

Running head: Excited Delirium and its relationship

Excited Delirium and its Relationship to the use of Tasers

University of West Florida

Introduction

The purpose of this research is to introduce the reader to the concept of excited delirium and its relationship to the use of tasers in law enforcement. The focus of the research is to establish the need for a training program for law enforcement officers. The training program will concentrate on the signs and symptoms of excited delirium, and what an officer can expect when dealing with an individual experiencing excited delirium. Excited delirium was first described as an “acute behavior change(s) associated with the abuse of stimulant drugs such as methamphetamine, PCP, and cocaine” (Heck, 2005, p. 1). Excited delirium is “most often associated with substance abuse and/or mental illness. Excited delirium is becoming recognized as a medical emergency because it is associated with a number of detrimental physiological effects” (Everett, 2005, p. 1). Individuals experiencing excited delirium often display behaviors such as unbelievable strength, imperviousness to pain, bizarre and violent behavior, extreme paranoia, and incoherent speech. These individuals may also have dilated pupils, be perspiring heavily, and are often times nude due their body temperature being extremely high (Everett, 2005). Individuals who are experiencing excited delirium may appear normal until they are confronted or challenged. When the person is confronted, a sense of paranoia develops and he or she may become defiant, angry and extremely aggressive (Conner, 2005), these behaviors may lead to a struggle if the subject is encountered by law enforcement. An individual exhibiting signs of excited delirium is likely to have a more heightened sense of wanting to run at the first opportunity. The individual is likely to destroy property, such as smashing glass. Their speech may be garbled or jumbled and will display “animal-like” behavior such as grunting, biting or scratching. They will have “eight-ball eyes”; their eyes will be “wide open so that white is visible on all four sides of the iris” (Remsberg, 2006, p. 2).

Since the concept of excited delirium developed, there has been controversy over whether or not law enforcement's encounter with individuals experiencing excited delirium is fatal, specifically when the taser is used. Although excited delirium was not recognized as a medical or psychiatric condition in the past, recent unexplained deaths ignited many research studies. These studies focus on the condition to determine if there is a direct relationship between excited delirium, and the use of a taser or even a struggle between law enforcement and an individual experiencing excited delirium where the end result is fatal.

With the rise of deaths related to excited delirium and law enforcement interaction with these individuals it is important for law enforcement agencies to focus on training protocol to help reduce the risk of sudden unexplained deaths of these individuals in law enforcement's custody. Training for law enforcement officers is one of the most crucial aspects of their job. If officers are not efficient in their agency's training and procedures, they are definitely at a higher risk for getting hurt or even dying on the job. Training for officers will help them do their day to day job more effectively and efficiently. Officers will be better prepared to make quick and assertive decisions if they are confident in the training they have received.

It is vital for law enforcement agencies to implement training programs and develop policies and procedures for recognizing excited delirium due to the increase in deaths recently brought to the public's attention. With the growing numbers of unexplained deaths related to less lethal force, particularly the taser, it is imperative law enforcement officers receive the proper training in order to help reduce the risk of deaths and minimize the chance of lawsuits for a wrongful death. The protocol for law enforcement training programs in relation to less lethal force and excited delirium should "incorporate psychiatric mental health training techniques in managing individuals who either have mental illness or displaying symptoms of such due to

drugs” (DiMaio, 2005, p. 100). Most law enforcement officers only receive training on mental health patients during the police academy, which can be considered an insufficient amount of training. It is crucial for officers to be able to quickly recognize they are dealing with an individual who is displaying signs of excited delirium. If the officer knows what to expect he or she can take the proper measures to restrain the subject and only resort to less lethal force, specifically the taser, when the officer believes the only way to subdue the subject is by deploying the taser.

The taser has become a nationwide phenomenon among law enforcement agencies. Taser International the company which developed the taser was founded in 1993. The taser is a less lethal weapon, which allows law enforcement officers to incapacitate a person in order to take him or her into custody safely. The taser is a handheld device that deploys two small fish-hook like probes from a cartridge. The cartridge contains compressed nitrogen, which launches the probes up to twenty-one feet. The probes penetrate up to two inches into the skin of a target and deliver fifty thousand volts of electricity, rendering the person incapacitated (Taser International, 2007).

There are two types of tasers utilized by law enforcement agencies, the M26 and the X26. The M26 was developed six years after Taser International began producing products, and is considered to be the "first Electronic Control Device (ECD) with true Neuromuscular Incapacitation (NMI) technology" (Taser International, 2007, p. 3). The M26 was law enforcement's first introduction to a less lethal weapon just short of lethal force that could truly stop an aggressive subject so the individual could be safely taken into custody with little or no harm done to either the subject or officer.

The X26 was introduced to law enforcement in 2003 and is considered to be Taser International's premier law enforcement electronic control device (Taser International, 2007). The X26 is considerably smaller than the M26 which makes it more practical. The X26 also has greater stopping capability with an individual, which allows an officer to gain control faster. The X26 is also a more optimized option for an officer's duty belt (Taser International, 2007). The X26 is by far one of the best less lethal weapons for a law enforcement officer.

