CITY OF RIVERSIDE
COMMUNITY
POLICE REVIEW
COMMISSION

MARLON OLIVER ACEVEDO
OFFICER-INVOLVED DEATH
PUBLIC REPORT

CPRC Case No. 08-047

RPD Case No. P08157587

Approved
December 14, 2011

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Date of Incident: October 31, 2008 2145 Hours

Location: 7857 Cypress Avenue, Riverside

Decedent: Marlon Oliver Acevedo

Involved Officers: Dan Koehler, Police Officer
Jeff Ratkovich, Police Officer
James Heiting, Police Officer

I. Preamble:

The finding of the Community Police Review Commission ("Commission") as stated in this report is based solely on the information presented to the Commission by the Riverside Police Department ("RPD") criminal investigation case files, and follow-up investigate report submitted by CPRC Independent Investigator, Mike Bumcrot of "Mike Bumcrot Consulting," Norco, California, and Investigator Gurney Warnberg, "The Baker Street Group," San Diego, California. Mike Bumcrot Consulting and The Baker Street Group are not associated or affiliated with one another.

The Commission reserves the ability to render a separate, modified, or additional finding based on its review of the Internal Affairs Administrative Investigation. Because the Administrative Investigation contains peace officer personnel information, it is confidential under State law. Any additional finding made by the Commission that is based on the administrative investigation would also be confidential, and therefore could not be made public.

II. Finding:

On August 24, 2011, by a vote of 5 to 0 (2 absent), the Commission found that the officer's use of deadly force was consistent with policy (RPD Policy 4.30 – Use of Force Policy), based on the objective facts and circumstances determined through the Commission's review and investigation.

Rotker	VACANT	Johnson	Brandriff	VACANT	Jackson	Roberts	Santore	Adams
✓		✓	A		✓	A	✓	✓

III. Standard of Proof for Finding:

In coming to a finding, the Commission applies a standard of proof of "Preponderance of Evidence." Preponderance generally means "more likely than not," or may be considered as just the amount necessary to tip a scale. This means also that the Commission need not have certainty in their findings, or that the Commission need not reach a finding beyond a reasonable doubt.

The Preponderance of Evidence standard of proof is the same standard applied in most civil court proceedings.

IV. Incident Summary:

On January 17, 2009, at approximately 2145 hours, Officers Koehler and Ratkovich were dispatched to the area of 7850 Cypress Avenue reference a male adult subject in the roadway screaming at passing vehicles. RPD Dispatch had received multiple calls from citizens in the area stating the subject was drunk or mentally disturbed. When the officers heard the call come out on the police radio, they suspected it was a subject they had passed by earlier in the evening in that same area around 1700 hours. At that time, they saw a male subject, later identified as Acevedo, standing in the street and yelling at passing vehicles. The officers made brief contact with Acevedo at that time. Acevedo told the officers to go out and keep the streets safe. The officers then left and continued with their work assignment.

As the officers arrived on scene pursuant to the 911 calls, they approached the area west on Cypress Avenue and saw a male subject, later identified as Marlon Oliver Acevedo, standing in the roadway. Officer Ratkovich parked the marked police unit in the middle of Cypress Avenue. Both officers, dressed in their Riverside PD marked uniforms, exited the police unit and walked up to Acevedo. Officer Koehler began the initial dialogue with Acevedo.

Upon initial contact with Acevedo, he refused to comply with any directions given by the two officers. Instead, he began to grunt and growl at the officers, raised his clenched fists in a "fighter's stance" and took a punch at Officer Koehler, but missed him. Due to Acevedo's physical aggression, Officer Koehler and Officer Ratkovich removed their expandable batons, extended them, and instructed Acevedo to get down on the ground. Acevedo did not comply and continued with his aggressive behavior. Both officers struck Acevedo with their expandable batons. Officer Ratkovich struck Acevedo twice near the right knee, both of which had no effect on him. Officer Koehler struck Acevedo several times in the left thigh, none of which had any effect.

Acevedo continued to swing his fist at Officer Koehler, striking him in the face and knocking his glasses off. Officer Koehler then grabbed Acevedo to gain control of him. The two struggled for several moments and fell to the ground. While Koehler and Acevedo were struggling on the ground, Officer Ratkovich fired his department issued X26 Taser at Acevedo. The darts of the X26 Taser struck Acevedo in his abdomen. The Taser cycled through its charge, but did not incapacitate Acevedo. It appeared to have no effect on him. Officer Koehler continued to struggle with Acevedo, while at the same time commanding him to give up his hands. Acevedo did not comply with the commands and continued to struggle with Koehler.

Officer Ratkovich stated that Acevedo appeared to be rolling back and forth on the ground as if he was trying to break free from the Taser darts. Since the first charge had no effect, Officer Ratkovich depressed the trigger of his X26 Taser four (4) to five (5) more times in an on-going attempt to incapacitate Acevedo. None of the Taser charges from the darts had any effect on Acevedo. Ratkovich thought perhaps the darts were not making the necessary contact for Acevedo to receive the charges and elected to use the other option of deployment, which is direct contact from the Taser onto the body. While Koehler and Acevedo were still rolling around on the ground in a physical struggle, Ratkovich made a direct contact charge to Acevedo's upper back. This direct charge incapacitated Acevedo and gave the officers the opportunity to place him into handcuffs in order to control him. Medical aid was summoned and AMR and RFD responded to the scene.

While waiting for the arrival of medical aid, Acevedo began to kick at the officers while still in handcuffs. The officers requested further assistance from RPD so that they could use a Hobble

restraint to control Acevedo's kicking. This would be necessary in order for paramedics to render aid without injury. Officer Heiting arrived on scene and assisted by applying the hobble to the suspect's feet. The hobble restraint device was then attached to the handcuffs in order to prevent Acevedo from kicking the officers or arriving medical aid. Acevedo was then secured in the TARP position as medical personnel arrived on scene. Acevedo was rolled onto his side while restrained. Medical personnel made contact with Acevedo while he was lying on his side. As they began to assess and treat Acevedo, they noticed that he was in medical distress, so the handcuffs and hobble restraint device were removed so that proper emergency medical treatment could be applied.

Acevedo was placed onto an emergency medical aid gurney in preparation to transport him to the hospital. Medical personnel continued to apply emergency treatment to Acevedo as he was placed into an AMR ambulance and during transportation to the hospital. Acevedo was taken to Parkview Hospital in Riverside where he was pronounced deceased by hospital staff after his arrival.

V. CPRC Follow-Up:

The Commission requested a review of the Criminal Casebook by an independent investigative firm known as "The Baker Street Group." This firm is located in San Diego, California. The assigned investigator, Gurney Warnberg, submitted two reports. One report was submitted on October 14, 2010, and the other on November 29, 2010. After Mr. Warnberg submitted the first report, he believed that a few other interviews of certain witnesses might offer additional insight. The second report he prepared included a couple of these interviews. Other potential witnesses could not be located and / or would not cooperate with Mr. Warnberg for a follow-up interview.

The Commission requested a cover-to-cover review of the Criminal Casebook by CPRC Independent Investigator Mike Bumcrot of Bumcrot Consulting, located in Norco, California. Mr. Bumcrot is a nationally recognized expert in homicide and officer-involved death cases. The purpose of this review was for Mr. Bumcrot to provide the Commission with his findings based upon his experience and expertise. Mr. Bumcrot felt that the investigation conducted by the Riverside Police Department was thorough in content and that any additional interviews would not change what or how the death of Mr. Acevedo occurred.

Commission members received training in the subject matter of Excited Delirium. The training sessions were provided by Dr. John G. Peters, Institute for the Prevention of In Custody Deaths, Henderson, Nevada. On Wednesday, June 15, 2011, Dr. Peters gave a 2-hour presentation on Excited Delirium at a special training meeting for the CPRC. All commissioners were present except for Robert Slawsby and Rogelio Morales. Also present during this presentation were Sgt. Pat McCarthy and Officer Erik Lindgren of RPD, who provide Excited Delirium and other mental health training to all members of the Riverside Police Department.

On June 16 and 17, 2011, Commissioners Robin Jackson, Dale Roberts, Art Santore, Jon Johnson, and Robert Slawsby attended a 16-hour "Instructor's Course" by Dr. Peters at the Riverside County Sheriff's training facility at Ben Clark Training Facility.

VI. Evidence:

The relevant evidence in this case evaluation consisted primarily of testimony, including that of three civilian witnesses, three of the officers who were involved in the altercation with Acevedo, emergency medical personnel, hospital staff and a Deputy Coroner. Other evidence included police reports and photographs, involved weapons, forensic examination results and reports by independent CPRC investigators.

VII. Applicable RPD Policies:

All policies are from the RPD Policy & Procedures Manual.

- Use of Force Policy, Section 4.30.
- Less Lethal Weapons Systems & Deployment, Section 4.49
- Total Appendage Restraint Methods/Equipment, Section 4.31-7
- Excited Delirium, Section 4.60

The United States Supreme Court has ruled on one (1) case that has particular relevance to the use of force in this incident. All decisions by the United States Supreme Court are law throughout the United States. The case is incorporated into the Use of Force Policy of the RPD.

Graham v. Connor, 490 U.S. 396 (1989), considered the reasonableness of a police officer's use of force, and instructed that the reasonableness must be judged from the perspective of a reasonable officer on scene.

VIII. Rationale for Finding:

The question that this Commission was to answer in the review of this case is whether or not the force used by the officers was reasonable under the circumstances, and conducted in conformance with the established policies and procedures of the Riverside Police Department. After reviewing the criminal casebook, the RPD Use of Force Policy, training, and Commission discussion, it is the opinion of the Community Police Review Commission that the use of force and defensive tools utilized by Officers Koehler and Ratkovich in taking Mr. Acevedo into custody were both reasonable and consistent with the RPD Use of Force Policy, Section 4.30, and Searching, Handcuffing and Prisoner Transportation, Section 4.31.

The RPD Use of Force Policy, 4.30, which governs the force an officer may use, is consistent with California State Law that authorizes peace officers to use force to overcome resistance. California Penal Code, Section 835(a), basically states that *officers can use reasonable force to affect an arrest, prevent escape, or overcome resistance, when they believe someone has committed a public offense. Officers do not need to retreat from their efforts when a suspect resists arrest, and the officers have a right to self-defense.*

The autopsy conducted on Mr. Acevedo by the Riverside County Sheriff-Coroner's Office determined that he (Acevedo) had ingested Phencyclidine (PCP), Cannabinoids (Marijuana), and Atropine. The cause of death is listed in the autopsy report as "Acute Phencyclidine Intoxication."

The Commissioners discussed the drug Atropine since it is not as commonly heard on the street as is PCP and Marijuana. One Commissioner researched Atropine via the internet through

Wikipedia and WebMD. Although the Commissioners were aware that the cause of Acevedo's death was listed as Acute Phencyclidine Intoxication, the Commission asked whether Atropine could have been a contributing factor in his death.

What was learned through this research is that Atropine is derived from the belladonna and jimsonweed plants, which are poisonous and can cause death. Although Atropine has prescribed medicinal uses, it should not be used without a doctor's supervision. Toxic doses of Atropine can lead to palpitations, restlessness, excitement, hallucinations, delirium, and coma. In severe cases, depression and circulatory collapse can occur, leading to a drop in blood pressure and respiratory failure.[1] According to the investigative reports, Acevedo's behavior included restlessness, excitement, hallucinations, and delirium.

The Coroner also indicated that Mr. Acevedo had Hypertrophic Cardiomyopathy, a genetic disease in which the heart muscle becomes abnormally thick and makes it hard for the heart to pump blood. In some cases, this condition causes abnormal heart rhythms and can cause sudden cardiac death.

Officers Koehler and Ratkovich were uniformed patrol officers working a two-man team in a marked RPD police unit. The uniforms and marked police unit should have made it clear to a reasonable person that these were police officials.

On October 31, 2008, at approximately 2145 hours, the RPD emergency communications center began receiving calls from residents in the 7800 block of Cypress Avenue reporting that a male Hispanic, later identified as Marlon Acevedo, was in the middle of the street yelling, throwing things at cars, threatening motorists, and impeding the flow of traffic.

Most of the callers said they believed the subject was under the influence of drugs or alcohol, or suffering from a mental disorder. The callers also informed Dispatch that a female subject, later identified as Acevedo's girlfriend, was trying to get him out of the street, but he was yelling and fighting with her. She subsequently became one of the callers who phoned police asking for assistance.

Officers Koehler and Ratkovich arrived on scene at 2150 hours and found Acevedo in the middle of the street making grunting and growling sounds. They described him as having a "crazed look on his face," and appearing very angry and agitated. Based upon the call information and observations of Acevedo upon arrival, the officers had a duty to detain Acevedo in order to determine if he could care for his safety or the safety of others, and if criminal activity was afoot. Police officers can detain a person based upon "reasonable suspicion" that a crime may be occurring. At this point in the series of events, it is the belief of this Commission that sufficient information existed for the contact and temporary detention of Acevedo pending further investigation.

The officers responded appropriately upon arrival by first illuminating Acevedo with police car lighting. Doing so created an awareness of caution for motorists and served to gain Acevedo's attention. The officers acted appropriately when they initiated verbal contact with Acevedo in asking him to get out of the street, a reasonable direction to remove him from the street for both his personal safety and that of passing motorists.

[1] Atropine information gathered from Wikipedia and WebMD

When Acevedo was unresponsive to the verbal directions given by the officers, Officer Koehler approached Acevedo. Koehler had a duty to inquire about Acevedo's unusual behavior and a duty to attempt to remove him from a dangerous place in the roadway. When Officer Koehler approached Acevedo, he (Acevedo) raised his fists and took a "fighter's stance." It would be reasonable to conclude that, at a minimum, Acevedo did not want to be approached and that he intended to engage the officers in a fight. In response to Acevedo's actions, Officers Koehler and Ratkovich retrieved their expandable batons.

When Acevedo advanced upon Koehler, he struck Koehler in the face with a closed fist, causing Koehler's mouth to bleed and his glasses to fly off. Koehler and Ratkovich acted properly in defending themselves and / or others with baton strikes against Acevedo. Both officers used their batons against Acevedo's legs and avoided body areas that potentially could cause serious injury (as defined in RPD policy). NOTE: The law does not require that an officer actually be battered before taking defensive action and officers are trained to defend themselves upon aggressive action by another.

When the batons were ineffective and the officers wound up on the ground fighting with Acevedo, their next option to use their fists was appropriate. RPD Policy allows fists to be used as intermediary weapons and, under the circumstances in this physical fight with Acevedo, the officers had limited options available to them. Batons had already failed, pepper spray in close contact fighting would likely incapacitate the officers, and no other less-lethal weapons were immediately available. Officer Koehler said he considered use of the carotid control hold, but was unable to get into a position to do so.

Mr. Acevedo was successful in preventing any physical controls by officers and continued to punch and kick. It did not appear that Acevedo felt any pain. Koehler asked Ratkovich to deploy the Taser in a further effort to gain control and compliance from Acevedo.

This Commission believes that, under the circumstances, the use of the Taser was appropriate since it was the last immediate less-lethal weapon available to the officers since nothing else was working. Acevedo's resistance to the officers' efforts was violent and physical.

Officer Ratkovich's discharge of the Taser for five (5) second cycles was reasonable. There was still no effect. For a physically violent person, it could require several cycles to gain compliance. Officer Ratkovich knew the Taser darts struck Acevedo, but he noticed that the darts were close to one another which limited their effectiveness. Ratkovich exercised reasonable judgment by removing the dart cartridge and directing a contact stun to Acevedo's body. Officers are trained that the contact stun may be more effective than poorly located darts in close-quarter fighting.

The direct contact stun worked to the extent that it allowed the officers to place handcuffs onto Acevedo. Nonetheless, Acevedo continued to kick his feet at the officers, striking Officer Ratkovich several times. A hobble restraint device was placed onto Acevedo in order to control his attempts to kick and possibly injure others. The handcuffs and hobble restraint devices were used appropriately to maintain control of Acevedo. Acevedo was initially on his stomach with the restraints on him and he was rolled onto his side within approximately 30 seconds.

The officers acted properly by promptly informing medical aid responders about the events leading to Acevedo's handcuffing and hobbling. Further, the officers acted properly and without delay, to remove all restraints once medical personnel identified that Acevedo was in medical distress.

This Commission does not believe the officers' actions were the proximate cause of Mr. Acevedo's death. As noted earlier, Officers Koehler and Ratkovich used reasonable force in gaining control and restraint of Acevedo, who was violently combative. Acevedo had a preexisting health condition that, together with the ingestion of PCP, Marijuana, and Atropine, of his own free will, combined with the physical exertion of violently fighting with the officers, may have contributed to his deteriorating condition and subsequent death.

IX. Recommendations:

At the time of this incident, RPD did not have a policy on Excited Delirium. On September 10, 2010, RPD implemented a policy referred to as Excited Delirium. The Commission felt that this was a positive step for the Department to address a potential Excited Delirium incident.

X. Closing:

The Commission offers its empathy to the community members, police officers, and City employees who were impacted by the outcome of this incident, as any loss of life is tragic, regardless of the circumstances.

APPENDIX

Section A

RPD Press Release

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Press-Enterprise Articles
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PRESS RELEASE

Riverside Police Department • 4102 Orange Street • Riverside, CA 92501
Phone (951) 826-5147 • Fax (951) 826-2593

FOR IMMEDIATE RELEASE

Date: Friday, October 31, 2008
Contact: Sergeant Mark Rossi
Phone: (951) 353-7106
P08157587

Combative Subject Dies at Local Hospital

Riverside, CA -- On Friday October 31st, 2008 , at approximately 9:45 pm, Riverside Police Officers responded to the 7800 block of Cypress Avenue in Riverside reference several phone calls to the Riverside Police Department's Dispatch Center of an adult male subject standing in the roadway screaming at passing motorists creating a traffic hazard.

Officers arrived on scene and contacted the subject standing in the roadway. The subject became agitated with the officers and refused to comply with their orders. The subject became physically combative and assaulted one of the officers. The adult subject was taken into custody. Riverside Fire Department and American Medical Response personnel responded to the scene to provide medical aid for the adult subject. The adult subject was transported to a nearby hospital where he was pronounced deceased a short time later.

Name of the subject will be released by the Coroner's Office pending notification to next of kin. Anyone with information about this incident is asked to call Detective Ron Sanfilippo at (951) 353-7105.

###P08157587

PE.com
THE PRESS-ENTERPRISE

Riverside police to discuss death of man in custody with review commission

BY SONJA BJELLAND
THE PRESS-ENTERPRISE

Reach Sonja Bjelland at 951-368-9642 or sbjelland@PE.com

A Riverside Police Department captain will give a public briefing tonight about the circumstances surrounding the death of a man in police custody.

The Community Police Review Commission investigates officer-involved deaths. The briefing will take place at the commission meeting at 5:30 p.m. at City Hall, 3900 Main St. in Riverside.

On Halloween at 9:45 p.m., Marlon Oliver Acevedo stood in Cypress Avenue, screaming at motorists and creating a traffic hazard, according to a Riverside police news release. He became agitated with officers and did not comply with their orders, the release stated.

Acevedo then assaulted one of the officers, police said.

Acevedo was then taken into custody. The Riverside Fire Department and American Medical Response treated Acevedo for an undisclosed illness before he was taken to a hospital, where he was pronounced dead, police said.

Acevedo, 35, was pronounced dead at 10:37 p.m. at Parkview Community Hospital, according to the Riverside County coroner's office. Police have not released more details.

The commission previously requested more timely briefings from the Police Department after a man died after being handcuffed. The police did not provide the typical briefing, and City Attorney Greg Priamos told commissioners they would violate the City Charter if they investigated because the case did not involve officer conduct but Priamos would not explain why.

The commission voted to begin a preliminary investigation to determine whether the death was related to officer conduct. The coroner's office ruled that Martin Gasbar Pablo died from natural causes. That created a rift between the city and the commission that led to a directive to withhold money from the commission for investigations until law enforcement investigations are complete.

That directive has meant the commission has not begun investigations into two fatal officer-involved shootings that occurred last month.

PE.com
THE PRESS-ENTERPRISE

Riverside police give version of man's death in custody

10:00 PM PST on Wednesday, November 5, 2008

By SONJA BJELLAND
The Press-Enterprise

A man who died in police custody last week had been beaten with batons and shocked.

Riverside police Capt. Mark Boyer addressed the Community Police Review Commission on Wednesday night, providing the first public details of the incident.

The commission cannot investigate the death until law enforcement investigations conclude, which could take several months.

Marlon Oliver Acevedo, 35, was screaming and standing in stopped traffic on Cypress Avenue in Riverside about 9:45 p.m. Friday, Boyer said.

Police do not know why Acevedo was screaming at traffic. An autopsy report will not be complete for about eight weeks.

When police approached, Acevedo raised his fists and walked toward the officers. Officers Koehler and Ratkovitch struck Acevedo in the knees and legs with retractable batons, Boyer said. The officers' first names were not provided.

Acevedo punched Koehler in the right eye and Ratkovitch shocked Acevedo with a Taser, Boyer said.

The officers then handcuffed Acevedo and called for medical aid, the captain stated.

While waiting for paramedics, Acevedo began kicking and the officers requested another officer, Boyer said.

Officer Heiting arrived and assisted in restraining Acevedo with a device called a "hobble" that controls the legs.

Boyer said Acevedo was on his side after he was restrained.

When paramedics arrived, the handcuffs and hobble were removed once they realized there was a medical emergency, he said.

Boyer said he would have to assume that Acevedo was collapsed or unconscious and no longer resisting.

Acevedo was taken by ambulance to Parkview Community Hospital Medical Center where he was pronounced dead at 10:37 p.m. Friday.

Acevedo's family has hired attorney Samer Habbas to begin investigating if excessive force was used.

Habbas said the preliminary report from the Riverside County coroner's office showed Acevedo had been shocked twice and suffered multiple scratches and cuts on the head and face and multiple bruises and cuts to the arms and legs.

He called the incident tragic, saying that most of it happened in front of Acevedo's girlfriend and mother and that he had a 2-year-old and 4-year-old.

Reach Sonja Bjelland at 951-368-9642 or sbjelland@PE.com

PE.com
THE PRESS-ENTERPRISE

Family of Riverside man who died in custody speaks out

07:01 AM PST on Wednesday, November 12, 2008

By SONJA BJELLAND
The Press-Enterprise

The family of a man who died in Riverside police custody disputes the department's account of how he was handled during his detainment and says their trust in law enforcement is shattered.

A photo of Marlon Oliver Acevedo, 35, with his two children sits in the living room next to lit devotional candles and flowers at his home in Riverside. He died Halloween night after a struggle with police.

Now the family recalls the man who loved music, air guitar and making his children laugh. Every month he sent money to his three sisters in Nicaragua, said his mother, Martha Garay.

Elizabeth Lomeli, 23, Acevedo's girlfriend of five years, was back home on Cypress Avenue with their children, 2 and 4 years old, after trick or treating. She looked outside and saw police wrestling with Acevedo.

Riverside police Capt. Mark Boyer told the Community Police Review Commission that Acevedo was in the street yelling at cars when officers arrived. He raised his fists and walked toward the officers, who struck him with retractable batons.

Lomeli said she and Garay ran outside. One officer had a knee in the back of Acevedo's neck and another was putting on handcuffs.

They put on a leg restraint and then used a stun gun to shock him, Lomeli said.

"He was moving a little bit and they Tased him," she said.

Lomeli said Acevedo was kept on his stomach until he was rolled onto a gurney and put into an ambulance.

"When he wasn't moving no more we knew something had happened," Lomeli said.

Boyer said Acevedo was kept on his side after he was restrained.

Lomeli called local hospitals and figured out that he might be at Parkview Community Hospital Medical Clinic. She wanted to leave the home but was told she could not because she was part of the investigation.

Lomeli said she wasn't allowed to go to the hospital for an hour and a half, and it was another two hours before anyone at the hospital was allowed to tell her anything.

The preliminary report from the coroner's office showed multiple abrasions to Acevedo's head and face, said the family's attorney, Samer Habbas.

The coroner has not yet determined the cause of death.

Habbas said the family would not comment on whether Acevedo was intoxicated or had a mental illness.

"They didn't need to do all that," Lomeli said. "They could have handled the situation in a different way."

Reach Sonja Bjelland at 951-368-9642 or sbjelland@PE.com

Section B

Fact Sheet

Acevedo OID Fact Sheet
CPRC Meeting Date November 10, 2010
Version 1.0

1. On Friday evening, October 31, 2008, RPD Officer Dan Koehler ("Koehler") was on duty assigned to uniformed patrol during the "C" watch (1500-0100) with partner Officer Jeff Ratkovich ("Ratkovich"), who was driving.[1]

2. Koehler and Ratkovich said that at about 5:00 p.m., they were driving on Cypress between Harold and Montgomery when they saw a man, later identified as Marlon Oliver Acevedo ("Acevedo"), who raised his hands over his head and called something out.[2]

3. Koehler and Ratkovich said the officers made a u-turn, pulled alongside the man, and asked, "What's up?" and Acevedo replied, "We gotta keep the streets safe man. Keep the streets safe."[3]

4. Koehler said the officers replied that they would keep the streets safe then drove away.[4]

5. At 9:46 p.m., RPD Dispatch received the first of several calls advising of a man, screaming in the middle of the street in at 7850 Cypress.[5]

6. The area was lit by a street light, which was on the south side of Cypress Avenue, across from 7875.[6]

7. Witness Elizabeth Lomeli ("Lomeli") said that Acevedo is the father of her child.[7]

8. Lomeli said that she came back from trick-or treating and saw Acevedo standing in the street, "acting all weird."[8]

9. Lomeli said Acevedo was saying "kill me," and that he pushed her away when she tried to pull him from the middle of the street.[9]

10. Lomeli went into her home and called the police.[10]

11. When Lomeli went back outside, she saw Acevedo fighting with police officers.[11]

12. Lomeli said officers hit Acevedo with batons, then tased him.[12]

13. Lomeli said Acevedo was calming down, but the officers kept tasing him.[13]

14. Witness Justin Rescorl ("Rescorl") said at about 9:40, he was coming home from trick or treating with his wife Sarah and his 2 children when he saw Acevedo standing in the street screaming in front of 7850 Cypress.[14]

15. Rescorl thought Acevedo either "was drunk or some crazy."[15]

16. Rescorl saw Acevedo throw a square object, possibly a suitcase, at a parked car.[16]

17. Rescorl said Acevedo was yelling, "kill me."[17]

18. Rescorl said Acevedo walked into the street and almost got hit by a car, so Rescorl called the police at 9:44.[18]

19. Rescorl saw a woman approach Acevedo and try to pull him from the street, but he did not comply, and she then left the street.[19]

20. Rescorl saw a black & white police car arrive and illuminate a spotlamp onto Acevedo.[20]

21. Rescorl said 2 uniformed police officers exited the car and approached Acevedo, and he tensed up and moved like he was going to swing.[21]

22. Rescorl said one of the officers responded by striking Acevedo in the leg, and Acevedo then did take a swing at the officer.[22]

23. Rescorl said a second police officer struck Acevedo in the side, then took him down, and hit him several times.[23]

24. Rescorl described Acevedo as “pretty big,” about 6 feet tall and 220 pounds.[24]

25. Rescorl said as the officers were on the ground, he heard them say, “Stop struggling,” to Acevedo, and he replied, “Get the fuck off me.”[25]

26. Rescorl saw that one officer got off of Acevedo, pointed a taser at him, said “stand back,” then discharged the taser, which Rescorl described as “click, click, click.”[26]

27. Rescorl saw that Acevedo was still “bucking” after that.[27]

28. Rescorl said after a few minutes of struggling, Acevedo calmed down then the ambulance arrived.[28]

29. Rescorl said he saw Acevedo with his hands behind his back, but did not see the handcuffing.[29]

30. Rescorl said he was standing about 100 feet from the struggle, and he had a very clear view.[30]

31. Witness Sarah Rescorl (“Sarah”) said she was standing in front of her residence at 7850 Cypress, and she saw Acevedo standing in the middle street yelling “kill me” and “fuck you” to passing traffic.[31]

32. Sarah said Acevedo threw a suitcase or briefcase at a parked car, and struck the car.[32]

33. Sarah said Acevedo was “going in front of” cars, and she was surprised he was not struck by any cars.[33]

34. Sarah said her husband called police because they feared Acevedo was going to get struck.[34]

35. Sarah said a woman went to Acevedo and tried to get him out of the road, but he wouldn’t go.[35]

36. Sarah said 2 uniformed police officers arrived in a black and white car.[36]

37. Sarah said when the 2 officers approached Acevedo, he started swinging at them.[37]

38. Sarah saw both officers respond by striking Acevedo on his legs with their “sticks.”[38]

39. Sarah then saw both officers and Acevedo went to the ground.[39]

40. Sarah said Acevedo continued to struggle, and the officers hit Acevedo “a couple more times,” then tased him.[40]

41. Sarah described the taser as having the sound of a “machine thing” and then “clicking.”[41]

42. Sarah said Acevedo continued to struggle, and the officers held his feet down and then Acevedo stopped moving.[42]

43. Sarah saw that Acevedo was down on his stomach, and appeared to be handcuffed, with his legs bent and an officer holding his legs.[43]

44. Sarah said the ambulance arrived within 5 minutes, or "really fast," and subsequently placed Acevedo on the gurney on his back.[44]

45. Sarah described Acevedo as "pretty big" 5'8" to 5'9", about 280 pounds.[45]

46. Witness Germain Gabaldon ("Gabaldon") said at about 9:40 p.m., he was inside his apartment at 7850 Cypress when he heard a scream and a noise in the street that sounded like someone punching a car.[46]

47. Gabaldon went outside and saw Acevedo in the street screaming and holding traffic, and almost twice was struck by passing traffic.[47]

48. Gabaldon saw 2 uniformed police officers arrive in a black and white Riverside police car.[48]

49. Gabaldon said the 2 officers approached Acevedo, and he began swinging his fists at them.[49]

50. Gabaldon said that 1 officer then used a baton on Acevedo, "in self defense."[50]

51. Gabaldon said Acevedo was a "big guy," 5'8" to 5'9", around 300 pounds.[51]

52. Gabaldon said Acevedo and the 2 officers ended up on the ground.[52]

53. Gabaldon said the officers were trying to restrain Acevedo, but he wouldn't listen and he kept trying to get up.[53]

54. Gabaldon said he then heard a taser twice, which he described as a "zapping" followed by a "sss" sound.[54]

55. Gabaldon said afterwards, it looked like Acevedo was vomiting.[55]

56. Witness Sidney Zamora ("Zamora") said he was on his balcony at 7851 Cypress and he saw Acevedo in the street with his hands up, holding up traffic.[56]

