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Letters to the Editor

Restraint Asphyxiation

To the Editor:

O'Halloran and Lewman wrote an excellent paper on the causes and mechanisms of death resulting from restraint asphyxiation in excited delirium (1). I agree with their interpretations of the physiological stresses and the fatal interplay of increased oxygen demands, catecholamine stimulation, and decreased oxygen delivery due to postural compromise of ventilation and respiration.

All but one of the 11 reported fatalities were certified as accidental (the 11th death was "manner undetermined"). The authors go on to state, "It seems reasonable to consider these accidents rather than homicides since prone, hogtied restraint was not generally considered 'potentially lethal force' by most police departments in the recent past." I have a contrary point of view about the manner of such deaths.

"Homicide," as used by medicolegal officials in manner-of-death determinations, is a generic term that includes various degrees of murder, manslaughter, and criminally negligent homicide, as defined by law. The legal definitions of each species of homicide are not useful as criteria for the medicolegal official, because we do not classify homicides as some degree of murder or manslaughter. Also, in most jurisdictions, the medicolegal official is neither empowered nor required to subclassify homicides as either justifiable or culpable. In other words, the medicolegal official makes an administrative decision to classify a death generically as homicide when that death occurs at the hand of another person or from the illegal act of another person (usually exclusive of motor vehicle fatalities, other than those in which an assailant uses a motor vehicle as a weapon to kill intentionally). Classification of a death as a homicide does not require that the "assailant" used what might be "generally considered potentially lethal force." Many vulnerable persons have had fatal outcomes from the application of force that would be nonlethal to the general population. Further, our administrative classification of a death as homicide is not legally binding on the police, prosecuting attorneys, or other participants in the criminal justice system.

Bearing in mind the foregoing limitation of the consequences of our manner of death determinations, I believe it prudent and appropriate for medicolegal officials to consistently classify as homicide the type of deaths reported by O'Halloran and Lewman. Making that classification in a nonjudgmental, nonaccusatory fashion transfers each such death to the criminal justice system for legal evaluation that usually involves a presentation to a grand jury, a procedure that can be followed regardless of the medicolegal classification of the manner of death.

Consistency of classification is crucial if the medicolegal official is to be an unbiased, objective participant in the criminal justice process. We must be aware that we may not be in possession of all of the relevant information about a death; that we do not receive testimony under oath, on the record; and that we do not have the last word in adjudicating criminal or civil controversies arising from the deaths that we investigate. Furthermore, we ought never to place ourselves in a position where we make a classification of accident because the police restrained someone, in contrast to a classification of homicide if a civilian similarly restrained someone.

Deaths in police custody have a propensity to become high-profile, contentious issues of great public concern. I believe that medicolegal officials serve the public interest best and most credibly by acting neutrally and consistently.

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REFERENCE

1. O'Halloran RL, Lewman LV. Restraint asphyxiation in excited delirium. *Am J Forensic Med Pathol* 1993;14:289–95.

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Letters to the Editor

The Authors' Response

To the Editor:

We wish to thank Dr. Hirsch for his comments about our article on restraint asphyxiation. Our primary goal was to raise the level of awareness about prone restraint as a causal factor in some custody deaths.

Dr. Hirsch raises the important and often contentious issue of manner of death certification. He suggests that deaths such as the 11 we reported should be certified as homicides by medicolegal officials because they are deaths "at the hand of another person." We wish to clarify that ours was a retrospective collection of case reports from several jurisdictions and that the manner of those deaths was certified long before our paper was written.

When a person's death is caused in whole or in part by the actions of another person, the question is raised whether the death should be certified as a homicide. We, as medicolegal officers, lack a nationally accepted workable definition of homicide. Most states simply define homicide by its various legal subcategories of murder, manslaughter, justifiable homicide, and excusable (or accidental) homicide for use by the criminal justice system. The general public and the press tend to equate homicide with murder.

In the particular case of positional asphyxiation deaths from prone restraint while in police custody, Luke and Reay (1) suggest a classification of accidental. That opinion may change as information about the potential lethality of prone restraint is disseminated and the law enforcement community can reasonably be expected to know that death may result from this procedure.

Until such time as we have a national consensus or definition of what a homicide is for purposes of death certification, it is the responsibility of each medicolegal officer, office, or system to establish its own definition. No matter what definition is used, in complex cases there will be controversy. We agree with Dr. Hirsch that the definition should be applied uniformly whether or not police are involved.

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REFERENCE

1. Luke JL, Reay DT. The perils of investigating and certifying deaths in police custody. *Am J Forensic Med Pathol* 1992;2:98–100.

Subendocardial Hemorrhages

To the Editor:

The paper by Dr. Harruff (1) entitled "Subendocardial Hemorrhages in Forensic Pathology Autopsies" was noteworthy because it pointed out the high incidence of subendocardial hemorrhage in head-injured patients and warned cardiac transplant physicians of the possibilities of cardiac dysfunction in heart transplant recipients. However, the author did not indicate the nature and extent of resuscitation in his 43 cases, with particular reference to administration of epinephrine or norepinephrine and defibrillation. It is widely known—and indeed is indicated in the discussion section of this paper—that iatrogenically administered catecholamines and cardiac defibrillation may produce subendocardial hemorrhage. Is it possible that some or all of his 43 patients had subendocardial hemorrhage as a result of catecholamine administration or defibrillation received during resuscitation?

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