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10 TRAINING TIPS FOR HANDLING "EXCITED DELIRIUM"

DIRECTOR'S NOTE: One of the missions of the Force Science Research Center is to bring the latest research (ours and others) to the law enforcement community. Excited Delirium is a very high profile, significant social problem that although rare in occurrence has been very costly to the LE in terms of the health and safety of all concerned, reputation of the profession and certainly financially in terms of lawsuits against officers, departments and community.

It is our hope that this newsletter, which combines the latest research with the resulting suggested policy and procedures, stimulates thoughtful discussion in the areas of policy, practice and training.

--Dr. Bill Lewinski, executive director, Force Science Research Center

A representative of a large insurer of law enforcement agencies advises that new criteria are evolving for dealing with a special type of EDP-the person in the violent throes of Excited Delirium.

Attorney William Everett, a former police officer, offers 10 recommendations he believes will help patrol officers better manage high-risk ED confrontations. He presented these last month [9/05] in Utah at a conference of LE administrators and government risk managers and elaborated on them recently in an interview with Force Science News.

Litigation stemming from in-custody deaths is not uncommon. "In minimizing risk," Everett says, "agencies and officers should be aware of the latest developments in medical and scientific research and use those findings to develop protocols for dealing with ED."

Everett is associate administrator for the League of Minnesota Cities Insurance Trust, which provides liability coverage for more than 800 communities, and is also a member of the National Advisory Board of the Force Science Research Center at Minnesota State University-Mankato.

"Studies estimate that ED may be a factor in 50 to 125 in-custody deaths a year in the United States alone," Everett says. "Part of the problem seems to be that officers tend to see the bizarre and alarming behavior of a subject experiencing this condition as strictly a control-and-arrest situation rather than as a serious medical emergency that can be fatal.

"Fifteen to 20 years ago, it became important for officers and trainers to start thinking about distinguishing the difference between a combative drunk and a person in a diabetic crisis. Even though they may share some common behaviors, one needs to go to jail and the other needs to go to a hospital.

"Now, with the research that has been done on ED in the last few years, there's a need to distinguish between people who are just choosing to act in a violent criminal way and those who are doing so because of an underlying medical condition that is affecting them mentally and physically.

"When you put the latter subject in jail without proper medical attention and he dies, you have both a tragedy and a liability problem."

Excited Delirium has been described as "a state of extreme mental and physiological excitement," characterized by exceptional agitation and hyperactivity, overheating, excessive tearing of the eyes, hostility, superhuman strength, aggression, acute paranoia, and "endurance without apparent fatigue."

Officers' encounter this condition under "very consistent" circumstances, according to Chris Lawrence, defensive tactics coordinator at the Ontario Police College in Aylmer (ON) and a member of FSRC's Technical Advisory Board. Lawrence is recognized as a leading LE authority on ED. He will soon debut a column on ED and other LE issues for FSRC's strategic partner, PoliceOne at www.policeone.com.

The subject officers confront, often on a property damage or unusual behavior call, will be "acting in a bizarre manner, often partially clothed or naked," Lawrence reports. He will likely be incoherent or speaking in gibberish or what seems to be another language. He'll be yelling or screaming loudly, seem to be disoriented or hallucinating and may be foaming at the mouth or drooling. He may be sweating profusely or the opposite, his body temperature soaring and uncooled by perspiration. Glass often will somehow be involved in the encounter, reason unknown.

Usually ED symptoms are well underway when officers arrive, but lately Lawrence has found instances in which a subject is speaking calmly and rationally with officers and then suddenly explodes into ED. However the onset occurs, the condition, while relatively rare, is always high-risk, he stresses.

As officers try to gain physical control of the subject, his "extraordinary strength" will be "a central feature of the struggle." Several officers will be needed to overcome his determined resistance and immunity to pain.
"During the restraint process, the subject will often be grunting and making animal-like noises."

The biggest problem may come after he is controlled-when, after struggling against restraint, there may come "a period of sudden tranquility." At this point, Lawrence says, "the officers realize the subject has stopped breathing. Invariably resuscitation efforts fail." At autopsy, "the pathologist is typically unable to determine the exact cause of death," but the police, of course, generally end up being blamed.