57. Zamora heard Acevedo say, "I don't care if you kill me."[57]

58. Zamora said he called the police.[58]

59. Zamora said 3 or 4 minutes before the police arrived, a woman tried to pull Acevedo from the street, but he pushed her away.[59]

60. Zamora saw that 2 uniformed police officers approached Acevedo, and he heard the officers tell Acevedo to lie down, but he did not comply.[60]

61. Zamora said Acevedo moved so that from his balcony, Zamora could then only see the police officers, but could no longer see Acevedo.[61]

62. Ofcr. Koehler said that at about 9:45, he and partner Ratkovich took a dispatched call of a possible 5150 in the roadway screaming at cars.[62]

63. "5150" refers to California Health & Safety Code section 5150, which allow a peace officer to take into custody for mental evaluation any person who is believed to be a danger to self or others due to a mental disorder.[63]

64. Koehler said when they arrived on Cypress, they found traffic backed up in both directions due to a man standing in the street.[64]

65. Koehler said as soon as he saw Acevedo, he recognized him as the man they had contacted on Cypress earlier in the shift.[65]

66. Koehler said as he approached, he saw that Acevedo had his head down and was making grunting sounds.[66]

67. Koehler said he told Acevedo several times to get out of the street, and Acevedo looked at him but did not respond.[67]

68. Koehler said that when he approached to within a few feet, Acevedo suddenly jumped into a fighting stance with his hands up, and Acevedo barked or growled.[68]

69. Koehler said he jumped back and pulled his expandable ASP baton, and Acevedo advanced toward him.[69]

70. Koehler said he used a two-handed strike to Acevedo's left thigh, which had no visible effect.[70]

71. Koehler said he then delivered a 2nd baton strike to Acevedo's leg, again with no effect, and Acevedo continued to advance.[71]

72. Koehler later viewed Coban video of the fight, and noted that he actually delivered approximately 5 baton strikes to Acevedo's legs.[72]

73. Koehler said he intended to deliver another strike to the legs, but his baton collapsed, and Acevedo then punched Koehler in the face, knocking off his glasses.[73]

74. Koehler said he abandoned his baton and delivered a punch to Acevedo, who then tackled Koehler and tried to take him to the ground.[74]

75. Koehler said Acevedo ended up on his knees, with Koehler on top of him, and Koehler could feel Acevedo attempting to move his face in to bite Koehler on the thigh.[75]

76. Koehler said he grabbed Acevedo's head and turned it, then punched Acevedo in the face several times, forcing Acevedo to go to the ground on his back.[76]

77. Koehler said he was trying to grab Acevedo's arms, and yelled at him to roll over, but Acevedo kept turning and fighting, and prevented control of his arms.[77]

78. Koehler said Acevedo was strong, and the fight was hard, so he yelled to Ratkovich to use the taser.[78]

79. Koehler said he heard the rattling discharge of the taser, but Acevedo was not immobilized, and appeared to be trying to roll over onto the taser wires.[79]

80. Koehler said he was on his knees trying to control Acevedo, who was rolling away toward Ratkovich, so Koehler yelled to tase Acevedo again.[80]

81. Koehler was able to climb onto Acevedo's shoulders, and grab one arm, but Acevedo kept lifting Koehler off the ground, despite Koehler's weight of 265 pounds, and despite Koehler punching Acevedo in the back.[81]

82. Koehler told Ratkovich to contact tase Acevedo, who yelled out at the contact but did not stop fighting and struggling.[82]

83. Koehler said he and Ratkovich were able to get control of first one arm for handcuffing, then after more struggling they cuffed the other arm, but Acevedo continued to fight and struggle even as the officers lied on top of him, and Acevedo was "out of control."[83]

84. Koehler later viewed Coban video, and noted that after Acevedo was handcuffed, he rolled into position to bite Koehler's left inner leg, and when Koehler felt Acevedo's teeth starting to close, Koehler punched Acevedo.[84]

85. Koehler was able to get on the radio and requested a hobble to restrain Acevedo's feet.[85]

86. Koehler said Officer Lim ("Lim") arrived and provided the hobble, and helped to control Acevedo's legs, and that finally Acevedo became compliant.[86]

87. Koehler said he rolled Acevedo onto his side, and at the same time RFD and AMR were pulling up, so Koehler explained to paramedics that the officers had just tased and fought Acevedo.[87]

88. Koehler said a paramedic said, "He's not breathing," and told Koehler to take off the handcuffs, which Koehler did.[88]

89. Koehler said as the result of the fight, he suffered an injured (and subsequently swollen) left knee, injured right collarbone (complaint of pain), and injured lip (swollen and bleeding).[89]

90. Ofcr. Ratkovich said Dispatch put out a call of a 5150 on Cypress in the middle of the street, and Ratkovich thought it might be the same man he had contacted earlier.[90]

91. Ratkovich also noted that his unit was closer than he assigned police units, so he took the call.[91]

92. Ratkovich said when they arrived, he saw that the RPD helicopter had illuminated Acevedo standing in the middle of the street, with multiple cars stopped in the roadway, and several pedestrians nearby on the sidewalks.[92]

93. Ratkovich turned on the overhead bright "takedown" lights to illuminate Acevedo and to slow traffic.[93]

94. Ratkovich said Koehler was first to speak with Acevedo, and told him to get out of the road, and Acevedo immediately "keyed in on" Koehler.[94]

95. Ratkovich said Acevedo immediately raised his hands and took a fighting stance toward Koehler, so both Ratkovich and Koehler deployed their ASP expandable batons.[95]

96. Ratkovich said Acevedo took a swing at Koehler, and although Ratkovich did not see contact, he thought Acevedo had struck Koehler.[96]

97. Ratkovich said he then began delivering baton strikes to Acevedo's right knee, and ordered him to the ground, but Acevedo responded to neither the force nor the commands.[97]

98. Ratkovich said Acevedo was "fairly big," and he and Koehler were on opposite sides facing Acevedo, who remained focused on Koehler.[98]

99. Ratkovich said Acevedo had a "crazed" or "wild" look on his face, and did not appear to be registering what was going on.[99]

100. Ratkovich said he didn't recall exactly how, but Koehler and Acevedo ended up on the ground, and Ratkovich could not find a safe place to deliver any more baton strikes.[100]

101. Ratkovich said he discarded his baton, and tried to grab Acevedo's arms, but Acevedo was "incredibly strong" and was fighting back, and punching Koehler.[101]

102. Ratkovich said Acevedo was on his back, punching and kicking, and the officers could not get Acevedo onto his stomach, despite Ratkovich weighing about 220 pounds.[102]

103. Ratkovich said Koehler told him to use the taser, so Ratkovich kept hold of Acevedo with his left hand, while backing up his upper body 2-3 feet, and fired the taser with his right hand.[103]

104. Ratkovich said he saw the darts make contact with Acevedo, so he discharged a first 5-second burst, but the tasing had no visible affect on Acevedo.[104]

105. Ratkovich said Acevedo continued fighting Koehler, and Acevedo also starting rolling, apparently to roll over the taser wires and break their connection with the taser.[105]

106. Ratkovich said he discharged (cycled) the taser several more times, but Acevedo continued to fight and did not respond to the tasing.[106]

107. Ratkovich said at one point, he felt the taser charge, and realized the wires were getting wrapped around his hand, so he disconnected the dart cartridge so he or Koehler would be protected from taser charge.[107]

108. Ratkovich then delivered a drive stun (contact tase) directly between Acevedo's shoulder blades, as Acevedo was on his side facing away from Ratkovich, still fighting Koehler.[108]

109. Ratkovich said Koehler was finally able to cuff Acevedo's left arm, and Ratkovich then controlled the right arm, and they were able to handcuff Acevedo, who still continued to struggle and kick.[109]

110. Ratkovich said Acevedo was down on his stomach, and Ratkovich was trying to hold Acevedo's legs, but he was able to kick Ratkovich at least 3 times, so Ratkovich removed Acevedo's shoes as other officers began to arrive for assistance.[110]

111. Ratkovich said with the assistance of Ofcrs. Lim and Heiting, they were able to get a hobble onto Acevedo's ankles, and finally secure Acevedo's feet and legs.[111]

112. Ratkovich said that he then noticed that a crowd had formed, so he got up, collected the discarded batons, notified Dispatch that Fire could roll in, and began to contact persons who appeared to be possible family members.[112]

113. Ratkovich said Fire arrived, so he advised them that Acevedo had received baton strikes and taser, and Fire personnel began providing medical attention.[113]

114. Ratkovich said Koehler was still on the ground with Acevedo, who was grunting, and Lim and Heiting were still assisting Koehler.[114]

115. Ratkovich said he saw that medical personnel appeared concerned, and said something about Acevedo being unresponsive, and then Koehler began removing the handcuffs.[115]

116. Officer James Heiting ("Heiting") said he responded to a call for assistance, and when he arrived, he saw Koehler and Ratkovich trying to control Acevedo, who was kicking and moving around.[116]

117. Heiting saw Koehler on Acevedo's upper body, and Ratkovich at Acevedo's feet.[117]

118. Heiting said he assisted by providing a tarp device to secure Aceveo's legs, and Acevedo continued to struggle the entire time.[118]

119. Heiting saw RFD arrive within 30 seconds of him assisting in the struggle to control Acevedo.[119]

120. Heiting said as medical personnel approached, he rolled Acevedo onto his side, and saw as an AMR paramedic reached down for what he perceived as the "standard" task of checking pulse.[120]

121. Ofcr. Lim responded to the 5150 radio call, and when he arrived he saw Ofcrs. Koehler and Ratkovich on top of Acevedo, using their weight to keep him down.[121]

122. Lim said he assisted by first holding down Acevedo's legs, then going to his car to get a hobble for leg restraint.[122]

123. AMR Paramedic Susan Brien ("Brien") said she was on duty when her unit received a call that RPD had a 5150 in need of medical attention in the 7800 block of Cypress.[123]

124. Brien said on arrival, she saw Acevedo lying with his stomach on the ground, handcuffed, and his face to the left.[124]

125. Brien said an RPD officer advised that Acevedo had been combative and had been tased.[125]

126. Brien said it was about 30 seconds from the time she arrived, exited her ambulance, received the preliminary information, and contacted Acevedo.[126]

127. Brien said she could see drool coming from Acevedo's mouth, so she suggested to an officer that Acevedo should be rolled over, and the officer complied.[127]

128. Brien said after Acevedo was rolled onto his side, she reached down to check for a pulse and saw Acevedo take "one last breath."[128]

129. Brien said she told her partner to grab a backboard, and an RPD officer began removing all restraints from Acevedo.[129]

130. Brien said as soon as Acevedo was on the backboard, she began CPR, and CPR continued from that time until after his arrival at Parkview Hospital.[130]

131. RFD Fire Captain Robert Abbruzzese ("Abbruzzese") said he was on duty at RFD Station No. 7, at 10191 Cypress, when he received a call of RPD needing assistance with a 5150 in custody in the 7800 block of Cypress.[131]

132. Abbruzzese said when he arrived, he saw numerous police cars, and a male "hog-tied" (feet together, tied to handcuffs), lying flat on his stomach with his face to the side, on the ground.[132]

133. Abbruzzese said the officers told him that Acevedo appeared to possibly be under the influence of something, due to his erratic behavior.[133]

134. Abbruzzese said Firefighter Bradley Fike attended to Acevedo, so Abbruzzese checked with a police officer who had blood on his mouth, and had his name tag dangling down, indicating that he had been in a fight.[134]

135. Abbruzzese said he asked the officer if he needed help, but the officer asked Abbruzzese to help Acevedo.[135]

136. Abbruzzese said he then assisted other medical aid personnel attending to Acevedo, and Abbruzzese found that Acevedo was not breathing and had no pulse.[136]

137. Abbruzzese said he then told officers that he needed the handcuffs removed immediately from Acevedo.[137]

138. Abbruzzese said he then went into the ambulance, and prepared a breathing tube, which he intubated into Acevedo when he was loaded into the ambulance, lying on his back on a backboard.[138]

139. RFD Firefighter-Paramedic Bradley Fike ("Fike") said he was on duty at RFD Station No. 7, at 10191 Cypress, when he received a call of RPD needing assistance with a 5150 in custody in the 7800 block of Cypress.[139]

140. Fike said when he arrived, he saw several RPD officers and Acevedo handcuffed lying chest down in the street, slightly tilted on his left shoulder, with his face turned to the right.[140]

141. Fike said when he asked the officers what was going on, they told him Acevedo was agitated and appeared to be under the influence and "5150" (possible need of mental evaluation).[141]

142. Fike said at about the same time, a female AMR responder arrived and approached Acevedo, and said, "Hey, I don't think he's breathing."[142]

143. Fike said he turned from the officer, and immediately began to assist with Acevedo, including directing an officer to immediately remove the handcuffs and hobble.[143]

144. Fike said he then assisted getting Acevedo onto a backboard, beginning CPR, moving Acevedo to the ambulance, and transported to Parkview.[144]

145. CAD data showed that Koehler and Ratkovich were on scene on Cypress at 2149 hours, and RPD "Air 1" was on scene at 2150.[145]

146. CAD data showed a dispatch at 2152 by Air 1 that, the "subj[ect] is subdued."[146]

147. Post mortem examination of Acevedo identified bruising on both legs about the knee and thigh, a possible impact mark on the left rib cage, an abrasion to the inside of the lower lip, 2 taser markings to the stomach area (with one dart still imbedded), and 2 taser marks on the right ribcage, possibly from a contact tase.[147]

148. Download of data from Ofcr. Ratkovich's taser showed six (6), five-second burst deployments on October 31, beginning at 21:43:23, and ending at 21:44:22 (note: taser internal clock not calibrated with CAD clock).[148]

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[1] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 2-3, 87-101; & Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 3, 110-129.
[2] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 184-189; & pg. 8, 303-305; & Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 4, 157-175.
[3] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 4, 189-194; pg. 8, 318-320; & Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 4, 157-175.
[4] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 4, 194-197.
[5] CAD printout, tab 41 a, pg. 1, 2146 entry.
[6] Det Cobb, supp. report, tab 19, pg. 2.
[7] Ofcr Franco interview of E. Lomeli, tab 17, pg. 1, 19.
[8] Ofcr Franco interview of E. Lomeli, tab 17, pg. 2, 55-81.
[9] Ofcr Franco interview of E. Lomeli, tab 17, pg. 3, 94-96; & pg. 7, 304-315.
[10] Ofcr Franco interview of E. Lomeli, tab 17, pg. 2, 89; & pg. 4, 164-170.
[11] Ofcr Franco interview of E. Lomeli, tab 17, pg. 4, 172-180; & pg. 9, 363-365.
[12] Ofcr Franco interview of E. Lomeli, tab 17, pg. 5, 182-188.
[13] Ofcr Franco interview of E. Lomeli, tab 17, pg. 5, 187-188.
[14] Det Rowe interview of J. Rescorl, tab 20, pg.1, 74-75; & pg. 3, 93-100; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 2-3, 86-104.
[15] Det Rowe interview of J. Rescorl, tab 20, pg.1, 76; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 2, 68-70.
[16] Det Rowe interview of J. Rescorl, tab 20, pg. 2, 78; & pg.3, 123-134; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 3, 101-110.
[17] Det Rowe interview of J. Rescorl, tab 20, pg.4, 143-166; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 2, 68-69.
[18] Det Rowe interview of J. Rescorl, tab 20, pg.1, 78-82; & pg. 3, 99-100; & pg. 4, 175-176; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 1, 36.
[19] Det Rowe interview of J. Rescorl, tab 20, pg. 6, 233-255; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 3, 112-122.
[20] Det Rowe interview of J. Rescorl, tab 20, pg. 10, 505-519.
[21] Det Rowe interview of J. Rescorl, tab 20, pg.2, 84-85; & pg. 6, 260-268; & pg. 7, 270-306; & pg. 12, 502-538; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 3-4, 131-159.
[22] Det Rowe interview of J. Rescorl, tab 20, pg.2, 85-87 & pg. 7, 310-313; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 4, 163-165.
[23] Det Rowe interview of J. Rescorl, tab 20, pg.1, 87-88; & pg. 9, 366-371; & pg. 9, 393-404; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 4, 165-174.
[24] Det Rowe interview of J. Rescorl, tab 20, pg.9, 374-391; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 5, 201.
[25] Det Rowe interview of J. Rescorl, tab 20, pg.8, 320-336.
[26] Det Rowe interview of J. Rescorl, tab 20, pg.1, 74-75; & pg 10, 405-414; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 4, 174-179.
[27] Det Rowe interview of J. Rescorl, tab 20, pg.2, 89; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 5, 187-188.

[28] Det Rowe interview of J. Rescorl, tab 20, pg.3, 90-91; & pg. 10, 422-430; Ofcr. Heiting interview of J. Rescorl, tab 24, pg. 5, 223-224.
[29] Det Rowe interview of J. Rescorl, tab 20, pg.10, 429- 432.
[30] Det Rowe interview of J. Rescorl, tab 20, pg.8, 349-359.
[31] Ofcr DeGruy interview of S. Rescorl, tab 10, pg. 1, 12-33; Det Brandt interview of S. Rescorl, tab 22, pg. 5, 196.
[32] Det Brandt interview of S. Rescorl, tab 22, pg. 4, 166-171.
[33] Ofcr DeGruy interview of S. Rescorl, tab 10, pg. 1, 35-43; Det Brandt interview of S. Rescorl, tab 22, pg. 1, 89-90; & pg. 2, 96.
[34] Ofcr DeGruy interview of S. Rescorl, tab 10, pg. 2, 47-48.
[35] Det Brandt interview of S. Rescorl, tab 22, pg. 3, 102-104; & pg. 14, 590-602.
[36] Det Brandt interview of S. Rescorl, tab 22, pg. 6, 228-265.
[37] Ofcr DeGruy interview of S. Rescorl, tab 10, pg. 2-3, 86-96; Det Brandt interview of S. Rescorl, tab 22, pg. 3, 104; & pg. 7, 296-314.
[38] Det Brandt interview of S. Rescorl, tab 22, pg. 8, 315-369.
[39] Ofcr DeGruy interview of S. Rescorl, tab 10, pg. 1, pg 3, 100-122; Det Brandt interview of S. Rescorl, tab 22, pg. 3, 105; & pg. 9, 368-382.
[40] Ofcr DeGruy interview of S. Rescorl, tab 10, pg. 1, pg 3, 122-128; Det Brandt interview of S. Rescorl, tab 22, pg. 9, 381-403.
[41] Det Brandt interview of S. Rescorl, tab 22, pg. 9, 393-395.
[42] Det Brandt interview of S. Rescorl, tab 22, pg. 9, 383-388.
[43] Det Brandt interview of S. Rescorl, tab 22, pg. 10-11, 417-460.
[44] Det Brandt interview of S. Rescorl, tab 22, pg. 11-12, 462-511.
[45] Det Brandt interview of S. Rescorl, tab 22, pg. 12-13, 537-552.
[46] Det Brandt interview of G. Gabaldon, tab 22, pg. 3, 94-96; & pg. 7, 308-310.
[47] Det Brandt interview of G. Gabaldon, tab 22, pg. 3, 94-106; & Ofcr Bonome, supp. report, tab 9, pg. 2.
[48] Det Brandt interview of G. Gabaldon, tab 22, pg. 13-14, 567-608.
[49] Det Brandt interview of G. Gabaldon, tab 22, pg. 4, 145-147, & 167-175; & pg. 9, 395-403; & pg. 13, 547.
[50] Det Brandt interview of G. Gabaldon, tab 22, pg. 13, 548-553; & pg. 17, 754-755.
[51] Det Brandt interview of G. Gabaldon, tab 22, pg. 14-15, 621-631.
[52] Det Brandt interview of G. Gabaldon, tab 22, pg. 9, 380-393.
[53] Det Brandt interview of G. Gabaldon, tab 22, pg. 11, 463-469.
[54] Det Brandt interview of G. Gabaldon, tab 22, pg. 10, 426-440; & pg. 11, 469; & pg. 12, 527-537.
[55] Det Brandt interview of G. Gabaldon, tab 22, pg. 12, 495.
[56] Det Rowe interview of S. Zamora, tab 21, pg. 1-2.
[57] Det Rowe interview of S. Zamora, tab 21, pg. 4-5, 175-183.
[58] Det Rowe interview of S. Zamora, tab 21, pg. 2, 79; & pg. 5 187-188.
[59] Det Rowe interview of S. Zamora, tab 21, pg. 7, 274-302.
[60] Det Rowe interview of S. Zamora, tab 21, pg. 3, 104-122; & pg. 12, 495-501.
[61] Det Rowe interview of S. Zamora, tab 21, pg. 5, 225-226.
[62] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 201-204; & transcript of radio traffic, tab 42, pg. 1.
[63] California Health & Safety Code, section 5150 (2008).
[64] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 204-206; & pg. 9, 373-380.
[65] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 208-209.
[66] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 209-211; & pg. 8, 358-359.
[67] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 211-213; & pg. 9, 391-396.
[68] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 213-216; & pg. 9, 395-404; & transcript of radio traffic, tab 42, pg. 2.
[69] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 216-218.
[70] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 218-221.
[71] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 221-222: & pg. 11, 461-476.

[72] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26a, transcript pg. 2, para. 3.
[73] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 5, 222-224; & pg. 11, 478-487.
[74] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 225-227.
[75] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 227-229; & pg. 121, 493-508.
[76] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 229-235.
[77] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 232-237.
[78] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 233-238.
[79] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 238-240.
[80] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 240-242.
[81] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 244-249; 259; & pg. 22, 951-968.
[82] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 249-253; & pg. 15, 636-644.
[83] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 256-261.
[84] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26a, transcript pg. 2-5.
[85] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 6, 266-269.
[86] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 7, 275-283.
[87] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 7, 283-287; & pg. 18, 801-803.
[88] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 7, 288-290.
[89] Det Sanfilippo interview of Ofcr. D. Koehler, tab 26, pg. 4, 135-155: & Det Rowe, supp report, tab 32, pg. 2.
[90] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 5, 199-209.
[91] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 5, 208-214.
[92] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 5, 218-222.
[93] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 17, 723-739.
[94] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 5-6, 223-225.
[95] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 6, 226-230.
[96] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 6, 230-232; & pg. 14, 601-613.
[97] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 6, 236-255.
[98] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 6-7, 254-276.
[99] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 7, 280-289.
[100] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 8, 342-346.
[101] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 8, 348-358.
[102] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 9, 362-373: & pg. 18, 782-783.
[103] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 9, 373-378.
[104] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 9, 378-380.
[105] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 9, 380-384.
[106] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 9, 385-386; & pg. 14-15, 622-649.
[107] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 9, 393-397.
[108] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 9, 397-399; & pg. 15, 657-669.
[109] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 9-10, 399-414.
[110] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 10, 414-424; & pg. 16, 671-674.
[111] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 10, 424-434.
[112] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 11, 459-467; & pg. 16, 688-708; & transcript of radio traffic, tab 42, pg. 3; & pg. 5.
[113] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 11, 475-487.
[114] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 12-13, 504-576.
[115] Det. Sanfilippo interview of Ofcr. J. Ratkovich, tab 27, pg. 13, 569-581.
[116] Det Sanfilippo interview of J. Heiting, tab 28, pg. 8, 337-360.
[117] Det Sanfilippo interview of J. Heiting, tab 28, pg. 10, 423-425.
[118] Det Sanfilippo interview of J. Heiting, tab 28, pg. 12, 511-533.
[119] Det Sanfilippo interview of J. Heiting, tab 28, pg. 9, 367-369.
[120] Det Sanfilippo interview of J. Heiting, tab 28, pg. 9, 371-376.
[121] Ofcr Lim, supp report, tab 8, pg. 1.
[122] Ofcr Lim, supp report, tab 8, pg. 1.

[123] Det Sanfilippo interview of S. Brien, tab 25, pg. 1-2, 36-72.
[124] Det Sanfilippo interview of S. Brien, tab 25, pg. 2-3, 77-104.
[125] Det Sanfilippo interview of S. Brien, tab 25, pg. 3, 109-112.
[126] Det Sanfilippo interview of S. Brien, tab 25, pg. 6-7, 254-275.
[127] Det Sanfilippo interview of S. Brien, tab 25, pg. 3-4, 116-145.
[128] Det Sanfilippo interview of S. Brien, tab 25, pg. 4, 140-149.
[129] Det Sanfilippo interview of S. Brien, tab 25, pg. 4, 157-179.
[130] Det Sanfilippo interview of S. Brien, tab 25, pg. 5, 205-224.
[131] Det Sanfilippo interview of R. Abbruzzese, tab 25, pg. 1-2, 12-59.
[132] Det Sanfilippo interview of R. Abbruzzese, tab 25, pg. 2, 69-90; & pg. 8, 353-354.
[133] Det Sanfilippo interview of R. Abbruzzese, tab 25, pg. 6, 238-255.
[134] Det Sanfilippo interview of R. Abbruzzese, tab 25, pg. 3, 107-135.
[135] Det Sanfilippo interview of R. Abbruzzese, tab 25, pg. 4, 139-142.
[136] Det Sanfilippo interview of R. Abbruzzese, tab 25, pg. 4, 150-158.
[137] Det Sanfilippo interview of R. Abbruzzese, tab 25, pg. 4, 170-178.
[138] Det Sanfilippo interview of R. Abbruzzese, tab 25, pg. 5, 193-207.
[139] Det Sanfilippo interview of B. Fike, tab 25, pg. 1, 12-40.
[140] Det Sanfilippo interview of B. Fike, tab 25, pg. 2, 54-63; & pg. 5, 218; & pg. 6, 227-255.
[141] Det Sanfilippo interview of B. Fike, tab 25, pg. 2, 64-79.
[142] Det Sanfilippo interview of B. Fike, tab 25, pg. 3, 88-90.
[143] Det Sanfilippo interview of B. Fike, tab 25, pg. 3, 94-122.
[144] Det Sanfilippo interview of B. Fike, tab 25, pg. 3-4, 126-136; & pg. 9-10, 391-420.
[145] CAD, tab 41a, pg. 1; & transcript of radio traffic, tab 42, pg. 2.
[146] CAD, tab 41a, pg. 2; & transcript of radio traffic, tab 42, pg. 3.
[147] Det Cobb, supp. report, tab 37, pg. 2.
[148] Sgt. Rossi, supp. report, tab 28, pg. 5-6, sequence nos. 0099-0104.

Section C

Questions & Answers

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Information Requested
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Excited Delirium

Excited Delirium / Hypothermia

ExcitedDelirium.org
(website only)

ANN PRICE et al., Plaintiffs,
v.
COUNTY OF SAN DIEGO et al.,
Defendants

January 11, 2011

Commission Member Art Santore asked staff to provide information on the following two terms: “Excited Delirium” and “Hyperthermia.” An e-mail response was requested.

According to RPD policy section 4.60 (see attached General Order and RPD Policy Section 4.60), Excited Delirium is defined as a state of extreme mental and physiological excitement, usually associated with chronic illicit drug use, characterized by exceptional agitation and hyperactivity, hyperthermia, hostility, exceptional strength, aggression, acute paranoia, and endurance without apparent fatigue.

The web links below provide further discussion on the term Excited Delirium, its symptoms, and medical status:

http://www.exciteddelirium.org/indexForLawEnforcement.html

http://www.policeone.com/columnists/chris-lawrence/articles/121675/

http://www.policeone.com/columnists/chris-lawrence/articles/126389/

Hypothermia is a medical term that refers to having a core body temperature of less than 35 C or 95 F. (Source: MedicineNet.com) It is one of the conditions associated with Excited Delirium.

GENERAL ORDER

Police Department

SERGIO G. DIAZ
Chief of Police

NO.: 2010- 006

DATE: SEPTEMBER 24, 2010

TO: ALL PERSONNEL

FROM: SERGIO G. DIAZ
CHIEF OF POLICE

RE: SECTION 4.60 EXCITED DELIRIUM

POLICY AND PROCEDURES MANUAL - REVISIONS, DELETIONS AND ADDITIONS:

Section 4.60 Excited Delirium Policy has been added to the Riverside Police Department Policy and Procedures Manual.

Refer to the attached policy for further instructions and implementation.

The attached policy is adopted and effective immediately.

SD/mjb

Distribution: RPD Email

Effective Date: 09/15/2010

Approval:

Sergio G. Diaz
Chief of Police

4.60 EXCITED DELIRIUM:

A. POLICY:

Excited Delirium (ED) is a life-threatening medical emergency, disguised as a police problem. Once officers encounter a person displaying symptoms of excited delirium (err on the side of caution if unsure), steps must be taken to ensure appropriate medical intervention as soon as possible. A person in the throes of this acute excited state should be considered in extreme medical crisis, and may die, despite all reasonable precautions taken by officers and other emergency responders to help and protect the subject.

In addition to whatever law enforcement response may be required, the incident shall be managed as a medical emergency. As there can be no medical intervention without custody, officers will take reasonable and necessary action, consistent with provided training and this directive, to ensure that the person receives a police response which is appropriate to the subject's needs, while protecting the safety of all concerned.

B. DEFINITION:

Excited Delirium – A state of extreme mental and physiological excitement, usually associated with chronic illicit drug use, characterized by exceptional agitation and hyperactivity, hyperthermia, hostility, exceptional strength, aggression, acute paranoia, and endurance without apparent fatigue.

Excited Delirium presents as a cluster of physiological and behavioral symptoms, which may include:

a. Bizarre and/or violent behavior
b. Confusion or disorientation
c. Incoherent/nonsensical speech
d. Hyperactivity
e. Acute paranoia
f. Aggression
g. Profuse sweating
h. Hyperthermia
i. Shedding of clothes or nudity
j. Hallucinations
k. Attraction to glass (smashing glass common)
l. Drooling/Foaming at the mouth
m. Fear and panic
n. Exceptional physical strength
o. Endurance without apparent fatigue
p. Ability to effectively resist multiple officers

C. PROCEDURE:

1. Communications Bureau Responsibilities

a. Upon receipt of a call for service that may lead the dispatcher to believe a person is exhibiting signs of Excited Delirium, as described above, a minimum of one (1) supervisor and four (4) officers will be dispatched, if practical, and the Watch Commander will be notified.

b. Emergency medical services consistent with a response to a subject experiencing an extreme medical crisis will also be dispatched to respond when the original nature of the call dictates, or when requested by officers on the scene. EMS personnel shall be advised to stage at a location a safe distance from the scene until notified by officers that the scene is secured.

