Excited-Agitated Delirium & Sudden In-Custody Death

Excited Delirium (ED) • Agitated Delirium (AD) • Acute Behavioral Disorder

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 (103º F to 110º F; 39.44º C to 43.33º 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)

Design and layout: Christopher J. Loretz

- 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, **E**xtreme agitation, **E**motional 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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