ED episodes most likely occur between Thursday and Sunday, with Sunday the most common day, Lawrence has found. The hot months, May through September, are the most common time of year. Male subjects in their early 30s are most frequently afflicted, with subjects under 20 or over 50 least likely; female ED subjects are "extremely rare." Of illegal substances potentially involved, cocaine is most common (more than half the cases). Alcohol is common, too. About one-third of the time, the subject will have a diagnosed mental illness, schizophrenia most likely.

During his 15 years as a street cop, Everett says he saw "all kinds of people with mental impairments," but he believes he encountered only one memorable subject exhibiting ED--a young man pounding furiously on a plate glass window, then jumping on the hood of a car, trying to gain entry to a bar on a Sunday night when it was closed.

The melee with officers that ensued was "the closest I ever got to an unarmed life-and-death confrontation," Everett recalls. The difference between that subject and the multitude of other EDPs he encountered in his career he likens to "the difference between a Tyrannosaurus and a tabby cat. There's no subtlety about the intensity of energy, the physicality. It doesn't seem like you're dealing with anything human."

Seemingly invulnerable physically, the subject, in fact, may be experiencing a cluster of life-threatening physiological stresses, including hyperthermia, a change in blood acidity, electrolyte imbalances, a breakdown of muscle cells, and a leaching of cellular contents into the blood stream, all of which put his heart at significant risk.

With more research desperately needed, identifying "definitive, scientifically validated 'best practices'" for dealing with dangerous and difficult ED subjects may be impossible at present, Everett concedes. But based on his review of available data, he believes that "the overarching operational objective" when these individuals are confronted must be to bring them under control in a manner that does not unnecessarily aggravate their affliction and to get them immediate medical treatment.

Everett adds that ED is rare and that agencies may have other more prominent life and safety concerns to deal with. Based on what is known about ED now, he makes these recommendations:

1. Coordinate in advance with EMS. "ED is a medical emergency that presents itself as a law enforcement problem." Police and medical communities should strive to develop a coordinated approach for dealing with these incidents, with everyone involved understanding "what ED is and what their roles are"
when dealing with an episode.

2. If feasible, train dispatchers to recognize and question for indicators of ED so that responding officers can be cautioned before reaching the scene. When ED is suspected, EMS personnel and any available crisis intervention teams should be promptly notified.

3. Where ED seems probable, EMS should be dispatched and stand by at a safe distance until the individual is restrained. "EMS involvement is warranted as early as possible."

4. "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 medical personnel are on the scene.

5. As soon as the first responding officers believe they are dealing with ED, "they should ensure that SEVERAL officers are sent as backup." If physical restraint becomes necessary, they'll be needed for the protection of everyone involved. "Backing off until help is there makes sense and rushing to intervene alone, unless there is a compelling public safety threat, is foolhardy."

6. Once sufficient numbers are on hand, including medical personnel, then "police efforts should be focused on getting the subject under control as quickly and safely as possible." He needs medical treatment, but there can be no treatment until he has been brought under control.

7. In considering tactics, keep in mind that "ED is often characterized by superhuman strength and imperviousness to pain. Thus, control through empty-hand, mechanical techniques may be more difficult to achieve, and pain-based techniques may be relatively ineffective." The subject is typically "unresponsive to verbal direction."

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 be trained in advance to function as part of a multiple-officer takedown team."

A better choice may be Conducted Energy Devices (Tasers). However, current research cautions about a possible link "between MULTIPLE such applications and death in persons with symptoms of ED. To mitigate this risk, a SINGLE Taser application should be made before the subject has been exhausted."
(The Taser should be used not in the hope of gaining compliance but to create a window of disablement during which officers can establish physical control of the subject.)

One Taser firing in the probe mode, "followed by a restraint technique that does not impair respiration, may provide the optimum outcome." NOTE: "The Taser should not be used in the pain-distraction (push/stun) mode in dealing with ED individuals," since that is primarily a pain-reliant technique.

Whatever the tactical approach, "without a common plan and without training and practice in working together in multi-officer techniques, officers may very likely end up working against each other."

8. Adjust your restraint tactics. "People are designed to fight what is in front of them, and officers are almost universally trained to place individuals into a prone position because of safety and control advantages.
This position may make it more difficult for the person to breathe, and this concern is heightened when dealing with ED." Therefore, once control is achieved, "the subject should be placed on his side if this can be done without creating an unreasonable risk to officers or others. As soon as he is controlled, hand him off to the medics."