2. Responding Patrol Officers(s) Responsibilities

a. Responding officers shall assess the situation to determine if the person is suffering from ED. The determination must necessarily be based on a rapid assessment of the overall scenario and behavior of the subject. If ED is suspected, (err on the side of caution if unsure), immediately request EMS and the Watch Commander if they have not been initially dispatched.

b. If the ED subject is armed and/or combative or otherwise poses a threat that requires immediate intervention, officers shall employ reasonable and necessary force to protect themselves and others and take the person into custody.

c. If the ED subject is unarmed and presents no immediate threat to self or others, officers shall, if practical, contain the subject while maintaining a safe distance and remove others who might be harmed.

Officers shall formulate a custody plan prior to making physical contact with the subject, if possible. There can be no medical intervention without custody. The object of the plan is to de-escalate the situation, calm the individual and gain control of the person so that he may be medically cared for. If practical, attempt to gain the ED subject's voluntary compliance with these tactics:

(1) Preferably, only one officer should attempt to engage the subject in conversation. Remain calm, speak in a conversational, non-confrontational manner, and reassure the subject that you are trying to help.

(2) Attempt to have the individual sit down, which may have a calming effect. Also, refrain from making constant eye contact, which may be interpreted as threatening.

(3) Because of the subject's mental state, statements and questions may need to be repeated several times. The subject may be extremely fearful and confused, so be patient and reassuring, as it may take some time for him to calm down.

d. Once sufficient officers are present and if the determination is made that physical force is necessary, the custody plan must be implemented quickly, and with overwhelming force, to minimize the intensity and duration of any resistance and to avoid a prolonged struggle, which may increase the risk of sudden death. If possible, officers should ensure medical personnel are staged nearby prior to implementing the custody plan.

e. Officers shall take into consideration all available force options and control techniques, with the realization that ED subjects often demonstrate unusual strength, resistance to pain, as well as instinctive resistance to the use of force. Primary consideration should be given to proper application of the TASER, which has proven effective as it temporarily causes neuromuscular incapacitation, providing officers with a window of opportunity to safely control and restrain the subject. Immediately upon TASER application, a multi-officer take-down team, using a coordinated group tactic, should swarm the subject, gain physical control and handcuff the subject while he or she is incapacitated by the TASER.

f. When needed, the objective of using a restraining device is to secure the feet and legs of a suspect to control kicking, fighting and standing. Restraining is also used to control a subject's feet to prevent injury to officers and/or the subject.

g. Approved restraining devices that may be used during an ED incident are:

(1) The Department's approved hobble and/or handcuffs.

(2) AMR and RFD personnel carry four point soft restraints that are also acceptable to restrain a subject experiencing excited delirium incidents.

Officers who restrain a subject are reminded that **immediately** following restraint of the subject; he or she must be rolled onto their side, thereby relieving pressure from the chest and abdomen, allowing the subject to breathe easier.

h. Once the subject is in custody and the scene is secured, immediately summon EMS personnel. Until primary responsibility for the care of the subject is transferred to EMS personnel, officers must keep the restrained subject under constant observation. Place the individual in a supine position or on his side and continually monitor and assess vital signs. Be especially vigilant if he suddenly stops resisting and becomes tranquil. Initiate CPR as indicated.

i. Officers shall coordinate with on-scene EMS personnel and transfer custody of the subject to them, assisting in any way, to avoid delay in the transportation of the individual to a medical facility. An officer shall be assigned to accompany EMS personnel during the ambulance transport.

j. Upon arrival at the emergency room, ensure that the subject's core body temperature is recorded.

3. Supervisor Responsibilities

a. A supervisor shall respond to and assume command of all ED calls.

b. The supervisor shall ensure that all necessary police and administrative forms and reports are completed as required, to include as much of the following information as possible:

(1) Description and duration of subject's behavior prior to and after police contact, to include subject utterances and actions, i.e., running, shouting, pacing furiously, etc.

(2) Type and duration of resistance.

(3) Number and identity of officers involved.

(4) Method of subject transport, to include time transport begins and ends.

(5) Struggle against restraints during transport.

(6) Presence or absence of sweating by subject.

(7) Air Temperature/Humidity at scene of incident.

(8) Describe resuscitation efforts, if applicable, number of times attempt was made, and by whom.

(9) Note subject's body temperature at scene, if available, at arrival at medical facility and, if applicable, upon death.

ANN PRICE et al., Plaintiffs, v. COUNTY OF SAN DIEGO et al., Defendants.

CIVIL NO. 94-1917-R (AJB)

UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF CALIFORNIA

990 F. Supp. 1230*; *1998 U.S. Dist. LEXIS 9397

January 8, 1998, Decided
January 9, 1998, Filed

DISPOSITION: [**1] Judgment granted for Defendants.

COUNSEL: For ANN PRICE, an individual, ANN PRICE, as Guardian ad Litem of Benjamin Price, UNBORN BABY PRICE, ROBERT PRICE, MARGARET PRICE, DANIEL L ESTATE OF DANIEL L. PRICE, plaintiffs: Charles R Woods, Trost Street Woods and Messina, San Diego, CA.

For COUNTY OF SAN DIEGO, JOHN GROFF, STEVEN CLAUSE, MARK TALLEY, JIM ROACHE, SAM SHEPARD, defendants: John J Sansone, Dep County Counsel, Office of County Counsel, Ricky R Sanchez, County of San Diego, Office of County Counsel, San Diego, CA.

JUDGES: John S. Rhoades, Sr., United States District Judge.

OPINION BY: John S. Rhoades, Sr.

OPINION

[*1234] FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. Overview

Daniel Price died after San Diego Country Sheriff's Department deputies forcibly restrained him. His family and estate then sued the deputies, then-Sheriff Jim Roache, and the county of San Diego. Plaintiffs allege causes of action for wrongful death, assault, battery, negligence, and violation of Price's civil rights.

The Court held a bench trial. After a lengthy trial and a careful review of the evidence, the Court hereby issues its findings of fact and conclusions of law in narrative form. [1]

> 1 The Court has elected to issue its findings and conclusions in narrative form because a narrative format more fully explicates the reasons behind the Court's conclusions, which facilitates appellate review and provides the parties with more satisfying explanations.
>
> However, *Federal Rule of Civil Procedure 52(a)* requires the Court to "find the facts specially and state separately its conclusions of law . . . ." *Fed. R. Civ. P. 52(a)*. Nevertheless, it is "sufficient if the findings of fact and conclusions of law . . . appear in an opinion . . . filed by the court." *Id.* Accordingly, the Court has included an Appendix at the end of this Opinion that states separately its findings and conclusions. The Court incorporates the Appendix into this Opinion by reference.

[**2] **II. Background**

On June 28, 1994 Daniel Price inspected a house that was for sale. Price, who had a history of chronic methamphetamine abuse, wore only shoes, socks, and shorts. Price did not seem to be intoxicated, but he was very animated, extremely demonstrative in his gestures, and spoke loudly. After touring the house, Price attempted to give his wallet to the occupant, Timothy Malone.

Price then hugged Malone and departed. As Price walked away from the house, Malone saw him throw his appointment book and checkbook into some bushes.

Price then walked to a gate that led to the backyard of a nearby house, in which Christine Arrigo was sunbathing. After attempting to open the gate, Price made several unintelligible comments and departed.

Ms. Arrigo called 911, claiming that a man had thrown rocks at her windows. San Diego County Sheriff's Department deputies John Groff and Steven Clause arrived at the scene and contacted Price. Price told the deputies that he was fixing his truck and that he intended to go to a nearby house. The deputies allowed him to leave. Price then got into his truck and drove away -- past the house to which he had told the deputies he was going. [**3] Although Price did not drive faster than thirty-five miles per hour, the deputies became suspicious and decided to contact him again.

The deputies stopped Price and asked him to exit his truck. Price did not comply and a violent scuffle, more properly characterized as a brawl, ensued. Witness Sandy Bias testified that Price was "resisting totally" and shouting at the deputies as they tried to calm him. Ms. Bias described Price as a man "going crazy," as if under the influence of drugs. Price knocked Deputy Groff's eyeglasses from his face, and the deputies believed [*1235] that Price was trying to grab their guns.

The deputies sprayed Price with small amounts of pepper spray and wrestled him to the ground. The deputies placed Price face-down and handcuffed him with his hands behind his back. Price continued to resist, struggle, yell, and kick at the deputies.

Deputies Sam Sheppard and Steven Tally then arrived. Because Price was kicking, Deputy Tally bound Price's legs together with leg shackles. Nevertheless, Price continued to kick at the deputies with both legs at once.

To control Price, the deputies held him down with their body weight and connected the leg shackles to the handcuffs [**4] with a second set of handcuffs. In other words, they bound his hands and legs together behind his back as he lay prone. This four-point restraint, or "hog-tie," immobilized him.

The parties agree, and Plaintiffs' police-procedures expert confirmed, that the deputies used reasonable force up to the moment of the hog-tie, and that it was proper to subdue Price with body weight. The parties also agree that applying the hog-tie, in and of itself, was reasonable. Thus, the actions of the deputies up to the moment the hog-tie was accomplished are not at issue, nor is their decision to use the hog-tie restraint.

The issues in this case revolve around what happened next. As the deputies hog-tied Price, they necessarily applied some pressure to his torso. A deputy knelt next to Price and placed one knee on his back. The deputy also placed his hand on Price's shoulder. After the deputy completed the hog-tie, he may have maintained pressure for a short time as he paused before rising from the ground.

Deputy Tally then knelt next to Price and placed one knee on his back. Deputy Tally rested most of his weight on his heels. Deputy Tally maintained contact in an effort to calm Price and as a means of [**5] communicating his presence. Deputy Tally did not apply significant pressure to Price's torso.

At some point, Price began to smash his face into the ground repeatedly. In an effort to prevent Price from injuring himself, a deputy placed his foot on the back of Price's head and a kleenex box was placed underneath his face. Because of the blood on Price's face, the deputies called for medical assistance.

The deputies left Price lying shirtless on the hot asphalt for several minutes, despite a nearby shaded area. The asphalt temperature was approximately 133.9 degrees Fahrenheit. Although Deputy Tally was near Price after the hog-tie was complete, the deputies did not monitor Price closely as he lay hog-tied.

At some point, Price began turning blue, which suggests that he could not breathe properly. [2] As might be expected with such a dynamic and traumatic event, there is considerable variance in the testimony about when Price began to turn blue and how much time elapsed before the medics arrived.

2 Not all witnesses testified that Price turned blue. For example, one of the medics who responded did not see and did not note in his report that Price was blue. Another medic testified that Price was blue.

[**6] Nevertheless, it appears that before the medics arrived, the deputies noticed Price turning blue. [3] However, they did not release him from the hog-tie immediately, nor did they administer cardiopulmonary resuscitation ("CPR"), despite the fact that each of them had CPR training. [4]

3 Although some evidence indicates that the deputies called for medics because of the change of color, the stronger evidence suggests that the deputies called for medical assistance because of the blood on Price's face.

4 Testimony was not completely consistent about whether Price was still hog-tied when the medics arrived. It appears that Deputy Tally was

preparing to release Price and administer CPR when the medics arrived.

The medics arrived within minutes, but by that time Price had no pulse and had stopped breathing. The medics administered CPR but to no avail. They then loaded Price into an ambulance and took him to the hospital. While in transit, the medics managed to restore Price's vital signs by administering "shots [**7] to the heart" and anti-narcotic medication. However, he did not regain consciousness.

[*1236] On June 30, 1994 Price died. A county medical examiner, John W. Eisele, M.D., conducted the autopsy. Dr. Eisele found low levels of methamphetamine in Price's system. He also found petichaie (pinpoint) hemorrhaging in Price's left eye, which suggests that Price's torso had been compressed. [5] Dr. Eisele listed the cause of death as "hypoxic encephalopathy due to restrictive asphyxia with cardiopulmonary arrest due to maximum restraint in a prone position by law enforcement." (Pls.' Ex. 12 at 1.) Dr. Eisele listed a contributing cause of death as "acute methamphetamine abuse." (*Id.*) [6]

5 One of Defendants' expert witnesses, Thomas Neuman, M.D., testified that numerous other factors can cause petichaie hemorrhaging, including problems that Mr. Price experienced while in the hospital. In addition, Dr. Eisele testified that heart failure, which Mr. Price experienced, can cause petichaie hemorrhaging.

6 Dr. Eisele testified at trial that the pepper spray did not contribute to Price's death. (Eisele Excerpt of Trial Tr. at 27.)

[**8] Plaintiffs then sued the deputies, then-Sheriff Jim Roache, and the county of San Diego. Plaintiffs allege a cause of action against the deputies under *42 U.S.C. § 1983*, for allegedly violating Price's *Fourth* and *Fourteenth Amendment* right to be free from excessive force. [7] Plaintiffs also allege state-law causes of action against the deputies for wrongful death, assault, battery, and negligence.

7 *Section 1983* provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State of Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law . . . .

Plaintiffs have sued Defendant Roache under *§ 1983* for the actions of the deputies. Plaintiffs also have sued Defendant Roache under *§ 1983* for being deliberately indifferent [**9] to Price's civil rights. Additionally, Plaintiffs assert a negligence cause of action against Defendant Roache.

Plaintiffs next allege a cause of action under *§ 1983* against the county, relying on the theory of municipal liability articulated in *Monell v. New York City Department of Social Services, 436 U.S. 658, 56 L. Ed. 2d 611, 98 S. Ct. 2018 (1978)*. Plaintiffs also seek to hold the county liable under the doctrine of respondeat superior. [8]

8 Plaintiffs also sought to hold Defendant Roache liable under a respondeat superior theory. In addition, Plaintiffs alleged a cause of action under *California Civil Code section 52.1*. The Court granted summary judgment for Defendants on these claims on November 6, 1996.

The Court will discuss each cause of action in turn.

III. Discussion

A. The Claims Against The Deputies

1. The *§ 1983* Claim

Plaintiffs have sued the deputies under *§ 1983*, arguing that the deputies used excessive force on Price, in violation of the *Fourth* and *Fourteenth Amendments*. [**10] Plaintiffs allege that the hog-tie, as applied in the unique circumstances of this case, constituted excessive force. Plaintiffs also allege that a deputy used unreasonable force when he placed his foot behind Price's head. Plaintiffs further claim that the deputies used excessive force by leaving Price prone on hot asphalt. Lastly, Plaintiffs argue that the failure to render CPR constituted excessive force.

The *Fourth Amendment* governs the use of force. The *Fourth Amendment* requires peace officers to use only an amount of force that is objectively reasonable in light of all the surrounding circumstances. *Graham v. Connor, 490 U.S. 386, 397, 104 L. Ed. 2d 443, 109 S. Ct. 1865 (1989)*. Assessing the level of permissible force "requires a careful balancing of the nature and quality of the intrusion on the individual's *Fourth Amendment* interests and the countervailing governmental interests at stake." *Id.* (internal quotation marks and citations omitted); *see also Mendoza v. Block, 27 F.3d 1357, 1362 (9th Cir. 1994)*. Courts must give due regard to the fact that officers frequently make split-second judgment about the amount of force to use without the benefit of hindsight. [**11] *Graham, 490 U.S. at 396-97*.

[*1237] With these principles in mind, the Court must determine whether the deputies acted reasonably

with respect to each of the actions that Plaintiffs claim they took.

a. The Hogtie Restraint

Plaintiffs argue that the hog-tie restraint constituted excessive force because it is potentially lethal. Plaintiffs claim that the hog-tie restraint can cause "positional asphyxia." Asphyxia is a decrease in blood oxygen levels or an increase in blood carbon dioxide levels -- either of which can kill. (Eisele Excerpt of Trial Tr. at 16.) Positional asphyxia is asphyxia that results from body position.

Plaintiffs argue that positional asphyxia can occur when a hog-tied person lies prone with pressure on his back. Plaintiffs claim that hog-tying poses an especially great danger to large-bellied persons, such as Price. Plaintiffs claim that if the deputies had closely monitored Price and/or placed him on his side, then the hog-tie's dangers would have been reduced or eliminated.

The Court first will discuss whether the hog-tie restraint, in and of itself, constituted excessive force. The Court then will discuss whether the hog-tie restraint constituted excessive force [**12] in light of Price's girth and the pressure on his torso.

i. Whether The Hogtie Restraint Itself Constituted Excessive Force

Plaintiffs primarily rely on the testimony of Donald T. Reay, M.D., who first hypothesized the concept of positional asphyxia. [9] Dr. Reay conducted experiments and concluded that after exercise (such as a violent struggle with deputies) blood oxygen levels decrease. Dr. Reay found that the hog-tie restraint prevent these oxygen levels from rising again because the hog-tie restraint impairs the mechanical process of inhaling and exhaling. *See* Donald T. Reay et al., *Effects of Positional Restraint on Oxygen Saturation and Heart Rate Following Exercise*, 9 Am. J. Forensic Med. Pathology 16 (1988); Donald T. Reay et al., *Positional Asphyxia During Law Enforcement Transport*, 13 Am. J. Forensic Med. Pathology 90 (1992). [10]

9 Dr. Reay is the chief medical examiner for King County, Washington. He is board certified in anatomic, forensic, and clinical pathology.

10 Following Dr. Reay's studies, other scientists examined the subject of positional asphyxia. *See, e.g.*, C.S. Hirsh, *Restraint Asphyxiation*, 15 Am. J. Forensic Med. Pathology 266 (1994). These scientists generally agreed with Dr. Reay's hypothesis. Based on this storehouse of scientific theory, several law enforcement agencies, including the San Diego Police Department, either have banned hog-tying or have trained their deputies to take precautions when applying the restraint. However, the vast majority of law enforcement agencies have not done likewise, nor has the California Commission on Peace Officers Standards and Training promulgated any training guidelines for using the hog-tie restraint.

[**13] Plaintiffs also rely on the testimony of Dr. Eisele. Dr. Eisele testified that Price experienced lactic acidosis. Lactic acidosis is a natural bodily reaction to exercise in which the body produces lactic acid. To compensate for the increased acidity of the blood, the body then produces extra carbon dioxide.

Dr. Eisele testified that because the hog-tie restraint impairs the mechanical process of exhaling, it prevents the body from "blowing off" excess carbon dioxide. In other words, Dr. Eisele opined that Price suffered from asphyxia (an increase in carbon dioxide levels) that, because of the hog-tie, Price's body could not correct.

Dr. Eisele based his opinions largely on Dr. Reay's work. In fact, it appears that every scientist who has sanctioned the idea that hog-tying causes asphyxia has relied to some degree on Dr. Reay's studies. However, it appears that no scientist had ever critically examined Dr. Reay's methodology and logic -- until recently.

After Price's death, at the request of defense counsel, Thomas Neuman, M.D., of the University of California at San Diego Medical Center ("UCSD") conducted a sophisticated study of positional asphyxia and the hog-tie restraint. [11] [**14] Dr. Neuman found, contrary to Dr. Reay's findings, that blood oxygen levels do not decrease after exercise. Dr. Neuman also found that although the hog-tie restraint impairs the mechanical process [*1238] of inhaling and exhaling to an extent, the hog-tie does not affect blood oxygen or carbon dioxide levels. In other words, the impairment is so minor that it does not lead to asphyxia, and in fact has no practical significance. Dr. Neuman explained the disparity between his findings and those of Dr. Reay by describing methodological flaws in Dr. Reay's experiments and logical flaws in Dr. Reay's reasoning.

11 Dr. Neuman is a professor of medicine and surgery at UCSD. He is board certified in internal medicine, pulmonary disease, emergency medicine, and occupational medicine. He recently published his study. *See* Tom Neuman et al., *Restraint Position and Positional Asphyxia*, 30 Annals of Emergency Med. 578 (1997).

The UCSD study, which Dr. Reay concedes rests on exemplary methodology, eviscerates Dr. Reay's conclusions. [**15] The UCSD study refutes Dr. Reay's underlying premise -- that blood oxygen levels decrease after exercise. Thus, the UCSD study refutes Dr. Reay's

ultimate conclusion -- that the hog-tie restraint prevents the lungs from replenishing the blood's oxygen supply; according to the UCSD study, the blood needs no replenishment after exercise because it already has adequate oxygen.

The UCSD study also refutes Dr. Eisele's opinion that the hog-tie prevents the lungs from "blowing off" excess carbon dioxide. The UCSD study found no difference in carbon dioxide levels between subjects who had exercised and been hog-tied, and subjects who had exercised and not been hog-tied. Thus, as Dr. Neuman testified and Dr. Reay now concedes, the hog-tie restraint is "physiologically neutral." (Reay Excerpt of Trial Tr. at 47.) [12]

12 The Court is aware that the UCSD study did not replicate the circumstances of Price's death perfectly. Numerous dissimilarities existed. For example, Dr. Neuman's subjects did not have methamphetamine in their systems, nor did they lie on hot asphalt. Plaintiffs argue that these differences mean that the UCSD study does not apply to Price.

This argument does not help Plaintiffs for several reasons. First, despite the differences, the UCSD study simply demonstrated basic physical principles -- that the hog-tie restraint, although it impairs breathing, does not affect blood gas levels. Second, the UCSD study at least has more applicability to Price than Dr. Reay's studies, which, by all accounts, are wholly flawed. Third, *no one knows* what effect factors such as methamphetamine would have on a hog-tied person. Dr. Reay and Dr. Neuman merely testified that further study is needed. In light of this uncertainty, Plaintiffs have not established that factors such as methamphetamine made the hog-tie particularly dangerous to Price.

[**16] After Dr. Reay's retraction, little evidence is left that suggests that the hog-tie restraint can cause asphyxia. All of the scientists who have sanctioned the concept of positional asphyxia have relied to some degree on Dr. Reay's work. The UCSD study has proven Dr. Reay's work to be faulty, which impugns the scientific articles that followed it. Like a house of cards, the evidence for positional asphyxia has fallen completely.

In light of the UCSD study, the hog-tie restraint in and of itself does not constitute excessive force -- when a violent individual has resisted less severe restraint techniques, applying a physiologically neutral restraint that will immobilize him is not excessive force. *See Mayard v. Hopwood, 105 F.3d 1226, 1227-28 (8th Cir. 1997)* (holding that placing a person wearing handcuffs and leg restraints in a prone position was reasonable as a matter of law where the person had violently resisted arrest). [13]

13 Plaintiffs' argument that the deputies should have taken precautions because of the dangers of hog-tying obviously fails. The UCSD study has shown the dangers to be fictitious, which obviates the need for precautions.

[**17] **ii. Whether Price's Girth Made The Hog-tie Particularly Dangerous For Him**

Plaintiffs press, however, that the hog-tie *as applied to Price* posed a grave danger. Plaintiffs note that even the UCSD study found that hog-tying impairs the mechanical process of breathing to a small extent. Plaintiffs argue that this impairment, combined with Price's girth, caused him to asphyxiate.

Plaintiffs have failed to prove this alleged fact. Plaintiffs have adduced no reliable evidence that suggests that Price's girth impaired his breathing. Dr. Reay opined that as Price lay prone, his belly may have applied pressure to his lungs, which could have impaired his breathing. However, Dr. Reay admitted that he has no empirical evidence that suggests that lying prone with a large belly can impair breathing to a significant extent. Thus, his testimony was wholly speculative.

[*1239] Moreover, Dr. Neuman studied individuals of Price's general size, shape, morphology, and body mass index. Dr. Neuman's study included persons with a body mass index of thirty, which is greater than Price's body mass index at the time of the struggle. [14] Dr. Neuman testified that although his study has limited applicability [**18] to extremely obese individuals, Price was merely somewhat overweight. As Dr. Neuman testified, it is wild speculation to say that a person lying prone with a potbelly will asphyxiate to death while a slightly smaller person will have no physiological reaction whatsoever. Thus, the Court finds that Plaintiffs have not established that Price's girth made the hog-tie especially dangerous for him.

14 Plaintiffs note that Dr. Eisele calculated Price's body mass index as 30.001, which is outside the parameters of Dr. Neuman's study. This contention does not help Plaintiffs for two reasons. First, the difference is negligible. Second, Dr. Eisele calculated this body mass index during the autopsy, which was after Price took in fluids at the hospital. While in the hospital, Price took in approximately ten more liters of fluid than his body expelled. Because a liter of fluid weighs approximately 2.2 pounds, Price gained approximately 22 pounds while in the hospital, which dramatically increased his body mass index.

Thus, when the deputies applied the hog-tie, Price's body mass index was squarely within the parameters of the UCSD study.

[**19] **iii. Whether The Pressure The Deputies Applied To Price's Back Made The Hogtie Particularly Dangerous**

Plaintiffs next argue that pressure on Price's back impaired his breathing. Plaintiffs argue that this pressure, combined with the breathing impairment caused by the hog-tie, led to Price's death. [15]

15 Relying on Dr. Reay's studies, Plaintiffs initially argued that the hog-tie alone caused Price's death. After the UCSD study came out, however, Plaintiffs began to argue that pressure on Price's back led to his death. Dr. Reay and Dr. Eisele both testified that pressure could have caused the death.

Plaintiffs have failed to establish this alleged fact. Plaintiffs' witnesses produced wildly different accounts of the deputies' actions. Some witnesses claimed that the deputies "sat on" Price. Other witnesses did not recall seeing the deputies apply any pressure at all. Even those witnesses who testified that the deputies applied pressure provided different accounts about whether the deputies applied pressure [**20] before or after they applied the hog-tie restraint.

The Court doubts that a deputy sat on Price, for three reasons. First, sitting on a hog-tied person (whose hands and feet are necessarily above his torso) would be awkward indeed. Second, the deputies simply had no reason to sit on Price -- the hog-tie had immobilized him. It seems unlikely that a deputy would have sat in an awkward position for no reason. Third, Plaintiffs themselves have relentlessly claimed throughout this lawsuit that the deputies stood far away from Price after they hog-tied him.

The deputies admit, however, that they applied minor pressure to Price's back. As they handcuffed and hog-tied him, they necessarily had to control him from thrashing around, so a deputy placed a knee in Price's back and a hand on his shoulder. The Court finds that this action was reasonable. *See Estate of Phillips v. City of Milwaukee, 123 F.3d 586, 593 (7th Cir. 1997)* (holding on similar facts that "the officers' response was reasonable [inasmuch as the officers] placed just enough weight on [the arrestee] to keep him from rolling over and kicking"). A deputy testified that he may have maintained this pressure for a few seconds [**21] after he completed the hog-tie as he got up from the ground. The Court holds that this innocent, brief action was reasonable.

In addition, Deputy Tally testified that he knelt next to Price, placing most of his weight on his heels. However, he placed a knee in Price's back. Deputy Tally did this to calm Price (and thus keep him from smashing his face into the ground) and to convey a sense of control in a tense, confused situation. Notably, Deputy Tally did not apply significant pressure to Price. The Court finds that Deputy Tally's actions were reasonable. *See id.*

Plaintiffs have not established that the deputies applied any more than the above-described pressure. Even if the deputies applied more pressure, Plaintiffs have not shown that the pressure impaired Price's breathing to a significant degree. Plaintiffs have not offered any evidence that indicates the *amount* of the pressure, nor have they [*1240] established what amount of pressure can impair breathing. [16]

16 Each of the deputies weighed over two hundred pounds. Plaintiffs argue that this weight was more than sufficient to impair Price's breathing. However, this argument assumes that a deputy applied his full weight to Price. It seems entirely likely that as the deputy knelt next to Price and placed a knee in his back, he brought the bulk of his weight to bear on the knee that was on the ground, and applied only minor pressure to Price. Moreover, when Deputy Tally applied pressure to Price, he rested most of his weight on his heels.

[**22] Thus, Plaintiffs have failed to establish that any pressure that Price may have experienced impaired his breathing or affected his blood gas levels. In short, plaintiffs have not proven that the hog-tie as applied posed any danger to Price, or that it led to his death. Accordingly, the Court concludes that the deputies used reasonable force when they placed Price face-down and hog-tied him, with incidental pressure applied to his torso. Insofar as the hog-tie and pressure are concerned, Plaintiffs' excessive force claim fails. [17]

17 The Court emphasizes the limited nature of its holding. The Court merely holds that on the particular facts of this case, the hog-tie restraint did not constitute excessive force. Given the limitations of the UCSD study noted above, the Court intimates no view on whether the hog-tie restraint might constitute unreasonable force if used on other individuals in other circumstances.

The obvious question remains, however: What *did* cause Price's death? The Court finds that, as several [**23] expert witnesses testified, he most likely died from a cardiac arrest that occurred during his encounter with the deputies. [18] Numerous factors indicate that methamphetamine-induced toxic delirium caused this cardiac arrest. [19] First, Price had methamphetamine in his

system when Dr. Eisele conducted the autopsy, which means that he had recently used it. [20] Second, methamphetamine irritates the heart and makes it more prone to a cardiac arrest. (Eisele Excerpt of Trial Tr. at 25, 27.) Third, Price had "internal derangements" within his heart that chronic methamphetamine abuse could have caused. (*Id.*) Fourth, methamphetamine can cause the body to release catecholamines (adrenaline) which also can irritate the heart. Dr. Eisele found catecholamines in Price's body. Fifth, Price had been acting in a bizarre fashion, which indicates that he was suffering from a methamphetamine-induced psychosis. (Neuman Excerpt of Trial Tr. at 34-35.) Sixth, Price developed a high fever at the hospital, which methamphetamine-induced toxic delirium frequently causes. (*Id.* at 36.) Seventh, while in the hospital, Price developed rhabdomyloysis, which is a breakdown of muscle cells. This is also [**24] a symptom of methamphetamine-induced toxic delirium.

18 Expert witnesses testified that Price also experienced a pulmonary arrest. Although some experts expressed doubt about which type of arrest came first, Dr. Eisele and Dr. Neuman opined that the cardiac arrest came first. In fact, Dr. Eisele, who testified for Plaintiffs, specifically stated that the cardiac arrest led to the pulmonary arrest. (Eisele Excerpt of Trial Tr. at 47-48.) Both of these doctors testified that they have no evidence that the hog-tie restraint leads to cardiac arrests. This further indicates that the hog-tie did not cause Price's death.

19 Dr. Neuman described toxic delirium as "a syndrome, [a] whole constellation of signs and symptoms seen in people who use methamphetamine. One aspect of the syndrome is delirium." (Neuman Excerpt of Trial Tr. at 35.)

20 Plaintiffs note that Dr. Eisele only discovered low levels of methamphetamine in Price's system. Plaintiffs argue that this means that methamphetamine did not kill Price. The Court rejects this argument for two reasons. First, the body metabolizes methamphetamine, so Price necessarily had more methamphetamine in his system at the time of the cardiac arrest than he did at the time of his death. Second, Dr. Neuman, who has had extensive experience with methamphetamine users, testified that "there is a very poor relationship between the blood levels of methamphetamine and whether or not you get into medical trouble from them." (Neuman Excerpt of Trial Tr. at 38.)

