

Sudden Death, “Excited” Delirium, and Issues of Force:



Part III - Behavioral Cues and Response Plans for Sudden and In-Custody Deaths

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Part III focuses on scientific information about sudden death and the behavioral cues many high risk individuals exhibit prior to their demise. The information presented is believed to be the most current available.

On an early Saturday evening in July, a woman looks out the front window of her home and sees a young male adult, about 30, dressed only in his underwear, smashing car windows with a stick as he passes them. The evening is very hot and humid and the man

appears to be drenched with sweat. Concerned, she calls 911 and speaks to a dispatcher.

“He’s acting crazy,” the woman caller tells the dispatcher. “After he smashes a car window, he runs around the car, and then runs across the street and smashes another car window,” she says. “No, he’s not trying to get into any of the cars; he doesn’t even look inside them after he breaks a window,” she calmly tells the dispatcher. “I think he’s a karate student,” she continues, “because, every time he breaks a car window, he grunts and groans loud enough that I can hear him from the house.” After collecting the information, the dispatcher sends one patrol officer to the scene.

Officer Arrives at the Scene

Stopping her patrol car at the end of the street, the officer can see the man, only dressed in his underwear, smashing car windows with a stick, as he approaches her end of the street. The man is sweating heavily, but it is very hot and humid outside. He is grunting loudly, but does not attempt to take anything from the vehicles. The officer approaches him and notices the man appears to be talking to invisible people.

“Can I help you?” she asks. The man ignores her. When she gets a bit closer, he stares at her with a long stare and goes to smash another car window. The officer tells him that he is under arrest and, when he ignores her, she removes her pepper spray and sprays him. The spray has no effect on him and he is now looking right at her. He gets angry and then lifts the rear end of a small car. The officer calls for emergency backup to her location and she can hear the sirens getting louder as the wild male continues to bash car windows.

Backup Officers Arrive

Two more officers arrive and decide to physically subdue the man. The first officer strikes the man’s leg with an ASP baton, but it has no effect. Then, all three officers jump the person, but he throws them off like dolls. Finally, one officer trips the man and down to the ground they go. The other two officers enter the mêlée and attempt to handcuff the violently resisting male. Suddenly, he gets calm and one male officer says, “Finally, he has learned his lesson and has stopped resisting.” “I can’t breathe,” the man says as two officers push down on his back while struggling to handcuff him. “Sure you can or you couldn’t talk to us,” says a sergeant who has now arrived at the scene. After they get the man handcuffed, he remains motionless. The sergeant looks at the man’s face and sees that he is in medical distress, and immediately radios for EMS, but, by the time they arrive, the man is dead.

Another Restraint Death and Negative Publicity

The headline in the next morning's paper screams, "Police kill another during handcuffing." The mayor has called the chief of police into his office and wants answers. The public is calling the mayor's office and the news media want an immediate interview with the officers, the chief of police, and the mayor.

This Was a Medical Emergency

Based upon what the 911 caller told the dispatcher, coupled with what was seen by the responding officers, clearly indicates this man needed emergency medical help, not a fight with the officers over an arrest. Therefore, it is important to remember the behavioral cues listed and discussed, that a high risk candidate for a sudden and/or in-custody death may first need medical assistance. For many officers, this requires a paradigm shift. Consider this: Bizarre behavior, struggling, and resistance can indicate a **medical emergency** and not a criminal act.

It is not that officers should ignore the criminal activity, but, when confronting a person who, without reasonable explanation, exhibits one or more behavioral cues as listed and discussed below, it is important for them to keep in mind that this is most likely a medical emergency and EMS should be immediately called to the scene, unless EMS is en route. Better yet, EMS should have rolled with the responding officers. There are two basic types of relevant behavioral cues: invisible and visible.