9. The goal is to get the subject into the hands of Advanced Life Support personnel or into a hospital as quickly as possible. Ideally, do not transport ED subjects in a police car. "They should be transported to a hospital in an ambulance," unless waiting for an ambulance would cause unreasonable delay. Officers should train in advance with EMS on how these individuals should best be placed on and secured to a stretcher.

10. Medical personnel should have protocols for dealing with ED cases, including the possibility of considering the prompt use of "chemical restraint" (powerful tranquilizing agents) to bring them down from their state of extreme agitation and violence. "At the very least, medical personnel are better equipped to intervene than police officers would be if there is a cardiac event."

Lawrence characterizes Everett's recommendations as "a forward-thinking attempt to advance our understanding and response" to ED. But he stresses that there are still many mysteries about this syndrome and that these suggestions should not all be regarded as guaranteed lifesavers.

For example, delaying physical control attempts until more officers and medical personnel are on hand may, in fact, permit a subject's condition to worsen, although Lawrence agrees that waiting will likely be more prudent from an officer-safety standpoint.

Similarly, rolling a subject onto his side after he is controlled in the prone position will not necessarily prevent his dying, "since we don't really know what is killing these people," Lawrence says. However, he agrees with relieving pressure on the subject's respiratory system in that manner, provided that his legs are securely restrained to prevent him from kicking officers. Also, he reminds, the subject needs constant monitoring after being "controlled," given the ability of many suspects to defeat seemingly secure behind-the-back handcuffing. (Although some medical critics of police tactics object to using the prone position to gain control because of its potential restriction on breathing, Lawrence says he has never found a critic who could suggest an effective alternative. Even the premise that prone positioning is related to ED deaths continues to be

debated.)

Also, Lawrence points out, in remote locations where distance and lack of ready availability may delay the arrival of paramedics, it may be safer to quickly transport an ED subject by squad car to a hospital than to wait at the scene for an ambulance and field medical personnel. "Officers need to assess the circumstances and do what they think is most appropriate," he advises.

Everett agrees that his recommendations should be considered only "starting points" and that officers, trainers and agencies are "well advised to continue monitoring ED research for further developments and insights.

"As more research is done, the best practices will become clearer, and over time these will become the basis against which the profession is measured.
Agencies that don't keep their training current will inevitably be compared with those that do when there's a lawsuit."

To assist in understanding and preparing for ED intervention, you may want to view a video training program developed by the Las Vegas Metro P.D. and posted on the internet at http://media.cchd.org/ems_excited_delirium.htm.
This presentation includes vivid recreations of ED encounters, plus a post-training test.

Also a comprehensive report on ED, prepared by Sgt. Darren Laur of the Victoria (BC) P.D., is available through the Canadian Police Research Centre at:

http://www.cprc.org/tr/tr-2005-02_e.pdf

Chris Lawrence has published an article on the proper protocol for investigating sudden in-custody deaths, available from the archives of The Police Chief magazine at:

http://policechiefmagazine.org/magazine/index.cfm?fuseaction=display_arch&article_id=191&issue_id=12004

FSN readers can contact Lawrence directly at elginsci@execulink.com for a copy of a form he has designed to guide such investigations. He is currently designing another form which will aid first responders in capturing "transient evidence" of ED episodes at the scene. This is expected to be published and posted by the Canadian Police Research Centre by the end of this month [10/05].

The CPRC also features a significant section on ED in a report of a year-old study of Taser use. This report can be viewed at www.cprc.org/tr/tr-2006-01.pdf

An information bulletin called "Law Enforcement Responses to Excited Delirium," which contains Everett's recommendations and background on the ED phenomenon, is scheduled to be accessible: www.lmnc.org by the end of the week of October 10.

"Sudden Deaths in Custody," a book that deals with ED, is scheduled to be published next January ['06] by Humana Press. Authors are Darrell Ross of East Carolina University and Ted Chan of the University of California-San Diego.

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NAKED SUSPECT INFO PAYS DOUBLE FOR THREATENED OFFICER

When Sgt. Drury Bishop read our report last April about the exceptional danger posed to officers by naked suspects, he decided to share it with his patrol platoon on the Anne Arundel County (MD) P.D.

