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Beat-1 with Chris Lawrence
10/28/2005

[CHAS'REVIEW COMMENTS = YELLOW HIGHLIGHTED & between brackets!]

PoliceOne Exclusive: The varied faces of excited delirium

Most of the police related literature associated to excited delirium (ED) usually starts with a description of a "typical event." Police arrive at a disturbance call and encounter a partially clothed or naked subject, soaked in sweat. He (ED almost exclusively involves men*) is often depicted breaking glass, and/or banging on doors and windows. The subject is described as impervious to painful stimulus, including pepper spray and exhibits extraordinary strength, particularly during the ensuing struggle with responding officers.

[*Yes. The "reported" cases of ED almost exclusively involve men – but, women also have died from restraint asphyxia following excited delirium. Those women were "almost exclusively" obese. Yet, because women of all sizes suffer the same kinds of medical and traumatic emergencies that cause excited delirium as men do, one cannot help but wonder if female ED victims are simply treated differently than male ED victims when it comes to the application of force and restraint.]

Regardless of the control method used or control option deployed the subject suddenly becomes calm once subdued.* Upon closer inspection officers notice the subject has stopped breathing. Resuscitation efforts are almost universally unsuccessful.

[*Had SUPINE control methods or options been deployed (or, had the handcuffing officer held her/his breath during handcuffing and RELEASED the subject from forceful-prone-restraint when the Officer HAD to take a breath), no subject would have suffered restraint asphyxia. Thus, this statement is inaccurate.]

The fact is ED events do not always follow this pattern. There appears to be a subset of subjects who provide few, if any cues that they are about to experience a full blown ED type event. Officers are able to talk with these subjects, who despite their worsening condition, are able to provide reasonable responses to police inquiries. This subset of subjects may provide few outward clues of the explosive behavior about to occur.

The following case studies arose during a recent research project.

Case 1

Officers attended a disturbance call at an apartment building. Upon arrival they found an apartment considerably damaged and the resident absent. As the officers began to search the home's interior the subject returned, perspiring profusely, out of breath, yet "sounding quite reasonable." He walked to the fridge, removed a large pitcher of water, drank it, and went into the bathroom. The officers spoke with him and learned that he was the resident. One of the officers was aware of the subject's mental health issues and was able to convince him to go to the hospital.

Upon learning that he would be transported in an ambulance rather than a police car the subject suddenly attacked. A substantial struggle followed which exhausted both original and backup officers. Once successfully restrained the subject continued to struggle until he suddenly went limp. Resuscitation efforts were unsuccessful.

Case 2

Several officers responded to a disturbance call in an apartment building. The subject was found with his shirt and shoes off, trying to breach the door to his residence. Although the subject's initial responses were unusual he did respond to the officer's inquiries.

The officers were able to convince the subject to cease his actions, put his shirt and shoes back on, and have a cigarette. The subject consented to the suggestion that he attend the hospital for a check up. The subject was not touched by the responding officers. Upon reaching the front lobby of the building, the subject suddenly bolted into the street.
During the ensuing struggle the subject exhibited extraordinary strength, was impervious to pepper spray, and died suddenly and unexpectedly.

Case 3

Police attended to check on the well being of a subject's family member after a call from concerned neighbors. The subject was known to suffer from a mental illness that involved sudden onset of paranoia. During the investigation the subject returned to the residence, where he engaged in a calm discussion with both police and medical personnel. The subject's behavior changed suddenly and he attacked one officer. A struggle followed and the subject was restrained in handcuffs and his feet immobilized through the use of a belt. The subject was checked by a physician who was on scene and involved in the investigation. The doctor determined that the subject had a rapid, strong pulse. The subject was turned onto his back and found to be unresponsive. The subject died suddenly and unexpectedly despite the presence of a physician.

Case 4

Police were called to investigate a naked man, who had boarded a transit bus. The person had been outside in subfreezing temperatures. He was found sitting on the bus, requesting to be taken to hospital.

The responding officer spoke with the subject who again asked to be taken to the hospital. Upon the arrival of a second officer, it was determined upon the totality of the circumstances that the subject should be taken to the hospital immediately. The subject was placed in the back seat of the police car after a brief struggle. Staff at the hospital saw the subject moving in the rear seat area of the police car as they opened the car door. Immediate checks found the

subject without pulse and no longer breathing. He died within 20 minutes of arriving at the hospital.

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Excited delirium reports often link the incident to bizarre subject behavior that results in a police response. While this feature still remains true there seems to be a sub-set of people who, with the clarity of hindsight, were involved in unusual or occasionally bizarre behavior. However, the officers initially interacting with the subject are able to converse in a relatively normal manner with the subject, who is able to give reasonable responses to the incident at hand. The change in behavior is sudden, as in the above cases, without any overt provocation. When the behavior does change it is rapid and dramatic with the subject initially engaging in either fight or flight type behavior. The classic signs of ED arise during the altercation, at a time when it is difficult for the officer to assess the totality of the situation. In the above cases death occurred after the use of empty hand tactics, pepper spray, and baton use. TASER™ devices were not involved in any of these cases.

[I wholeheartedly AGREE with Chris about the possibility that – at times – an excited delirium victim may “appear” to be behaving or discoursing in a “normal” manner.

So what should law enforcement personnel take from these cases? Does this mean that we are to treat each citizen as someone who may suddenly explode into a state of ED?

[NO. Because excited delirium victims are universally found to be “incredibly strong,” and universally RESIST RESTRAINT, it means that must be especially vigilant when having to ***STRUGGLE*** to put handcuffs on someone. In those cases, while the incredibly strong subject is being forcefully-prone-restrained for handcuffing, the handcuffing officer SHOULD HOLD HER/HIS BREATH. If the handcuffing officer has to take a breath BEFORE the handcuffs are successfully attached, the attempt to handcuff must be ABANDONED, and the subject must IMMEDIATELY be rolled to her/his side. Once the handcuffing officer has recovered (SAME OFFICER!), then the handcuffing process can be attempted again.]

The purpose of providing this information is to illustrate the variety of conditions under which ED incidents can occur and to make officers aware that these types of situations do in fact occur. Part of the problem that police officers and their agencies face is the critics, the "watchers and waiters" who think that the issue of ED is based on poor or "cloudy science." These situations seem to occur under a variety of conditions. The better we understand the problem the greater the likelihood that we, as a police community, will be able to develop strategies to reduce sudden and unexpected deaths to the extent possible.

There are likely other situations that followed a similar evolution of events. Unfortunately these types of events have not been catalogued, or tracked in any consistent manner.

If anyone has experienced cases where a "classic excited delirium" event unfolded in a non-typical manner, and you want to share the information, you can always e-mail me and your information may contribute to future columns.

Note: The opinions expressed are those of the author and do not necessarily reflect the opinions or policies of the Ministry of Community Safety and Correctional Services or the Ontario Police College.

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with Chris Lawrence

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Chris' teaching experience started in 1983 and includes training related to his assignments, including 4 years as adjunct faculty at Sheridan College in Brampton, Ontario and 10 years as a consultant in the security industry. He became a full-time staff instructor at OPC in 1996.

Chris has a Master of Arts degree in Leadership and Training from Royal Roads University in British Columbia, and is a Technical Advisor to the Force Science Research Center, Minnesota State University-Mankato. He has testified regarding use of force training and subject control in Canada and the United States and has published and presented on the subject of police use of force and sudden deaths throughout North America and in Australia.

- ***PoliceOne Exclusive:*** Excited Delirium and its medical status - 01/20/2006
- ***PoliceOne Exclusive:*** The varied faces of excited delirium - 10/28/2005