[**25] Dr. Neuman perfectly captured the cause of death when he made the following statement:

> We have clear data that there is no respiratory component to the hog-tie position. We also have clear data that Price was a chronic methamphetamine abuser. He had essentially all of the signs and symptoms of methamphetamine use, and he died a death that was completely consistent with toxic delirium secondary to methamphetamine use. To suppose anything [*1241] else placed a significant role in his death is speculation.

(*Id.* at 43.)

Moreover, Defendants' expert on methamphetamine abuse, Joseph Shannon, M.D., stated: "The only factor that can explain his death in and of itself was acute methamphetamine intoxication or excited delirium . . . . This is a highly lethal illness which may well have caused his death regardless of where he was, the restraints used or the struggle involved." (Shannon Excerpt of Trial Tr. at 7.) [21]

21 Dr. Shannon is a senior psychiatrist at a seven hundred patient drug rehabilitation center. The largest group of these patients have suffered from methamphetamine-induced psychoses. Dr. Shannon has also been a full-time faculty member at the University of California at Los Angeles School of Medicine, where he taught students about drugs and drug addiction.

[**26] Thus, in the words of Dr. Neuman which the Court hereby adopts, "Mr. Price did not asphyxiate due to the hog-tie position. Rather, the most obvious cause of death is toxic delirium secondary to methamphetamine abuse, which in turn caused Mr. Price to experience a cardiac arrest." (Neuman Decl. at 13.)

b. The Foot On Price's Head

Plaintiffs next assert that a deputy used excessive force by placing his foot against the back of Price's head. Plaintiffs asserted during closing argument that the deputy did so for a malicious purpose.

Plaintiffs have offered no evidence to back up their assertion of maliciousness; indeed, all evidence points to the contrary. Price had been smashing his face into the asphalt repeatedly. The deputy testified that he placed his foot against Price's head in order to stop him from doing so. In fact, a deputy placed a kleenex box underneath Price's face in order to protect him further.

The Court has no reason to doubt this testimony. The Court finds that the deputy placed his foot against Price's head for a patently reasonable, benevolent purpose. Thus, Plaintiffs' excessive force claim fails with respect to the foot on the back of Price's head.

[**27] **c. Leaving Price On Hot Asphalt**

Plaintiffs next argue that the deputies used excessive force by leaving Price on the hot asphalt. The asphalt temperature was approximately 133.9 degrees Fahrenheit.

Although the Court does not suggest that leaving him lying on hot asphalt was ideal, the Court cannot find that this action was unreasonable. The struggle with Price had tired the deputies, which would have made it somewhat difficult to move a hefty, belligerent person. Moreover, the deputies had to perform other tasks, such as calling for medical assistance, controlling onlookers, and sundry other tasks that law enforcement work involves. The fact that the deputies did not move Price immediately is therefore understandable.

In addition, despite the high asphalt temperature, Price did not suffer any burns. Of course, the primary danger of leaving someone lying on hot asphalt is that the person might sustain burns. The fact that Price did not suffer burns indicates that the asphalt temperature was not so high that it was unreasonable to leave him lying on it for the short time that he did. Similarly, Plaintiffs have not established that the hot asphalt caused Price's death.

Thus, [**28] Plaintiffs' excessive force claim fails with respect to leaving Price on the asphalt.

d. Failure To Administer CPR

Plaintiffs next argue that the deputies used excessive force by failing to give Price CPR after they noticed him turning blue. [22]

22 It is somewhat awkward to conceptualize a failure to give medical aid as excessive force. *See Estate of Phillips, 123 F.3d at 595*. "The duty to render medical aid is more often thought of as one arising under the Due Process Clause [of the *Fourteenth Amendment*] . . . ." *Id.; see also DeShaney v. Winnebago County Dep't of Social Servs., 489 U.S. 189, 200, 103 L. Ed. 2d 249, 109 S. Ct. 998 (1989)* (stating that "when the State . . . so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs -- e.g., . . . medical care, . . . it transgresses the substantive limits . . . set by the Due Process Clause"). Nevertheless, the Supreme Court recently has held that "*all* claims that law enforcement officers have used excessive force . . . in the course of an arrest . . . should be analyzed under the *Fourth Amendment* and its 'reasonableness' standard, rather than under a 'substantive due process' approach." *Graham, 490 U.S. at 395*. Because "the *Fourth Amendment* requires that seizures be reasonable under all the circumstances, . . . it would be objectively unreasonable in certain circumstances to deny needed medical attention to an individual placed in custody who cannot help himself." *Estate of Phillips, 123 F.3d at 596*.

It appears that a due process analysis applies after the initial "seizure" has ended but the individual remains in custody. *See id.* It is not always easy to determine when the seizure has ended. *See generally* Mitchell W. Karsch, Note, *Excessive Force and the Fourteenth Amendment: When Does Seizure End?, 58 Fordham L. Rev. 823 (1990)*. In the present case, however, the seizure clearly had not ended. *See Graham, 490 U.S. at 389-90* (using a *Fourth Amendment* analysis on similar facts); *Estate of Phillips, 123 F.3d at 595-96* (same).

[**29] [*1242] Before the Court can reach the merits of this claim, the Court must determine whether the deputies are entitled to qualified immunity. [23] Qualified immunity protects government officials from lawsuits based on their conduct in situations in which they exercise discretion, insofar as their conduct does not violate clearly established rights. *Harlow v. Fitzgerald, 457 U.S. 800, 818, 73 L. Ed. 2d 396, 102 S. Ct. 2727 (1982)*. Qualified immunity protects peace officers so that they "should not err always on the side of caution because they fear being sued." *Hunter v. Bryant, 502 U.S. 224, 229, 116 L. Ed. 2d 589, 112 S. Ct. 534 (1991)* (internal quotation marks and citation omitted).

23 In its Order Granting in Part and Denying in Part Defendants' Motion for Summary Judgment, the Court held that the deputies were not entitled to qualified immunity from Plaintiffs' excessive force claim. However, this holding rested on the possibility that the deputies may have acted unreasonably by applying the hog-tie, applying pressure to Price's back, etc. The Court did not hold that the deputies were not entitled to qualified immunity with respect to the CPR issue alone.

[**30] The inquiry of whether the deputies are entitled to qualified immunity "begins with the question of whether the 'right the [deputies are] alleged to have violated [was] clearly established.'" *Mendoza, 27 F.3d at 1360* (citing *Anderson v. Creighton, 483 U.S. 635, 640, 97 L. Ed. 2d 523, 107 S. Ct. 3034 (1987))*. If the right was not clearly established, then the deputies are entitled to qualified immunity. *See Romero v. Kitsap County, 931 F.2d 624, 629 (9th Cir. 1991)*. In *Mendoza*, the Ninth

Circuit provided guidance on how to determine whether a right is clearly established. The Ninth Circuit stated:

> The plaintiff's legal right cannot be so general so as to allow a plaintiff to "convert the rule of qualified immunity . . . into a rule of virtually unqualified liability simply by alleging [a] violation of extremely abstract rights." *Anderson, 483 U.S. at 639*. . . . For example, the Supreme Court in *Anderson* suggested that although "the right to due process of law is quite clearly established . . . and thus there is a sense in which any action that violates [the Due Process Clause] (no matter how unclear it may be that the particular action is a violation) [**31] violates a clearly established right," such a general allegation is not enough to overcome a defendant's qualified immunity. *Id.*
>
> For qualified immunity purposes, a right must [be] clearly established in a more particularized, and hence more relevant, sense . . . .

Mendoza, 27 F.3d at 1361 (internal quotation marks and citation omitted).

Thus, because Plaintiffs claim that the deputies violated Price's right to receive CPR from them, the issue becomes whether the deputies had a clearly established duty to administer CPR. *See Rich v. City of Mayfield Heights, 955 F.2d 1092, 1097 (6th Cir. 1992)* (inquiring, for qualified immunity purposes, whether the officer had a clearly established duty to render medical aid).

The cases that have addressed this issue indicate that no such duty exists. In *City of Revere v. Massachusetts General Hospital, 463 U.S. 239, 77 L. Ed. 2d 605, 103 S. Ct. 2979 (1982)*, a police officer shot a suspect. The police then summoned an ambulance, which took the suspect to a hospital. The Supreme Court held:

> The Due Process Clause . . . require[s] the responsible government . . . agency to provide medical care to persons . . . who have [**32] been wounded while being apprehended by the police. . . . We need not define, in this case, [the city's] due process obligation to pretrial detainees or to other persons in its care who require medical attention. Whatever the standard may be, [the city] fulfilled its constitutional obligation by seeing that [the arrestee] was [*1243] taken promptly to a hospital that provided the treatment necessary for his injury.

Id. at 244-45 (citations and footnote omitted). Thus, the Supreme Court suggested that a peace officer has no duty to provide medical care personally; rather, the Court suggested that an officer merely must summon medical aid.

The Ninth Circuit addressed a similar case in *Maddox v. City of Los Angeles, 792 F.2d 1408 (9th Cir. 1986)*. In *Maddox*, the defendant police officers placed an arrestee in a chokehold and then transported him to a hospital. When they arrived, they discovered that the subject did not have a pulse. Although each officer had CPR training, none administered CPR. Instead, they took the arrestee to the jail ward of the hospital where he received medical attention.

The trial court instructed the jury that "any failure by the officers themselves [**33] to render [CPR] is not a violation of the decedent's constitutional rights." *Id. at 1414*. Using a due process analysis, the Ninth Circuit upheld this instruction, stating that

> the due process clause requires responsible governments and their agents to *secure* medical care for persons who have been injured while in police custody. We have found no authority suggesting that the due process clause establishes an affirmative duty on the part of police officers to render CPR in any and all circumstances. Due process requires that police officers seek the necessary medical attention for a detainee when he or she has been injured while being apprehended by either *promptly summoning the necessary medical help* or by taking the injured detainee to a hospital.

Id. at 1415 (emphasis added and citations omitted). Thus, the Ninth Circuit suggested that peace officers merely have a duty to summon medical aid, and need not personally administer CPR. [24]

> 24 This holding is perhaps limited by the Ninth Circuit's use of the phrase "any and all circumstances." This phrase seems to leave open the possibility that a duty to give CPR could arise in some circumstances. However, "one ambiguous bit of dictum in a Ninth Circuit opinion cannot form the basis for a 'clearly established' and 'par-

ticularized' duty." *Wilson v. Meeks, 52 F.3d 1547, 1555 (10th Cir. 1995)* (analyzing *Maddox*).

[**34] The Tenth Circuit later considered *Maddox* in addressing a similar case. The Tenth Circuit construed *Maddox* as "holding there is no duty to give, as well as summon, medical assistance, even if the police officers are trained in CPR." *Wilson v. Meeks, 52 F.3d 1547, 1555 (10th Cir. 1995)*. The Tenth Circuit followed *Maddox* and other cases to hold that "the Constitution does not empower [courts] to command police officers to show compassion for those they injure in the line of duty. . . . To do [so] would undermine the policies of the qualified immunity doctrine." *Id. at 1556*.

The Eighth Circuit has reached a similar conclusion. In *Tagstrom v. Enockson, 857 F.2d 502 (8th Cir. 1988)*, the plaintiff led police officers on a motorcycle chase that ended when the plaintiff crashed into a tree, suffering severe injuries. The first officer to arrive on the scene immediately called an ambulance for the plaintiff but did not give him medical aid personally.

The Eighth Circuit stated:

> [The plaintiff] asks us to find that [the defendant police officer] had an affirmative duty to render medical assistance himself, such as giving . . . CPR. However, [the plaintiff] [**35] points to no cases that clearly establish that [the officer] had such a duty. [Citing *Maddox*]. [The officer] properly performed his duty by immediately calling an ambulance. His decision not to give medical assistance . . . did not violate [the plaintiff's] right to prompt medical assistance.

Id. at 504. Based on this reasoning, the Eighth Circuit held that the officer was entitled to qualified immunity.

None of the above cases used a *Fourth Amendment* "reasonableness" analysis. Nevertheless, they strongly suggest that the constitution does not impose a duty on peace officers to administer CPR personally. Plaintiffs have not cited, nor has the Court's independent research revealed, any case that has imposed such a duty on peace officers under any analysis. [25] Given this legal landscape, [*1244] even if such a duty exists, it certainly is not clearly established. Thus, the deputies are entitled to qualified immunity on the CPR issue. *See Romero, 931 F.2d 624 at 629* (holding that officers were entitled to qualified immunity because the right they allegedly violated was not clearly established).

25 Even Plaintiffs' police-procedures expert testified that peace officers do not have a legal duty to administer CPR.

[**36] **2. The State-Law Claims**

a. The Assault And Battery Claims

Plaintiffs next allege state-law causes of action for assault and battery. Defendants claim that they have immunity from these claims as well.

California Government Code section 820.2 provides immunity to peace officers for their discretionary acts in arrest situations. *See Reynolds v. County of San Diego, 858 F. Supp. 1064, 1074 (S.D. Cal. 1994), aff'd in part and rev'd in part on other grounds, 84 F.3d 1162 (9th Cir. 1996)*; *Martinez v. County of Los Angeles, 47 Cal. App. 4th 334, 349 (1996)*. [26] It does not confer immunity, however, if an officer uses unreasonable force. *Scruggs v. Haynes, 252 Cal. App. 2d 256, 266, 60 Cal. Rptr. 355 (1967)*. [27]

26 *Section 820.2* provides: "Except as otherwise provided by statute, a public employee is not liable for an injury resulting from his act or omission where the act or omission was the result of the exercise of the discretion vested in him, whether or not such discretion be abused." *Cal. Gov't Code § 820.2*.

27 In its Order Granting in Part and Denying in Part Defendants' Motion for Summary Judgment, the Court held that the deputies were not entitled to qualified immunity from suit because Plaintiffs had presented evidence that the deputies had used excessive force. The Court could not rule on whether the deputies had used excessive force at the summary judgment stage. Now that the trial has concluded, however, the Court has determined that the deputies did not use excessive force, and so can definitively determine whether the deputies are entitled to qualified immunity on Plaintiffs' state-law claims.

[**37] The Court already has found that the deputies used reasonable force by applying the hog-tie restraint, applying pressure to Price's torso, leaving him on the asphalt, and placing a foot against his head. Thus, *section 820.2* grants immunity to the deputies with respect to Plaintiffs' assault and battery claims, insofar as the claims derive from these actions.

However, the Court did not affirmatively find that the deputies acted reasonably when they failed to administer CPR. Rather, the Court merely found that they were entitled to qualified immunity. *Section 820.2* will not confer immunity from Plaintiffs' state-law claims if the

deputies' failure to provide CPR amounted to excessive force. *See Scruggs, 252 Cal. App. 2d at 266.*

Yet even assuming that the deputies' failure amounted to excessive force, any assault or battery claim that stems from their omission fails as a matter of law. A battery involves a touching. *See Restatement (Second) of Torts § 18* (1965). An assault involves an apprehension of a touching. *Id.* § 21. A failure to provide CPR obviously involves neither a touching nor an apprehension thereof. Thus, Plaintiffs' causes of action for assault and battery [**38] fail.

b. The Wrongful Death Claim

Plaintiffs also have alleged a cause of action for wrongful death against the deputies.

Section 820.2 grants the deputies qualified immunity on the wrongful death claim unless they used excessive force. *See Reynolds, 858 F. Supp. at 1074*; *Martinez, 47 Cal. App. 4th at 349*; *Scruggs, 252 Cal. App. 2d at 266.* Thus, the deputies enjoy qualified immunity from the wrongful death claim, except perhaps insofar as the claim stems from the failure to provide CPR.

However, even assuming that the deputies used unreasonable force by not administering CPR, Plaintiffs' wrongful death claim still fails. To establish a wrongful death claim, Plaintiffs must prove that the deputies' failure to provide CPR *caused* Price's death. *See Jacoves v. United Merchandising Corp., 9 Cal. App. 4th 88, 113 (1992).* Plaintiffs have not done so.

Plaintiffs presented the testimony of Janet Goldfarb, a registered nurse. Nurse Goldfarb testified that she has used CPR to revive patients and that she probably could have revived Price.

[*1245] The Court cannot give too much weight to this testimony for several reasons. First, even if Nurse Goldfarb could have revived [**39] Price, that does not mean that the deputies could have done so. The deputies necessarily had far less medical training and experience than Nurse Goldfarb. Second, Nurse Goldfarb testified that she never has revived a person in cardiac arrest, as Price was. Third, it is unclear whether Nurse Goldfarb has ever administered CPR in the field, as opposed to a more sophisticated hospital setting.

Fourth, Dr. Neuman, who has vast experience in emergency room medicine, testified that "people with toxic delirium are most frequently not resuscitated." (Neuman Excerpt of Trial Tr. at 50.) He also testified that "neurologically intact survival from cardiac arrest when CPR is given properly and promptly is in the neighborhood of a couple of percent." (*Id.* at 50-51.) This dismally low statistic strongly suggests that the failure to give CPR did not contribute to Price's death. [28]

28 The medics managed to resuscitate Price after they loaded him into the ambulance. However, they did so using technologically advanced life-saving techniques, which are far different from the rudimentary CPR procedures the deputies could have used in the field. Thus, the fact that the medics managed to resuscitate Price does not mean that the deputies would have been able to do so.

[**40] Because Plaintiffs have not established that the deputies' failure to provide CPR caused Price's death, Plaintiffs' wrongful death claim fails.

c. The Negligence Claim

Plaintiffs additionally have alleged a negligence cause of action against the deputies. [29]

29 Despite the qualified immunity conferred by *California Government Code section 820.2*, it appears that *section 820.4* creates an exception for negligent acts. *See Cal. Gov't Code § 820.4* (stating that "[a] public employee is not liable for his act or omission, exercising due care, in the execution of any law"); *Reynolds, 858 F. Supp. at 1075* (finding that because an officer had exercised due care, "his conduct does not fall into the *section 820.4* exception").

To prevail on their negligence claim, Plaintiffs must show that the deputies acted unreasonably and that the unreasonable behavior harmed Price. *See Jacoves, 9 Cal. App. 4th at 113.* Except for the CPR issue, the Court already has found that the deputies acted reasonably. Thus, [**41] the negligence claim fails.

Insofar as the negligence claim stems from the failure to provide CPR, the claim fails on causation grounds for the reasons stated above.

B. The Claims Against Defendant Roache

Plaintiffs also have asserted three causes of action against Defendant Roache. First, Plaintiffs have sued him under *§ 1983* for the actions of the deputies. Second, Plaintiffs have sued Defendant Roache under *§ 1983* for his alleged failure to train his deputies adequately. Third, Plaintiffs have sued him for negligence. The Court will discuss each of these claims in turn.

1. The *§ 1983* Claim Based On The Actions Of The Deputies

To hold Defendant Roache liable for the constitutional violations of his subordinates, Plaintiffs must show that he either participated in or directed violations, or that he knew of violations and failed to act to prevent

them. *Taylor v. List, 880 F.2d 1040, 1045 (9th Cir. 1989)*.

With respect to the CPR issue, even assuming that the failure to provide CPR amounted to a constitutional violation, Defendant Roache obviously did not participate in or direct the violation. Plaintiffs also have not proven that similar violations had occurred [**42] in the past, or that Defendant Roache knew about them and failed to prevent further violations.

With respect to the other actions of the deputies, the Court already has found that no constitutional violation occurred, so Plaintiffs cannot hold Defendant Roache liable for the actions of the deputies.

2. The *§ 1983* Action For Failure To Train

Plaintiffs next invoke the principle that "a governmental officer may be held liable for damages for constitutional wrongs engendered by his failure to adequately supervise or train his subordinates." *Ting v. United States, 927 F.2d 1504, 1512 (9th Cir. 1990)*. Insufficient training can form a basis [*1246] for liability under *§ 1983* if the failure to train amounts to deliberate indifference to the rights of people with whom peace officers may come into contact. *Id.*

Plaintiffs note that Defendant Roache had a substantial amount of information prior to Price's death that indicated that hog-tying poses grave dangers. Plaintiffs argue that by not acting on this information, Defendant Roache failed to train his deputies properly and that this failure amounted to deliberate indifference to the rights of Price.

This argument fails. Because [**43] the hog-tie restraint did not inflict a constitutional injury on Price, *§ 1983* liability cannot attach. Moreover, Defendant Roache did not inadequately train his deputies about the dangers of hog-tying; the UCSD study has shown these dangers to be fictitious. Defendant Roache cannot be liable for being deliberately indifferent to a nonexistent risk. Accordingly, Plaintiffs' *§ 1983* claim against Defendant Roache fails.

3. The Negligence Claim

Plaintiffs next have sued Defendant Roache for negligence based on his failure to train his deputies about the dangers of hog-tying. To establish a negligence claim, Plaintiffs must show that Defendant Roache acted unreasonably and that his unreasonable behavior caused Plaintiffs' harm. *Jacoves, 9 Cal. App. 4th at 113*.

Plaintiffs have not established either of these essential elements of a negligence claim. Defendant Roache did not act unreasonably by failing to alert his deputies to nonexistent dangers. Moreover, even if he acted unreasonably, Plaintiffs have not established that the hog-tie caused Price's death. Plaintiffs' negligence claim therefore fails.

C. The Claims Against The County

Plaintiffs also have alleged a *§* [**44] *1983* action against the county, relying on the theory of municipal liability articulated in *Monell v. New York City Department of Social Services, 436 U.S. 658, 56 L. Ed. 2d 611, 98 S. Ct. 2018 (1978)*. Plaintiffs also seek to hold the county liable under the doctrine of respondeat superior. The Court will address each of these claims in turn.

1. The *Monell* Claim

Under *Monell*, "when execution of a government's policy or custom, whether made by its lawmakers or by those whose edicts or acts may fairly be said to represent official policy, inflicts [a constitutional] injury [then] the government as an entity is responsible under *§ 1983*." *Id. at 694*. In order to establish municipal liability, Plaintiffs must show that the county had a policy that exhibited deliberate indifference to the constitutional rights of the people with whom the deputies could come into contact, and that the policy was the "moving force" behind the constitutional violation in question. *City of Canton v. Harris, 489 U.S. 378, 389-91, 103 L. Ed. 2d 412, 109 S. Ct. 1197 (1989)*; *Henry v. County of Shasta, 132 F.3d 512, 1997 WL 784487*, at *4 (9th Cir. 1997).

[**45] Plaintiffs claim that the Sheriff's Department's decision not to train its deputies in applying the hog-tie restraint constituted a governmental policy or custom that inflicted constitutional injury on Price. Plaintiffs also have suggested that the Sheriff's Department had a custom or policy not to train its deputies to administer CPR.

These arguments fail. The hog-tie restraint did not inflict a constitutional injury on Price, so *Monell* liability cannot attach. *See City of Los Angeles v. Heller, 475 U.S. 796, 89 L. Ed. 2d 806, 106 S. Ct. 1571 (1986)*; *Quintanilla v. City of Downey, 84 F.3d 353, 355-56 (9th Cir. 1996), cert. denied, 136 L. Ed. 2d 856, 117 S. Ct. 972 (1997)*. Moreover, the Sheriff's Department did not show "deliberate indifference" by not teaching its deputies about nonexistent dangers.

Additionally, even if failing to administer CPR was a constitutional violation, Plaintiffs have not adduced evidence that would suggest that the deputies' omission stemmed from an official custom or policy. To the contrary, Defendant Roache testified that he hoped that his deputies would administer CPR to people in the field. [30]

30 Plaintiffs argue that this testimony created a duty to administer CPR. This assertion does not

help Plaintiffs for two reasons. First, opinion testimony does not create duties; duties are imposed by law. Second, even if the sheriff's hopes or expectations could create a duty, they could not create a constitutional duty, and so would not affect Plaintiffs' *§ 1983* claim. At most, the duty would sound in tort, and so would apply only to Plaintiffs' state-law claims. The state-law claims that arise from the failure to provide CPR fell not on grounds of duty, but on grounds of causation.

[**46] [*1247] Plaintiffs thus have failed to establish *Monell* liability.

2. Respondeat Superior Liability

Because Plaintiffs can hold neither the deputies nor Defendant Roache liable, Plaintiffs cannot hold the county liable on a respondeat superior theory. *See Cal. Gov't Code § 815.2*; *Martinez, 47 Cal. App. 4th at 349*.

IV. Conclusion

The events of this case are undeniably tragic. They are tragic for Price's widow. They are tragic for his young children. They are tragic for his parents. Above all, they are tragic for Price himself.

The events of this case are also tragic for the deputies. Undoubtedly, the deputies did not expect or desire Price to come to any grave harm. The Court is well aware of the distress that deaths in the field daily cause peace officers.

Plaintiffs, who had the burden of proof, ably presented a strong case with strong facts. However, as in most cases, other evidence contradicted Plaintiffs' evidence. In the end, the weight of the evidence preponderated against Plaintiffs. Plaintiffs simply did not meet their burden of proof.

In many ways, this case is symptomatic of a larger problem that has swept the San Diego area in recent years. The [**47] scourge of methamphetamine daily ravages its victims. Quite apart from the medical cause of death, which the Court discussed at length above, methamphetamine abuse precipitated this entire case. If Price had not abused methamphetamine, he would not have acted in a bizarre fashion, the deputies never would have arrived, and none of the incidents of this case would have transpired. Methamphetamine has devoured another of its victims, and forever transformed the lives of his family members.

The Court's rulings today in no way seek to downplay the tragic events of this case. In the end, the Court simply could not conclude that Defendants were the ones to blame for the unfortunate events that transpired. Accordingly, the Court must grant judgment for Defendants. [31]

31 At the close of Plaintiffs' evidence, Defendants filed a Motion for Judgment on Partial Findings. That Motion is denied as moot.

IT IS SO ORDERED:

Date: 1/8/98

John S. Rhoades, Sr.

United States District Judge

Appendix

I. Findings [**48] **of Fact**

1. The Court hereby incorporates by reference each and every factual recitation made in Section II of the preceding opinion.

2. Asphyxia is a decrease in blood oxygen levels or an increase in blood carbon dioxide levels.

3. Exercise does not cause blood oxygen levels to decrease.

4. The hog-tie restraint impairs the mechanical process of inhaling and exhaling.

5. Despite the hog-tie restraint's impairment of breathing, the hog-tie restraint, in and of itself, does not affect blood oxygen or carbon dioxide levels.

6. The hog-tie restraint, in and of itself, does not cause asphyxia, i.e., the hog-tie restraint is inherently physiologically neutral.

7. Price's body mass index at the time of the struggle with the deputies was less than thirty. Price was not extremely obese.

8. Plaintiffs have not proven by a preponderance of the evidence that Price's girth impaired his breathing as he lay prone.

9. A deputy placed a knee in Price's back and a hand on Price's shoulder as Price was being hog-tied.

10. A deputy may have maintained pressure on Price's torso for a few seconds after the hog-tie was applied.

11. Deputy Tally knelt next [**49] to Price after the hog-tie was applied, bringing most of his weight to bear on his heels. Deputy Tally applied only minor pressure to Price for the sake of calming him and [*1248] conveying a sense of control in a tense, confused situation.

12. A deputy did not sit on Price.

13. Plaintiffs have not established that a deputy or deputies applied more than the above-described pressure to Price's torso.

14. Plaintiffs have not established what amount of pressure on a person's torso is sufficient to impair breathing or affect blood gas levels.

15. Plaintiffs have not established that pressure on Price's torso impaired his breathing, affected his blood gas levels, or in any way contributed to Price's death.

16. Price had methamphetamine in his system at the time of the autopsy.

17. Methamphetamine can irritate the heart.

18. Price had "internal derangements" in his heart that methamphetamine may have caused.

19. Price had catecholamines (adrenalin) in his system at the time of the autopsy.

20. Catecholamines can irritate the heart.

21. Price had been acting in a bizarre fashion shortly before his contact with the deputies.

22. Price developed [**50] a high fever while in the hospital, which methamphetamine abuse could have caused.

23. Price developed rhabdomyloysis in the hospital, which could have been caused by methamphetamine abuse.

24. Price most likely had a cardiac arrest during his encounter with the deputies. This preceded his pulmonary arrest. Hog-tying does not lead to cardiac arrests.

25. Methamphetamine abuse was a cause of Mr. Price's death.

26. After being restrained by the deputies, Price repeatedly smashed his face into the ground.

27. A deputy placed his foot against Price's head for the purpose of preventing Price from smashing his face into the ground.

28. A deputy placed a kleenex box under Price's face in order to protect him from self-inflicted injuries.

29. The asphalt temperature on the day, time and place in question was approximately 133.9 degrees Fahrenheit.

30. Price did not suffer burns from lying on the asphalt.

31. Some of the deputies were tired on account of the struggle with Price.

32. A failure to render CPR does not involve a touching or an apprehension of a touching.

33. People suffering from a cardiac arrest due to methamphetamine-induced [**51] toxic delirium usually are not resuscitated.

34. When CPR is administered properly and promptly, neurologically intact survival from cardiac arrest is approximately two percent.

35. The failure to render CPR did not contribute to Price's death.

36. Defendant Roache did not direct, participate in, or know of any constitutional injury that may have been inflicted on Price by the deputies. Similarly, Plaintiffs have not established that Defendant Roache knew of previous constitutional violations that were similar to any violation that may have occurred in this case.

37. Prior to Price's death, Defendant Roache had information that suggested that hog-tying is dangerous. Defendant Roache did not provide training to his deputies based on this information.

II. Conclusions of Law

1. All claims that law enforcement officers have used excessive force in the course of an arrest must be analyzed under the *Fourth Amendment* and its "reasonableness" standard.

2. Under the *Fourth Amendment*, peace officers must use only an amount of force that is reasonable in light of all the surrounding circumstances.

3. In assessing the level of permissible force, courts [**52] must give due regard to the fact that peace officers frequently make [*1249] split-second judgments about the amount of force to use, without the benefit of hindsight.

4. The deputies did not use excessive force prior to the moment of the hog-tie.

5. Applying the hog-tie restraint to an individual who is violently resisting arrest is not, in and of itself, excessive force.

6. The deputies did not use excessive force by hog-tying Price in a prone position.

7. The deputies did not use excessive force by placing a knee in Price's back and a hand on his shoulder as Price was being hog-tied.

8. The deputies did not use excessive force by applying incidental pressure to Price's torso after the hog-tie restraint was applied.

10. Deputy Tally did not use excessive force by kneeling next to Price and applying minor pressure to his torso.

11. The deputies did not use excessive force by placing a foot against Price's head.

12. The deputies did not use excessive force by leaving Price lying on the asphalt.

13. Aside from the failure to provide CPR, all the actions of the deputies, taken together, did not constitute excessive force.

14. In order for the deputies [**53] to be stripped of qualified immunity with respect to Plaintiffs' excessive force claim that they should have administered CPR, there must have been a clearly established constitutional duty to administer CPR.

15. If a constitutional duty exists that would require peace officers to administer CPR, that duty is not clearly established.