Scarcely a month later, his newest officer, a 22-year-old rookie fresh from field training, came face to face with a violent nude offender and drew on the information to defend himself with 4 rounds from his Sig-Sauer 229 .40-cal. when the suspect lunged for his throat.

Now the report has been used again--this time in testimony before a grand jury investigating the shooting. "I'm sure it helped," Bishop told Force Science News. Last month [9/16/05], the panel cleared the officer of any wrongdoing.

The shooting evolved from a dispatch one evening last May to a townhouse in a low-income neighborhood in Glen Burnie, MD. A 20-year-old subject who was living there with a relative was said to be in "a delusional state," using drugs, "claiming people were after him" and otherwise behaving strangely.
During one phone call from the residence to police, gunshots could be heard in the background, Bishop recalls.

Later the subject's family would claim he was on the verge of "turning his life around," but on that Tuesday he was still headed in the wrong direction. When Bishop and other responders arrived they found that "6 or 8 9mm rounds had been fired through a bathroom door." Some of these had penetrated the common wall to the adjoining townhouse where, fortunately, no one was home.

"The subject had jumped out of a second-floor bedroom window, landing in the backyard," Bishop explains. In scrambling over a 6-foot wooden privacy fence, he snagged his shirt, which he wiggled free of and left hanging there as he fled across several other properties.

"In a neighboring street, he jumped into a van occupied by 2 males and screamed for them to take him away," says Bishop. To reinforce his demands or to carjack the vehicle, he reached toward his waistband, apparently intending to brandish his gun. He discovered he no longer had it. During their investigation at the townhouse, officers recovered the weapon near where he had hit the ground after his leap from the window.

The suspect then bailed from the van and ran into nearby woods, disappearing from sight.

Rookie Officer Tommy Pleasant was among patrol personnel canvassing the area by car when he spotted the suspect hiding behind an electrical box near a roadway. "By this time the guy was stark naked," apparently having stripped off the rest of his clothing in the woods, Bishop says.

Pleasant exited his unit and at gunpoint commanded the suspect to get down on the ground. Instead, Bishop says, the man, sweaty and muscular, "charged at him. Pleasant retreated backward, trying to give himself more time and distance, but the subject kept coming, and lunged for the officer's throat."

Pleasant fired 4 fast rounds, all hits. One struck the subject in the face, the others in the shoulder and lower torso. "The autopsy revealed that all the shots were at a downward angle, indicating the subject was leaning forward-lunging," Bishop says. "He had enough 'road rash' to indicate he was moving quite rapidly when he hit the pavement."

This contradicted the statement of one eyewitness who claimed the naked man was "trotting toward the officer, with arms outstretched as if pleading for help." Other witnesses supported Pleasant's version of things.

At the station after the shooting, Bishop pulled a copy of the article on naked suspects from his files and asked Pleasant if he remembered it.
Indeed he did, Pleasant replied, as well as the training session that Bishop had fashioned around it for the platoon. "He said the information flashed through his mind as soon as he saw the subject was naked," Bishop recalls. "He told himself, 'This guy is trouble.'"

Among other things, the article quoted Dr. Bill Lewinski, executive director of the Force Science Research Center at Minnesota State University-Mankato, as saying, "The vast majority of police contacts with mentally ill subjects are nonviolent. But naked people are among those categories that are particularly difficult...[T]he chances are overwhelming that they're in the midst of a full-blown psychotic episode...and potentially very dangerous."

See Force Science News #16 ("Naked Suspects: No Laughing Matter") at:

http://www.forcesciencenews.com/home/detail.html?serial=16

Per protocol, Pleasant's shooting was reviewed by a county grand jury.

During the proceeding, the state's attorney asked Bishop to read the full FSN article to the jurors, who listened attentively. When they voted a no bill afterward, that ended all criminal investigation of the encounter.

A lawyer for the dead man's family responded bitterly. "It seems like the only time when they go into a grand jury and come out without an indictment is when they go in with a police officer's case," he told a reporter.

But Pleasant's attorney observed, "Until you've been in the position he's been in, it is easy to second-guess."

"Naked people continue to be a threat to officers," Lewinski says. He is currently involved as an expert in 2 fatal naked-subject shootings, one in Michigan, where the officer has been charged criminally, and the other in Oregon, where a grand jury is investigating circumstances that have sparked significant local controversy.

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