According to Taser International, "Tasers provide a safer, effective tool for law enforcement officers to face violent situations that pose threats to their safety. Tasers are reliable devices that utilize innovative technology to stop violent suspects and provide effective alternatives to lethal force" (Taser International, 2007, p. 3). Tasers provide law enforcement officers an entire new way of subduing a suspect, which usually results with minor or no injuries.

With the introduction of tasers to the law enforcement world, the public began focusing on the negative aspects of the taser. There have been many reported cases of taser-related deaths associated with the phenomena of excited delirium. Excited delirium is defined as "an infrequently occurring but serious medical condition that can result in death" (Everett, 2005, p. 1). Excited delirium is usually associated with substance abuse, which causes an individual to slip into a state of sudden tranquility, either during or after a struggle when an officer is attempting to take the individual into custody (Everett, 2005). Public Safety employees, law enforcement officers in particular, deal with individuals experiencing excited delirium. It is vital for officers to be able to recognize the symptoms of excited delirium in order to render the proper care and medical attention for the individual they are attempting to take into custody.

Statement of the Problem

Taser-related deaths have become a major controversy. They damage the public's faith in law enforcement agencies. An individual who is in police custody is expected to be safe and be provided medical care if needed (Benner & Isaacs, 1996). These unexpected, inexplicable deaths of individuals who are in police custody have been described as a “cover-up”, by the public. Many of these taser-related deaths associated with excited delirium could have been prevented if the officer was trained to readily recognize the symptoms of excited delirium, so the proper medical attention and care could be provided to the person. Officers who have not received the proper training on taser use on individuals exhibiting symptoms of excited delirium risk the chance of an in-custody death of a person, which ultimately places the law enforcement agency at risk for legal liabilities.

Implementing a training program for local law enforcement officers, which employs both hands on training and procedures for dealing with calls for services that may involve a person displaying signs of excited delirium will help prevent in-custody deaths. Training will be a requirement for any officer that carries a taser. It is vital for an officer to be able to recognize excited delirium both for the safety of the officer and the person he or she is encountering.

Individuals displaying symptoms of excited delirium can become an extreme officer safety risk. It is important law enforcement officers are trained to identify symptoms of excited delirium in order to effectively take the person into custody without injury or death. Training and implementation ultimately save the lives of law enforcement officers and the individuals they encounter. Officers never know what they are going to face when they arrive at a call. The situation can go from good to bad at any moment, and the officer must be confident in the training received to make quick and rational decisions.

Literature Review

This literature review will highlight some of the research addressing the issues of deaths related to taser use. Many mental health professionals are opposed to the use of tasers and other forms of less lethal force to subdue an individual who is displaying signs of a “mental health crisis” (NZ Nurses, 2006, p. 8). Since the introduction of excited delirium in the mid 1990s, related deaths have become more and more apparent, especially when associated with law enforcement and the use of less lethal force. Many studies were conducted to connect the deaths to less lethal force. According to Amnesty International, tasers have been associated with over 150 deaths in the United States and Canada between 2001 and 2006 (O’Brien & McKenna, 2006). While the majority of deaths that occur in police custody are not related to less lethal force, a causal association between excited delirium, taser use, and death has been proposed.

In 2005, the death of a man in Nashville, TN which was linked to excited delirium was brought into the limelight due to law enforcement’s involvement. The man identified as Patrick Lee was in a night club, and was described as “acting strangely inside and kept trying to get onto the stage of the lounge” (Jozefowicz, 2006, p. 1). Law enforcement officers responded to the nightclub and escorted Lee outside. Once the officers were outside with Lee he began acting aggressively towards the officers, and also removed his clothing. Lee openly admitted to officers he was under the influence of narcotics. Officers called for an ambulance due to Lee’s unusual behavior and his own admission of being high. Lee became very aggressive towards the officers, and they resorted to using pepper spray, batons, and their tasers in an attempt to subdue him. Lee was taken to the hospital because of difficulty breathing, and died two days later. His family and friends believed the taser use on Lee is what contributed to his death. Lee’s autopsy report revealed he died from excited delirium. “Excited delirium can cause people who are high on drugs or who have some form of mental illness to become extremely agitated in stressful

situations. They may show increased strength or resistance to pain. The stress and agitation may cause dangerously high body temperatures and organ failure” (Jozefowicz, 2006, p. 3). Lee’s family sued the police department and Taser International for Lee’s death.

The American Civil Liberties Union (ACLU) of Northern California released a report proposing tasers were linked to over 150 deaths in the United States and Canada since 1999 (Jozefowicz, 2006). The ACLU advocates for more regulations with taser use, and believes the less lethal weapon should only be used when deadly force is required. Lee’s family believed the taser was in connection with Lee’s death, which is a good example of why law enforcement agencies across the country should establish training protocols involving excited delirium. Although the taser has not been listed as the cause of death, the mere connection it has to the deaths of individuals experiencing excited delirium is an obvious reason law enforcement agencies establish training programs for their officers.

