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with Force Science Institute

Special protocol for ExDS response is valuable liability shield

With the symptoms and dangers of excited delirium now well-publicized and solidly confirmed by numerous research studies, agencies that fail to have a response protocol in place are inviting needless liability problems, according to a day-long presentation recently at a training seminar sponsored by the Illinois Tactical Officers Association.

"Usually administrators start to take notice of this problem when they have a sudden in-custody death," said the featured speaker, Lt. Michael Paulus, a certified Force Science Analyst and 25-year veteran of the Champaign (Ill.) PD. "But that's too late. Agencies need to change their approach and get ahead of this problem in order to have different results.

"It doesn't cost big bucks to put an effective protocol in place, it doesn't require new equipment, and it's much more cost-effective than settling or losing a lawsuit. As education about excited delirium spreads, it gets harder for agencies to say they didn't know about the problem and the need to address it."

To illustrate how a "model" program might be developed and put into practice, Paulus drew on the experience of his own department and surrounding agencies, whose procedures he also described during a panel on excited delirium syndrome (ExDS) at the annual conference of the International Assn. of Chiefs of Police last fall. He credits Force Science instructor Chris Lawrence, a recognized authority on ExDS, with helping to craft those policies.

As is often true in law enforcement, the measures were reactive to unfortunate controversy, Paulus explains. In a series of violent encounters across a seven-year period, two "extremely agitated subjects" died in custody in Champaign and neighboring Urbana and others were "near-misses" for fatal outcomes after intense struggles with police, not uncommon occurrences in the history of documented ExDS cases.

After whip lashings by the media and, in one case, a significant payout to settle a lawsuit, Paulus persuaded his administration to let him organize planning and training on the ExDS issue before another "HSM" (Holy Shit Moment), as he terms it, rained blame on the department.

It took him nine months to complete the assignment, but since the countywide protocol was instituted, Paulus said there have been 27 "incident responses" in the area — with no subject deaths occurring.

Here are what he considers the system's key components.

Multidisciplinary Involvement
"Would you send the fire department to handle a burglary in progress or EMS to a bank robbery? No!" Paulus declares. "But what on a cop's belt lets him handle metabolic acidosis, hyperventilation, or hyperthermia, conditions believed to be common to extremely agitated subjects?

"We are not sending the right resources to deal with a life-threatening medical emergency that presents itself as a law enforcement problem and we wonder why these subjects end up dead?"

An effective protocol requires multidisciplinary input, training, and support — "a paradigm shift in thinking," Paulus says, "because the police alone can't likely get the best results."

To win essential stakeholder buy-in for a new, coordinated approach, Paulus recruited more than 40 decision-makers from a panoply of interest groups throughout his county for briefing sessions on the nature of ExDS and "best practices" for managing these challenging events.

Included were representatives of law enforcement, corrections, EMS, fire/rescue, telecommunications, hospital ER staffs, mental health/behavioral services providers and consumers, the local state's attorney, the coroner, the medical examiner — even, eventually, the media so that procedures could be explained to the general public.

"Everyone was encouraged to offer input to the ultimate plan," Paulus says. "Then these leaders spearheaded training for their own constituencies to instill the skills they needed to make the 'big picture' work, and to understand everyone else's role as well." All LEOs in the county, for example, received two hours of classroom instruction and 2two hours of hands-on exercises, with dispatchers getting two hours' training of their own.

Simultaneous Dispatch
Dispatchers are critical to the success of the protocol. They are trained on when it's appropriate to probe 911 callers for indications of possible ExDS at a trouble scene, such as subjects shedding clothing; breaking glass; raving incoherently or seeming delusional; displaying "superhuman" strength; acting highly agitated, aggressive, paranoid, or confused.

"EMS needs to be dispatched at the same time as law enforcement, preferably with an advanced life-support ambulance," Paulus says.

In some communities by law, a fire/rescue truck must also be sent on any EMS dispatch.

