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with Charles Remsberg

# Do's and don'ts of handling "excited delirium" suspects -- *Special ILEETA Conference series (May 31, 2006)*

## PART 1

By Chuck Remsberg
PoliceOne Senior Contributor

***A subject in the throes of excited delirium "may be so far down the road to destruction" that realistically you have little hope of doing more than "witnessing his death. Even if you're able to manage the situation perfectly, he may still die."***

That stark message was delivered at the recent annual training conference of the International Law Enforcement Educators & Trainers Assn. (ILEETA) by Canadian academy instructor Chris Lawrence as a reality check for officers who have to deal with one of today's most perplexing street problems: the sudden and seemingly inexplicable physical and mental melt-down of an individual that can easily boomerang into a tactical, media and courtroom nightmare.

Futile as the prospects may be, you have to do something when you confront what looks like an ED event. "The subject may in fact be experiencing some other type of medical emergency (like a diabetic crisis) that could readily be helped by appropriate medical intervention. To just stand by, hoping he'll calm down, may unnecessarily doom him.

In any case, restraining people who are dangerously beyond self-control, whatever the cause, is one of your jobs as a cop. The trick is to not make a situation that's already desperate and foreboding even worse.

In a couple of years, you may have a more promising protocol for suspected ED calls. An in-depth study of the problem involving San Diego PD, Las Vegas Metro and a wide variety of Canadian police agencies is just getting underway by Dr. Christine Hall of the University of Calgary medical faculty. Among other things, she intends for the first time

to investigate extensively the sufferers of ED episodes in hope of finding clues that will help police and medical personnel more successfully resolve these incidents.

But in the meantime, based on what is currently known, what steps can you take-and avoid-to provide the maximum chance for you and the subject to safely survive a confrontation, while exposing yourself and your agency to the least amount of liability risk in the event the confrontation ends in the suspect's serious injury or death?

Chris Lawrence and his wife Sharon, who shared his ILEETA presentation, are part of a multi-disciplinary team of professionals that has comprehensively researched the existing knowledge of the ED phenomenon. Chris is the DT coordinator at the Ontario Police College and a member of the Force Science Research Center's technical advisory board. Sharon, also on the FSRC board, is a pharmacist with a background that includes cardiology research and clinical experience in a teaching hospital where she specializes in mental health care.

Here are highlights of what they reported to a standing room-only class of officers and trainers at ILEETA:

**WHAT IS ED?**

"As we learn more and more about excited delirium, we realize we know less and less about it," said Chris Lawrence. But in broad terms ED describes a condition in which, according to Sharon Lawrence, a subject abruptly displays aberrant behavior, becomes very agitated and possibly extremely violent, often (but not always) engages in a vigorous struggle with someone trying to control him and may end up dying suddenly.

An adrenalin peak appears generally to occur 3-5 minutes after significant exertion, and death frequently strikes after the subject has been handcuffed, although the episode may not turn fatal until a couple of hours or even a couple of days later. An autopsy typically reveals "no obvious mechanism of death."

Police intervention is often blamed when a death occurs, but professional literature records deadly ED-like episodes as early as 1650, long before Tasers, OC, hog-tying or other LE tools and techniques that some critics have tried to link to fatalities.

Based on a review of 29 ED-related deaths during a 15-year period in Ontario and confirmed in at least one US study, 97% of victims in fatal ED events are male, with an average age of 33. (Why women have such a low representation is not known, but keep in mind that ED subjects can be female.)

Over 80% are substance abusers, with cocaine (55%) and alcohol (17%) most common. A significant minority (34%) are associated with mental illness, 17% of those

afflicted with schizophrenia and 10% with clinical depression. Some show evidence of both mental illness and drug ingestion, but ED seems to be "a substance-abuse problem more than a mental health issue," Chris explained.

"Virtually every known death has involved these core elements: substance abuse or mental illness, bizarre behavior and physical exertion."