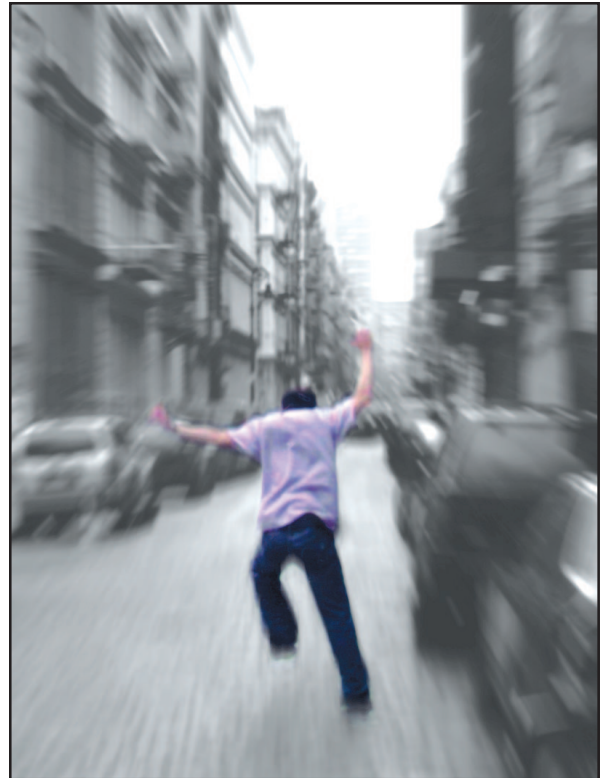
Predisposing Factors

Research has shown that there can be several predisposing factors which may be unknown to you. Remember, most of these people have made long-term negative lifestyle choices (e.g., chronic cocaine or methamphetamine abusers) or have mental or other serious illnesses, and now they are exhibiting behaviors which are not only antisocial, but also that may indicate that they are in a medical emergency.

The following list of predisposing factors may exist during an encounter with an individual who has them:

- The person has a large belly (may indicate alcohol disease);
- The person has an enlarged heart (this won't be visible);
- The person has coronary artery disease (this won't be visible);
- The person has had a prior heart attack (officers may not know it);
- The person has myocarditis (inflamed muscles) – this won't be visible;
- The person has a fibrotic heart (scar tissue formation, possibly from chronic cocaine abuse) – this won't be visible;
- The person is under the influence of illicit drugs (e.g., cocaine, methamphetamine, LSD, PCP, polydrugs, etc.); also note that some instances of excited delirium and sudden death can occur months after the last ingestion of illicit drugs;
- The person has taken too much (or too little) of his (or her) neuroleptic medications or the medications simply are not working at this moment in time;
- The person has failed to take his/her prescription drugs;
- The person is diabetic and has low blood sugar (hypoglycemic);
- The person has hyperthyroidism (overactive thyroid);
- The person has a head injury or has a previous head injury;
- The person is dehydrated; and/or
- The person has an underlying psychiatric disease (e.g., paranoid schizophrenic).

Remember, officers and first responders will not be able to see



One of the many behavioral cues which help to identify excited delirium is the suspect running about wildly.

any of these predisposing factors, except for the large belly. Also, the person may be under the influence of alcohol or in alcohol withdrawal. Watch carefully for both of these conditions. Also look for medic alert insignia.

Physical Characteristics

The following physical characteristics may be visually evident, if officers and/or first responders can get close and/or touch the person for an appropriate amount of time. Remember, officers are not being told to disregard officer safety practices, as officer safety is very important. At times, officers and/or first responders will not be able to get close to the individual for safety reasons. Also, keep in mind there may be other reasonable explanations for many of these characteristics.

- The person has dilated pupils;
- The person has a high body temperature – hyperthermia;
- The person is sweating profusely; and
- The person has skin discoloration.

Some officers may think there is no way they will get that close to the person.

However, if they grab the person or attempt to apply handcuffs, there is a good chance they will feel the person's elevated temperature, see skin discoloration, and notice the heavy sweating. These physical characteristics may indicate the person is in a medical emergency. Of course, if the person has been lying in the sun (say, here in Las Vegas where the temperature is 100+ degrees) and just exited a swimming pool, the person may feel hot and look as if (s)he is sweating heavily. Unless officers can eliminate a reasonable explanation about the person's condition, consider this a medical emergency and get EMS rolling to the scene, if it has not already been dispatched to their location.

