

# Hidden danger

Little is known in the UK among police officers about a medical condition called excited delirium syndrome. But it could cost a life if not quickly identified. Kevin Huish, Federation lead on custody matters, writes

Police officers are under increasing scrutiny in relation to deaths during or following police contact and anything that can help prevent such a tragedy occurring is paramount. Both myself and John Coppin from the Federation attended the Annual Conference of the Institute for Preventing Deaths In Custody in America and this proved incredibly useful in highlighting a number of issues, including the existence of a psychiatric condition caused by drug abuse called 'excited delirium' (ED) that UK officers should be aware of.

In 2008 to 2009 there were 92 deaths during or following police contact, the details behind these figures are multifaceted but there is little information available on whether excited delirium syndrome was present in any of these cases as there is so little information available in the UK.

Excited delirium has been on the Federation's radar for sometime and we were aware of a DVD of a scenario being circulated to forces in the UK some time ago, but since then what developments have there been, what's changed? The simple answer for the UK is not a lot. This may be partly because we have not seen the apparent rise in the numbers of deaths due to this syndrome as our colleagues in the US have. I say apparent rise as we may and probably have had some deaths where ED could be suspected and be a major contributing factor but there are real



difficulties in knowing for sure. This is mainly due to a lack of knowledge, understanding and even existence of ED within the British medical profession. Because of this lack of acceptance there is no specific training for medical staff and therefore the rapid actions required to identify possible indicators and treatments aren't undertaken and post mortems do not look for any of the potential signs.

### So what is Excited Delirium Syndrome (EDS)?

Two definitions are:

**'Excited Delirium is at the end of a spectrum of adverse psychiatric conditions due to drug abuse.'** (Dr D Mash 2007)

**'When delirium involves combative and/or violent behaviour, it is termed excited delirium.'** (Dr Di Maio & Di Maio 2009)

What the definitions above do not tell us is that in most circumstances ED is a very serious life threatening medical emergency disguised as a police problem. When the public see a person behaving in a strange manner ie; taking their clothes off, shouting, screaming and smashing things their first response is naturally to call the police. The focus is therefore put on to the subject's behaviour, any offences they may be committing and the medical emergency overlooked. The reality is that ED is a serious condition that requires immediate medical intervention in order to save the subject's life. Any offences that have been committed by the subject can be dealt with in due course.

Until fairly recently, with a few very prominent exceptions, the medical profession in the USA were also very sceptical about the existence of excited delirium as a condition. In 2008 that began to change when the American College of Emergency Physicians (ACEP) set up a task force to study excited delirium in order to determine whether it existed or not, and if so then go on and identify characteristics that would help identify the presentation (of ED) and the risk of death being the outcome from excited delirium. They were also to study emerging methods of control and treatment.

The ACEP taskforce published a white paper in September 2009 where they accepted that excited delirium exists and classified it as a syndrome in its own right, not a disease, but a collection of symptoms. This recognition by a highly respectable medical college is a very important step forward for the wider medical world to accept and recognise EDS as a very real condition.

This recognition is already having great impact in the US both within law enforcement and emergency medical services. Emergency medical services have developed emergency treatment protocols for use both within emergency departments and when working alongside their law enforcement colleagues in the field.

American police colleagues have developed a range of joint training programmes that cover all aspects of an incident from the first call to resolution. This training is delivered to

despatch (control room) operators, officers, coroners and emergency medical services, is wide ranging but crucially includes attendance protocols with emergency medical services.

The major culture change that has and is taking place in the US is that ED is now being responded to properly as a life threatening medical emergency and not only as a police problem. A key protocol that in place is that when an EDS is suspected a minimum of four officers and a sergeant are despatched along with emergency medical services, they meet at a predetermined point and together formulate and execute a plan to restrain and control the subject for life saving treatment to be administered.

**“The reality is that ED is a serious condition that requires immediate medical intervention in order to save the subject's life.”**

Here in the UK we have the opportunity to learn from the experiences of our American colleagues, to look at their protocols and training programmes and then adapt them to suit our environment and legislation. There will be some hurdles to overcome a major one being a possible change in legislation to allow UK police officers to restrain a subject for medication to be administered.

The first step required is the acceptance and recognition by the UK medical profession that EDS is a very real condition. The question is how do we go about doing that? A recent European study in Spain will help, the study, conducted at the Institute of Legal Medicine in Seville, Spain, surveyed forensic autopsies of 1,114 natural deaths. Roughly 60 percent (668) met the criteria for being sudden and unanticipated and acknowledges the existence of EDS.

Dr Bill Lewinski, from the Force Science Research Centre, said: “It is important to note that among the causes of death listed by the investigators in this study is excited delirium. They do not elaborate on this, other than to describe it as ‘a syndrome characterized by psychosis or delirium accompanied by agitation and hyperthermia.’ But they do tacitly acknowledge that it does exist as an identifiable condition, capable of resulting in death, the same as heart, brain, respiratory, and metabolic disorders.”