The phenomenon appears to be largely "a warm-temperature event," and can be further aggravated by high humidity, he said. It's "not exclusively a big-city occurrence." And Sunday, "the end of the weekend," is statistically the most likely day for an ED onset, with Thursday through Sunday the heaviest span of days.

**WHAT SYMPTOMS ARE YOU LIKELY TO SEE?**

"It's asking a lot to expect a police officer with conventional training to accurately identify and diagnose ED," which is essentially a medical/psychiatric condition, Chris points out. But there does tend to be a "constellation" of indicators that should at least alert you that you are facing an especially volatile and dangerous situation and need to take special precautions in trying to resolve it. Symptoms itemized by the Lawrences include:

- **An exaggerated version of the flight-or-fight response.**

"These subjects will run at the first opportunity, without regard to context," Chris said. "They seem to be attracted to running in traffic, for example. Their aggression is unpredictable and can be unprovoked. They exhibit superhuman strength and tend to ignore painful stimuli. Struggling with them is like wrestling with King Kong."

- **Attraction to glass.**

"Smashing glass is common, although we don't know why." Subjects experiencing ED-type behavior often destroy other property as well. "These incidents tend to involve a lot of noise."

- **"Animal-style" behavior.**

This may include "grunting, biting, scratching, pushing-very primitive actions." Speech may seem unintelligible or "nonsensical," although it may actually be another language that sounds like gibberish because you don't understand it.

- **"8-Ball" eyes.**

They may be *wi-i-i-i-i-i-i-ide* open, so that white is visible on all 4 sides of the iris.

- **Nudity.**

Stripping naked may indicate a psychotic break from reality, or it may be associated with an overheated body. Sharon explained that the chemical imbalances in the brain that accompany mental illness "can throw off the body's ability to tolerate or expel heat." Often (but not always) there is profuse sweating and a feverish temperature.

- **Impaired thinking.**

This can include disorientation, hallucinations, an acute onset of paranoia, panic for no apparent reason, and the ignoring of obvious injuries.

- **Sudden tranquility after frenzied activity.**

"Physiologically we are designed to sustain a 'goal-oriented maximum exertion' for about 2 minutes. ED people can go far beyond this," Chris stated. Sharon added:

"Normally after exertion, the body's internal mechanisms then quiet down. But with ED subjects, the quieting response is a shut down because the normal feedback mechanisms seem to be impaired.

"The paradox is that although the subject exhibits superhuman strength and endurance, he may actually be physiologically fragile. If he has exhausted 5 or 6 officers as they are bringing him under control, his own state of exhaustion is likely to be pretty significant, perhaps more than his system can handle, particularly if he continues to struggle against restraints."

## PART 2

In *Part 1*, we shared excited delirium expert and PoliceOne columnist Chris Lawrence's insights into the definition of ED and what behavior may be associated with someone in the midst of an ED event.

In this next installment, we reveal the things you should do when faced with a subject who may be experiencing ED, and things you shouldn't do.

### WHAT SHOULD YOU DO?

If the symptoms you see and intelligence on the suspect's background you gather from available witnesses convinces you he may be experiencing ED, the following considerations may help you protect yourself, your agency and potential civilian victims, as well as the subject himself, the Lawrences advised.

1. Recognize that you're dealing with a medical emergency that requires prompt transport to a health facility. Get EMS to the scene ASAP. If Advanced Life Support service is available, get it there also. "You want to transition your approach to this situation from a simple law enforcement intervention to a coordinated response to a medical emergency," Sharon explained. "We need to remind the public that there can be no medical assistance until the subject is controlled."

2. "Transport requires control, and control requires force," Chris asserted, "and officers will need to exert greater effort that the subject, otherwise control will not be established." Later this critical truth may need to be explained to a naive jury.

For now, call for abundant backup. Overwhelming the suspect with manpower is likely to be your most realistic and effective tactic for establishing control. Expect a high level of resistance. The more officers you get involved the less likely anyone will be seriously injured.

3. If it is safe to do so, responding officers should kill sirens, headlights and overheads at the scene. This will decrease stimulation that may otherwise only heighten the subject's hyper status.