During the period of January 2001 and January 2005, a case series was conducted on taser-related deaths occurring in the United States. This study approved by the University of Medical Center focused on autopsy reports of individuals who died in police custody after a taser deployment or in-custody restraint. Letters requesting autopsies reports were sent to the medical examiners for the counties and states in which taser-related deaths occurred in the time frame of the study (Strote & Hutso, 2006). The inclusion criteria requested was a “complete autopsy report of any case where death occurred in association with a taser injury” (Strote & Husto, 2006, p. 3). The exclusion criteria requested was any other injury that was cited by the medical examiner, which was the cause of death, any documented cardiopulmonary arrest that occurred outside the immediate context of in-custody restraint and taser use (Strote & Hutso, 2006).

The study consisted of 75 cases of law enforcement taser-related deaths where a form of excited delirium existed. Of these cases 33 of the medical examiners either refused or failed to send the autopsy reports. Five of the cases did not meet the requirements of the study, which left 37 cases eligible for review. The cases reviewed consisted of all men, with the average age of 36, and a range from 18 to 50 years old. Of the 37, 18 were white, 15 were black, and 4 were Hispanic (Strote & Hutso, 2006). The autopsy reports revealed 28 of the cases were “specifically given a diagnosis of excited delirium by the medical examiner” (Strote & Hutso, 2006, p. 4) and 29 provided a positive toxicology for illegal substances. Only 4 of the individuals had a completely negative toxicology screen, and were still given the diagnosis of excited delirium.

In 29 of the cases, law enforcement use of restraints was cited in the autopsy report, and 17 of the deaths were considered to be caused by stimulant intoxication. Only 13 out of the 37 cases associated the death as a result of taser injury, 4 described the taser as contributory cause to the death, 6 described the taser as a potential cause, and 3 stated the taser had no relation to the death (Strote & Hutso, 2006).

The study concluded that the data received did indicate sudden deaths do occur after taser use. “A common factor in these deaths is extreme agitation, often in the setting of stimulant drug use and/or or preexisting heart disease” (Strote & Hutso, 2006, p. 5). Tasers were designed to be used on individuals exhibiting signs of excited delirium because of the violent and aggressive behavior the individual displays. It is apparent that the combination of stimulant use, preexisting disease, struggle against law enforcement, and restraint maneuvers produces a high-risk chance of restraint related deaths. The study focused on establishing a connection between the signs and symptoms of excited delirium and the use of a taser that will ultimately result in the death of the individual. The other side to this controversial topic is the focus on the death of individuals

experiencing excited delirium being attributed to the individual's extensive life history of substance abuse and/or mental illness, and not the deployment of a taser. Individuals experiencing excited delirium can die without any agitation from an outside source. The symptoms they are experiencing and the high body temperatures can cause any the individual to die. Individuals in this excited state can have a body temperature of 107 degrees.

In 2006, the Academy of Emergency Medicine conducted a study on the cardiovascular and physiological effects of tasers on 66 volunteers attending a taser use training course (NZ Nurses, 2006). The volunteers consisted of 65 men and 1 woman, with a mean age of the volunteers being 40 years old. "Of the volunteers, 51 had no medical history, 6 had hypertension, 6 had hypercholesterolemia, and 1 had prior myocardial infarction before a triple bypass. One had a history of previous congestive cardiac failure, one had a transient ischemic attack, and one had Type II diabetes. Eight of the volunteers had a significant family history of coronary artery ischemia, and 17 of the volunteers had engaged in strenuous physical activity on the day of the test." (NZ Nurses, 2006, p. 8). All volunteers were shot with the X26 taser probes, for a five second cycle. Prior to being shot with the taser, thirty-two of the volunteers were randomly selected, and underwent electrocardiograms.

After being shot with the taser all volunteers underwent a 24 hour observation period following the five second application (NZ Nurses, 2006). None of the volunteers experienced any affects of cardiac electrical activity. "There was no evidence of any cellular damage or changes in the long list of metabolic parameters recorded both before and after the deployment of the taser" (NZ Nurses, 2006, p. 8). This is one of many studies conducted on the taser that indicates the taser has no detrimental or fatal risks to an individual being taken into custody with the deployment of the taser. By documenting the volunteers' medical history it provides an

example of how the taser is not necessarily a risk to individuals who have been tased, even though the person has a history of heart problems or engaged in physical activity prior to being tased. This controversial topic and the fact there is not a lot known about excited delirium and its connection to the deployment of a taser has stimulated many research studies. It is clear the recent controversy over deaths related to excited delirium and the use of tasers has established the need for more research studies to be conducted.

In 2003, the Treatment Advocacy Center reported that fifty-two individuals who exhibited signs of mental illness were killed by law enforcement and seven law enforcement officers were killed by the individuals who were exhibiting the abnormal behaviors. In response to the growing number in deaths related to excited delirium and the taser, the Summit County mental health professionals and the Akron Police Department created the Crisis Intervention Team (CIT). The CIT provides intensive training about excited delirium, other mental illnesses and the treatment system to patrol officers who volunteered for the additional training. This is clearly an effort to reduce the growing number of deaths (American Psychiatric, 2006). The training's main focus was teaching these officers de-escalation skills while interacting with individuals experiencing excited delirium.