16. With respect to Plaintiffs' *Fourth Amendment* claim that the deputies should have administered CPR, the deputies are entitled to qualified immunity.

17. *California Government Code section 820.2* provides immunity to the deputies from Plaintiffs' assault, battery and wrongful death claims, insofar as those claims do not stem from a failure to administer CPR.

18. A battery involves a touching.

19. An assault involves an apprehension of a touching.

20. In order to establish their wrongful death claim, Plaintiffs must prove that an action of the deputies caused Price's death.

21. To hold Defendant Roache liable for the constitutional wrongs of his subordinates, Plaintiffs must prove that Defendant Roache either participated in or directed violations, or knew of violations and failed to act to prevent them.

22. A governmental [**54] officer may be held liable for damages for constitutional wrongs engendered by his failure to supervise or train his subordinates adequately. Insufficient training can form the basis for liability under *42 U.S.C. § 1983* only if the failure to train amounts to deliberate indifference to the rights of people with whom peace officers may come into contact.

23. Absent a constitutional injury, Plaintiffs cannot hold Defendant Roache liable under *42 U.S.C. § 1983*.

24. Defendant Roache did not fail to train his deputies adequately regarding the dangers of hog-tying, inasmuch as the dangers are largely fictitious.

25. Defendant Roache cannot be held liable for being deliberately indifferent to a fictitious risk.

26. To establish a negligence claim against Defendant Roache, Plaintiffs must prove that he acted unreasonably and that his unreasonable behavior caused Plaintiffs' harm.

27. Defendant Roache did not act unreasonably by failing to train his deputies about the alleged dangers of hog-tying, inasmuch as the dangers are largely fictitious.

28. To hold the county liable for constitutional wrongs inflicted by its deputies, Plaintiffs must prove that the county [**55] had a policy or custom that exhibited deliberate indifference to the rights of people with whom the deputies could come into contact, and that the policy was the moving force behind the constitutional violation in question.

[*1250] 29. Absent a constitutional injury, Plaintiffs cannot hold the county liable under *42 U.S.C. § 1983*.

30. The county did not show deliberate indifference to Price's rights by not teaching its deputies about the dangers of hog-tying, inasmuch as the dangers are largely fictitious.

29. The county did not have a custom or policy that would tend to cause its deputies not to administer CPR.

30. If Plaintiffs cannot hold the county's agents liable, it cannot hold the county liable under the doctrine of respondeat superior.

Positional Asphyxia

Positional Asphyxia: Wikipedia

"The Positional Asphyxia Hypothesis, Part One:
Fact or Fiction?"
by Gary W. DeLand

"Positional Asphyxia"
Best Practices -
NYPD Tactics & Procedures
by The Training Bureau
(video via web)

Positional asphyxia

From Wikipedia, the free encyclopedia
Jump to: navigation, search

Positional asphyxia, is also known as **postural asphyxia**, is a form of asphyxia which occurs when someone's position prevents them from breathing adequately. A small but significant number of people die suddenly and without apparent reason during restraint by police, prison (corrections) officers and health care staff.[1] Positional asphyxia may be a factor in some of these deaths.

- Positional asphyxia is a potential danger of some physical restraint techniques,
- People may die from positional asphyxia by simply getting themselves into a breathing-restricted position they cannot get out of, either through carelessness or as a consequence of another accident.

Research has suggested that restraining a person in a face down position is likely to cause greater restriction of breathing than restraining a person face up.[2] Many law enforcement and health personnel are now taught to avoid restraining people face down or to do so only for a very short period of time.[1] Risk factors which may increase the chance of death include obesity, prior cardiac or respiratory problems, and the use of illicit drugs such as cocaine.[3] Almost all subjects who have died during restraint have engaged in extreme levels of physical resistance against the restraint for a prolonged period of time.[3] Other issues in the way the subject is restrained can also increase the risk of death, for example kneeling or otherwise placing weight on the subject and particularly any type of restraint hold around the subject's neck. Research measuring the effect of restraint positions on lung function suggests that restraint which involves bending the restrained person or placing body weight on them, has more effect on their breathing than face down positioning alone [4]

There is a degree of controversy amongst researchers regarding the extent to which restraint positions restrict breathing. Some researchers report that when they conducted laboratory studies of the effects of restraint on breathing and oxygen levels, the effect was limited.[5] Other researchers point out that deaths in real life situations occur after prolonged, violent resistance which has not been studied in laboratory simulations.[6]

Positional asphyxia may also occur as a result of accident or illness. Olympic track athlete Florence Griffith-Joyner[7] and ex-Major League Baseball player John Marzano[8] both died due to positional asphyxia, the former following an epileptic seizure and the latter following a fall down a flight of stairs.

[edit] References

1. ^ a b Reay, D.T. (1996) 'Suspect Restraint and Sudden Death.' Law Enforcement Bulletin. Quantico, Virginia: Federal Bureau of Investigation. (http://www.fbi.gov/publications/leb/1996/may966.txt)
2. ^ Parkes, J. (2002) 'A Review Of The Literature On Positional Asphyxia As A Possible Cause Of Sudden Death During Restraint.' British Journal Of Forensic Practice. 4(1) 24-30
3. ^ a b Stratton SJ, Rogers C, Brickett K, Gruzinski G (2001). "Factors associated with sudden death of individuals requiring restraint for excited delirium". *Am J Emerg Med* **19** (3): 187–91. doi:10.1053/ajem.2001.22665. PMID 11326341.
4. ^ Parkes, J. & Carson, R. (2008) 'Sudden Death During Restraint: Do Some Positions Affect Lung Function.' Medicine, Science and the Law 48(2) 137-41
5. ^ Chan TC, Vilke GM, Neuman T, Clausen JL (1997). "Restraint position and positional asphyxia". *Ann Emerg Med* **30** (5): 578–86. doi:10.1016/S0196-0644(97)70072-6. PMID 9360565.
6. ^ Roeggla G, Roeggla H, Moser B, Roeggla M (1999). "Cardiorespiratory consequences of the hobble restraint". *Acad Emerg Med* **6** (10): 1076–7. doi:10.1111/j.1553-2712.1999.tb01201.x. PMID 10530674.
7. ^ Kristina Rebelo Anderson. "The Uneasy Death Of Florence Griffith Joyner". *salon.com*. http://www.salon.com/news/1998/12/cov_04newsa2.html.
8. ^ Medical examiner says a fall killed John Marzano | Philadelphia Inquirer | 07/18/2008

[edit] External links

- http://www.fbi.gov/publications/leb/1996/may966.txt
- http://www.cpsc.gov/businfo/frnotices/fr01/bedrail.html
- http://www.cdc.gov/niosh/face/in-house/full8723.html

Categories: Medical emergencies | Law enforcement | Causes of death

The Positional Asphyxia Hypothesis, Part One: Fact or Fiction?

By Gary W. DeLand

Background

When unexpected death occurs and there is no obvious cause, leaps of faith not supported by adequate research may occur. For example, in the 1970s climate experts were warning of a new ice age. Chicken Little was on overdrive. Now a few decades later, the same experts are warning of global warming and the approaching disaster. I will leave it to history to determine which – if either – theory ultimately turns out to have some degree of merit.

In the criminal justice world, we are not immune from well-meaning, seemingly logical theories being concocted by experts, gaining acceptance from other experts, and eventually becoming incontrovertible truths. Positional asphyxia is an example of a theory being developed by a respected state pathologist who then published his conclusions in a professional journal.[1] A flood of other pathologists conducting post-mortem examinations who had read his persuasive theory suddenly had a convenient cause of death when a person suddenly died while being restrained and there was no other obvious cause of death.

What is positional asphyxia? "Asphyxia" is defined as an inadequate oxygen level in the blood and/or an excessive increase of carbon dioxide in the blood causing unconsciousness or death. "Positional asphyxia" is described as asphyxia brought on by the subject being placed in a body position which does not allow the subject to breath freely and replace the spent oxygen in sufficient time to prevent death. Positional asphyxia during the late 1980s and through the 1990s become a widely accepted theory of wrongful death alleged by plaintiffs in litigation in cases involving death when substantial exertion was immediately followed by application of restraints or compression on the subject's thorax.

One such example occurred in a California jail when a physically powerful prisoner (about 6'5" and well over 200 lbs.) violently resisted efforts to search him during the admission process. The prisoner described as being built like Karl Malone was able to physically withstand the combined efforts of four jail deputies to control him. One witness stated the prisoner was "tossing officers around like rag dolls." It required the addition of two more husky jail officers to join in and use their combined strength and weight to force the prisoner to the floor.

After an exhausting effort and with the subject face down officers handcuffed the prisoner. The prisoner's breathing became labored and he suffered cardiac arrest. Despite the fact the autopsy showed that the prisoner had a seriously enlarged heart and was high on both cocaine and alcohol, Plaintiffs sued claiming the cause of death was caused by positional asphyxia resulting from the deputies' pressure on the prisoner's torso.

In many of the so-called positional asphyxia deaths, there are many factors that likely caused or contributed to the prisoner's death. Cocaine and alcohol consumption can place such persons at risk of heart arrhythmia, an even greater risk for persons with heart problems. Risks of cardiac arrest increase following heavy physical exertion. But, in such cases, making positional asphyxia claims is an attempt to shift the blame to the officers with whom the prisoner chose to engage in physical combat, rather than the prisoner's own actions (i.e., use of drugs and/or alcohol and violent exertion) and/or medical issues (i.e., preexisting cardiac or other health problems).

The Positional Asphyxia Hypothesis

The theory of positional asphyxia suffered a head-on collision with objective scientific research during the Price

1 [1]Dr. Donald T Reay, M.D., "Effects of Positional Restraint on Oxygen Saturation and Heart Rate Following Exercise," 9 *Am. J. Forensic Med. Pathology* 16 (1988); Reay et al., "Positional Asphyxia During Law Enforcement Transport," 13 *Am. J. Forensic Med. Pathology* 90 (1992).

v. County of San Diego[2] trial – a battle between experts who had conducted research on the effects of physically restraining prisoners during or immediately after vigorous exertion. The plaintiff's expert, Dr. Donald T Reay, M.D., (chief medical examiner for King County, Washington) is credited by the court as being the first person to hypothesize the theory of positional asphyxia. The Defendants relied on expert Dr. Thomas Newman, University of San Diego Medical Center, who had been part of a team of medical experts who conducted extensive research on the positional asphyxia theory that refuted Dr. Reay's findings.

Factual Review of Incident

Daniel Price, a chronic abuser of methamphetamine, after refusing San Diego County deputy sheriffs' demands that he exit his vehicle, aggressively resisted efforts to control and restrain him. After getting Price face down on the road, deputies handcuffed Price's wrists behind his back and shackled his ankles. He continued to kick at the deputies, so they used a second pair of handcuffs to secure the handcuffs securing his wrists to the shackles on his ankles. This method of restraint is often referred to as hogtying. During the effort to apply the restraints, deputies applied pressure to Price's torso, holding him down with a knee on his back to "communicate [the deputy's] presence." Price appeared to be experiencing trouble breathing so deputies called an ambulance. Medics responded quickly, but Price had no pulse when they arrived. Price's vital signs were briefly restored en route to the hospital, but he failed to regain consciousness.

Dr. John W. Eisele, a medical examiner for San Diego County, conducted the autopsy, concluding that the cause of death was "due to restrictive asphyxia with cardiopulmonary arrest due to maximum restraint in a prone position. . . ."[3] Dr. Eisele testified that the manner in which Price was restrained prevented him from "blowing off" excess carbon dioxide. In concluding the death was the result of positional asphyxia, Dr. Eisele relied largely on the research of Dr. Reay, who was subsequently retained as an expert witness by Plaintiffs in the Price litigation.

Dr. Reay had conducted experiments that led him to believe that after physical exercise oxygen levels in the blood significantly decrease. He further concluded that restraints such as hogtying prevented the body from recovering to adequate oxygen levels by impairing the process of inhaling and exhaling.[4] Since no serious researcher had ever challenged or critically evaluated Dr. Reay's methodology or conclusions, it appeared that the positional asphyxia finding would not be easily refuted; however, the San Diego County Counsel's office asked Dr. Neuman to conduct a study of positional asphyxia and the hogtie method of restraint. The study which the court characterized as "sophisticated," attacked the two pillars on which Dr. Reay's conclusions were supported, that:

(1) blood oxygen levels decrease after exertion; and

(2) hogtying so impairs a subject's ability to inhale and exhale that the body cannot replenish the oxygen and "blow off" the carbon dioxide.

U.S. District Court Evaluates the Research

Dr. Neuman was able to refute Dr. Reay's conclusions, finding that blood oxygen levels do not decrease significantly after exercise. Neuman's research[5] also found that hogtie restraint does not significantly affect blood levels of either oxygen or carbon dioxide. Plaintiffs' expert Dr. Reay conceded Dr. Newman's research "rests on exemplary methodology." The court found that, "the impairment is so minor that it does not lead to asphyxia, and in fact has no practical significance." Further, the Neuman study concluded the blood needed no replenishment of oxygen because it was already adequately supplied. Dr. Neuman compared the blood carbon dioxide levels of two groups of subjects: those who had exercised and then been hogtied and those who had exercised and not been hogtied. No difference in carbon dioxide levels was observed.

Dr. Neuman's research was persuasive to both the court and even to Dr. Reay, the plaintiffs' expert and leading proponent of the positional-asphyxia theory. The court said, "Thus, as Dr. Neuman testified and **Dr. Reay now concedes**, the hogtie restraint is 'physiologically neutral.'" The Court concluded, Dr. Neuman's study "eviscerates" Dr. Reay's conclusions. The **Price** court then turned its attention to the other research that supported the positional asphyxia hypothesis.

After Dr. Reay's retraction, little evidence is left that suggests the hogtie restraint can cause asphyxia. All of the

2 [2]990 F.Supp. 1230 (S.D. Cal. 1998).

3 [3]Dr. Eisele found "acute methamphetamine abuse" as a contributing factor in Price's death.

4 [4]See Reay et al., "Effects of Positional Restraint on Oxygen Saturation and Heart Rate Following Exercise," 9 *Am. J. Forensic Med. Pathology* 16 (1988); Reay et al., "Positional Asphyxia During Law Enforcement Transport," 13 *Am. J. Forensic Med. Pathology* 90 (1992).

5 [5]The Neuman research was published as "Restraint Position and Positional Asphyxia.," 30 *Annals of Emergency Medicine* 578 (1997).

other scientists who have sanctioned the concept of positional asphyxia have relied to some degree on Dr. Reay's work. The [Neuman] study has proven Dr. Reay's work to be faulty, which impugns the scientific articles that followed it. **Like a house of cards, the evidence for positional asphyxia has fallen completely**. (emphasis added).

After the positional asphyxia claim was dismantled, the court concluded that hogtie restraint in and of itself does not constitute excessive force when used to immobilize a violent individual who has resisted less severe restraint techniques. The court cited for support **Mayard v. Hopkins**,[6] holding that placing a person in handcuffs and leg restraints in a prone position was reasonable as a matter of law where the person had violently resisted arrest.

The Price Court also shot down the Plaintiffs' claim that the Defendant deputies should have taken special precautions when using the hogtie technique. "Plaintiffs' argument that the deputies should have taken precautions because of the dangers of hogtying obviously fails. The [Neuman] study has shown the dangers to be fictitious, which obviates the need for precautions." The Plaintiffs' next argument was that even if positional asphyxia does not occur with persons, generally, with obese subjects such physical restraints pose a grave danger. The court found, however, "Plaintiffs have adduced no reliable evidence that suggests that Price's girth impaired his breathing." While Dr. Reay testified that hogtying a subject with a large abdomen "could have impaired his breathing," the court noted that **Dr. Reay admitted that he had no empirical evidence to support that opinion.** It is important to note that while Dr. Neuman's study included over-weight persons, he cautioned that his study would have limited applicability to extremely obese individuals.

Regarding Plaintiffs' claim that the pressure applied to Price's back by deputies impaired his breathing and caused his death. The deputies testified that in the process of handcuffing and hogtying Price, it was necessary for a deputy to apply pressure with a knee in Price's back "to control him from thrashing around." The judge compared the subduing of Price to the facts and findings in **Estate of Phillips v. City of Milwaukee**,[7] where the Court ruled it was reasonable for officers to apply enough weight to keep the arrestee from rolling over and kicking while he was hogtied. The Court in **Phillips** had also found it reasonable that the deputy continued the pressure on the back for a few seconds after he had been secured. In **Price** the court found it reasonable that a deputy continued to maintain some pressure with a knee on Price's back even after he had been hogtied. The deputy testified that he did so "to convey a sense of control in a tense, confused situation" and to prevent Price from hurting himself. Regarding the more-or-less constant pressure to Price's back, the Court ruled, "Plaintiffs have not proven that the hogtie as applied posed any danger to Price, or that it lead to his death. Accordingly, the Court concludes that the deputies used reasonable force when they placed Price fade-down and hogtied him, with incidental pressure to his torso."

Price is a very important decision in responding to positional asphyxia claims. However, it is not the final punctuation on the issue. Part two, "The Positional Asphyxia Hypothesis: Lessons Learned and Precautions," will follow. ✪

6 [6]105 F.3d 1226, 1227-28 (CA8 1997).

7 [7]123 F.3d 586, 593 (CA7 1997).

Phencyclidine (PCP)

Acute Phencyclidine Intoxication
and related drug information
(www.drugabuse.org)

Therapeutic use; Treatment;
PCP rehab
(www.ecstasy.com.ua)

PCP / Phencyclidine

Brief Description: PCP is a synthetic drug sold as tablets, capsules, or white or colored powder. It can be snorted, smoked, or eaten. Developed in the 1950s as an IV anesthetic, PCP was never approved for human use because of problems during clinical studies, including intensely negative psychological effects.

Street Names: Angel dust, ozone, wack, rocket fuel

Effects: PCP is a "dissociative" drug, distorting perceptions of sight and sound and producing feelings of detachment. Users can experience several unpleasant psychological effects, with symptoms mimicking schizophrenia (delusions, hallucinations, disordered thinking, extreme anxiety).

Statistics and Trends: In 2009, 122,000 Americans age 12 and older had abused PCP at least once in the year prior to being surveyed. *Source: National Survey on Drug Use and Health (Substance Abuse and Mental Health Administration Web Site).* The NIDA-funded 2010 Monitoring the Future Study showed that 1.0% of 12th graders had abused PCP at least once in the year prior to being surveyed. *Source: Monitoring the Future (University of Michigan Web Site)*

NIDA's Featured Publications

NIDA InfoFacts: PCP/Phencyclidine. Brief description of the health hazards and extent of use of PCP. For a general audience. (Fact sheet).
En Español

NIDA Research Report: Hallucinogens and Dissociative Drugs. Detailed look at current research findings on PCP, LSD, Ketamine, and others. For a general audience. (Report).
En Español

Publications:

- Mind Over Matter - An eight-part series designed to encourage young people in grades five through nine to learn about the effects of drug abuse on the body and the brain.
- *Additional Publications*

Research Monographs (Archives):

See Also:

Other Recommended Reading

- Drugs, Brains, and Behavior - The Science of Addiction
- Preventing Drug Use Among Children and Adolescents: A Research-Based Guide for Parents, Educators, & Community Leaders, 2nd edition

NIDA's Publication Series

- Research Reports
- InfoFacts (fact sheets)
- NIDA Notes (newsletter)
- Addiction Science & Clinical Practice (journal for researchers & health care providers)
- Mind Over Matter: Drug info for grades 5-9
- Topics in Brief

Other Web Sites

- NIDA for Teens
- MEDLINEplus Health Information on Substance Abuse - National Library of Medicine, NIH
- www.abovetheinfluence.com - Office of National Drug Control Policy

- Monograph 133: Sigma, PCP, and NMDA Receptors
- Monograph 64: Phencyclidine: An Update
- Monograph 21: Phencyclidine (PCP) Abuse: An Appraisal
- *Additional Research Monographs*

Controlled Substances
http://ecstasy.com.ua/pcp-phencyclidine

PCP (Phencyclidine): Therapeutic use, Treatment. PCP rehab.

Last modified: Saturday, 20. June 2009 - 2:44 pm

Official names: Phencyclidine, PCP, phencyclidine hydrochloride, phenyl cyclohexyl piperidine, Sernylan, Sernyl

Street names: AD, amoeba, angel, angel dust, angel hair, angel mist, angel poke, animal crackers, animal trank, animal tranquilizer, aurora borealis, bad pizza, belladonna, blud madman, boat, busy bee, butt naked, Cadillac, cheap cocaine, cristal, cliffhanger, Columbo, cozmo's, crazy coke, crazy Eddie, crazy edge, crystal, cystalT, cycline, cyclones, Detroit pink, devil's dust, dipper, do it Jack, drink, dummy dust, dummy mist, dust, dust of angels, dusted parsley, elephant, elephant tranquilizer, embalming fluid, energizer, erth, fake STP, flakes, fresh, good, goon, goon dust, gorilla tab, gorilla biscuits, green leaves, green tea, greens, guerilla, HCP, heaven and hell, herms, Hinkley, hog, horse tracks, horse tranquilizer, illy, jet, jet fuel, K, kaps, K-blast, killer, kools, krystal, KW, LBJ, leaky bolla, leaky leak, lemon 714, lethal weapon, little ones, live ones, log, loveboat, madman, mad dog, magic, magic dust, mauve, mean green, milk, mint leaf, mintweed, monkey dust, monkey tranquilizer, more, mumm dust, new acid, new magic, niebla, OPP, orange crystal, ozone, paz, peace pill, PeaCe pill, peep, Peter Pan, pig killer, pit, puffy, purple, purple rain, rocket fuel, scaf-fle, scuffle, sheets, Shermans, sherms, smoking, snorts, soma, special LA coke, spores, squeeze, STP, super, superacid, super kools, surfer, synthetic cocaine, synthetic THT, taking a cruise, TCP, t-buzz, tac, tic tac, tic, tish, titch, trank, t-tabs, TTi, TT2, TT3, wet, white horizon, wobble weed, wolf, worm, yellow fever

Drug classifications: Schedule II, hallucinogen

Key terms

AFTERSHOCK: Similar to a flashback with LSD, this is the reoccurrence of symptoms associated with taking PCP days, weeks, or months after taking the drug. This happens because PCP is stored in fatty cells in the body.

BUMMER TRIP: Another term for a bad trip, this refers to negative experiences while taking a drug.

DEPERSONALIZATION: A feeling of detachment from one's own mind and body. People experiencing deper-sonalization might feel they are watching themselves from a distance.

DISSOCIATIVE: A drug action that makes people feel cut off from themselves, their bodies, and reality.

DUSTED: Being intoxicated on PCP.

DUSTER: Someone who regularly takes PCP.

DUSTING: Adding PCP to another drug.

PCP ORGANIC MENTAL DISORDER: A condition similar to schizophrenia that can occur as a result of taking PCP and last for weeks, months, or even a year. It is characterized by confusion, disordered thinking, paranoia, and speech problems.

SCHIZOPHRENIA: A medical condition that falls under the category of psychotic disorders. People with schizophrenia suffer from a variety of symptoms, including confusion, disordered thinking, paranoia, hallucinations, emotional numbness, and speech problems.

Overview

Phencyclidine, commonly known as PCP, is a difficult drug to categorize. The United States Drug Enforcement Administration (DEA) categorizes it as a hallucinogen, like LSD, because it can make people see, hear, or sense things that are not there. Scientists categorized PCP as a dissociative anesthetic because it has a profound numbing effect and makes people feel like they are somehow separated from their bodies.

In fact, PCP was first developed as an anesthetic for use during surgical procedures, but side effects led to its falling out of favor for this purpose in the 1960s. It was used as an animal anesthetic in veterinary medicine for a few years, but as people on the street began to abuse the drug more and more, all legal manufacture of PCP stopped in 1978. The effects of taking PCP are unique. At lower doses, the drug causes stimulation; while at higher doses, it tends to have a depressant effect. Most people find a PCP high to be disturbing because of the sense of separation from the body it produces. In fact, taking PCP results in the same type of experiences that sensory deprivation does, such as altered awareness of the boundaries of the body and dissociation from body parts. This strange sensation makes many people panic. Such people have been known to seriously harm themselves and others.

People on PCP have impaired judgment similar to that which is produced by drinking too much alcohol. The drug can also numb the body so much that people are virtually impervious to pain. The resulting combination can be deadly. People on PCP may do crazy things, like jump into frigid water or set themselves on fire, and not feel the pain that it produces until severe injury or death results.

A PCP high can be so unpleasant that many people will not knowingly take the drug more than once. However, PCP is quite easy and cheap to produce. As a result, PCP is very often sold on the street disguised as another drug, from marijuana to LSD to mescaline.

PCP acts on several chemicals in the brain, called neurotransmitters, including dopamine, norepinephrine, serotonin, NMD A, and GABA. Recently, studies in animals have suggested that taking PCP results in brain changes that are associated with the mental disorder schizophrenia. People with schizophrenia have many of the same symptoms as people taking PCP, including paranoia, hallucinations, delusions, disordered thinking, and disrupted speech.

PCP is very similar to another drug that was also initially developed as an anesthetic, ketamine. Both these drugs have experienced a recent increase in their popularity as drugs of abuse, particularly among those who attend clubs and all-night dance parties called raves.

PCP is a completely artificial substance. That is, it is not derived from anything in nature; it is made purely from industrial chemicals. In fact, police are often tipped off to the presence of an illegal PCP laboratory when neighbors complain of terrible chemical smells or when careless criminals create chemical fires and explosions. In its pure form, PCP is a white crystalline powder that easily dissolves in water to produce a clear liquid. Often, street PCP is contaminated with chemical impurities, which can change a white powder or clear liquid to tan or brown and change the consistency from powder to sludge. Purity of street PCP can range from 5% to 100%, but 100% pure PCP is considered to be extremely rare on the street. A common contaminant in PCP is a chemically related drug called PCC, which releases cyanide when burned. It does not produce enough cyanide to cause symptoms with one use, but use over time can lead to brain cell and nerve damage.

Street PCP is often contaminated with other chemicals because its easy and cheap manufacture makes it attractive to drug producers without a chemical background. These amateur drug makers do not know how to purify their final product or perform proper experiments to test for purity.

PCP is easy and cheap to manufacture but not very popular, so it is often sold as another drug. Most often, it is sold on the street as THC, the active ingredient in marijuana. In fact, real THC is almost impossible to obtain on the street. PCP might also be sprayed or sprinkled on oregano, parsley, or another herb and sold as marijuana. Alternatively, lower quality marijuana might be laced with PCP to make it seem more potent. Other drugs that PCP is sold as include LSD, cannabinol, mescaline, psilocybin, amphetamine, methamphetamine, peyote, cocaine, Hawaiian woodrose, and other psychedelics. In one study, only 3% of analyzed street drugs containing PCP were sold as PCP.

PCP is very often mixed with other drugs to produce special highs. PCP mixed with crack is known as wack, space base, beam me up Scottie, clicker, dusty roads, DOA, missile basing, mist, space cadet, space dust, tragic magic, and wickey. PCP mixed with marijuana is known as supergrass, killer weed, super weed, dusters, crystal supergrass, killer joints, ace, bohd, chips, frios, lovelies, peace weed, stick, yerba mala, and zoom. PCP combined with heroin is known as oil or polvo.

Other combinations include PCP with LSD, (black acid), cocaine, methamphetamine, amphetamine, and MDMA (ecstasy). PCP may also be combined with more than one drug at a time.

There are several drugs that are chemically similar to PCP, which are often sold on the street as PCP or other drugs. These include PCPy, TCP, and PCE. Given the makeshift ways in which illegal PCP is manufactured, probably many people who think they are producing and selling PCP are actually producing one of these similar drugs. They are classified as Schedule I hallucinogens by the DEA, which is the same category as LSD.

RPD Policy 4.50

(5150 WIC)

Custody and Detention
of
Mental Patients

Effective Date: 10/84
Revision Date: 8/86
Approval:

_____
Ken Fortier
Chief of Police

4.50 CUSTODY AND DETENTION OF MENTAL PATIENTS:

A. AUTHORITY:

1. Section 5150 of the Welfare and Institutions Code states, in part, "When any person, as the result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer . . . may, upon probable cause, take the person into custody and place him or her in a facility designed by the County for the purpose of 72-hour evaluations and treatment . . . "

2. Riverside County General Hospital is such a facility.

B. POLICY:

1. Riverside Police Department officers shall abide by and adhere to the provisions set forth in the Welfare and Institutions Code pertaining to the custody and detention of persons falling within the definitions described in Section 5150 of the Welfare and Institutions Code.

a. When responding to, or initiating investigations into criminal activities, officers will label the investigation as to the type of criminal activity involved regardless of whether or not the suspect appears to meet the requirements of 5150 WIC.

b. If the suspect is in such an obvious mental state that the jail would not accept that person, then the suspect should be lodged at County Hospital with criminal charges pending.

c. Reports carried as 5150 WIC will be only those that are non-criminal in nature.

2. Officers shall obtain supervisory approval for any 5150 detention.

3. **Violent Patients:** If possible, violent subjects should be transported by ambulance.

4. **Use of Force:** Officers shall act in accordance with law and Department procedure when using force to affect a detention for 5150 WIC.

5. **Unconscious Person:** In all cases, unconscious persons shall be first evaluated by emergency medical personnel and then transported by ambulance to a hospital.

6. **Application for 72 Hour Detention for Evaluation and Treatment:**

Officers shall complete the applications for 72-hour detention.

a. Officers must remain with 5150 subjects until released by hospital authorities.

b. If an officer should experience an unreasonable delay at the hospital, a supervisor should be notified, so that he/she may attempt to expedite the process.

7. Weapons in the Possession of 5150 Subjects:

a. In accordance with Section 8102 WIC, officers shall confiscate and retain custody of any firearm or other deadly weapon which is owned, in the possession, or under the control of any person who has been detained or apprehended for examination of his/her mental condition, or who is a mental patient in any hospital or institution, or who is on leave of absence from such hospital.

b. "Deadly weapon" means any weapon, the possession or concealed carrying of, which is prohibited by Section 12020 of the Penal Code. (WIC 8100, Stats. 1985)

c. If the 5150 subject has been assessed and admitted to Riverside General Hospital or other County mental health facility for evaluation and treatment because that person is a danger to himself/herself or to others, Section 8103 WIC prohibits that individual from possessing the confiscated firearm or other deadly weapon for a period of five years. The firearm or other deadly weapon shall not be released "except upon an order of the Superior Court based upon a finding that the person may possess the firearm or other deadly weapon without endangering others." (WIC 8103(f)(4))

d. Alternatively, if the 5150 subject is detained for the purpose of a mental health evaluation but is not admitted to the facility following the initial assessment, the firearm or other deadly weapon must be returned to the subject unless the City Attorney initiates a petition in the Superior Court for a hearing to determine whether the return of a firearm or other deadly weapon would be likely to result in endangering the person or others within 30 days of the subject's release. (WIC 8102) For further direction, please refer to Section 4.47 regarding the seizure of firearms or deadly weapons from mentally disturbed persons.