4. Understand that hallucinations the suspect may be experiencing "will seem very real to him," Chris cautioned. "You can't know for certain what he may be seeing or hearing. For all you know, his attacking you may in his mind be an effort to 'save' you from some danger he believes is coming." Reasoning with him is not likely to be an effective option. Remember that "things can go sideways at any time, without warning."

5. You and the others most likely will need to take the suspect to the ground. "The ground gives you a stable, consistent surface where you can use mechanical leverage rather than brute strength" to restrain him, Chris said.

6. Initially the suspect may need to be proned on the ground for handcuffing, but as soon as possible roll him onto his side to give him the best possible breathing capability.

7. Without hog-tying him, CONTROL HIS LEGS. "This is vital," Chris said. "Otherwise, once he's on his side he can put the soles of his feet back on the ground and bring his legs back up into the fight." Chris recommended a hobble restraint strap around the ankles that you can step on after it is cinched.

8. For transport, the ankle restraint strap should be tied to the end of the ambulance gurney. This will help protect EMS personnel from thrashing legs and keep the suspect from pulling his legs free of the stretcher strap that is usually placed across the knees.

9. Explain in your report of the incident why you chose whatever force options you used and point out what you did to help assure prompt and effective medical attention for the subject.

10. If the suspect does die, ask medical personnel to take core body temperature readings at regular intervals even after death. In some ED cases, subjects have shown a temperature as high as 108 degrees even 2 hours after they've died. These measurements may help the medical examiner to establish a firm cause of death.

**WHAT SHOULD YOU NOT DO?**

The natural outcome of ED may prove to be highly negative, regardless of your best efforts. Don't help the Monday-morning quarterbacks make things look even worse by taking inappropriate actions that you should avoid. According to the Lawrences:

1. Don't Taser the subject in the stun mode. In ED, he's impervious to pain, so he won't feel it and won't be controlled by it. You'll only end up connecting the Taser to his death (if he dies) without winning any benefit.

2. Don't deliver more than one cycle of Taser barbs if you decide to try that control option. Use the Taser to create a window of opportunity during which you can try to restrain him. Multiple Taser cycles are not recommended where you believe the subject may be experiencing ED.

3. Don't deploy pepper spray. Again, no pain for him...no gain for you. Even the pain of baton strikes may not stop his aggressive behavior, and repeated forceful strikes may cause injuries that increase the risk of an adverse outcome.

4. Try not to cause any impairment to the suspect taking full breaths. That means avoid spit hoods, towels over his face—anything that lessens fresh air coming in or retains exhaled air. The subject needs to take in oxygen and to get rid of carbon dioxide. Use of a neck restraint may lead to a misperception by the suspect that you are shutting off his breathing. If he thinks he can't breathe, this becomes his reality in his psychotic state.

5. Avoid transporting the subject in a police car unless no other option is available. The average adult is longer than the car is wide. An ED subject is not likely to sit quietly on the seat for you. Laying him on his belly is not recommended, and laying him on his side will often result in windows being kicked out. Transport to a hospital via ambulance whenever reasonably possible.

Although compared to other types of high-risk calls ED incidents are rare, training for them is vital, the speakers stressed. "The time to do training is not after you have an

ED death," Sharon declared. She advised also to let your community know that you are working to prepare your troops to deal with this problem. "It shows you are proactive, anticipating and addressing problems before they strike."

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Charles Remsberg co-founded the original Street Survival Seminar and the Street Survival Newsline, authored three of the best-selling law enforcement training textbooks, and helped produce numerous award-winning training videos. His nearly three decades of work earned him the prestigious O.W. Wilson Award for outstanding contributions to law enforcement and the American Police Hall of Fame Honor Award for distinguished achievement in public service.

Pre-order Charles Remsberg's latest book, *Blood Lessons*, which takes you inside more than 20 unforgettable confrontations where officers' lives are on the line.



http://www.policeone.com/edp/articles/134670-Dos-and-donts-of-handling-excited-delirium-suspects-Part-1-Special-ILEETA-Conference-series/