If officers call in from a scene having encountered a suspected ExDS situation without prior warning, dispatchers get EMS en route immediately.

Police Role Defined
"Ideally, everyone should get to the scene at the same time," Paulus says. "If police arrive first, they should try to contain the situation, talk to the subject in an effort to calm him, and — if possible — wait for EMS before laying hands on. This is a medical crisis and the medics should be regarded as the primary responders."

The role of the police will be to "capture, control, and restrain" so that medical attention can begin, Paulus says. If they unnecessarily intervene too soon, "they may make the problem worse."

Restraint Cooperation
At the scene, officers and EMS confer briefly to develop a plan. The medical team needs to park where they can observe the subject, to assess his level of agitation. If paramedics are authorized to inject a sedative (they aren't in all jurisdictions), they decide whether they are willing to do so once the subject is restrained.

There's little to no chance that ExDS subjects can be talked into cooperating, Paulus says; "they're unresponsive to language and logic." The effectiveness of OC, given their imperviousness to pain, is dubious. Weighing results vs risk of injury for all involved, Tasering is probably the best choice, Paulus believes. But if physical force is the only option, it needs to be fast and overwhelming, with a vascular neck restraint possibly considered as part of the package.

"The struggle needs to end ASAP," Paulus explains. "The longer it lasts, the more intensely the subject will fight back, perceiving that he's fighting for his life, and the worse his medical risk will become."

However the subject is brought to the ground, Paulus favors an MOTC (Multi-Officer Control Tactic) taught by Chris Lawrence and his fellow DT instructors at Canada's Ontario Police College for restraint. Optimally, it involves the coordinated effort of 5 officers, all trained in the technique to use their weight and leverage to tightly control the subject's limbs and head. "The tactic can be adapted to work even with 3 officers, with a lot of communication and coordination," Paulus says.

"If there aren't enough cops, our protocol calls for firemen or EMS personnel to get involved." Given the usual, well-known reluctance of EMS personnel even to get close to any police action, Paulus says, "when we showed them what we needed them to do to help, I was shocked at the cooperation we got. They understood that this is a dire medical emergency and that police can't resolve it alone."

Fast sedation. Once the struggling has been minimized, that's when field sedation may occur. The sedative is injected, through the subject's clothing, into the butt or thigh.

"Rapid sedation is the field treatment for excited delirium," says Dr. Thomas Scaggs, EMS medical director for Carle Foundation Hospital in Urbana who shared the IACP panel with Paulus. Tranquilizing the subject will stop the adverse effects of struggling and "will start to reverse acidosis, muscle breakdown, and hyperthermia. It's one key thing that may save the subject."

The sedative selected needs to be "effective, reliable, safe, deliverable intramuscularly, and produce a fast onset (within three to four minutes)," he said. His choice is ketamine, which he described as "the drug for this syndrome." First used as a field anesthetic during the Vietnam War, "it has no contraindications — does not suppress breathing, for example — and if it turns out the subject is not experiencing excited delirium, there's no harm done."

If sedation is not administered at the scene, it certainly will be in the ER, to make treatment possible.

Special Handcuffing
While the subject's positioning is not important for the field injection, EMS ultimately wants him supine for treatment during ambulance transport, Paulus explains. However, he's handcuffed on the ground while prone. At least 3 sets of swivel-style cuffs are linked in a daisy chain behind his back, so he can lie with his arms at his side when he's face up. His legs are bound with a hobble to prevent him from kicking.

Once he's hooked up, the subject is turned on his side, a backboard is placed so he can be rolled back down onto it, he's strapped down and then loaded into the ambulance. "An officer rides along and takes notes to document any procedures EMS administers or changes that occur with the suspect en route to the hospital," Paulus advises.

Medical Follow-through
In their training to support the protocol, medical professionals are thoroughly briefed on the challenges they'll likely confront with ExDS, from the extraordinarily high body temperature to the strong probability of cocaine intoxication.