8. In all cases, officers shall complete a report when persons are detained for a 5150 WIC evaluation.

9. Handling 72-Hour Mental Health Evaluation (5150) calls at Riverside General Hospital:

Uniformed officers are occasionally summoned to Riverside General Hospital (RGH) in order to execute the necessary application for a 72-hour mental health evaluation pursuant to Welfare and Institutions Code, Section 5150.

Officers should be aware that completing an application for 72-hour evaluation on a subject effectively transfers probable cause and any potential liability for the detention from the hospital to the Riverside Police Department.

Members of the attending staff at RGH are authorized by Section 5150 to take an individual into custody for the purpose of a 72-hour mental health evaluation. Therefore, it is recommended that officers refuse to participate in the mental health detention of individuals who have not been taken into their custody. This will eliminate potential civil liability surrounding the detention.

Other Questions and Answers

Commissioner Slawsby's

Question Regarding

Involved Officers'

Mental Health Issues Training

Response to Question Posed by Commissioner Slawsby regarding the Acevedo OID

1. **Commissioner Slawsby asked about the training that the officers involved in the Acevedo OID had prior to the event.**

This information was requested from RPD. We learned that each officer received training in dealing with people who suffer from mental illness. The training block includes a portion on "exciting delirium." One officer had the training on June 5, 2007, and the other on July 18, 2007. The Acevedo incident occurred on October 31, 2008.

Section D

CPRC

Independent

Investigators'

Reports

Baker Street Group

Mr. Gurney Warnberg's Reports

Report dated Oct. 14, 2010

Follow-up Report dated Nov. 29, 2010

San Diego Office
16476 Bernardo Center Drive
Suite 221
San Diego, CA 92128
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Fax (858) 673-1050
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1370 Stewart Street
Seattle, WA 98109
Phone (206) 686-3300
Fax (206) 686-3307
WA PI Lic# 1777

BAKER STREET GROUP, INC.
www.bakerstreetgroup.com

Report of Investigation

Date: October 14, 2010

Client: Community Police Review Commission
Mario Lara
Interim CPRC Manager
City of Riverside
3900 Main Street
Riverside, CA 92522

Case: GI-10-3969

Report Matter: OID: Marlon Oliver Acevedo

Investigator: G. Warnberg

This investigation was initiated following a written request by CPRC Manager Kevin Rogan on September 4, 2010. Baker Street Group Inc, (BSG) was asked to review the "on line" Officer Involved Death (OID) case book recently provided the Commission by Riverside Police Department (RPD) pertaining to the death of Marlon Oliver Acevedo on 10/31/2008. Following the review, BSG was asked to provide a written opinion based upon our professional judgment as to whether there would be any substantial benefit, to the Commission, from additional investigative work regarding the incident.

It needs to be noted early in this report that investigations of this nature; upon which the primary evidence available to investigators is dependant upon eye witness accounting of circumstances and events, is ideally obtained as soon as possible following the incident. Early witness interviews and accurate reporting is advantageous in order to minimize witness memory fade, or perhaps witness memory contamination by other witnesses, events, or media coverage.

This incident occurred two years ago on 10/31/2008 and the investigation presented to BSG for review is the RPD OID formatted investigation. The OID case book available for this review is a redacted "on line" version of the investigation as presented by RPD to CPRC. Several tabbed sections are fully redacted as well as other isolated details in various reports and interview transcriptions. The book contains (50) tabbed sections that include witness statements, scene evidence, and investigative details. Included, in the case book is a section containing copies of (4) newspaper articles. However, due to the

redactions of this report it must be considered incomplete for purposes of the review but not for purposes of the overall investigation.

Event:

Marlon Oliver Acevedo died in the early evening hours on 10/31/208 during a fight with RPD Officers Koehler and Ratkovich in the 7800 block of Cypress Avenue Riverside, CA.

Officers Koehler and Ratkovich were dispatched to the scene following witness complaints to the Police Department's dispatch office about Acevedo's unusual, threatening and dangerous behavior. When the Officer's arrived they contacted Acevedo standing in the street.

Acevedo refused to comply with the officer's commands and a fight ensued resulting in the applied use of force by the officers that included baton strikes, wrestling techniques and the deployment of a taser weapon several times. Restraining techniques used by the officers to end the fight included the use of handcuffs, additional wrestling techniques and a hobbling device used to control Acevedo's legs.

When the fight ended, Acevedo was restrained. Officer Koehler requested medical support via RPD dispatch. AMR and FD Medical were dispatched to the scene by RPD dispatch. AMR and FD Medical personnel arrived on the scene at the same time. Within seconds of initial contact with the officer's and patient, medical personnel recognized that Acevedo was in medical distress, no pulse and not breathing. They ordered the removal of restraints and initiated treatment and transport. Acevedo was pronounced dead at Parkview Community Hospital.

Investigation:

The OID investigation was conducted by Riverside Police Department. The RPD OID case book is the only material presented to BSG for this review.

Review:

The review has consisted of a detailed review and analysis of the entire RPD OID case book as presented.

Conclusion:

Under more timely circumstances a neighborhood investigation to identify other witnesses would be recommended. Additional interviews and follow up interviews would have been recommended with the following known civilian witnesses:

- Elizabeth Lomeli: Lomeli was Acevedo's girlfriend. Lomeli called 911.
- Melissa Herrera: Neighbor who called 911.

- Anthony Herrera: Neighbor who's wife called 911 and witnessed event.
- Unidentified: Acevedo's mother who was at the scene.
- Unidentified: Acevedo's brother who was at the scene.

However, it is considered unlikely, given that 2 years has elapsed from the date of the incident, additional witnesses would be located and known witnesses would be able to provide any spontaneous and objective information that would assist in clarity and detail to the investigation.

The physical evidence is well documented in the investigation. It is of limited value to the overall understanding of the events. However, some video and audio evidence does exist and should be reviewed.

If officer training records, including class outlines for taser weapon instruction, are available for review they should be analyzed.

The medical history of the event and autopsy information should be fully reviewed and analyzed.

Report of Investigation

Date:	November 29, 2010
Client:	Community Police Review Commission Mario Lara Interim CPRC Manager City of Riverside 3900 Main Street Riverside, CA 92522
Case:	GI-10-3969
Report Matter:	OID: Marlon Oliver Acevedo
Investigator:	G. Warnberg

Baker Street Group Inc (BSG) was tasked with efforts to locate civilian witnesses and conduct additional interviews in the OID of Marlon Oliver Acevedo on 10/31/2008.

Following a previous review by BSG of the RPD OID investigation, several witnesses had been left unidentified and or not interviewed in the RPD investigation.

The OID occurred during the evening hours on 10/31/2008 in the 7800 block of Cypress Avenue between Montgomery Street and Warren Street in front of the Acevedo residence, 7857 Cypress Ave, and across the street from the Cypress Springs Apartments, 7850 Cypress Ave.

Typical public record data base research was conducted in order to establish identities and address information for known witnesses. A through and appropriate neighborhood investigation was conducted in an attempt to identify and interview previously unknown witnesses.

The following information has been developed during this investigation.

Elizabeth Lomeli: DOB 2/15/1985: SSN 553-89-xxxx

Elizabeth Lomeli was the girlfriend of Marlon Oliver Acevedo. On the date of the OID,

Lomeli lived at 7857 Cypress Ave. with her mother, Martha Casteneda, Marlon Acevedo, Lomeli's brother currently identified only as Michael Lomeli and two young children.

Elizabeth Lomeli is currently living with her mother at 4992 Foothill Ave, Riverside, CA. I have traveled to the residence on three occasions attempting to establish contact and request an interview. On each occasion I left written requests in the form of business cards and CPRC introductory letters requesting contact. I have also talked to neighbors and corroborated that Lomeli and Casteneda live at the residence. I have not been able to establish contact as a result of the above described efforts.

Martha Castaneda (aka) Martha Garay: DOB 9/1/1956: SSN 610-34-xxxx

Martha Castaneda currently lives at 4992 Foothill Ave, Riverside, CA. The property is owned by Samuel and Bertha Fernandez. Attempts to contact Castaneda have gone unsuccessful.

Melissa Herrera: DOB 4/22/1990: SSN 607-38-xxxx

Melissa Herrera lives at 7875 Cypress Ave, Riverside, CA. Herrera witnessed the OID incident. Herrera talked to a RPD 911 operator after the call was placed by a friend using her residence telephone. Herrera was interviewed on 11/23/2010 at her residence. Present during the interview was Herrera's cousin Anthony Hernandez. The interview was recorded but has not been transcribed. Herrera told me the following information:

Herrera said she returned home from "trick or treating" on the night of the incident with a friend who lived up the street. Herrera said her friend no longer lives in the area and she could not remember her last name, but identified her as "Jocelyn". Herrera described the residence and I later identified the property located at 7990 Cypress Ave. The residence is currently not occupied.

Herrera said when they returned home she observed Acevedo standing in the street, yelling, and acting strange and in a dangerous way. Herrera said she assumed Acevedo "was on something" suggesting she believed he may have been under the influence of drugs and she thought he may be hit by cars traveling on Cypress Ave.

Herrera said Acevedo lived next door with his girl friend she identified as "Lisa". Herrera said her family had not been friendly with the neighbors but she knew others that lived in the residence were Lisa's mother, Lisa's brother identified as "Michael" and two younger children.

Herrera said Jocelyn called the police calling 911. Jocelyn then laid the telephone down and Herrera said she picked it up and talked with the police dispatcher.

Herrera said the police arrived within 10 minutes. Herrera watched from the front door of her residence as the officers contacted Acevedo and tried to tell him to get out of the street. Acevedo refused to cooperate and Herrera watched as the officer's fought with

him. Acevedo said Acevedo was "yelling and crying" but she could not understand what he was saying. Acevedo swung his fist at the officers and they hit him with their nightsticks. Eventually, Acevedo fell to the pavement and the officers used their "taser" to shock him several times. Herrera said once Acevedo was on the ground, he did not move very much and then stopped moving completely. Herrera said she was not able to hear any of the conversation between the officers and Acevedo.

Anthony Hernandez: DOB 8/14/1992:

Hernandez was present during the interview with Herrera. Hernandez said he also watched the incident from the doorway of the residence and the front step in front of the door.

Hernandez said the officers attempted to talk and get Acevedo to leave the street but he was yelling and crying and would not comply to the officers orders. Hernandez said he thought Acevedo was yelling his girlfriends name but did not know for sure.

Hernandez said Acevedo swung his fist at the officers and they hit him with their night sticks in the legs. Hernandez said a third officer arrived and they were able to force Acevedo to the ground and then they used their "taser" to shock him several times.

Hernandez said a lot of people from the apartments were watching the incident but he could not identify any additional witnesses.

Hernandez said he could not hear any of the conversations between Acevedo and the officers.

Bumcrot Consulting

Mr. Mike Bumcrot's

Report

dated June 4, 2011

MIKE BUMCROT CONSULTING

REPORT OF INVESTIGATION

DATE: June 4, 2011

CASE: Riverside Police Department File # P08157587

SUBJECT: Officer Involved Death of Marlon Oliver Acevedo, which occurred on October 31, 2008 @ 2145

On June 1, 2011, I received a written request from Frank Hauptmann, Manager of the Community Police Review Commission, to review the circumstances surrounding the officer involved death investigation of Marlon Acevedo. I was then asked to provide my expert opinion in a written report on the manner in which the case was investigated by the Riverside Police Department.

I reviewed over 500 pages of police reports, photographs and other documents contained in the presentation by the Riverside Police Department to the Community Police Review Commission. I also drove to the scene of the incident, to better understand the police reports.

CASE SYNOPSIS

On October 31, 2008, Halloween, at approximately 2145, Riverside Police Department received several 911 calls regarding a man standing in the street, blocking traffic in the 7800 block of Cypress Ave.

Riverside Police Officers, Dan Koehler, a 20 year law enforcement veteran, and Jeff Ratkovich, a Riverside Policeman for just 2 years, responded to the radio call. Just a few hours earlier, at the same location, the officers were flagged down by an adult male, standing on the side of the road. The officers stopped and asked the male if he required assistance and were told that he was keeping the streets safe and asked that

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the officers do the same. Upon hearing the radio call, Officers Koehler and Ratkovich wondered if the subject of the call was the same male.

Officers Koehler and Ratkovich were the first officers on scene and immediately recognized the subject in the street, Marlon Acevedo, as the same man they had made contact with earlier.

The officers exited their marked police car and Officer Koehler asked Mr. Acevedo to get out of the street as he was holding up traffic. Mr. Acevedo began to grunt and growl and advanced on Officer Koehler. Mr. Acevedo had his fists up, in a fighting position, as he approached the officer, ignoring orders to lay on the ground. Mr. Acevedo swung his fist at Officer Koehler's face, missing him. Both officers deployed their batons, striking Mr. Acevedo in both legs. Mr. Acevedo struck Officer Koehler in the face, knocking off his glasses. All three men fell to the ground and Mr. Acevedo attempted to bite Officer Koehler in the groin. Officer Ratkovich stood and fired his taser into Mr. Acevedo's stomach in an attempt to overcome his aggression. In a period of 59 seconds, Mr. Acevedo received 6 cycles from the taser. He was subdued when, after the fifth cycle, Officer Ratkovich removed the taser cartridge and produced a "drive stun" shot directly into Mr. Acevedo.

As assisting units began to arrive, Officer James Heiting was asked to get his hobble restraint from the trunk of his police car and help place Mr. Acevedo in a TARP position, with his legs tied together and connected to his hands.

Within seconds, Riverside Fire Department and an ambulance arrived on scene. Paramedics discovered that Mr. Acevedo was in medical distress and all restraints were removed from Mr. Acevedo while he was being treated. He was transported to a local hospital where he was pronounced dead approximately one half hour later.

A post mortem examination of Mr. Acevedo revealed no obvious cause of death. However, after a toxicological examination, the cause of death was attributed to PCP

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intoxication. Cannabinoids and atropine were also found in his system. He was also suffering from hypertrophic cardiomyopathy, heart disease.

EXPERT QUALIFICATIONS

I was employed as a peace officer for the Los Angeles Sheriff's Department for 34 years. I worked as a jail deputy, 18 months as a patrol officer, and four years assigned to the Special Enforcement Bureau (SWAT team). My last 27 years on the department, I was assigned to the Detective Division, including over 22 years assigned to the Homicide Bureau. I investigated over 450 homicides and suspicious deaths and over 100 Officer Involved Shootings, including the murders of ten police officers.

In 1994, I assisted in writing the LASD Homicide Bureau Investigative Manual. I was also selected to be a member of the Joint LASD/LAPD Crime Lab Development Committee as well as the JET Committee to develop Homicide Bureau job standards and selection criteria. In 1995, I was selected as California's Deputy Sheriff of the Year by the California Organization of Police and Sheriffs (COPS) for the investigation, arrest, and conviction of a suspect in the murders of two local policemen.

For over 15 years, I have taught "High Profile Murder Investigations", "Homicide Scene Management", and "Officer Involved Shooting Investigations" for the Robert Presley Institute of Criminal Investigation, police academies, advanced training classes, supervisor training, college classes, Homicide School, and in-service training. I am currently on staff with the Police Policy Studies Council where I teach and consult nationally on officer involved shooting, homicide, and suspicious death investigations. I am currently the investigator for the Riverside Police Review Commission. Although I retired from LASD in 2002, I was immediately signed to a contract to train newly assigned homicide detectives. In 2006, I was also assigned to the LASD Cold Case team where I have reviewed over one thousand unsolved murders and specifically work the unsolved DNA and latent print cases.

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INVESTIGATION AND REVIEW

The investigation into the officer involved death of Mr. Acevedo was conducted by the Riverside Police Department and the Riverside County District Attorney's Office.

I reviewed all the reports submitted to the Community Police Review Commission. I also extensively researched excited delirium and discussed this phenomenon with both Medical, Legal and Law Enforcement Experts.

CONCLUSION

At the time of this incident, several citizens called 911 to report someone standing in the street. Sidney Zamora reported there was "a crazy guy in the street" and the person was "looking to fight". Justin Resorl said "he's either real drunk or frickin crazy".

Even the 911 Operator is heard to ask "Is that him screaming in the back?". Officer Koehler stated that when he initially approached Mr. Acevedo, the subject took a combative stance and Officer Koehler held up his arms in an attempt to diffuse the situation.

Officer Koehler told the Detectives "I'm a big guy...I had no control over him". Officer Ratkovich stated that Mr. Acevedo looked "angry and upset" and had a crazed look on his face".

Detectives discovered that on May 3, 2008, Riverside police officers were called to the same location when Mr. Acevedo was discovered on the bathroom floor, yelling and throwing things. He appeared confused and excited and was grunting, sweaty, and could not stand. He was transported to the hospital where he had admitted smoking PCP and said "PCP is hard to get a hold of because nobody has it anymore". A blood test revealed the presence of PCP and cannabinoids, the same drugs found in Mr.

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MIKE BUMCROT CONSULTING

Acevedo's system at the time of his death. This suggests that he smoked marijuana, laced with PCP.

In researching Excited Delirium, I discovered that individuals with this condition are confused, irrational, hyperactive, and usually violent. After a violent struggle, they become unresponsive, develop cardiopulmonary arrest, and do not respond to CPR.

The National Institute of Justice (NIJ) just completed a study of nearly 300 deaths, nationwide, after suspects were shot by tasers. NIJ found that most of the deaths were caused by underlying health problems. (Note: Mr. Acevedo had heart disease.)

The study concludes that it is appropriate for officers to use stun guns and that the risk of death is less than 0.25%.

I have attached several handouts, i.e., Medical Panel Issues Interim Findings on Stun Gun Safety; Tactical Emergency Medicine; Excited Delirium; What is Excited Delirium; 10 Training tips for Handling Excited Delirium; Does Excited Delirium Kill Taser Victims?; Excited Delirium (from Dimaio's Forensic Pathology) Neurochemistry of Excited Delirium (from Karch's Pathology of Drug Abuse); and more.

The Seattle, Washington Police Department reports 70 cases of excited delirium in the last 2 years. Due to the large number of these types of cases, patrol officers and paramedics train together. Closer to home, in the last several months, Los Angeles Sheriff's Department, Homicide Bureau, has investigated 4 Excited Delirium officer involved deaths.

Riverside Police Department Detectives were assigned a controversial, complex case. After completing my review of the indicated material, it is my expert opinion that this officer involved death investigation met or exceeded the POST Standards of Practice. It was also conducted in a fair and impartial manner and I saw no evidence to suggest Riverside Police Department gave nothing but their best effort.

MB

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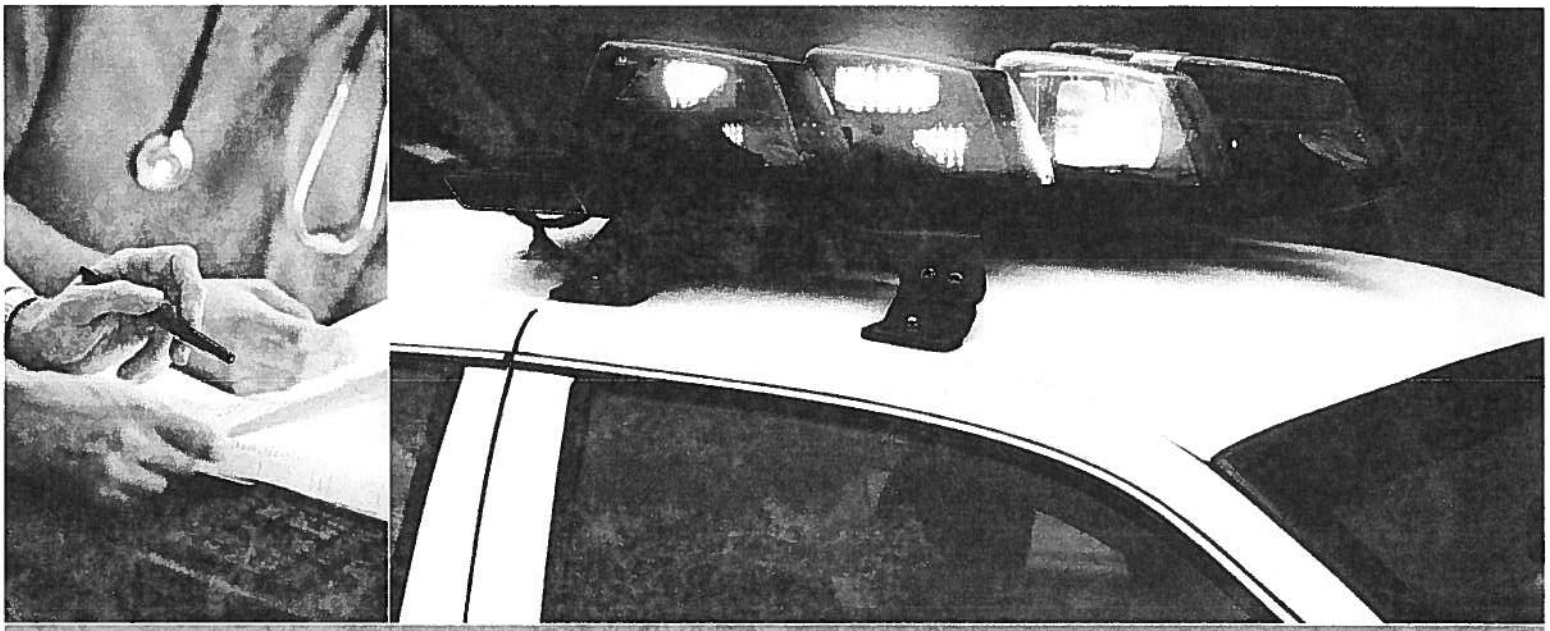

Medical Panel Issues Interim Findings on Stun Gun Safety

by John Morgan, Ph.D.

During the three-year period from 2003 to 2005, 47 states and the District of Columbia reported 2,002 arrest-related deaths to the Bureau of Justice Statistics' Deaths in Custody Reporting Program.[1] For many years, police leaders have sought alternatives to lethal force and better methods to subdue individuals to limit injuries and death.

Less-lethal devices have been used by law enforcement for decades; during the early 1990s, pepper spray became the less-lethal option of choice for law enforcement and corrections agencies. Although pepper spray is inherently safer than lethal-force options and may be preferable to blunt-force methods, many advocates were concerned that pepper spray was associated with in-custody deaths. The National Institute of Justice (NIJ) reviewed those cases and, in 2003, issued a report that found pepper spray was safe and effective.[2]

In recent years, electro-muscular-disruption technology — also known as conducted-energy devices (CEDs) or stun guns or by the trade name Taser® — has become the less-lethal device of choice for a growing number of law enforcement agencies. CEDs use a high-voltage, low-power charge of electricity to induce involuntary muscle contractions that cause temporary incapacitation. Industry reports suggest that approximately 11,500 law enforcement agencies around the country have acquired CEDs, with approximately 260,000 devices now deployed. In 2003, TASER International introduced the Taser X26®, the conducted-energy device most widely used by law enforcement today.

Although studies by law enforcement agencies have found that the deployment of CEDs reduced injuries to officers and suspects,[3] a significant number of individuals have died after CED exposure. Some were normal healthy adults; others were chemically dependent or had heart disease or mental illness. These deaths have given rise to questions from law enforcement and the public regarding the safety of CEDs.

Because many gaps remain in the body of knowledge with respect to the effects of CEDs, NIJ sponsored an independent research program to address the safety and effectiveness of CEDs and a study to address whether CEDs can contribute to or cause mortality and, if so, in what ways. An interim report on this study was recently released. *Deaths Following Electro Muscular Disruption* is available at http://www.ncjrs.gov/pdffiles1/nij/222981.pdf; a final report is expected in 2009.

The study is being conducted by an expert medical panel assembled by NIJ. The panel reviewed the full range of current scientific research, reviewed a number of CED-associated deaths and held substantive discussions with industry, academia and community advocates. At this time, many questions about the safety of CEDs cannot be answered based on current research, especially with respect to at-risk individuals. Nonetheless, although exposure to CEDs is not risk free, NIJ's medical panel found no conclusive medical evidence in current research that indicates a high risk of serious injury or death from the direct effects of CED exposure.

NIJ's Research Program

Prior to NIJ's involvement, most of the relevant research in this field had been industry sponsored. Although much of this prior work had been published in peer-reviewed journals, some questions had been raised about the influence of industry funding on the results. For its CED safety studies, NIJ funded researchers, physicians and other professionals who have never been employed by companies in the field, including TASER International, Inc.[4] Device manufacturers did cooperate with and provide important information to NIJ-sponsored researchers and studies.

NIJ's research program has included three main types of study. In general, physiological research provided a controlled way to examine the limits of CED exposure and how such exposure might affect at-risk populations, such as individuals with high body temperature or who were compromised by drug exposure.[5] Human subject testing was performed with police volunteers during training to determine the effects of CED exposure on healthy individuals, especially with respect to changes in heart function and blood chemistry. Field data collection provides information about how CEDs are used and how they affect a range of individuals in real-world settings. Some field data were retrospective, based on reconstruction of information in police reports. Other field data were collected by medical personnel soon after the use of CEDs by law enforcement.[6]

Although exposure to CEDs is not risk free, NIJ's medical panel found no conclusive medical evidence in current research that indicates a high risk of serious injury or death from the direct effects of CED exposure.

These studies have improved the understanding of the safety and effectiveness of CEDs. Researchers at the University of Wisconsin found that CEDs can directly "electrocute" the heart rhythm, although the chance of this happening is quite small.[7] Theoretically, this can happen only in individuals with very little distance from their skin surface to their pericardium, the sack around the heart muscle. Research published in 2007 shows that CEDs can cause heart fibrillation (a dangerously disturbed heart rhythm) in people with pacemakers, presumably because the CED shock can travel down the electrical leads of the pacemaker device.[8]

One concern with CEDs has been that they cause involuntary muscle contractions and thus might cause muscle breakdown, changes in blood chemistry, and perhaps resulting heart failure. Physiological testing has not shown significant signs that these problems actually occur.[9] CED exposure can cause a small, temporary increase in lactate, similar to what might be seen during moderate exercise. This result confirms industry studies.

The panel said that law enforcement need not refrain from deploying CEDs, provided the devices are used in accordance with accepted national guidelines.

Cases of Excited Delirium

Supporters of the use of CEDs attribute many in-custody deaths to a syndrome called excited delirium. Excited delirium is not a medical diagnosis, but a term describing people who may have psychosis or drug intoxication. These individuals may show great strength, agitation and violent behavior. Their body temperature will often be very elevated, to potentially lethal levels.

Law enforcement officers encounter suspects in excited delirium frequently and must use force to subdue them. People in excited delirium are at high risk of death even if they do not encounter a police officer and even if a CED or other weapon is not used against them. These individuals must be calmed and their body temperature reduced as soon as possible to avoid sudden death.

Although preliminary data from physiological studies suggest that CEDs may increase the risk of sudden death in cases of excited delirium, NIJ's study panel concluded in its interim report that CEDs do not directly cause death in excited delirium cases. The panel noted that this does not mean that CEDs are entirely ruled out from having a role in such deaths. Everything that happens to a person that causes excited delirium and stresses a person in excited delirium may be a contributing factor in his or her death, whether he or she ingested drugs or engaged in a physical struggle.

Many police departments are working with emergency medical responders to deal with excited delirium cases more effectively. In Dade County, Fla., responders have implemented protocols based on Canadian research to reduce the risk of death in these individuals. Interventions include sedation with the drug Versed and reduction in body temperature using chilled intravenous fluids. Although not recommending Dade County's protocol specifically, NIJ's interim report on in-custody deaths does support active intervention in excited delirium cases, which may include cooling, sedation and hydration.

The Panel's Recommendations

As stated earlier, the NIJ medical panel noted that, at this time, many questions about the safety of CEDs cannot be answered based on current research, especially with respect to at-risk individuals. The panel found, however, that there is no conclusive medical evidence to indicate a high risk of serious injury or death from the direct effects of CED exposure. In fact, field experiences in many police departments indicate that exposure is safe in the vast majority of cases.[10] Therefore, the panel said, law enforcement need not refrain from deploying CEDs, provided the devices are used in accordance with accepted national guidelines. (See *Electronic Control Weapons*, a model policy of the International Association of Chiefs of Police.[11])

The panel's interim report includes significant recommendations for post-event medical care and investigation of in-custody deaths. It is not possible, the panel said, to reach a definitive conclusion concerning the role of less-lethal devices in a death unless the relevant facts have been established about the incident and the decedent. The report also includes a bibliography of scientific papers that have been systematically reviewed for their relevance and quality. This bibliography represents an authoritative foundation for the inclusion or exclusion

About the Author

John Morgan is the Deputy Director for Science and Technology at the National Institute of Justice. He co-chaired the Steering Group of NIJ's study, *Deaths Following Electro Muscular Disruption.*

of CEDs in deaths. Although it does not include every possible source of information, the bibliography does represent a reliable set of information accepted by the NIJ medical panel.

NIJ's review of CED technology provides the needed basis for the appropriate use of these devices. The legitimacy of law enforcement is, in part, derived from the care taken in choosing technology to subdue or suppress individuals. NIJ plays an integral role in this process by developing knowledge about a wide range of technology and practice — including this recent interim report on conducted-energy devices — based on rigorous scientific research.

NCJ 224086

For More Information

- Information on less-lethal technologies and NIJ's work in this area is available at http://www.ojp.usdoj.gov/nij/topics/technology/less-lethal/welcome.htm.