Behavioral Cues

The following cues have surfaced from research studies about individual cases which have led to a finding of excited delirium:

- The person demonstrates intense paranoia;
- The person demonstrates extreme agitation;
- The person demonstrates violent and/or bizarre behavior;
- The person is violent toward glass, shiny objects/materials, and other inanimate objects;
- The person is running and/or running about wildly;
- The person is screaming;
- The person uses pressured, loud, incoherent speech;
- The person is naked or is taking off clothes (remember, the person is hot and wants to get cool);
- The person is psychotic in appearance;
- The person manifests rapid changes in emotions, i.e., going from a state of hyperactive delirium to a state of flat delirium (sadness), or changes back and forth in the presence of officers and/or first responders or is reported by others to have fluctuated between the two which is known as mixed delirium;
- The person is disoriented about place, time, purpose, and even himself (or herself);
- The person has great, seemingly superhuman strength;
- The person has seemingly unlimited endurance;
- The person has muscle rigidity (e.g., when an arm is grabbed for handcuffing, the arm will not easily go behind the back. This may not indicate intentional resistance, but muscle rigidity caused by the person's medical condition);
- The person has a diminished sense of pain or is insensitive to pain (e.g., pepper spray and/or a baton strike is not felt by the individual). If this happens, put away these tools and use an electronic control device;
- The person is having hallucinations (e.g., hearing voices, talking to people who are not present, or talking to inanimate objects);
- The person shows aggression toward objects (e.g., signs, cars, etc.);
- The person violently resists during control and restraint or after being restrained;
- The person says, "I can't breathe" during or after being subdued;
- The person is easily distracted and has a lack of focus (e.g., you tell the person to turn around and put both hands behind the back. As he begins to comply, suddenly it appears he has forgotten what [s]he was told to do.);
- The person has delusions of grandeur;
- The person has scattered ideas about things;
- The person makes you feel uncomfortable; and
- The person is described as having "just snapped" or "flipped out" (Institute for the Prevention of In-Custody Deaths, Inc., 2005).

Not a Diagnosis, but Identification of Behavioral Cues

It is important to note that officers are not making a clinical or other diagnosis of the person, as this can only be done by qualified and/or licensed medical and health care professionals. Rather, the focus is on the identification of behavioral cues which indicate this individual is a high risk candidate for a sudden death or an in-custody death. These behavioral cues may also indicate the individual is in a *state of excited delirium*.

There is at least one group of trainers who is instructing officers how to "diagnose" individuals using a scorecard system. This same scorecard system approach was reported in medical literature in 2005 by two nurses. Using a scorecard to total arbitrary

values and then arrive at a figure which means nothing is sheer nonsense. There is no reliability or validity to such an approach, so this approach should not be adopted or used. In some cases, if only **one** behavioral cue is identified, that is all which is needed to treat the individual as a high risk candidate for a sudden or in-custody death.

Five Action Steps

Many agencies have adopted the following five actions steps which were initially suggested by medical researchers and officials. While scientific research is ongoing to support these recommendations, the steps are based upon a synergistic multidisciplinary approach. While each situation is different, there are common threads which appear to exist, without regard to geographic residence.

Plan: After reasonably assessing the scene and if time permits you to do so safely, develop a plan with other officers and EMS personnel. Review the following five step action plan with them and, if possible, practical, and reasonably safe, attempt to de-escalate the situation through verbal skills (notice I did not say "commands").

Step 1: Quickly and safely capture the person. This is best accomplished with an electronic control device (ECD), such as a TASER® X-26 or M-26, pepper sprays, multiple officer restraint tactics, etc. Although not scientific, there is a growing number of researchers and doctors who opine and field reports which suggest the use of ECDs are the best device to quickly capture this category of individual. (Remember: Many of these individuals have seemingly superhuman strength, are virtually impervious to pain, and do not physically tire.)

Step 2: Quickly and safely control the person. After capturing the person, one or more officers will gain control of the person. This may be accomplished by one or more officers safely grabbing both arms, or all of the appendages.

Step 3: Quickly and safely restrain the person. Restraint options include the use of plastic or metallic restraints, nylon restraints, leather restraints, restraint combinations, and so forth. It is recommended that the person not be left in the prone position for an unreasonable time, but rather rolled onto the side or sitting upright.

