.
6. **Restraint Position:** Officers are traditionally trained to place a controlled subject in a prone position. However, the prone position may make it more difficult for an individual to breathe. This is especially true for a person experiencing excited delirium. Once the excited delirium subject is in custody, and during paramedic transport in an ambulance, the individual should be placed in a supine position or on their side (left side is preferred). If the restrained subject suddenly stops resisting, monitor him for pulse and breathing. Initiate CPR as indicated.
7. **Maximum Restraint:** There is a strong correlation between the use of maximal restraint (hog-tie) and sudden in-custody deaths. If feasible, this type of restraint should not be employed on subjects experiencing excited delirium.
8. **Use of Force Options:** Part of the excited delirium protocol for any agency should include tactics and use of force options for establishing control of the excited delirium subject. Subjects with excited delirium may have superhuman strength and can be impervious to pain, making pain-based techniques relatively ineffective.

    - Empty hand techniques should be applied as part of a multiple-officer takedown team
    - Pepper spray may be ineffective on an individual who does not respond to pain
    - Impact techniques (i.e. batons) may be sufficient to stop movement in a subject's leg or arm, but these techniques may not result in pain compliance.
    - TASERs may be effective, as they temporarily override the central nervous system, providing officers a window of opportunity to control and restrain the subject. Research has linked multiple TASER applications with an increased risk for sudden death of subjects in excited delirium. One TASER firing in the probe mode is suggested.

9. **Transport:** Excited delirium is a medical emergency and all subjects should be transported to hospital by ambulance. Paramedics need to closely monitor the subject's heart rate, blood pressure, respirations, CO_2 levels, pH levels, and temperature.
10. **Debrief:** As with any critical incident, agencies and involved personnel should debrief after an encounter with an excited delirium subject, especially if the individual died in-custody

Remember that excited delirium is a **P.R.I.O.R.I.T.Y. M.E.D.I.C.A.L.** emergency. Use this mnemonic by Dr. Michael Curtis to remember the presenting picture of excited delirium and the appropriate responses.

Psychological issues
Recent drug/alcohol use
Incoherent thought processes
Off (clothes) and sweating
Resistant to presence/dialog
Tough, super-human strength
Yelling
Make an informed decision
Enlist backup
Disturbance-resolution model
Intervene (TASER with caution)
Contain
Attend medical needs
Least amount of force necessary

Strategies for dealing with Excited Delirium subject:

1. Where Excited Delirium seems probable, EMS should be dispatch and stand by at a safe distance until the individual is restrain. "EMS involvement is warrant as early as possible."

2. As soon as the first responding officers believe they are dealing with an Excited Delirium subject hey should attempt to have SEVERAL officers are sent as backup. .Unless there is an immediate public safety threat, the first responding officers should focus on containing the subject in an environment that offers him maximum possible safety and protects others as well. Unless there are compelling reasons to do otherwise, officers should not approach the individual until substantial backup and EMS personnel are on the scene.

3. Once sufficient numbers are on hand, including EMS personnel, then police efforts should focus on controlling the subject as quickly and with as little physical exercise as possible.

4. The subject is typically "unresponsive to verbal direction. And therefore Control tactics must consider that the subject is often imperviousness to pain able to summon high levels of strength. Thus, control through typical mechanical techniques and pain based techniques may be more difficult to achieve or be relatively ineffective. "

5. The effectiveness of pepper spray and impact techniques (baton strikes and beanbag rounds) "will likely be diminished with individuals who are unresponsive to pain." If empty-hand techniques are to be tried, "then the officers should train in advance to function as part of a multiple-officer takedown team."

6. Conduct Energy Devices (TASERS) may themselves increase the risk of death due to the added exertion created by the TASER. Current research cautions about a possible link between MULTIPLE applications and death in persons with symptoms of Excited Delirium. Know your agencies policy in this type of contact.

7. Understand your agencies policy on restraint tactics. The prone position makes it more difficult for the person to breathe, and this concern is heighten when dealing with Excited Delirium subject. Therefore, once the subject should be placed on his side if this can be done without creating an unreasonable risk to officers or others. You may need to assist EMS. Place the individual on a restraint board

8. Ideally, EMS should transport the subject to a hospital in an ambulance