Following this conference and our subsequent report the Federation is currently undertaking work to formulate a strategy which we intend to lead to recognition and acceptance of excited delirium syndrome by the British medical profession, training for both officers and emergency medical staff and the development of joint protocols between all agencies involved. These are far reaching ambitious goals and we are under no illusions as to the difficulties and work required to bring them to fruition.

● For further information click on:

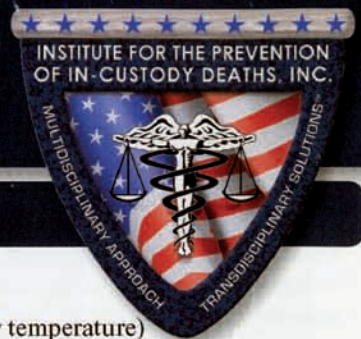
<http://www.polfed.org/sergeants.asp> and

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## Excited-Agitated Delirium & Sudden In-Custody Death

Excited Delirium (ED) • Agitated Delirium (AD)

### IPICD Roll Call Mini-Poster™



In 1849, symptoms of what is labeled *agitated or excited delirium* were described in the United States by Dr. Luther Bell.

The term *excited delirium* is found in an 1881 U.S. medical treatise. It was popularized in the 1980s by Dr. D. Fishbain and Dr. C. Wetli when they described a category of symptoms seen in some people after they had ingested stimulants (usually cocaine): delirium, bizarre behavior, violent struggle, often followed by death. Causes of excited delirium include *metabolic* (e.g., low blood sugar), *pharmacologic* (e.g., cocaine), *infectious* (e.g., meningitis), and *psychological* (e.g., underlying mental illness). [See *Pre-Disposing Factors*.]

#### Sudden In-Custody Death

The United States' *Death in Custody Reporting Act* defines an in-custody death as: the death of any person who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal or county jail, State prison, or other local or State correctional facility (including juvenile facility).

#### Four Phases of Excited Delirium

- Hyperthermia (may not always be present).
- Delirium with agitation (acute onset).
- Respiratory arrest (distress often during/after struggle).
- Cardiac arrest (often during/after restraint).

#### Who Is At Risk?

- 91%-99% male
- 31-45 years of age (generally)
- Person usually involved in a struggle
- Geographic location not a factor
- Death usually follows bizarre behavior episode, and/or use of illegal drugs or prescription medications

#### Behavioral Cues

Typically these visible behaviors and physical manifestations are guided by a hidden stimulus (e.g., cocaine, methamphetamine, Ecstasy, hypoglycemia, mental illness, etc.), either consciously or unconsciously.

#### Sudden Death: Pre-Disposing Factors

Studies show most of these factors will remain *invisible and unknown* until medical intervention and/or autopsy.

- Under the influence of alcohol or withdrawal
- Past use or under the influence of illicit drugs (i.e. cocaine, methamphetamine, Ecstasy, PCP, LSD)
- Failure to take prescription drugs (or took too much)
- Dehydration
- Hypoglycemic (low blood sugar)
- Epilepsy
- Head injury (prior or current)
- Underlying psychiatric disease (e.g., paranoid schizophrenia)
- Cardiomegaly (enlarged heart)
- Small vessel wall thickening
- Coronary atherosclerosis
- Fibrotic scar tissue

#### Excited-Agitated Delirium: Physical Characteristics

- Dilated pupils
- Profuse sweating (possible sign of high body temperature)
- Hyperthermia (in most cases, but not always)
- High core body temperature (103° F to 110° F; 39.44° C to 43.33° C)
- Skin discoloration (e.g., flushing)
- Large belly (may indicate alcoholism)
- Foaming at mouth (rare, but could be visible)
- Uncontrollable shaking, shivering (e.g., substance withdrawal)
- Respiratory distress (difficulty in breathing)

#### Excited-Agitated Delirium: Person's Behavioral Cues (based upon case studies)

In the presence of behavioral cues, **struggling or resistance** can indicate an immediate **MEDICAL EMERGENCY**, which takes precedent over criminal prosecution.

#### Psychological Behaviors

- Demonstrates intense paranoia (e.g., fearful; hiding)
- Demonstrates extreme agitation
- Rapid emotional changes (e.g., laughing, crying, sadness, anger, panic, etc.)
- Disoriented about place, time, purpose
- Disoriented about self (visions of grandeur)
- Hallucinations (e.g., hears voices, talks to invisible people and/or inanimate objects)
- Delusional
- Scattered ideas about things
- Easily distracted (cannot follow commands)
- Psychotic in appearance
- Described as "just snapped" or "flipped out"
- Makes people feel uncomfortable (including officers)

#### Communication Behaviors

- Screaming for no apparent reason
- Pressured, loud, incoherent speech (mumbling)
- Grunting; guttural sounds
- Talks to invisible people
- Irrational speech