Notes

1. Mumola, C.J., *Arrest-Related Deaths in the United States, 2003-2005,* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, October 2007 (NCJ 219534), available at http://www.ojp.usdoj.gov/bjs/pub/pdf/ardus05.pdf.
2. *The Effectiveness and Safety of Pepper Spray,* Research for Practice, Washington, DC: U.S. Department of Justice, National Institute of Justice, April 2003 (NCJ 195739), available at http://www.less-lethal.org/docs/59/NIJ-Effectiveness-of-Pepper-Spray.pdf.
3. See, for example, http://www.seattle.gov/police/publications/forg/community.htm.
4. Dr. Cynthia Bir, who presented information to NIJ's medical panel, tested and evaluated Stinger CEDs with funding received from Stinger in 2006. Bir is currently researching the development of new models to replicate excited delirium.
5. Webster, J.G., J.A. Will, H. Sun, J.Y. Wu, A.P. O'Rourke, S.M. Huebner, and P.S. Rahko, "Can Tasers® Directly Cause Ventricular Fibrillation?" *International Federation for Medical and Biological Engineering Proceedings* 14 (2006): 3307-3310.
6. Bozeman, W.P., J.E. Winslow, D. Graham, B. Martin, W.E. Hauda, and J.J. Heck, "Injury Profile of Electrical Conducted Energy Weapons," *Annals of Emergency Medicine* 50 (3) (September 2007): S65; Mesloh, C., M. Henych, L.F. Thompson, and R. Wolf, *A Qualitative and Quantitative Analysis of Conducted Energy Devices: Taser X26 vs. Stinger S200,* final report submitted to the National Institute of Justice, Washington, DC: May 2008 (NCJ 222769), available at http://www.ncjrs.gov/pdffiles1/nij/grants/222769.pdf; and Mesloh, C., M. Henych, and R. Wolf, *Less Lethal Weapon Effectiveness, Use of Force, and Suspect and Officer Injuries: A Five-Year Analysis,* final report submitted to the National Institute of Justice, Washington, DC: September 2008 (NCJ 224081), available at http://www.ncjrs.gov/pdffiles1/nij/grants/224081.pdf.
7. Webster et al., "Can Tasers® Directly Cause Ventricular Fibrillation?"
8. Cao, M., J.S. Sinbane, J.M. Gillberg, and L.A. Saxon, "Taser-Induced Rapid Ventricular Myocardial Capture Demonstrated by Pacemaker Intracardiac Electrograms," *Journal of Cardiovascular Electrophysiology* 18 (8) (August 2007): 876-879.
9. Chan, T., C. Sloane, T. Neuman, S. Levine, E. Castillo, G. Vilke, K. Bouton, and F. Kohokorst, "The Impact of the Taser Weapon on Respiratory and Ventilatory Function in Human Subjects," *Academic Emergency Medicine* 14 (5 Supplement 1) (2007): S104.
10. Bozeman et al., "Injury Profile of Electrical Conducted Energy Weapons," S65; and Mesloh et al., *Less Lethal Weapon Effectiveness.*
11. *Electronic Control Weapons Model Policy,* Alexandria, Va.: International Association of Chiefs of Police, National Law Enforcement Policy Center, August 2005.

ACEP

Tactical Emergency Medicine Sectio

Excited Delirium and Sudden Unexpected Death

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During a three-day period in June 2004, 3 individuals died after being restrained by police i Florida, Minnesota, and California. All had exhibited bizarre behavior necessitating police intervention. All arrests involved struggle and subsequent restraint, including one situation where the individual was struggling with neighbors prior to police and EMS arrival. All arrests eventually required the deployment of OC spray, a TASER device, or both. In the California case, the suspect was evaluated and cleared by EMS prior to being transported to jail. Within two miles from the scene, the patient began to complain of difficulty breathing and subsequently died. In the Minnesota case, the suspect became unresponsive shortly afte being cuffed, and was pronounced dead at a local emergency department. In the Florida case the patient was taken to an emergency department where he died. All final autopsy reports are pending at this time.

These cases show a striking similarity to a recent Cincinnati, Ohio case, which received international attention. During a videotaped arrest, an agitated male suspect attacked the responding officers. The two officers subsequently attempted to subdue the suspect, striking him repeatedly with their batons. Although knocked to the ground, he continued to struggle, requiring a total of 6 officers to place him in handcuffs. At this point, outside the view of the police camera, the suspect ceased struggling. An officer can be heard on the videotape statin

"He's still got a pulse. I don't see him breathing." The suspect was pronounced dead soon after arrival at the emergency department. The Hamilton County coroner noted that the suspect had an "enlarged heart", and that both PCP and cocaine were detected on toxicological tests. No evidence of internal injury was noted.

The term excited delirium (ED) was first used in 1849 to describe psychiatric patients who developed onset of continuous agitation and mania, in the presence of fever, and then suddenly collapsed and died. Fatal ED was first described in 7 cocaine users between April 1983 and May 1984 [1]. Since that time, more than 130 cases of fatal, cocaine-associated ED have been reported in the medical and forensic literature [1-5].

Fatal ED appears clinically to consist of 4 distinct phases, which occur sequentially: elevated temperature, agitated delirium, respiratory arrest, and death [6]. Patients initially appear agitated to grossly psychotic, and exhibit feats of superhuman strength, especially during attempts to restrain them. Shortly after being restrained, the violent struggling appears to cease, and a labored or shallow breathing pattern is noted [2-4]. The patients are typically found dead or near dead moments later. Death typically occurs within 1 hour of first contact with police [2]. More than 75% of patients died either at the scene or during initial transportation [2]. In one study, initial cardiac rhythms were described in 13 cases [3]. In contrast with acute cocaine toxicity, ventricular dysrhythmias occurred in only 1 patient. Asystole was the most common presenting rhythm.

The actual cause of cocaine-associated ED and sudden death is unknown. Studies have suggested that the elevated temperatures seen in these patients is due to abnormal changes i brain dopamine receptors [7]. The vast majority of these patients died after a struggle. Such struggles increase the levels of circulating epinephrine [5,6], and may also result in a metabolic acidosis.

While unexpected death is by definition unexpected, the stunning similarities observed in all these fatal ED cases provide law enforcement and EMS personnel with potential warning signs. All individuals who demonstrate evidence of ED should be taken to a medical facility for evaluation, rather than to a law enforcement facility. Individuals should be placed in a non-prone position as soon as possible, and continuous oximetry instituted to document the absence of asphyxia.

The cessation of struggling by an agitated ED patient should be regarded as an ominous, nea -terminal event, as should the development of shallow or labored breathing. The initial decompensation appears to be respiratory arrest, rather than cardiac arrest. Aggressive airway management and advanced cardiac life support protocols might be life-saving in thes circumstances, although there is insufficient data to make any firm conclusions. Aggressive temperature control measures, analogous to those used in caring for heat-stroke patients, should be instituted.

In conclusion, excitatory delirium has been attributed to approximately 10% of all cocaine deaths [6]. While the death is often referred to as "unexpected" by responding personnel, ther is a well-characterized progression of symptoms leading to death. It is hoped that increased awareness of warning signs might prevent future deaths.

References

Ruttenber AJ, Lawler-Heavner J, Yin M, et al. Fatal Excited Delirium Following Cocaine Use Epidemiologic Findings Provide New Evidence for Mechanisms of Cocaine Toxicity. J Forensic Sci 1997; 42: 25 - 31.

Ross DL. Factors Associated with Excited Delirium Deaths in Police Custody. Mod Pathol 1998; 11: 1127 - 1137.

Stratton SJ, Rogers C, Brickett K, et al. Factors Associated with Sudden Death of Individuals Requiring Restraint for Excited Delirium. Am J Emerg Med 2001; 19: 187 - 191.

Pollanen MS, Chiasson DA, Cairns JT, et al. Unexpected Death Related to Restraint for Excited Delirium: A Retrospective Study of Deaths in Police Custody and in the Community. CMAJ 1998; 158: 1603 - 1607.

O'Halloran RL and Lewman LV. Restraint Asphyxiation in Excited Delirium. Am J Forensic Med Pathol 1993; 14: 289 - 295.

Wetli CV, Mash D, and Karch SB. Cocaine-Associated Agitated Delirium and the Neuroleptic Malignant Syndrome. Am J Emerg Med 1996; 14: 425 - 428.

Karch SB and Stephens BG. Acute Excited States are Not Caused by High Blood Concentrations of Cocaine. BMJ 1998; 316: 1171.

Related Links

Tactical Emergency Medicine Section

Excited delirium

From Wikipedia, the free encyclopedia

Excited delirium is a condition that manifests as a combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent and bizarre behavior, insensitivity to pain, elevated body temperature, and superhuman strength.[1][2] Excited delirium is sometimes called **excited delirium syndrome** if it results in sudden death (usually via cardiac or respiratory arrest), an outcome that is sometimes associated with the use of physical control measures, including police restraint and tasers.[1][2] Excited delirium arises most commonly in male subjects with a history of serious mental illness and/or acute or chronic drug abuse, particularly stimulant drugs such as cocaine.[1][3] Alcohol withdrawal or head trauma may also contribute to the condition.[4]

The diagnosis of excited delirium has been controversial.[5][6] Excited delirium has been listed as a cause of death by some medical examiners for several years,[7][8] mainly as a diagnosis of exclusion established on autopsy.[1] Additionally, academic discussion of excited delirium has been largely confined to forensic science literature, providing limited documentation about patients that survive the condition.[1] These circumstances have led some civil liberties groups to question the cause of death diagnosis, claiming that excited delirium has been used to "excuse and exonerate" law enforcement authorities following the death of detained subjects, a possible "conspiracy or cover-up for brutality" when restraining agitated individuals.[1][5][6] Also contributing to the controversy is the role of taser use in excited delirium deaths.[3][9] The American College of Emergency Physicians has officially recognized excited delirium as a unique syndrome[10] and "rejects the theory" that excited delirium is an "invented syndrome" used to excuse or cover-up the use of excessive force by law enforcement.[11]

Contents

Pathophysiology and symptoms

"Excited delirium" was first explicitly described in 1985 as a condition relating to acute cocaine intoxication.[12][4]

The pathophysiology of excited delirium has been unclear,[10] but likely involves multiple factors.[13] These may include positional asphyxia, hyperthermia, drug toxicity, and/or catecholamine-induced fatal cardiac arrhythmias.[13]

A substantial majority of fatal case reports involved men, most commonly African American.[10][2] Excited delirium patients commonly have acute drug intoxication, generally psychostimulants such as cocaine, PCP and methamphetamine.[2]

Effective Date: 10/84
Revision Date: 8/86
Approval:

_____
Ken Fortier
Chief of Police

4.50 CUSTODY AND DETENTION OF MENTAL PATIENTS:

A. AUTHORITY:

1. Section 5150 of the Welfare and Institutions Code states, in part, "When any person, as the result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer . . . may, upon probable cause, take the person into custody and place him or her in a facility designed by the County for the purpose of 72-hour evaluations and treatment . . . "

2. Riverside County General Hospital is such a facility.

B. POLICY:

1. Riverside Police Department officers shall abide by and adhere to the provisions set forth in the Welfare and Institutions Code pertaining to the custody and detention of persons falling within the definitions described in Section 5150 of the Welfare and Institutions Code.

a. When responding to, or initiating investigations into criminal activities, officers will label the investigation as to the type of criminal activity involved regardless of whether or not the suspect appears to meet the requirements of 5150 WIC.

b. If the suspect is in such an obvious mental state that the jail would not accept that person, then the suspect should be lodged at County Hospital with criminal charges pending.

c. Reports carried as 5150 WIC will be only those that are non-criminal in nature.

2. Officers shall obtain supervisory approval for any 5150 detention.

3. **Violent Patients:** If possible, violent subjects should be transported by ambulance.

4. **Use of Force:** Officers shall act in accordance with law and Department procedure when using force to affect a detention for 5150 WIC.

5. **Unconscious Person:** In all cases, unconscious persons shall be first evaluated by emergency medical personnel and then transported by ambulance to a hospital.

6. **Application for 72 Hour Detention for Evaluation and Treatment:**

Officers shall complete the applications for 72-hour detention.

a. Officers must remain with 5150 subjects until released by hospital authorities.

b. If an officer should experience an unreasonable delay at the hospital, a supervisor should be notified, so that he/she may attempt to expedite the process.

7. Weapons in the Possession of 5150 Subjects:

a. In accordance with Section 8102 WIC, officers shall confiscate and retain custody of any firearm or other deadly weapon which is owned, in the possession, or under the control of any person who has been detained or apprehended for examination of his/her mental condition, or who is a mental patient in any hospital or institution, or who is on leave of absence from such hospital.

b. "Deadly weapon" means any weapon, the possession or concealed carrying of, which is prohibited by Section 12020 of the Penal Code. (WIC 8100, Stats. 1985)

c. If the 5150 subject has been assessed and admitted to Riverside General Hospital or other County mental health facility for evaluation and treatment because that person is a danger to himself/herself or to others, Section 8103 WIC prohibits that individual from possessing the confiscated firearm or other deadly weapon for a period of five years. The firearm or other deadly weapon shall not be released "except upon an order of the Superior Court based upon a finding that the person may possess the firearm or other deadly weapon without endangering others." (WIC 8103(f)(4))

d. Alternatively, if the 5150 subject is detained for the purpose of a mental health evaluation but is not admitted to the facility following the initial assessment, the firearm or other deadly weapon must be returned to the subject unless the City Attorney initiates a petition in the Superior Court for a hearing to determine whether the return of a firearm or other deadly weapon would be likely to result in endangering the person or others within 30 days of the subject's release. (WIC 8102) For further direction, please refer to Section 4.47 regarding the seizure of firearms or deadly weapons from mentally disturbed persons.

8. In all cases, officers shall complete a report when persons are detained for a 5150 WIC evaluation.

9. Handling 72-Hour Mental Health Evaluation (5150) calls at Riverside General Hospital:

Uniformed officers are occasionally summoned to Riverside General Hospital (RGH) in order to execute the necessary application for a 72-hour mental health evaluation pursuant to Welfare and Institutions Code, Section 5150.

Officers should be aware that completing an application for 72-hour evaluation on a subject effectively transfers probable cause and any potential liability for the detention from the hospital to the Riverside Police Department.

Members of the attending staff at RGH are authorized by Section 5150 to take an individual into custody for the purpose of a 72-hour mental health evaluation. Therefore, it is recommended that officers refuse to participate in the mental health detention of individuals who have not been taken into their custody. This will eliminate potential civil liability surrounding the detention.

The signs and symptoms for excited delirium may include:[2][10][14][4][15]

- Paranoia
- Disorientation
- Hyper-aggression
- Tachycardia
- Hallucination
- Incoherent speech or shouting
- Incredible strength or endurance (typically noticed during attempts to restrain victim)
- Hyperthermia (overheating)/profuse sweating (even in cold weather)

Other medical conditions that can resemble excited delirium are panic attack, hyperthermia, diabetes, head injury, delirium tremens, and hyperthyroidism.[16]

A 2010 systematic review published in the *Journal of Forensic and Legal Medicine* argued that the symptoms associated with excited delirium likely posed a far greater medical risk than the use of tasers, and that it seems unlikely that taser use significantly exacerbates the syptoms of excited delirium.[17]

Society and culture

Some civil-rights groups argue that excited delirium diagnoses are being used to absolve law enforcement of guilt in cases where alleged excessive force may have contributed to patient deaths.[18][19][20] In 2003, the NAACP argued that excited delirium is used to explain the deaths of minorities more often than whites.[20]

Eric Balaban of the American Civil Liberties Union argued in 2007 that excited delirium was not recognized by the American Medical Association or the American Psychological Association and that the diagnosis served "as a means of white-washing what may be excessive use of force and inappropriate use of control techniques by officers during an arrest."[5] Melissa Smith of the American Medical Association stated in 2007 that the organization had "no official policy" on the condition.[6] Excited delirium is not found in the current version of the *Diagnostic and Statistical Manual of Mental Disorders*, however the term "excited delirium" has been accepted by the National Association of Medical Examiners and the American College of Emergency Physicians, who argued in a 2009 white paper that "excited delirium" may be described by several codes within the ICD-9.[1]

In Canada, the 2007 case of Robert Dziekanski received national attention and placed the a spotlight on the use of tasers in police actions and the diagnosis of excited delirium. Police psychologist Mike Webster testified at a British Columbia inquiry into taser deaths that police have been "brainwashed" by Taser International to justify "ridiculously inappropriate" use of the electronic weapon. He called "excited delirium" a "dubious disorder" used by Taser International in its training of police.[21] In a 2008 report entitled *An Independent Review of the Adoption and Use of Conducted Energy Weapons by the Royal Canadian Mounted Police*, the authors argued that excited delirium should not be included in the operational manual for the Royal Canadian Mounted Police without formal approval after consultation with a mental-health-policy advisory body.[22]

See also

- Electroshock weapon controversy
- Positional asphyxia
- Sluggishly progressing schizophrenia
- Delirium tremens

References

1. ^ *a b c d e f g* "White Paper Report on Excited Delirium Syndrome", ACEP Excited Delirium Task Force, American College of Emergency Physicians, September 10, 2009
2. ^ *a b c d e* Grant JR, Southall PE, Mealey J, Scott SR, Fowler DR (March 2009). "Excited delirium deaths in custody: past and present". *Am J Forensic Med Pathol* **30** (1): 1–5. doi:10.1097/PAF.0b013e31818738a0. PMID 19237843. http://ovidsp.tx.ovid.com/sp-3.3.1a/ovidweb.cgi?T=JS&PAGE=fulltext&D=ovft&AN=00000433-200903000-00001&NEWS=N&CSC=Y&CHANNEL=PubMed.
3. ^ *a b* Ruth SoRelle (October 2010). "ExDS Protocol Puts Clout in EMS Hands". *Emergency Medicine News* **32** (10): 1, 32. doi:10.1097/01.EEM.0000389817.48608.e4. http://journals.lww.com/em-news/Fulltext/2010/10000/ExDS_Protocol_Puts_Clout_in_EMS_Hands.1.aspx.
4. ^ *a b c* Samuel E, Williams RB, Ferrell RB (2009). "Excited delirium: Consideration of selected medical and psychiatric issues". *Neuropsychiatr Dis Treat* **5**: 61–6. PMC 2695211. PMID 19557101. http://www.dovepress.com/articles.php?article_id=2807.
5. ^ *a b c* "Death by Excited Delirium: Diagnosis or Coverup?". *NPR*. http://www.npr.org/templates/story/story.php?storyId=7608386. Retrieved 2007-02-26. "You may not have heard of it, but police departments and medical examiners are using a new term to explain why some people suddenly die in police custody. It's a controversial diagnosis called excited delirium. But the question for many civil liberties groups is, does it really exist?"
6. ^ *a b c* "Excited Delirium: Police Brutality vs. Sheer Insanity". ABC News. March 2, 2007. http://abcnews.go.com/Health/story?id=2919037&page=1&CMP=OTC-RSSFeeds0312. Retrieved 2007-03-13. "Police and defense attorneys are squaring off over a medical condition so rare and controversial it can't be found in any medical dictionary — excited delirium. Victims share a host of symptoms and similarities. They tend to be overweight males, high on drugs, and display extremely erratic and violent behavior. But victims also share something else in common. The disorder seems to manifest itself when people are under stress, particularly when in police custody, and is often diagnosed only after the victims die."
7. ^ "Suspects' deaths blamed on 'excited delirium'. Critics dispute rare syndrome usually diagnosed when police are involved". *Associated Press at MSNBC*. http://www.msnbc.msn.com/id/15001627. Retrieved 2007-04-29. "Excited delirium is defined as a condition in which the heart races wildly — often because of drug use or mental illness — and finally gives out. Medical examiners nationwide are increasingly citing the condition when suspects die in police custody. But some doctors say the rare syndrome is being overdiagnosed, and some civil rights groups question whether it exists at all."
8. ^ "Excited delirium, not Taser, behind death of N.S. man: medical examiner". *The Canadian Press*. September 17, 2008. http://canadianpress.google.com/article/ALeqM5jHZCd9nDd_33d9uGxPEzI3uHPmIA. Retrieved 2008-10-13. "Medical examiner Dr. Matthew Bowes concluded that Hyde died of excited delirium due to paranoid schizophrenia. He said Hyde's coronary artery disease, obesity and the restraint used by police during a struggle were all factors in his death. ... In a government news release, excited delirium is described as a disorder characterized by extreme agitation, violent and bizarre behaviour, insensitivity to pain, elevated body temperature, and superhuman strength. It says not all of these characterizations are always present in someone with the disorder."
9. ^ "Tasers Implicated in Excited Delirium Deaths". NPR. http://www.npr.org/templates/story/story.php?storyId=7622314. Retrieved 2007-04-29. "The medical diagnosis called excited delirium is the subject of intense debate among doctors, law-enforcement officers and civil libertarians. They don't even all agree on whether the condition exists. But to Senior Cpl. Herb Cotner of the Dallas Police Department, there's no question that it's real."
10. ^ *a b c d* Lisa Hoffman (November 2009). "ACEP Recognizes Excited Delirium as Unique Syndrome". *Emergency Medicine News* **31** (11): 4. doi:10.1097/01.EEM.0000340950.69012.8d.

http://journals.lww.com/em-news/Documents/ExDS-pdf-final.pdf.
11. ^ Mark L. DeBard, MD (November 2009). "Identifying New Disease as Excited Delirium Syndrome Rejects Idea that Police Brutality Causes Deaths". *Emergency Medicine News* **31** (11): 3, 5. doi:10.1097/01.EEM.0000340950.69012.8d. "The report has some political implications, too, because it rejects the theory that ExDS is an invented syndrome being used to cover up or excuse the use of force or even brutality by law enforcement officers when someone dies in their custody. It rejects the idea that specific forms of restraint in and of themselves are what cause deaths in ExDS patients. Instead, ExDS is a potentially fatal disease in which all forms of physiologic stress, from physical and noxious chemical to electrical conductive weapons (commonly called TASERs), can tip the balance of a condition on the edge of being fatal. It recognizes that some form of the use of force will often be necessary to control agitation in the face of delirium, but that it should be the minimal amount necessary to achieve patient control and ensure public safety, and be followed immediately by medical intervention.".
12. ^ Wetli CV, Fishbain DA (July 1985). "Cocaine-induced psychosis and sudden death in recreational cocaine users". *J. Forensic Sci.* **30** (3): 873–80. PMID 4031813.
13. ^ [a] [b] Otahbachi M, Cevik C, Bagdure S, Nugent K (June 2010). "Excited delirium, restraints, and unexpected death: a review of pathogenesis". *Am J Forensic Med Pathol* **31** (2): 107–12. doi:10.1097/PAF.0b013e3181d76cdd. PMID 20190633.
14. ^ Alan W. Benner, Excited Delirium, 1996
15. ^ "Excited Delirium.org: For Law Enforcement". *University of Miami*. http://www.exciteddelirium.org/indexForLawEnforcement.html. Retrieved 2011-07-01.
16. ^ "What other medical emergencies can look like excited delirium?". PoliceOne.com. October 2006. http://www.policeone.com/writers/columnists/ChrisLawrence/articles/1182796/. Retrieved 2007-03-26.
17. ^ Jauchem JR (January 2010). "Deaths in custody: are some due to electronic control devices (including TASER devices) or excited delirium?". *J Forensic Leg Med* **17** (1): 1–7. doi:10.1016/j.jflm.2008.05.011. PMID 20083043.
18. ^ Truscott A (March 2008). "A knee in the neck of excited delirium". *CMAJ* **178** (6): 669–70. doi:10.1503/cmaj.080210. PMC 2263095. PMID 18332375.
19. ^ Paquette M (2003). "Excited delirium: does it exist?". *Perspect Psychiatr Care* **39** (3): 93–4. PMID 14606228. http://onlinelibrary.wiley.com/resolve/openurl?genre=article&sid=nlm:pubmed&issn=0031-5990&date=2003&volume=39&issue=3&spage=93.
20. ^ [a] [b] "'Excited delirium' as a cause of death", Daniel Costello, *Los Angeles Times*, April 21, 2003
21. ^ Hall, Neil (2008-05-14). "Police are 'brainwashed' by Taser maker; Psychologist blames instructions". *Vancouver Sun* (Canwest): pp. A1. http://www.canada.com/vancouversun/news/story.html?id=28218a80-11db-47a3-baf9-90b7dc2618aa. Retrieved 2008-08-30.
22. ^ "An Independent Review of the Adoption and Use of Conducted Energy Weapons by the Royal Canadian Mounted Police", John Kiedrowski, Royal Canadian Mounted Police, June 5, 2008

External links

- [1] Video of an 'excited delirium' incident- police contact, suspect/patient restraint, CPR, and paramedic arrival at incident
- Is 'excited delirium' at the root of many Taser deaths? *CBC News* report by Armina Ligaya (2007).
- Taser firms picked up coroner's lecture tab *The Globe & Mail* (2007).
- Symposium aims to define 'excited delirium' *The Globe & Mail* (2007).
- Filings with S.E.C. & class actions for allegedly failing to disclose and misrepresention on safety.
- Taser manufacturer's view
- Excited Delirium Medical research review at the Canadian Police Research Centre
- Excited Delirium": A Two-Fold Problem S. Marshall Isaacs, M.D., San Francisco Department of Health, Paramedic Division, San Francisco, California
- Di Maio, Vincent J. M.; Theresa G. DiMaio; Di Maio, Theresa; Vincent J. M. Di Maio (2006). *Excited delirium syndrome: cause of death and prevention*. Boca Raton, FL: CRC/Taylor & Francis. ISBN 0-8493-1611-1.
- [2] Bell LV (1849) On a form of disease resembling some advanced stages of mania and fever. Am. J. Insanity 6:97-127.

Excited Delirium

Katherine G. England

Abstract

This paper will discuss several factions with excited delirium. I will discuss what the term excited delirium means, and where it came from. This paper will cover the many different ways excited delirium may be brought on, what happens to the body when it is experiencing excited delirium. Possible ways to decrease the occurrence of excited delirium, and will look into any nexus or correlation between the uses of "tools" in gaining compliance from the subjects, specifically a Taser.

Intro/Literature Review

Excited Delirium, what is this term? What does it mean? Where did it come from? There has been much controversy into what has caused and contributed to unexplained in-custody deaths in the past several years. Within the last few years there have been two primary resources/tools used by law enforcement to gain control and or compliance of suspects. Those two tools are pepper spray and the conducted energy weapon, more commonly known as Taser. In-custody deaths are generally given a cause of death but until recently these causes have been general. For example cocaine psychosis, cardiac, or many other terms that would sound familiar to the trained or untrained person. More recently there has been a new term for many unexplained deaths this term is "Excited Delirium." What is it, how is it brought on, what can be done to decrease its occurrence and is there any nexus to these types of in custody deaths and electro muscular disruption; more commonly known as Taser?

The term excited delirium is a recent name given to a cause of death that may encompass several criteria. You do not need all of the following factors to be a victim of excited delirium, but when one or more of them combine your likeliness to suffer from it are greater. Some things found to be signs of or symptoms of excited delirium are: "...bizarre or aggressive behavior, dilated pupils, high body temperature, incoherent speech, inconsistent breathing patterns, fear, panic, severe sweating, shivering and nakedness." (MDFR, 2007) These are just a few actions by persons that have been documented. According to this same protocol written by Miami Dade Fire Rescue there are also several possible causes of excited delirium. These causes are not limited to but include the following: "Overdose of stimulant or hallucinogenic drug, drug withdrawal, psychiatric patient off medication, illness, low blood sugar, psychosis, and head trauma" (MDFR, 2007). Excited delirium is believed to be a real and diagnosable disorder, and was first seen in the 1980s. In an article by Farnham he defines excited delirium as a "...state of mental and physiological arousal, agitation, hyperpyrexia with epiphora, and hostility" (Farnham & Kennedy, 1997).

While it is still unclear what exactly causes excited delirium there was much talk about this being around but called many different things and only since drug use has come into the picture has it finally started to receive the title or diagnosis of excited delirium. Many of the articles and databases used within this investigative report have stated that most of these types of deaths have occurred while the person is in police custody, or other places where there may be instances where physical confrontation may or may have already occurred. Excited delirium has contributing factors. When a person has a history of heart disease, drug use, and possibly even mental illness and they then get into a physically responsive state this begins the onset of events that lead up to excited delirium. When the person is struggling the body releases chemicals called catecholamines. When this is done and released into the body's circulation the body then reacts by pumping the heart faster, and thus the heart wants more oxygen. The person's potassium levels drop distinctly. When you combine this and many other medical terms together you find the heart beats faster, is not getting enough oxygen, and the arteries to the heart are constricting shutting down the blood flow. Once the person stops the struggle and there is a time of cessation, this is when the heart shuts down. Dr. Vincent DiMaio wrote a letter to a police agency explaining the death of a person. In this letter he states "...Danger time for arrhythmias in individuals with excited delirium is immediately following the cessation of physical activity, when blood catecholamine concentrations continue to rise while potassium levels drop..." (DiMaio, n.d.).

The term excited delirium came around in the early 1980's but was more widely known now in the early 2000's due to media coverage. In a book by Doctors Theresa and Vincent DiMaio they discuss the first references to excited delirium being within literature found in psychiatric books during the mid to late 19th century. This information was found not only in the United States but also in Europe (DiMaio & DiMaio, 2005). There were multiple names given for deaths that occurred during this time, and all seemed to have common attributes and were given the following different names "...acute exhaustive mania, Bell's mania, fatal catatonia, acute exhaustive psychosis, etc" (DiMaio, pg. 7). Physicians finally simplified their multiple diagnoses and started titling these deaths as "Bell's Mania". This diagnosis was given to the newly discovered disease because patients were dying and no one knew why. "Bell goes on to state that there are no residual impairment of mental integrity and the cure is permanent" (DiMaio, pg 8). Throughout the study findings showing death occurring at various time frames; within minutes or even hours after the start of the symptoms.

No one can say for sure what exactly brings on, or initiates the process within the body for excited delirium to occur. Within the law enforcement field there have been several tools that people have tried to link to this type of death, especially where the death occurs while in custody. There was much criticism of the Taser when it first came out and much more since there have been in custody deaths after the use of a Taser. Taser International Inc. who created and produces the Taser has done extensive research into how the Taser works what within the body it affects, and its safety. In an article written in the Palm Beach Post Taser International has been producing stun gun type devices since the 1990s (Kahn, March 2007). It was not until 2003 that the upward swing started for Taser and many agencies began investing in this new tool. Taser International was begun in 1993 by two brothers Rick and Tom Smith. They initially

started developing a stun gun, and said in their corporate web page they wanted to "...developing a more effective and safer use of force option for citizens and law enforcement" (Corporate History, 2007). The brothers then created an Air Taser in 1994, and this was able to track its deployments/uses thus making persons accountable for when it is used. This is the same time, June 1994, that "...ATF certified that Air Taser was not a firearm and is not subject to the stringent regulations that were placed on the original Taser device developed by Jack Cover" (Corporate History, 2007). Several more years of research product alignment and technology was upgraded which lead us to the more commonly known and most currently used form of Taser, the X-26. This Taser has "...dynamically influenced significant changes in over 11,000 law enforcement agencies worldwide" (Corporate History, 2007). A study was conducted in December of 2001 by the National Institute of Justice on the effects pepper spray may or may not have on a person's ability to breathe. This study focused on positional restraint after exposure to Oleoresin Capsicum (OC) spray. The basis of their findings was suggested there was no significant risk to persons who had inhaled OC even in conjunction with positional restraint. There were findings that it did have some effect on persons elevating their blood pressure. The study looked at several positions including sitting, and restrained. This study measured not only positions but included body weight, size, medical issues such as asthma, and history of smoking. This study was conducted and is included in material relative to excited delirium within literature for an in custody sudden death symposium. There was no significant results found that conclude OC spray causes positional or other asphyxiation. (Chan, et al, 2001). In an article by Lt. Benner for Police Chief Magazine he found there was a main problem when looking at and for excited delirium. It was not as of 1996 listed as a medical or psychiatric condition, and was still in a descriptive phase. He found increased attention was laid upon this new diagnosis for an unexplained death. Researched had realized that cocaine related emergencies had jumped and thus the increase in in-custody deaths associated. Departmental training in recognizing this condition had not been conducted at the levels needed, and there were published symptoms related to excited delirium. They are; bizarre and aggressive behavior, shouting, paranoia, panic, violence towards others, unexpected physical strength, and sudden tranquility. These issued for EDS were discussed at the IACP conference as far back as 1995 (Benner & Isaacs, 1996).

