Posted 7/8/20, edited 7/9/20

VIOLENT *AND* VULNERABLE

Some combative citizens may be at heightened risk of death

For Police Issues by Julius (Jay) Wachtel. It wasn't a chokehold that felled Robert Heston on that fateful Saturday afternoon some fifteen years ago. After going berserk, attacking his elderly parents and thrashing their home, Mr. Heston was in no mood to cooperate with Salinas (Calif.) police. He resisted violently, and they responded with a score of Taser strikes. But once the cuffs went on Mr. Heston stopped breathing. He remained unconscious and died in the hospital on the following day.

Mr. Heston had a substantial record of arrests for drug use, drunkenness, disorderly conduct and assault, so he wasn't exactly an unknown. Yet nothing in his past or in his conduct that day would justify killing him. So the onus landed square on the cops – and, collaterally, on the tool (the Taser) to which they turned. And yes, there was a lawsuit, which ultimately drew nothing from the authorities but yielded a small judgment against Taser.

Why did Mr. Heston die? Litigation generated a series of post-mortems. Their findings were set out in great detail in an expert's report. They were also summarized in Amnesty International's ground-breaking study of Taser-linked deaths. Here's an extract:

> The first…autopsy findings listed the Taser as a cause of death…a second report…listed an enlarged heart as cause of death and the Taser as contributory causes. The third and final report…determined that cause of death was multiple organ failure due to cardiopulmonary arrest; due to methamphetamine intoxication; *excited delirium*; left ventricular enlargement and fibrosis, with contributory causes: Rhabdomyolysis, secondary to multiple Taser application.

We italicized "excited delirium" for a reason. Here is how that term is defined by medical specialists:

> Excited delirium refers to a clinical situation that is characterized by a series of typical features that include agitation, aggression and paranoia, intolerance to pain, unexpected physical strength, failure to tire despite constant physical activity, lack of clothing, rapid breathing, profuse sweating, elevated temperature, an attraction to glass or mirrors, and failure to respond to police or medical directives.

As that article mentions, the syndrome, commonly referred to as "ExDS" has been stigmatized because some consider it a handy way to excuse police abuses. (For a comprehensive accusation to that effect check out this article in *Slate*.) Still, ExDS first appeared in nineteenth century medical literature as "Bell's mania," so its origin long predates current controversies in policing. And while some find it odious to attribute poor outcomes to anything other than officer misconduct, respected players in the policing community – say, IACP's Law Enforcement Policy Center – have determined that ExDS is very much real.

More importantly, that's also the view of the emergency medicine community. In a highly detailed 2009 "White Paper Report on Excited Delirium Syndrome," the American College of Emergency Physicians concluded that ExDS "is a real syndrome of uncertain etiology…characterized by delirium, agitation, and hyperadrenergic autonomic dysfunction, typically in the setting of acute on chronic drug abuse or serious mental illness." Two years later an article in the *Journal of Emergency Medicine* described the demeanor of persons in the throes of ExDS:

> Patients present to police, Emergency Medical Services, and the emergency department with aggressive behavior, altered sensorium, and a host of other signs that may include hyperthermia, "superhuman" strength, diaphoresis, and lack of willingness to yield to overwhelming force. A certain percentage of these individuals will go on to expire from a sudden cardiac arrest and death, despite optimal therapy.

As one might expect, ExDS is also well known to emergency medical responders:

> The hallmark of ExDS is agitation and violent behavior in a patient with altered mental status. Patients with ExDS often have superhuman strength, do not respond to physical compliance techniques due to increased tolerance to pain, and are highly resistant to physical restraint. On physical exam, patients will present with hyperthermia, tachycardia and tachypnea.

Officers, though, aren't clinicians. They don't work in anything that approaches a controlled environment. So while ExDS may indeed be "a medical problem masquerading as a police call" (that's what an NIJ-sponsored report calls it), the chaotic nature of street encounters may limit officers' willingness to let the fuse keep burning. After all, who says there won't be "bomb" at the other end? Bottom line: all that "superhuman strength" and unwillingness "to yield to overwhelming force" that accompanies a full-blown instance of ExDS will inevitably provoke a forceful police response.

Unfortunately, the U.S. lacks a national law enforcement use of force dataset. (In 2019 the FBI launched an effort to capture data about police use of firearms and any uses of force that caused death or serious bodily injury. For more about that click here.) However, two common tools – pepper spray and conducted energy devices (CED's, e.g., "Tasers") – have been examined in some detail. NIJ has little positive to say about pepper spray. It's not considered an effective way to prevent violence and has actually been blamed for increasing officer injuries. On the other hand, NIJ has reported that CED's can reduce harm to both citizens and police.

Yet CED's also have problems. A 2017 *Reuters* study reported there had been more than one-thousand deaths attributed to their use. However, the authors blamed strikes to the chest for most of the toll. According to PERF, though, some people are especially vulnerable to CED's. Among them are persons in the midst of an episode of ExDS:

> Some populations currently believed to be at a heightened risk for serious injury or death following an ECW application include pregnant women, elderly persons, young children, visibly frail persons or persons with a slight build, persons with known heart conditions, persons in medical/mental crisis, and persons under the influence of drugs (prescription and illegal) or alcohol. Personnel should be trained about the medical complications that may occur after ECW use and should be made aware that certain individuals, *such as those in a state of excited delirium*, may be at a heightened risk for serious injury or death when subjected to ECW application or other uses of force to subdue them. [Emphasis ours]

Now that "excited delirium" has again reared its nasty head, consider the case of Zachary Bearheels. Here's a condensed version, self-plagiarized from "Three (In?)explicable Shootings":

> Omaha officers came across a morbidly obese, mentally disturbed 29-year old man licking a store window. He accepted water and was let go. He was subsequently booted off a bus and caused a ruckus outside a store. Two officers got him into a squad car to go in for a mental check, but their sergeant said no.