The officers on the Crisis Intervention Team were provided the M-26 taser. Once the officers received the training on both the taser and recognizing excited delirium, there were thirty-five documented incidents over an eighteen month period involving the taser and individuals who were exhibiting abnormal behaviors that were considered to be some type of mental illness. Of the thirty-five incidents none of the individuals received serious injuries from the struggle or the taser. These CIT officers responded to a total of five hundred and forty one incidents over the eighteen month period and only deployed the taser thirty-five times. The

Akron Police Department focused on this CIT program because of the heightened controversy over deaths and serious injuries resulting from encounters between individuals with mental disorders, such as excited delirium and law enforcement officers. Some researchers believe the “deployment of less lethal weapons, such as the taser may be part of a solution to a significant public health problem” (American Psychiatric, 2006, p. 2). It is apparent the need for more research on tasers and its association to in-custody deaths. Until there is a resolution or definite connection there will always be controversy over the unexplained deaths. With the established need for more research it is also important for law enforcement agencies to recognize the connection between excited delirium and the use of tasers, and to implement training programs, so officers are prepared to deal with incidents involving individuals displaying signs of excited delirium.

The International Law Enforcement Educators & Trainers Association (ILEETA) recently addressed the “sudden and seemingly inexplicable physical and mental melt-down of an individual that can easily boomerang into a tactical, media and courtroom nightmare” (Remsburg, 2006, p. 1). Law enforcement officers are faced with the unknown when responding to an incident. A call that may appear easily resolvable can turn into facing an individual who is “dangerously beyond self-control”, and it is the officer’s job to restrain that person accordingly. It is important for an officer to be able to recognize the symptoms of excited delirium and what the officer should and should not do while interacting with such individuals.

It is important for law enforcement officers to have received an adequate amount of training in recognizing excited delirium symptoms. If the responding officer is able to readily recognize the person they are dealing with is in an excited state, the opportunity to render the proper de-escalation and aide will provide a better chance of the individual not dying. Officers

dealing with individuals who are experiencing excited delirium should recognize they are dealing with a medical emergency and immediately call for EMS (Remsberg, 2006). It is crucial the responding officer has an enough back-up officers to assist with the individual in order to establish control. The individual may be hallucinating and what he or she is seeing may appear to be reality. Reasoning with the person will not be an effective option. It is important once the person is taken into custody he or she is not left in the prone position, so he or she can breathe easily. When the person is placed in custody it is important his or her legs are restrained, but not in a “hog-tying” restraint. If the individual’s legs are free to move it is very likely they will be able to stand up without help from anyone, which could pose an officer safety issue (Remsberg, 2006).

Law enforcement and emergency medical personnel should also be aware of things not to do when interacting with an individual experiencing excited delirium. Remsberg (2006), states the officer should not deploy his taser when dealing with excited delirium patients. The individual is unreceptive to pain, so it is pointless to use the less lethal weapon. If the officer does deploy the taser on the individual, only give one cycle of the taser. Pepper spray should also not be used due to the individual being intolerant to pain. It is vital for the officer to focus on the individual’s breathing and assure he is taking full breaths. All of these recommendations are important for law enforcement officers to know and remember in order to reduce the risk of the individual dying (Remsberg, 2006). If officers utilize the training they have received when dealing with an individual experiencing excited delirium, the individual has a better chance of surviving, and the agency has a less likely chance of being sued for wrongful death. It is important too for law enforcement agencies and the public to have a clear understanding of what excited delirium is, and why it is so controversial.

The American Medical Association does not recognize excited delirium as a diagnosis for a medical or psychiatric condition, but the National Association of Medical Examiners has recognized excited delirium, as a factor associated with death, for more than a decade. It is unclear why these two organizations do not agree on how or if excited delirium should be recognized. Many people oppose the idea of excited delirium because there had never been any proof that individuals can become so excited it ultimately kills them. Researchers and even the public who are opposed to the theory of excited delirium believe death does not occur from drugs associated with abnormal behaviors. They believe death is a result of “psychological stress of being confronted with aggression that results in further physiological reactions” (Paquette, 2005, p.2). In fact, the Strote and Hutso (2006) research discussed earlier indicated that persons can excite themselves “to death”.

Advocates argue that individuals who die from excited delirium are not victims of police brutality, but are victims of their own long-term drug abuse, and lifestyle. According to some research, the real cause of death in these individuals who experienced excited delirium is the long-term use of cocaine, which will eventually cause heart disease. “Being high on stimulants and being paranoid lead to delirium and a heightened heart rate, often accompanied by a rise in body temperature” (Paquette, 2005, p. 2). This study provides recommendations to help minimize the risk of death for individuals experiencing excited delirium. Paquette’s main suggestion is to educate others, particularly law enforcement officers on the symptoms, causes, and identifications of excited delirium (Paquette, 2005). There will always be a continuous need for training among law enforcement officers. It is important for agencies to ensure their officers have been properly trained in order to prevent any problems. In order for the agency to be

effective, it must focus on maintaining the public's trust and confidence in the agency's ability as a whole.