Yet even with the broadest knowledge and the best efforts of all involved, the subject may still die at any point without warning. About 200 suspected ExDS deaths occur each year, Scaggs estimates. "The first sign of impending death in such cases is death itself," he says. "And these subjects can never be resuscitated."

The medical examiner's staff needs to be trained in the special autopsies that are required after these fatalities, in order to discover the findings most relevant to cause of death, Paulus explains. "They need to look for much more subtle cues than just the obvious physical damage that may have occurred during a struggle with the police."

Among other things, he says, pathologists need to know the purpose and value of promptly forwarding brain samples to the University of Miami's Brain Program, under the direction of Dr. Deborah Mash (see: www.exciteddelirium.org), where submissions can be examined for evidence of ExDS.

Investigators will also want to conduct what Paulus calls a "psychological autopsy," which includes rebuilding the subject's life back to a minimum of 72 hours before the incident to reconstruct what led up to the confrontation at the scene.

Legal Understanding
When the outcome of an ExDS encounter isn't favorable, having prosecutors also educated in excited delirium characteristics and the complexity of a proper response will help guard against the convenient but treacherous assumption that "whoever last touched a stricken subject is the one who killed him," Paulus believes. And an in-place protocol can also help an agency's defense in civil suits.

Another of Paulus's copanelists at IACP was Force Science Analyst Laura Scarry, a popular police attorney from Chicago and Wheaton (IL). Scarry told the chiefs:

"The vast majority of excited delirium cases will result in litigation. By putting a protocol in place, you're getting ahead of potential disaster. Jurors want to hear that you have policy and procedure on this subject. They favor education and training. They will appreciate the fact that you respond to people in medical crisis as patients rather than as criminal suspects.

"You can't always respond as you'd want in a perfect world, but jurors will appreciate communication and cooperation among groups toward a common goal. They won't appreciate a disconnect among agencies."

Toward that end, Paulus told Force Science News he is willing to help agencies formulate a protocol tailored toward their particular needs. "Wherever you are in the world, if you have people in your jurisdiction who are abusing drugs and/or have mental health issues, you have a near-certainty of this problem arising," he says. "The time to plan how to deal with it is not when you're standing face to face with an out-of-control subject who's on a freight train to death."

Just 4 days after the finished protocol "went live," it was put to the test in Champaign, he recalls. "We got a call of a mentally ill female...sweating profusely...breaking a glass coffee table...rolling around in shards of glass.

"True to their training, the responding players performed as we had hoped and in this case the stricken subject did survive."

For more information, Paulus can be reached at: michael923@yahoo.com; Chris Lawrence at: chris.lawrence@policeone.com; and Laura Scarry at: lscarry@deanoandscarry.com.

For a recent report on ExDS, see the article "Stop the Madness" by Sgt. Joel Johnston in Blue Line magazine, which can be accessed free on the Force Science site by clicking here or visiting www.forcescience.org/blueline.pdf Johnston, a 27-year veteran of Vancouver (BC) PD, a certified Force Science Analyst, and a member of an international panel of experts on ExDS convened by the U.S. NIJ, corrects 6 persistent myths about the syndrome that have resulted in law enforcement being unjustly blamed for high-profile in-custody deaths.

[Our thanks to the president of the Illinois Tactical Officers Assn., Chief Jeff Chudwin, for facilitating our attendance at Lt. Paulus's seminar.]

About the author

The Force Science Institute was launched in 2004 by Executive Director Bill Lewinski, PhD. - a specialist in police psychology -- to conduct unique lethal-force experiments. The non-profit Force Science Institute, based at Minnesota State University-Mankato, uses sophisticated time-and-motion measurements to document-for the first time-critical hidden truths about the physical and mental dynamics of life-threatening events, particularly officer-involved shootings. Its startling findings profoundly impact on officer training and safety and on the public's naive perceptions.

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