#### Physical Behaviors

- Demonstrates violent behavior (e.g., toward others or objects)
- Demonstrates bizarre behavior
- Demonstrates aggression toward inanimate objects (e.g., glass, mirrors, shiny objects and materials, rotator lights)
- Running into traffic (e.g., at parked or oncoming cars)

**Excited-Agitated Delirium & Sudden In-Custody Death (Continued)**

- Running for no apparent reason
- Running wildly
- Naked (trying to get cool)
- Stripping off clothing (trying to get cool)
- Apparent superhuman strength
- Seemingly unlimited endurance (fails to get tired)
- Resists violently during capture, control and restraint
- Resists violently after being restrained
- Muscle rigidity (e.g., stiff arm may not be resistance)
- Diminished sense of pain (e.g., OC may not work)
- Insensitivity to pain (e.g., baton strike(s) ineffective)
- Self-induced injuries (e.g., cuts self with sharp objects)
- Says “I can’t breathe” (indicative of respiratory distress, escalating into respiratory arrest spiral—exhaustive mania)

These behavioral cues only help identify the person as an elevated-risk candidate for a sudden death, but are not a clinical diagnosis. In most situations, **only 1 cue** is needed to request EMS, back-up officers, etc.

**A MEDICAL CRISIS™ Mnemonic**

(Developed and © by John G. Peters, Jr., Ph.D., CLS, IPICD, Inc.)

- A**cute onset (rapid; person “just snapped; “flipped out”)
- M**ental health issues (e.g., schizophrenia)
- E**xcited, Extreme agitation, Emotional changes,
- D**elusional, **D**isoriented, **D**istracted
- I**nsensitive to pain; **I**nvisible people
- C**all EMS, back-up officers, and supervisor to scene
- A**ggression toward objects (especially glass, mirrors)
- L**arge belly; **L**oud, incoherent speech, screaming
- C**onfused, disoriented about self
- R**esists violently, before, during, after restraint
- I**can’t breathe (may indicate respiratory issues)
- S**trips off clothing, naked; **S**weating profusely
- I**ntense paranoia
- S**uperhuman strength; **S**eemingly unstoppable; **S**truggles

**Action Steps**

The person experiencing the downward spiral toward sudden death cannot be medically treated until (s)he is captured, controlled, and/or restrained. Assistance is often not requested until the person has reached a critical (life-threatening) point.

- **Dispatcher Role:** Identify possible behavioral cues and related information from caller, dispatch officers, EMS, supervisor, and begin incident documentation (for detailed reports).
- **Assess scene:** Identify immediate safety concerns. If safe and reasonable, conduct a visual scan of the area, looking for cover, for concealment, and for others who may be experiencing a medical crisis.
- **Plan:** If safe and reasonable, discuss the following steps with other officers and EMS providers who should be at the scene.

- **Capture the person:** Do this safely and quickly to minimize stress to the person and others at the scene. Capturing tools include, but are not limited to: electronic control devices (ECDs) (e.g., TASER® M/X 26), pepper spray, multiple officer tactics. To minimize injury to all parties, TASER ECDs have been shown to be the most effective for quickly capturing this category of individual.
- **Control the person:** Quickly and safely control the person, even if (s)he is *under power* of ECDs.
- **Restrain the person:** Quickly and safely restrain the person, even if (s)he is *under power* of ECDs. Restraints may include metallic, plastic, or nylon devices. Do not permit the person to remain in the prone position (roll onto the side, or sit upright, if safe and reasonable).
- **Chemically sedate the person:** Chemical sedation should reduce the person’s stress and exertions, and also the stress of others who are involved in the capture, control, and/or restraint process. Only paramedics who are authorized can chemically sedate the person. Emergency Department medical doctors may restrict such chemical sedation until the person arrives at the hospital.
- **Transport the person:** Quickly and safely transport the person in an ambulance to a hospital. If no ambulance is available, transport immediately to the hospital in a patrol vehicle, with a second officer who will monitor the individual. Make sure the person is seat-belted inside the vehicle, and is not lying prone and is constantly monitored.
- **Investigation/Psychological Autopsy:** Conduct an in-depth forensic investigation to include the chronic, long-term, past, and current illicit substances and prescription medication(s) used by the person. A Psychological Autopsy includes a reconstruction of the person’s life for a pre-determined timeframe, and includes a complete mental health and/or mental illness history and assessment.

**Force Issues**

When attempting to *capture*, *control*, and *restrain* a person who is suspected of being in an excited-agitated delirium state, remember that each situation is unique, tense, rapidly evolving and uncertain, even though there are commonalities that have been identified through medical, psychological, and statistical research. There are also many unknowns about these subjects.

The force used to seize a free person must be objectively reasonable based upon the totality of the circumstances reasonably perceived by the officer at the moment the seizure occurs, unless state law is more restrictive.



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Institute for the Prevention of In-Custody Deaths, Inc.  
209 South Stephanie Street • Suite B-249  
Henderson, Nevada USA 89012

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