There are many critics who believe excited delirium is not real, but instead an excuse for inadequate police performance. Individuals who are opposed to the idea of excited delirium state it is a term used to cover up police brutality, and even to cover up improper training received by law enforcement officers. So the main question many researchers and even the public ask is where did the term excited delirium generate from? This question is still unanswered. There has been research conducted on reports concerning, "the sudden death of individuals restrained in a prone position by police officers" (Lawrence, 2005, p. 2). With the recent controversy over deaths that have been ruled a result of excited delirium, an effort to establish research protocols to study individuals exhibiting signs of excited delirium has begun. An issue which poses a problem for researchers is the "presenting symptom of excited delirium is death" (Lawrence, 2005, p. 2), which makes it hard to study the symptoms of excited delirium. Another problem is the medical field becoming so complex. In today's society doctors are specialized and only focus on one field. The emergency room physician must deal with the aggressive patient who in most cases cannot provide any medical history. The psychiatrist cannot pose any questions to the patient until he has received the medical treatment he needs. In most cases of excited delirium the individual dies before reaching the hospital. The need for so many specializations makes it difficult to determine a specific diagnosis.

Law enforcement officers will continue to face individuals displaying signs of excited delirium, and will have to take the necessary steps to subdue the person for the safety of all. Research will continue in order to determine whether or not excited delirium will become an

official diagnosis under the Diagnostic and Statistical Manual of Mental Disorders IV, and for the American Medical Association (Lawrence, 2005).

Clearly, it is important for law enforcement agencies to take a proactive approach by implementing training programs for their officers. The literature discussed in the previous section indicated two different outlooks on excited delirium and its connection to the taser. Some research indicated there has not been an established connection between the deaths of individuals in the excited state and the taser as the cause of death. These studies indicate the individual's cause of death is from an extensive history of narcotic abuse. Other studies indicate there is a direct connection between the taser, excited delirium, and death. These studies imply the taser can be lethal to individuals experiencing excited delirium. So the main question to ask, is there a need for law enforcement officers to be provided training on excited delirium? The answer to this question should be yes. Although it has not been an established cause of death, the risk of death is obvious for these individuals experiencing excited delirium. It is vital for officers to be familiar with excited delirium and to know what can occur after the individual has been hit with the taser, or has been fatigued from a struggle with officers.

Methodology

The Okaloosa County Sheriff's Office (OCSO) has approximately three hundred sworn personnel that range from civil process, investigations, environmental, traffic, judicial services, school resource, and of course the backbone of law enforcement, road patrol. In 2002, the OCSO began certifying deputies through the Taser International certification course to carry the taser on duty belts. The taser allows deputies to take non-compliant subjects into custody without using higher levels of force, and reduces the risk of injury for both the subject and officer.

The OCSO currently has 125 tasers. There 103 tasers issued to taser certified deputies.

Twenty two remaining tasers were sent back to the manufacture. There are approximately 70 road patrol officers who carry tasers on their duty belts. The remaining tasers are dispersed throughout the OSCO's specialized units. Anytime deputies are required to use force of any kind on an individual they are required to fill out a use of force report and submit it to Professional Standards for review. During the 2007 calendar year, the OCSO had 112 use of force reports, of those reports there were only 28 reports involving the deployment of the taser. There were 2 use of force reports where the taser was deployed, which indicated the person was exhibiting signs of mental illness and may have been under the influence of a controlled substance and/or alcohol. These individuals displayed many of the signs and symptoms of excited delirium, to include the combination of a mental illness and substance abuse. In both cases the individual received immediate medical attention and then was transported to a mental health facility where the individual was admitted under the Baker Act. The Baker Act, allows a law enforcement officer the authority to take an individual who is displaying behavior that indicates he or she is a threat to themselves or others to a mental health facility to receive the proper medical attention.

During the five years the OCSO has had deputies carrying tasers on their duty belts, there has only been one reported death where the taser was used on an individual. The person was non-complaint, and exhibiting many signs of excited delirium. The male was tased by an officer and assessed by medical personnel. He later died and the cause of his death could not be determined. The autopsy and toxicology report for this individual indicated he was under the influence of high levels of cocaine, and the medical examiner attributed the death to his body's chemical reaction to the cocaine. Although the death was not determined to be excited delirium, there were many people who believed the taser was the cause of this individual's death, and the OCSO was faced with many controversial issues brought out by the public. There were also many internal

concerns within the OCSO after this incident. This was the first recorded incident where the individual was possibly experiencing excited delirium. The OCSO concentrated on the Professional Standards section, also known as Internal Affairs becoming a little more acquainted with what excited delirium is, and what signs and symptoms to expect. A policy change did take effect, but only affected the dispatchers and how they screen incoming calls that may involve excited delirium (Okaloosa County, 2006).

The OCSO had approximately thirty percent of use of force incidents where the taser was deployed, and has only had one reported incident where the taser was involved and a death occurred after its deployment. It is important for the OCSO to take a proactive approach to excited delirium and its relationship to the taser. By implementing a training program for officers who are certified to carry a taser, the officer will receive hands on training on the use of the taser, and within that training have a required block focused on excited delirium. By implementing this training, officers will be better prepared to deal with incidents involving individuals who are displaying signs of excited delirium. This training will allow officers to readily recognize excited delirium, where as before the bizarre behavior would have been perceived as non-complaint behavior, and the officer's reaction could be detrimental to incident.