> Bearheels then broke free. Two other cops jumped in. They repeatedly Tasered Mr. Bearheels and struck him on the head. Zachary Bearheels went "motionless" and died at the scene. A coroner later ruled that his death was "associated with excited delirium (psychomotor agitation, hallucinations, speech and thought disturbances, reduced response to painful stimuli, bizarre and combative behavior, and hyperthermia), physical struggle, physical restraint, and use of conducted energy device."

Many essays in our "use of force" section discuss instances that clearly line up with the syndrome. Consider, for example, the shooting death of Michael Brown, which set off major protests and helped propel a national dialogue about the use of force against blacks. But as we pointed out in "Lessons of Ferguson," Mr. Brown was not blameless. Convenience store videos depict him shoplifting cigarillos and strong-arming a clerk who tried to stop him from leaving (1:12-1:35). Witnesses confirmed that Mr. Brown acted aggressively towards the officer who ultimately killed him. (The officer claimed that Brown punched him in the face and tried to take his gun.) And an autopsy revealed sufficient cannabinoids in Brown's blood to impair judgment.

Fast-forward to…today. ExDS-like patterns are evident in two notorious recent episodes: the police killings of George Floyd and Rayshard Brooks. No, we're not saying that the officers who encountered them acted appropriately. (For our in-depth assessments check the posts.) But we *are* saying that factors associated with ExDS syndrome helped set the stage for the deplorable outcomes.

- Mr. Floyd and Mr. Brooks had substantial criminal records. Mr. Brooks was on felony probation.

- When faced with arrest, Mr. Floyd and Mr. Brooks suddenly turned non-compliant and violently engaged officers in protracted physical battles. Knock-down, drag out fights do happen in policing, but they're definitely not typical.

- Mr. Floyd's death is commonly attributed to choking. His autopsy, though, revealed "no life-threatening injuries." Instead, the diagnosis cites blunt force injuries, serious pre-existing medical conditions (e.g. severe arteriosclerosis, hypertension), and a substantial amount of drugs in his blood, including fentanyl and meth. *Notably, one of the rookies involved in the arrest, officer Thomas Lane, voiced concern during the struggle that Mr. Floyd was suffering from "excited delirium or whatever"* (see "Punishment" and 7/9 update, below.)

- A field breath alcohol test indicated that Mr. Brooks was intoxicated. He had fallen asleep in his car in a drive-through lane, so something was clearly amiss. Manner of death was reported as two gunshot wounds to the back. No toxicology results or other medical information has been released.

In-custody deaths are frequently attributed to purposeful choking by police. Undoubtedly some have happened. But a recent *New York Times* review of seventy arrestees who died after telling police that they couldn't breathe paints a far more complex picture:

> Not all of the cases involved police restraints. Some were deaths that occurred after detainees' protests that they could not breathe — perhaps because of a medical problem or drug intoxication — were discounted or ignored. Some people pleaded for hours for help before they died…In nearly half of the cases The Times reviewed, the people who died after being restrained, including Mr. Williams [Byron Williams, Las Vegas], were already at risk as a result of drug intoxication. Others were having a mental health episode or medical issues such as pneumonia or heart failure. Some of them presented a significant challenge to officers, fleeing or fighting.

While this account seems almost a roadmap to excited delirium, the *Times* makes no mention of the syndrome. Still, its analysis is eerily consistent with findings reported in the American College of Emergency Physicians' "White Paper" on ExDS:

> There are well-documented cases of ExDS deaths with minimal restraint such as handcuffs without ECD use. This underscores that this is a potentially fatal syndrome in and of itself, sometimes reversible when expert medical treatment is immediately available.

In an extensive "law enforcement section" the paper's authors warn of the risks posed by persons in the grips of ExDS. But they also point out that virtually any technique or physical aid that's commonly used to control violent persons, including pepper spray, batons and joint locks, can prove lethal:

> Given the irrational and potentially violent, dangerous, and lethal behavior of an ExDS subject, any LEO interaction with a person in this situation risks significant injury or death to either the LEO or the ExDS subject who has a potentially lethal medical syndrome.

What about simply stepping back? That's something we've repeatedly counseled (see, for example, "First, Do No Harm.)" According to the authors, though, it may not be

feasible to let persons who exhibit the symptoms of ExDS calm down on their own, "as this may take hours in a potentially medically unstable situation fraught with scene safety concerns." Officers who encounter excited delirium are thus caught in the horns of a true dilemma, as any substantial application of force might kill. All they can realistically do is recognize when ExDS might be present, try to tailor their response accordingly, and call for EMS. And even if they do it all correctly, they're hardly out of the woods:

> This already challenging situation [ExDS] has the potential for intense public scrutiny coupled with the expectation of a perfect outcome. Anything less creates a situation of potential public outrage. Unfortunately, this dangerous medical situation make perfect outcomes difficult in many circumstances.

That paper was published during the halcyon days of 2009. More than a decade later its concerns about "potential public outrage" should policing prove lethally imperfect seem all too sentient. In these deeply polarized times it's far wiser to blame poor outcomes on the cops, and *only* the cops. So if you're an educator and decide to "pocket" this essay, we understand. We're not offended!