Step 4: Sedate the individual. This step is left to the paramedics who are on the scene or to the emergency department physicians, depending upon approved protocols. Under no circumstances should officers sedate the individual, or tell the paramedics what to do. Paramedics will customarily give an intramuscular shot (EMTs are not authorized to give injections) of a combination of benzodiazepine and haloperidol (Haldol) or begin an IV line to begin sedation. The paramedics may also give the person sodium bicarbonate in an attempt to level out acid levels, after blood gas levels are determined. In some cases, the paramedics will be directed to take the person to the hospital immediately so an emergency department physician can do the sedation. It is thought that the fast sedation of the individual will reduce stress to his body, and also reduce stress for all those who are involved in the incident.

The longer a person has exerted himself (usually unknown to the officers) and is permitted to struggle, whether it is during the initial confrontation with the officer, during the restraint process, or after the restraint process, the more likely (s)he will develop metabolic acidosis and/or exhaustive mania. During the struggle, the person will, most likely, become acidotic – in other words, the

acid level in the blood will change leading to low pH levels, preceding respiratory and cardiac arrest.

Also, the person may build up lactate during the fight or flight mode, progressing to a point where the gas exchange in the lungs is compromised. In short, the person cannot get rid of CO₂ buildup in the lungs which will often lead to the person saying, "I can't breathe." Although the person is breathing, there is a significant problem of exchanging carbon dioxide and oxygen which can lead to respiratory arrest and then cardiac arrest. This inability to oxygenate can also be found at the cellular level – the person simply is not capable of adequately oxygenating his body due to overexertion.

The individual can also exhaust him/herself to death by violently resisting during and after being restrained. It is believed the chronic stimulant abuse alters sections of the brain which prevent it from sending signals to the body to stop resisting. In short, the person exhausts him/herself to death.

Step 5: Immediately transport the person to the hospital.

It is not recommended that officers transport the individual in their patrol car. It is unlikely they are paramedics and they cannot possibly simultaneously drive, use the radio, and monitor the person who is now under their care, custody, or control. Therefore, transferring control of the person to the paramedics is recommended. The paramedics need to immediately take the person to the hospital. Remember: If the person does go into cardiac arrest, it is better for him (or her) to do so in the ambulance with medical professionals, than in the backseat of a patrol car.

Develop an Excited Delirium Response Team

It is recommended that law enforcement agencies develop a response team which can be immediately dispatched to the scene of an individual who demonstrates one or more behavioral cues. This response team should be trained in how to recognize behavioral cues, restraint techniques, report writing and investigation techniques (more on this in Part IV).

Summary

There are many agencies throughout the United States which have adopted the five step action plan as outlined above, or with slight modifications. One such agency is the Jacksonville, FL, Sheriff's Department. Not only does this agency have several Identification, Prevention, Management, and Investigation of Sudden and In-Custody Death qualified instructors, it has developed a systematic approach to these situations by involving the chief medical examiner for the county, the fire department, and hospitals.

The agency has also developed a special code for excited delirium events. Of course, this requires dispatchers to be trained not only in the code, but also behavioral cues. The Jacksonville Sheriff's Department administration made it a point to first train its dispatchers, so they would know what to "look and listen" for during a 911 call, and then dispatch the appropriate resources – officers, EMS, supervisor, etc.

Final Thoughts

Please reread the hypothetical story at the beginning of this article and see how many behavioral cues can now be identified. Remember: If one or more behavioral cues is identified, dispatch and/or responding officers should immediately request EMS to be sent directly to the scene along with additional officers and a supervisor. The restrained individual should immediately be taken to the hospital. Taking the person to the police station or to jail will only waste precious, potentially lifesaving time, so go directly to the hospital. For those officers who are out in the county by themselves, or the local EMS service is temporarily out of service, sit the person upright in the backseat of the police car, seat belt and shoulder harness him (or her), and then proceed directly to the hospital. It is strongly recommended that a second officer sit in the backseat with the individual so (s)he can be continuously monitored. Otherwise, let the EMS professionals handle the situation.

Note: This is Part III of a five part series about sudden death, "excited" delirium, issues of force, and jail suicide. In a pioneering and cooperative venture between Police and Security News and the Institute for the Prevention of In-Custody Deaths, Inc. (IPICD), readers can earn their Basic Certification in the Identification, Prevention, and Management of Sudden and In-Custody Deaths, including jail suicide from the IPICD, Inc. For additional information, please contact the IPICD, Inc. at www.ipicd.com.

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