To begin this training program, it is important to get an idea of how many officers within the OCSO know what excited delirium is. It is also crucial to know how many hours of training, if any officers have received to carry their taser. To ascertain this information, a survey will be provided to all sworn personnel within the OCSO in order to get a better understanding of how many officers are familiar with excited delirium specifically related to the use of taser. The survey will focus on distinguishing between how many officers within the OCSO have been certified to carry a taser, how many hours of training these officers have received on the taser,

and where they received the taser training. The next area the survey focuses on is whether or not officers have received any training on excited delirium. The survey asks officers if they have received training on excited delirium, if the officer answers yes, the officer is asked to indicate how many hours he or she has received within the last year. If the officers answered no, the survey inquires if they even know what excited delirium is. It is also important to find out if officers have received any additional training to carry a taser, such as first aid, CPR, or verbal judo. This information is important in order to get a better understanding of the various training officers have received in order to effectively implement a training program. The survey will be distributed to all sworn personnel by each unit's supervisor, and returned to the officer's supervisor by May 15, 2008. See Appendix A for a copy of the survey.

Expected Findings

The initial finding is that many of the officers will not be familiar with excited delirium, or have any understanding of what excited delirium is. The survey will indicate how many officers are certified to carry a taser within the department, it is anticipated there will be approximately 150 officers certified to carry the taser. It is also expected these officers will have approximately eight hours of training on the taser. The officers who are certified to carry the taser are expected to have at least two to three years of employment with the OCSO. The most important expected finding from the survey is if the officer believes he or she has received adequate training on excited delirium. It is anticipated that the majority of the sworn personnel will not know what excited delirium is, or have a very vague understanding of what it is. The officers who do know what excited delirium will most likely have less than four hours of training on the topic, and are only able to provide a few descriptors of what to expect in individuals exhibiting signs of excited delirium. All of the deputies should have received some type of first

responder training, to include CPR in the law enforcement academy. It is expected less than 75 deputies are actually certified in CPR. It is also anticipated at least 125 deputies will know what level of the use of force matrix the taser applies to. Officers who carry a taser are most likely to have only deployed their taser two to three times during the year of 2007. All of these aspects of the survey would be the first crucial finding for the upper echelon of the OCSO to recognize.

With the increase of public scrutiny and the media's focus on deaths that have occurred while the person was in police custody, and its relationship to the taser it is important for law enforcement agencies to concentrate on training officers. Once it has been determined how familiar officers are with excited delirium, the signs of excited delirium, and what can happen to a person experiencing excited delirium, it is anticipated that there will be a need for the training to be implemented.

If officers do not receive training on excited delirium and aren't prepared to take the proper steps after someone who is experiencing excited delirium is hit with the taser, the results could be detrimental to the OCSO. There are many events that could result if officers did not receive this training program. The OCSO could expect to deal with legal liabilities that would result from a death that occurred while the person was in law enforcement's custody. The biggest concern would be the loss of life. The OCSO would become responsible for a citizen who was in police custody and later died due to complications from either being tased or struggling with law enforcement officers. By officers having the training on what excited delirium is and what signs to look for, there would be a decrease in the chance of an individual who is experiencing excited delirium dying while in police custody. Even though the OCSO has only had once incident where they encountered problems associated with taser deployment and death it is better to have officers trained and prepared. It is important for officers to be trained and prepared for incidents

involving excited delirium.

The last expected finding is changing the public's outlook on the taser within Okaloosa County. By implementing this training program the OCSO will be taking precautionary measures to ensure the safety of individuals who encounter law enforcement officers. Training is a vital aspect of a law enforcement officer's career, and it is important the OCSO provides the necessary training to make sure their officers are prepared. If officers are prepared, the chances of in-custody deaths are reduced. Having the training on excited delirium and its relationship to taser use allows, officers to have more effective and efficient approach in dealing with subjects who may be experiencing excited delirium; rather than having a damaging effect, and ultimately the public out crying due to an individual dying or seriously injured while in police custody.

Policy Implications

Once the research is completed there will be apparent policy implications that will be recommended to the OCSO for implementation. Law enforcement officers are usually the first people to have interaction with individuals experiencing excited delirium. The OCSO current standard operating procedure (SOP) for excited delirium is directed towards the dispatchers who initially take the phone call. The SOP instructs dispatchers to recognize the signs of excited delirium, by asking the proper questions while on the phone with the caller, and based on the answers they receive they are to make a determination the condition may exist (OCSO, 2006). There is no directive SOP for the law enforcement officers and what they are compelled to do while interacting with a person experiencing excited delirium.

The main policy implication would be to establish a SOP for the deputies. The purpose of the SOP would be to provide procedures for dealing with calls for service involving an individual exhibiting signs of excited delirium. The first aspect of the SOP would be to adopt a

response to resistance matrix, which would be similar to the use of force matrix. A matrix provides a guide for officers for when they are allowed to deploy their taser on an excited delirium individual. The matrix will provide an escalation and de-escalation guide when dealing with a person displaying signs of excited delirium.

The second aspect of the SOP would be to coordinate in advance with emergency medical services. Excited delirium is considered to be a medical emergency that initially presents itself as a problem that requires a law enforcement response. There should be an established understanding and awareness of what excited delirium is and have a coordinated response for dealing with excited delirium incidents between law enforcement and emergency medical services (Everett, 2005). An existing aspect of the SOP is to ensure dispatchers are trained to recognize initial indicators of excited delirium, and to ask follow-up questions to assist in confirming the incident involves excited delirium. By dispatchers being able to determine an incident involves excited delirium the responding officer will be prepared and have a more cautious approach. Dispatchers can also have emergency medical services respond as a precautionary measure.

Containment is the next vital aspect of this SOP. The first responding deputies should focus on containing the individual to ensure no one else is in harms way of the individual. Responding officers should wait for efficient back up and medical personnel before approaching the individual, unless there are exigent circumstances such as public safety. Once the individual is brought under control, and the scene is secure the next immediate focus should be providing the individual acute medical care.

The most crucial aspect of the SOP is the use of force options for law enforcement officers when dealing with a person displaying signs of excited delirium. It is important for the

OCSO to have a SOP involving what use of force options would be appropriate for taking individuals with excited delirium into custody. A major aspect of this SOP is to take into consideration one of the symptoms of excited delirium is the superhuman strength the person may have, and the individual being immune to pain. So pain-based techniques such as joint manipulation may be unsuccessful. If officers believe they will not be able to take the person into custody without the help of a taser, it is recommended the taser is only deployed for one five second cycle before the person has been fatigued in a struggle. Once the taser has been deployed officers should use this as a window of opportunity to take the individual into custody. The taser should only be deployed against an individual who is actively resisting. Once the person has been brought under control, it is imperative the officer avoids placing the person in the prone position. Most law enforcement officers are trained to place a person actively resisting into the prone position because it presents the officer with an important advantage in terms of control and safety for both the person and the officer. Officers should avoid the prone position because it may restrict the individual's ability to breathe. Officers should lay the individual on his or her side once they are taken into custody, unless this creates an unreasonable risk to the individual, officer, or anyone else (Everett, 2005). Once the person is brought under control, the individual should immediately be transported to a medical facility by emergency medical services.

All of these aspects of the SOP are essential in reducing the chances of a person who is experiencing excited delirium from dying in police custody. By implementing the new SOP, officers have a procedure and guide to follow when dealing with individuals displaying signs of excited delirium. Having set guidelines allows officers to have procedures to follow, which ultimately reduces the chances of the OCSO facing any in custody deaths, because officers are taking every step they can to prevent the risk of death among individuals experiencing excited

delirium.

It will be important for the OCSO to establish a training program that contains all of the new SOPs being introduced. The training program will consist of annual training, and be broken down into eight hour training blocks officers will receive twice a year. The training will be primarily for officers who are certified to carry a taser on their duty belts. The training program will not only focus on excited delirium, but it will also concentrate on different aspects of the taser and its deployment ability. The training program will have a block focused on excited delirium. Although the department has not been faced with any lawsuits due to unexplained deaths, this training will help prevent any future lawsuits for wrongful death or circumstances that are similar.

The eight hour blocks of training will be broken down into two four hour sections. The first four hour section will be presented by a Taser instructor, and will concentrate on the taser itself and the many aspects of its deployment ability. It is important to have continuous training so officers maintain their proficiency with the weapon, which will ultimately minimize any risk of misuse. The next four hour section will concentrate on excited delirium. The excited delirium training will be provided by a mental health specialist who is able to address the signs and symptoms of excited delirium, and what an officer can expect when dealing with someone who is in this excited state. Some major recommendations for public safety workers who deal with excited delirium are to gain the subject's compliance by using simple tactics, for example:

1. "Attempt to talk the person down. The officer should project calmness and speak in a non-confrontational manner.
2. Attempt to have the individual sit down; this may have a calming effect.
3. The officer should refrain from maintaining constant eye contact, as the subject may

perceive this as threatening.

4. If the subject is combative or armed, the officer shall employ reasonable and necessary force to protect themselves and others and take the subject into custody.

5. Once the subject is in custody and the scene is safe, EMS personnel should respond.

Some excited delirium subjects have gone into cardiac arrest shortly after a struggle.”

(Force Science, 2007, p. 1).

These recommendations along with a focus on various mental illnesses and the reaction the illness may have with a controlled substance and/or alcohol are imperative for law enforcement officers to know and to be able to recognize. It is important for officers to be familiar with these behaviors in order to be better prepared to deal with individuals experiencing these behaviors.

Once officers have received the training, there should be an anticipated reduction in taser use on individuals who are experiencing bizarre behaviors that are encountered by officers. Once officers have received the training on excited delirium their ability to recognize the behavior should allow them to distinguish from someone who is resisting arrest and an individual who is experiencing excited delirium. By going through this training, officers should be able to readily recognize the signs of excited delirium, and would know only to resort to their taser as a last resort before lethal force. If an officer resorts to using his or her taser on an individual who is displaying signs of excited delirium, the officer should only deploy the taser once in order to take the person into custody.

Conclusion

Excited delirium is becoming a nationwide controversial topic among the public and law enforcement agencies. Even though excited delirium is not a common occurrence it is a serious

medical condition that can ultimately result in the death of an individual. There is still a lot that is unknown about excited delirium, but it is “becoming increasingly recognized as a medical emergency, and is believed to play a role in many in custody death incidents” (Everett, 2005, p. 1). It is important for law enforcement agencies to acknowledge that excited delirium is a growing phenomenon and can become a potential dilemma for the agency. Due to the recent rise in deaths related to excited delirium and its connection to the deployment of tasers, it is essential for law enforcement agencies to establish training protocols and set policies. By preparing officers to be ready to face situations where a person is experiencing excited delirium there is a better chance in reducing the risk of sudden unexplained deaths while the person is in police custody. Law enforcement agencies taking a proactive approach to excited delirium by training officers to recognize the signs of excited delirium, how to interact with these individuals and ensuring they receive immediate medical attention will help prevent any in custody deaths. It is up to the law enforcement agency to be organized and ensure their officers are prepared, rather than dealing with an unexpected death, and have to answer to the public, the family, and ultimately the criminal justice system.

Appendix A

Survey of Taser Use and Training among OCSO Members

***Please return this survey no later than May 15, 2008**

Please answer the following questions to the best of your knowledge

1. How long have you been employed by OCSO? _____

2. If you have been certified to carry a taser when did you receive your training?

(Month/Year) _____

3. Where did you receive your taser training? _____

4. Number of hours of taser training you have received during your employment with the OCSO?

4hours or less 4-7 hours 8-11 hours 12+ hours

5. Have you received training on recognizing Excited Delirium?

Yes No

-If you answered yes, how many hours of training have you received in the last year?

4hours or less 4-7 hours 8-11 hours 12+ hours

- If you answered no, do you know what Excited Delirium is?

Yes No

6. Have you received any additional training to carry a taser?

First Aid/CPR Verbal Judo None Other, Explain

7. What level of the Use of Force Matrix does the taser apply to?

Muscling Techniques OC/Pepper Spray Baton Deadly Force

Other:-

8. How many times have you deployed your taser in the last year?

0 1 2 3 4 5 more than 5

9. Have you ever had to deploy your taser on someone exhibiting signs of Excited Delirium?

Yes No I don't know

- If you answered yes, how many separate occasions?

0 1 2 3 4 5 more than 5

Describe the symptoms you observed the person exhibiting:

10. Do you believe you have been adequately trained on recognizing Excited Delirium?

Yes No I don't know

-If you answered no to the above question, what do you think the agency should do to adequately train officers who carry a taser?

References

- Anonymous, (2006). NZ nurses oppose use of taser stun guns. *Australian Nursing Journal*. 14, 14.
- Benner, A.W., & Isaacs, S.M. (1996). "Excited delirium": a two-fold problem. *The Police Chief*. 1-5.
- Conner, M.G. (2005). Excited delirium, restraint asphyxia, positional asphyxia and "in-custody death" syndromes. *Education Options*, Retrieved Aug 22, 2007, from www.educationoptions.org/
- DiMaio, T.G., & DiMaio, V.J. (2005). *Excited delirium syndrome: cause of death and prevention*. Boca Raton, FL: CRC Press.
- Everett, B. (2005). Law enforcement responses to excited delirium. *League of Minnesota Cities*. 1-5
- Force Science (2007). New excited delirium protocol issued by san jose pd. *Force Science News*. 73, 1-5.
- Heck, J. Excited delirium. *Southern Nevada Health District Emergency Medical Services*, Retrieved Aug 22, 2007, from http://www.southernnevadahealthdistrict.org/ems/documents/excited_delirium/excited_delirium_article.pdf
- Jozefowicz, C. (2006). Undue force?. *Current Science*. 91, 10-11.
- Lawrence, C. (2005). Excited delirium and its medical status. *Police One*, Retrieved Aug 22, 2007, from http://policeone.com/pc_print.asp?vid=121675
- Munetz, M.R., Fitzgerald, A., & Woody, M. (2006). Police use of the taser with people with mental illness in crisis. *Psychiatric Services*. 57, 883-884.

Okaloosa County Sheriff's Office (OCSO). (2006). *Standard Operating Procedure for Excited Delirium* [Brochure]. Shalimar, FL:

Paquette, M. (2003). Excited delirium: does it exist?. *Perspectives in Psychiatric Care*. 39, 93-94.

Remsberg, C. (2006). Do's and don'ts of handling "excited delirium" suspects: special conference series. *Police One*, Retrieved Aug 22, 2007, from

<http://www.policeone.com/writers/columnists/CharlesRemsberg/articles/134671/>

Strote, J., & Hutson, H.R. (2006). Taser use in restraint-related deaths. *Prehospital Emergency Care*. 10, 447-451.

Taser International, Taser International. Retrieved Aug 22, 2007, from Taser Web site:

<http://www.taser.com/products/law/Pages/TASERX26.aspx>