Much of the research found within this topical realm had no conclusive diagnosis or information on how to stop the occurrence of excited delirium. Many of them recognize it, and suggest how to best handle it. In a news report from ABC there is a question of the validity of this new "diagnosis" excited delirium. Many are skeptical, yet most doctors who have had persons that have died from the same set of symptoms and/or circumstances. "They tend to be overweight males, high on drugs, and display extremely erratic and violent behavior." In most cases found to be excited delirium the victims also have been under some sort of stress. The article spoke of the introduction of the term excited delirium starting as far back as 1980, and was introduced along the same time as the start of the cocaine craze. Doctors in this article are stating there is a real clinical diagnosis for this disorder, but the American Medical Association refuses to recognize it. Doctors in this study have linked the adrenalin released by the body during the stressful event in combination with the high levels of cocaine, or some other drugs

to excited delirium deaths (Goldman, 2007). An article published in Police Magazine focused on some very basic concepts for Excited Delirium and officer response to it in the field. As in previous articles this one discusses the many signs of this medical condition, and lists them as violent behavior and incredible strength among others. This study showed no single cause as to what is causing this delirium, and lists deaths attributed to Excited Delirium after contact with pepper spray, Tasers, and some restraint techniques. No one instance has been linked with this type of death. It is suggested that officers upon first realizing they may be encountering a person who is exhibiting some signs of Excited Delirium to call for medical personnel and have them stage down the street, and when given the opportunity have the subject immediately evaluated. It is normally too late when medical personnel are called after the subject has collapsed (Ho, 2007).

Methods

Present research was conducted by utilizing three different means. Research surveys were distributed to all accredited agencies with in the State of Florida utilizing a Florida Police Accreditation Coalition web based bulk e-mailer. This allowed access to approximately 160 accredited agencies throughout the State of Florida. These types of agencies were selected as they meet the requirements set forth by the Commission for Florida Accreditation to which my agency is also accredited. This means all agencies responding to the survey will meet, and adhere to the same set of criteria and standards as the Fort Pierce Police Department. There was no set methodology set forth such as size, geographic location. The surveys were sent out randomly. The survey consisted of 13 questions that were based upon yes or no answers. Some answers required a bit of explanation. There was no need for any Lykert scales or quotients.

The second form of research for empirical data is personal interviews. Interviews with Dr. Garavaglia and Dr. Mittleman were conducted. Both doctors are forensic pathologists. Dr. Mittleman is the Chief Medical Examiner for the 19th Judicial Circuit, and Dr. Garavaglia for Orange County. Both have had multiple dealings with excited delirium.

The final means of gathering data will be from personal/own agency, Fort Pierce Police Department, information and case file review. Our agency has had the misfortune to experience two deaths that were attributed to excited delirium. Review of coroner reports and facts surrounding the incidents and information leading up to the time of death were considered, and then filtered into this paper.

Results

Tabulation of survey information reflected a return rate of 33 responses equating to 21%. 14 of these agencies have had in custody deaths. Of these deaths three were self termination. The remaining eleven deaths can be connected to abnormal behavior, combative actions, and aggressiveness in general. The time frames for distress to death were all under 5 minutes with the exception of one being 10-20 minutes. All

agencies performed CPR and requested the response of medical personnel. All parties had narcotics in their system, and the most pronounced of these was cocaine.

In speaking with M.E. Dr. Mittleman he noted behavior of people while experiencing excited delirium is "unreal" almost super human strength. Dr. Mittleman stated "...like running down the street after jumping out of a two story window". I asked Dr. Mittleman if he had any experience with persons being affected by excited delirium who have not been on drugs. Dr. Mittleman reported he has no information relating excited delirium to anyone who has no history and no drugs in their system. That all deaths affiliated with excited delirium as he recalls have had drugs in their system. I asked Dr. Mittleman if he can attribute excited delirium to one specific drug, and he could not. Dr. Mittleman stated there are many different drugs he has seen in the system of a person effected with excited delirium ranging from cocaine to psychiatric medications that were prescribed. I asked Dr. Mittleman when he recalled his first diagnosis of excited delirium and he stated it was in the early 1980's in Miami Dade Florida. Dr. Mittleman added that these types of deaths were happening farther back than this, but persons did not realize what it was, and had no name for it. Dr. Mittleman offered that through his research on the topic this has been happening all the way back to times when it was legal to use cocaine, and that these types of unexplainable deaths, and irrational behaviors are what instigated the illegalization of cocaine, which is still law today. I asked Dr. Mittleman if he knows of a way to prevent excited delirium, and he did not. Dr. Mittleman stated that his experience with it is once the process starts there is no way to deviate from the course that the body takes. I asked Dr. Mittleman if he saw any correlation between the use of an electro muscular device, more commonly know as a Taser, and he did not. Dr. Mittleman stated he has had to rule on two cases here in St. Lucie County recently. Both of these cases involved the use of a Taser on drive stun. Dr. Mittleman stated these deaths were not related to the use of the Taser; "...if they were as a result of the application of the Taser the persons would have died when the Taser was applied". Dr. Mittleman did rule these deaths as a homicide which may confuse some people until they review the literal term of homicide. The killing of one human being by another. Homicide is of three kinds: justifiable, as when the killing is performed in the exercise of a right or performance of a duty; excusable, as when done, although not as duty or right, yet without culpable or criminal intent; and felonious, or involving what the law terms malice; the latter may be either manslaughter or murder. Dr. Mittleman stated that both deaths were ruled this, by clinical definition.

Dr. Garavaglia was interviewed by phone, and offered similar if not the same information as Dr. Mittleman. Dr. Garavaglia had heard of the processes spoken of earlier in this paper of trying to lessen/decrease the possibility of excited delirium by cooling the body, and calling for medical personnel when in doubt, but also did not know if any of this would work. Dr. Garavaglia was called away to an emergency autopsy and we were unable to make further contact as of the writing of this paper.

After reviewing both incidents occurring within the Fort Pierce Police Department and their in custody deaths none of the officers involved were found to have acted outside of their prescribed and appropriate responses and levels. All officer involved actions in these cases were found to be legal proper and just. The 19th Judicial Circuit also reviewed the files and did nor pursue criminal action. Moreover the medical examiner revealed both deaths were attributed/caused by excited delirium. Both

persons were of different cultural and socioeconomic lifestyles and areas of the country. But both persons had several attributes listed above in this paper such as drug use, and medical conditions.

Discussion

The Fort Pierce Police Department has had two in custody deaths within the last five years. The first case involved Law Enforcement On February 21, 2006, working a detail at Lawnwood ER. Officers were trying to remove an individual who had become disorderly and was causing a disturbance in the emergency room waiting/triage area. The individual refused to leave when asked several times to do so by Officers. Officers warned the individual that if he continued to be combative and refuse to leave he would be Tased. The individual continued to refuse to leave, and became more combative and threatening, at which time he was drive stunned. The individual continued, after being drive stunned 2 times, to refuse commands, and was forcefully handcuffed. Additional Officers arrived during this commotion and assisted the original officers with the handcuffing process. The individual still refused to cooperate by not walking out of the waiting room area on his own accord, and had to be placed onto a gurney, involuntarily, and wheeled out of the hospital. Between the time he was wheeled out of the hospital and the officers made it to their vehicles, it was noticed by one of the Officer that the individual did not appear to be breathing. Officers checked the individual for breathing and pulse. Finding none, an officer was sent ahead to inform E.R. staff of the situation. Officers raced the individual back into the E.R., where staff immediately tended to his needs. The following is a step-by-step description of the incident:

The second case occurred when officers were summoned to a disturbance in the parking lot of the Pilot Travel Center on Okeechobee Rd. in Ft. Pierce. Prior to officer arrival, several individuals had witnessed the subject acting in a manner which had been variously described as bizarre, paranoid and out of control. The subject was initially observed driving a large Budget Rental truck while following two of the witnesses into the Pilot parking lot. The subject was seen by several people throwing things from his truck acting irrationally. Driven by concern some of the witnesses went to the front of the Pilot Travel Center where they had seen the officer's vehicle in the front. Officers responded to the rear of the Pilot Travel Center and observed the subject running around his truck. The subject was observed throwing oil at or around his truck while yelling that someone was trying to kill him or steal his belongings. Officers made contact with the subject and tried to calm him. This did not work, and officers felt it necessary for the safety of the subject and those in the immediate area to place the subject in restraints. The first officer was able to do this after a brief struggle, and placed him in the rear of his patrol vehicle. The subject continued his bizarre behavior and actually even asked the officer to call the police. The officer was in full police uniform and had arrived in a marked patrol vehicle. The originating officer had also requested an additional unit be sent to him. The additional officer arrived on scene after the subject had been secured in the back of the patrol car. While on scene, the second officer stated he observed the subject thrashing about in the back of the patrol car. Both officers then patted the subject down as it had been too risky before the arrival of

the back up unit to conduct the search alone. The subject was then taken from the back of the car where he attempted to flee from the officers and was subsequently taken to the ground. While on the ground the subject resisted officers and was thrashing and kicking at the officers. The subject began to violently resist the officers. Both officers continued to verbally direct the subject to stop resisting and to calm down. The subject's resistance grew to a level necessary to escalate the level of force, and he was then warned several times if he did not stop resisting, and calm down he would be Tased. The subject did not calm down and officers elected to resort to pain compliance and not full deployment of the Taser. The subject was then given a drive stun to the rear shoulder area for the 5 second pre-programmed cycle. The effects of the Taser were not evident, and the subject continued to struggle and the officer then applied two additional Taser drive stuns to the subject, but did not administer the full 5 second application, and was unsure, given the subject's level of resistance, whether the Taser even came into contact with the subject as he continued to thrash about during this attempt to subdue him. Shortly after the third and final Taser deployment, the subject stopped resisting the officers. Noticing that the subject did not appear to be breathing, the officers checked for the subject's pulse. Detecting only a weak pulse, the officers initiated lifesaving measures/CPR. The officers requested emergency medical providers (rescue) be dispatched to the scene. The subject never regained consciousness and was declared dead upon arrival at the hospital.

In both of these cases there were drugs found in the system of the subject persons. Both persons were acting irrationally, yet there were separate and different actions also. This lends credence to the claim of not needing a specific set of criteria for this excited delirium to occur. One subject had a long medical history and the other did not. One was physically fit, not obese, and the other was obese, and not physically fit. Both subjects did not receive the full effects of a Taser deployment, and only felt pain compliance. The Taser when not fully deployed does not affect any of the muscles within the body.

As you can see from the results portion there is no systematic analysis that may be done to find out a specific cause and correlation of excited delirium. The results of the survey conducted shows less than half of the respondents have had an incident involving in custody deaths; finding that not all of these deaths were a result of excited delirium lessened these numbers also. Within the research gathered, there was no direct specific link to excited delirium. There was a large proportion of the population surveyed that did have similar behavior. Most of the persons who died were acting abnormal, were resisting law enforcement efforts, and were aggressively active. All subjects had drugs in their systems, with the largest number of persons having ingested cocaine. Ten of the eleven relative deaths occurred in less than five minutes after the struggle/incident had stopped. Five of these occurred in less than thirty seconds. Several of these deaths did utilize "tools of the trade". Some of these were pepper spray, handcuffs, Tasers, and leg restraints. Ten of the eleven relative in custody deaths surveyed did occur within the last five years.

Within the survey questions agencies were asked what training has been implemented in reference to excited delirium. Most of the agencies have introduced additional training on recognizing some "warning signs" of excited delirium, amended policy, and included Taser training for all personnel. This study was limited to that

information gleaned from agencies who responded. In the future I suggest doing a specific agency mailing, or e-mailing, and not using a bulk mailer. The idea of this group e-mailing was good in the number of agencies available to contact, but the response rate was low. I also suggest making the survey accessible on line. There are limitations to this study as the specific parameters of information are unable to be maintained. There are many different causes or contributors to excited delirium and not one thing can be pin pointed, which gave way to conduct this research in the first place. Finding through this process that there is no direct nexus to a specific event, tool, or drug limits the scope of research.

Recommendations

There are some recommendations that may be made based upon information gathered. New protocol and teaching is recommended for those employees who deal with the public in general, and in our detention facilities. I recommend law enforcement personnel be made aware of this syndrome, and its symptoms. I recommend when able, law enforcement notify medical personnel of the situation, and possibility of excited delirium, and request their response. I recommend all personnel monitor subjects closely after incidents of aggressive behavior until they have deescalated safely.

Commander Katherine "Kitty" England has been employed with the Fort Pierce Police Department since 1991. She has worked in several divisions to include Patrol, Criminal Investigations, Traffic and the Office of Professional Standards. She was Detective of the Year in 1991 and Manager of the Year in 2006 & 2007. Kitty was the first female SWAT member and is only the second female Lieutenant at her agency. Kitty is a graduate of Leadership St. Lucie Class #25 and a member of the National Association of Women Law Enforcement Executives (NAWLEE). Kitty has a bachelor's degree in Business from Nova Southeastern University and a Master's degree in Public Administration from Troy State University.

Bibliography

Benner, A., Isaacs, S.M., (1996, June) Excited delirium a two fold problem. *Police Chief Magazine,* Retrieved on April 16, 2007 from Zarc website: http:// www.zarc.com/english/other_sprays/reports/excited_delirium.html

Chan, T., Vilke, G., Clausen, J., Clark, R., Schmidt, P., Snowden, T, et al. (2001, December) *Pepper spray's effects on a suspect's ability to breathe.* National Institute of Justice Research in Brief. http://www.ncjrs.gov/pdffiles1/nij/188069.pdf

DiMaio, T. & DiMaio, V., (2005) *Excited delirium syndrome cause of death and prevention.* NY: Taylor and Francis.

DiMaio, V, *Letter to Sheriff* Lopez,

Farnham, F. & Kennedy, H., (1997, November) Acute excited states and sudden death, *British Medical Journal,* http://www.charlydmiller.com/LIB02/1998authorsreply.html

Goldman, R. (2007, March 2) *Excited delirium: police brutality vs. sheer insanity.* Retrieved on July 6, 2007 from ABC News website: http://abcnews.go.com/Health/story?id=2919037&page=1

Ho, J.D. (2007, July) *How to respond to excited delirium.* Retrieved August 16, 2007 from Police the Law Enforcement Magazine website: http://www.policemag.com/Articles/2007/07/How-to-Respond-to-Excited-Delirium.aspx

Kahn, C. (2007, March 18) After scrutiny over safety, Taser rebounds with profits. *The Palm Beach Post*, pp. F1, F6.

Miami Dade Fire Rescue Medical Operations Manual (2007, June) *Electronic control device.*

Taser International Web Site, *Corporate History,* Retrieved August 20, 2007, http://www.taser.com/company/Pages/factsheet.aspx

Webster's Dictionary, (1998, March) http://cancerweb.ncl.ac.uk/cgi-bin/omd?homicide

Appendix A

Interview Questions for Doctors Mittleman and Garavaglia

1. What is excited delirium?
2. What causes excited delirium?
3. Can excited delirium be prevented?
4. Have all excited delirium cases been related to drugs?
5. When do you recall seeing the first diagnosis of excited delirium?
6. Is there any correlation between the use of an EMD with excited delirium?

Appendix B

In-Custody Death Survey

Katherine G. England
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Senior Leadership Class #12

1. Has your agency had any in custody deaths?
   Yes_____ No_____ (If no please skip to number 12.)

2. Did any of those deaths occur within the last 5 years?
   Yes_____ No_____

3. Was pepper spray used in any of the in custody death cases?
   Yes_____ No_____

4. Was an electro muscular disruption device, more commonly known as a Taser used in any of the in custody deaths?
   Yes_____ No_____ If yes, how many? _____

5. Was there a different tool or restraint device utilized during the incident leading up to the in-custody death? If so what was it and how was it utilized?
   _____
   _____
   _____

6. What were the circumstances surrounding the death?
   (Please include any actions before, during and after death)
   _____
   _____
   _____
   _____
   _____
   _____

7. Was there a struggle with officers or others before the death?
   Yes_____ No_____

8. At what point did the person show signs of distress?
   During struggle_____ 0-30 seconds after struggle_____
   31-60 seconds after struggle_____ One minute to 5 minutes after struggle_____
   Other_____

9. What actions did officers take upon recognition of this distress?
   _____
   _____
   _____

10. Were any toxicological effects found during autopsy?
Yes_____ No_____ If yes what were they?

_____

_____

11. If any what drugs were being utilized by the person?
Cocaine_____ Heroine_____ Methamphetamine_____ Other_____

12. Did that person have a *history* of drug use, violence, and/or medical problems?
Yes_____ No_____

13. What training have you found and or implemented to inform your personnel about excited delirium?

_____

_____

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14. Agency Name_____

Results Tabulated Below.

Appendix C

Agencies with history of In Custody Death	W/in 5 yrs	Pepper Spray	EMD	Other Tool	Synopsis	Struggle	Distress Time	Ofc. Action	Drugs if any	History	Training Implemented
Altamont Springs Police Department	N	N	N	Cuffs	W/M acting abnormal, physical restraint hands on - 10/15	Y	1-5 min	CPR	Cocaine	Y	General, CPR, PPE, Roll Call
Boca Raton Corrections	N	N	N	N	Self Termination	N	N/A	N/A	Alcohol	N	In Service Training on E/D
Collier County Sheriff's Office	Y	Y	Y	N	Pursuit, resisting arrest with violence, cardiac arr. In water	Y	0-During struggle	CPR, called EMS	Cocaine	Y	Taser training includes E/D
Collier County Sheriff's Office	Y	Y	Y	N	Pursuit, Resisting arrest with Violence, Cardiac arr. On land	Y	0-During struggle	CPR, called EMS	Cocaine		Taser training includes E/D
Collier County Sheriff's Corrections	Y	N	N	N	Inmates Self Terminated	N	N/A	CPR	N/A	Y	In Service Training on E/D
Department of Corrections Orlando	Y	N	Y	N	Acting abnormal, screaming thrashing	Y	10-20 MIN	Called EMS	Y	Unknown	Training on symptoms of E/D
Hollywood Police Department	Y	N	Y	N	Aggressive action-fight between two subjects	Y	0-30 Sec	EMS	Y	Y	Changed Taser SOP
Lakeland Police Department	N	N	N	N	Self Termination	N	N/A	Contact EMS	Y	Y	Taser training includes E/D
Lee County Sheriff's Office	Y	N	Y	N	Disorderly combative, resisted arrest	Y	1-5 min	First Aid, called EMS	Y	Y	Monitor and look for E/D
Martin County Sheriff's Office	Y	N	Y	Cuffs	Pursuit, Hallucinating, incoherent resisting arrest.	Y		EMS on scene	Y	Y	Taser training includes E/D
Melbourne Police Department	Y	N	Y	N	Burglary, subject armed with broom	Y	1-5 min	Called EMS	Y	Y	E/D training, New E/D policy

Agencies with history of In Custody Death	W/in 5 yrs	Pepper Spray	EMD	Other Tool	Synopsis	Struggle	Distress Time	Ofc. Action	Drugs if any	History	Training Implemented
Okaloosa County Sheriff's Office	Y	N	Y	N	Agitated, aggressive, armed with flashlight	Y	0-30 Sec	Called EMS	Y	Y	Medical treatment for subject
Polk County Sheriff's Office	Y	Y	Y	Leg restraint	Combative, secured in vehicle	Y	31-60 sec	CPR		Y	
Saint Petersburg Police Department	Y	N	N	Cuffs	Acting erratically, restrained	Y	5 Min	CPR EMS	Y	Y	Taser training includes E/D
Agencies without history of In Custody Death	**W/in 5 yrs**	**Pepper Spray**	**EMD**	**Other Tool**	**Synopsis**	**Struggle**	**Distress Time**	**Ofc. Action**	**Drugs if any**	**Hisotry**	**Training Implemented**
Aventura Police Department					N/A						E/D-annual ECD training
Boca Police Department					N/A						In Service E/D Training
City of Atlantis Police Department					N/A						Training
Department of Environmental Protection					N/A						No formal training on E/D
Department of environmental Protection - Florida Wildlife Comm.					N/A						No formal training on E/D
Department of Transportation					N/A						OCAT format
Agencies without history of In Custody Death	**W/in 5 yrs**	**Pepper Spray**	**EMD**	**Other Tool**	**Synopsis**	**Struggle**	**Distress Time**	**Ofc. Action**	**Drugs if any**	**Hisotry**	**Training Implemented**

Florida Highway Patrol	-	-	-	-	N/A	-	-	-	-	-	-
Fort Walton Beach					N/A						
Gulf Port Police Department					N/A						CJSTC defensive tactics
Hernando Sheriff's Office					N/A						Annual E/D training
Jacksonville Police Department					N/A						Training and Formal Policy
Jupiter Police Department					N/A						Positional asphyxia training
Manalapan Police Department					N/A						
Ocala Police Department					N/A						Taser X26 training
Palm Bay Police Department					N/A						Taser & defensive tactics
Plantation Police Department					N/A						Positional asphyxia, & E/D
Punta Gorda Police Department					N/A						E/D in ECD training
Sebastian Police Department					N/A						

Version 2.2 April 1, 2011

Arrest-Related Death Evidence Collection

1. Highly Perishable Evidence (some items repeated below)

a. Get the AED (Automatic External Defibrillator) or cardiac monitor downloads (including rhythm strips and technical operational downloads). This is usually erased when the next paramedic shift starts. This information can eliminate "electrocution" by the TASER CEW (Conducted Electrical Weapon) 95% of the time. However, it is erased 80% of the time. Note that there can be 4 defibrillators: (1) Squad car, (2) Paramedics, (3) Ambulance, and (4) Hospital.
b. Maintain as evidence the CEW wires and probes! Microscopic analysis of the probes and wires will often show that no electrical current was delivered (as one probe missed) and eliminate the TASER CEW as a factor.
c. Core (rectal or liver) body temperatures at as close to time of collapse as possible by medical personnel. Not considered important by EMS or Emergency Department (ED) staff for therapy but important for Excited Delirium diagnosis.
d. Paramedic pulse oximeter recording if available.
e. End tidal CO_2 measurement from paramedics during CPR (cardiopulmonary resuscitation) or after they intubated the subject. Often not recorded.
f. Antemortem (pre-death) blood sample from ED in proper preservative tube for "quantitative" analysis – not just "qualitative" analysis.
g. If postmortem blood sample – get several blood samples (especially peripheral samples) and place in proper preservative tube for quantitative analysis – to avoid continuing metabolism within the tube.

2. Important Requests for ME (Medical Examiner)

a. Hair sample and chronic drug use analysis ($75). At least save a head hair sample (pencil thick when twisted) and a pubic hair sample.
b. Mash Miami brain test ($400). (1-800-UM-BRAIN and www.exciteddelirium.org)
c. Due to the importance of the hair and brain test, the LEA (Law Enforcement Agency) should offer to pay for them. The $475 is nothing compared to the typical $1 million settlement for an ARD (arrest-related death).
d. Save the heart (histologic heart blocks may be very important).
e. If any TASER probes were within 5 cm (2 inches) of the heart, ME should measure the exact distance (in millimeters) from the tip of the probe to the outer surface of the heart. Document all probe locations.
f. Save blood sample for genetic testing for "long QT" syndrome.
g. Collect and analyze gastric contents.

3. Acute Medical Information.

a. Body Core (rectal or liver) Temperature at time of death and as close to collapse as possible.
b. Collect 10 ml (milliliters) of blood as soon as possible after ED arrival for later quantitative drug testing.
c. Document (ideally photograph) all TASER probe and wound locations. Record if they removed the probes or subject arrived without.
d. Within 24 (preferably less than 12) hours of collapse, brain samples must be properly collected and frozen. Call 1 800 UM BRAIN **(also www.excitteddelirium.org)** for shipping instructions.
e. In suspected cocaine, methamphetamine, PCP, etc. smoking cases, swabs of mouth and bronchial tree are helpful for chemical analysis.
f. Remind treating physicians to keep documentation objective and don't write about things they do not understand. Occasionally hospital records will include statements about a "TASER" wound even though there was no TASER CEW used near that specific location.

4. Chronic Medical Information.

a. Obtaining hair and toe-nail samples. Twist strands of longest head hair available like a lock, about as thick as a pencil lead, hold together to keep strands aligned as you cut as close to skin as possible. Transfer lock to tin foil or paper, fold (to hold together), and secure. Collect similar samples from longest pubic/groin hair.
b. Obtain all available past medical records.
c. Obtain printouts from pharmacies used by suspect for past 2 years.
d. Obtain all criminal justice records.
e. Obtain all rehabilitation and treatment records.

5. Circumstances Regarding Arrest.

a. Distance CEW fired, probe spread, ***probe location***, and duration of cycles.
b. TASER CEW effects (such as change in behavior).
c. Subject's influence (drugs, alcohol, emotionally disturbed).
d. Any other use of force employed?
e. Was an AED, defibrillator, or cardiac monitor used?
f. Did the AED report a shockable rhythm?
g. Is there a printout (download) from the AED or cardiac monitor?
h. How long between the CEW exposure and the subject's collapse? Specifically detailed chronicle of all witnessed behaviors, actions, inactions, physiological status, etc.
i. Was the subject walking, fighting, or talking after the exposure?
j. MEs contact info or supporting info from medical attendants and ED.
k. Hospital exam information (if conducted).

6. Interviews.

a. Treat the EMTs (Emergency Medical Technicians) and Paramedics etc at the scene like any other witnesses. Get complete statements from them about what they observed and what interventions they made. Very often, they can make medical observations that the LEOs (Law Enforcement Officers) might not realize are important but

they will have forgotten by the time their depositions are taken two to three years later. Where did the probes land? *Don't assume that their standard report has enough information — it does not.*

b. Try to get eyewitness statements that address the rapidity with which the subject went from screaming, struggling, and yelling to unconscious, not breathing and pulseless.[1]
c. Get statements that include whether or not the subject could be heard to be breathing, screaming, yelling, etc throughout their confrontation against LEOs efforts to capture, control, and restrain. Screaming and yelling require that air is moving over the vocal cords and demonstrates that at least some degree of ventilation had to take place. How much yelling and screaming?
d. Debrief LEOs and witnesses regarding words and actions manifested by subject. Get details of patterns of walking, talking, gestures, facial expressions, breathing, pulse, etc. Ask interviewees to replay their memory with attention to DUI (Driving Under the Influence)/DRE (Drug Recognition Expert) type details. Sounds, even grunts, growls, and snarls, are important. Get collaborative reports.
    i. Was suspect growling? How?
    ii. What words could you make out?
    iii. Huffing and puffing?
    iv. Sweating?
    v. Drooling?
    vi. Eye movements?
    vii. Balance?
e. If subject is only injured and survives, debrief as soon as possible about subjective feelings, thoughts and drug effects. They were the only ones inside their bodies and looking out so ask how they saw and heard the world. Don't translate anything into your own words but describe mannerisms and expressions accompanying their descriptions.
f. SOUNDS: Ask all witnesses to describe any unusual sounds they heard. If they describe sounds like "arcing" or "electrical short" there was probably a connection break and the suspect was not getting current delivered at that time. Even "clicking" heard in a noisy situation or from > 10 ft, in a quiet situation, is indicative of a broken connection. Like a car or refrigerator, when the TASER CEW is making noise, there is usually something wrong. Adverse witnesses love to go on about the electrical noise, thinking they are hurting the police when the opposite is true.

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[1] Remember a respiratory death takes minutes whereas a cardiac death takes only a few seconds. Try to specifically determine the time sequence as clearly and carefully as possible in the early phase of the investigation. Advise LEOs to collect as much information about the passage from activity to unconsciousness as possible. The sequence of events for a sudden cardiac death as opposed to a respiratory death are markedly different and chronicling exactly what happened, how fast, when, and whether there was resistance, exertion, struggling, or fighting until "all of a sudden" or like a "light switch" things changed can be most important information.

7. Evidence Collection.

a. Photos of wounds and CEW probe or drive-stun impacts with ruler.
b. Photos showing distance of probe or drive-stun spread (scale).
c. Keep the original CEW battery in the CEW (DO NOT Remove). This will keep the integrity of the internal clock.
d. Do not discard probes or wires (treat them as evidence). Do not let EMS place probes in "sharps" container as information can be gathered from the probes and wires as to whether or not they actually delivered current.
e. Download CEW data within 48 hours of the event and maintain evidentiary copy of download (including time drift)
f. Collect 2–3 AFID (Anti-Felon Identification) tags and note their location; this will be helpful if multiple CEWs or cartridges were deployed.

8. Medical/Autopsy Data and Tissues

a. All treatment records
    i. EMS
    ii. Emergency department
b. Autopsy report
c. Autopsy microscopic slides (if any were prepared)
d. Autopsy gross tissues (if any were retained)
    i. Heart is especially useful

9. If the CEW Did Not Perform as Expected:

a. What was the failure or challenge?
b. What was the subject wearing (especially, multiple layers, thick layers, loose clothing, etc.)
c. Was the CEW dropped or subject to a high-moisture environment?
d. What were the operating conditions?
e. Did the CEW fire?
f. Did LEOs hear loud arcing – especially across the front of the CEW?
g. Drive-stun or probe deployment?
h. When was a last successful download or spark test done?

Excited Delirium Checklist

Excited delirium or excited delirium syndrome is only one form of potential sudden death that law enforcement officers may encounter. Other potential causes of unexpected arrest-related deaths include, but are not limited to: SUDEP[1, 2] (sudden unexpected death in epilepsy), sickle cell sudden death,[3] various cardiomyopathies,[4] drug induced arrhythmias (including those caused by alcohol[5, 6] and marijuana[7-10]), psychiatric arrhythmias (whether due to schizophrenia[11] or medications[12]), and severe coronary artery disease.

Present?	Criterion
911 Call – Emergency Contact for Assistance	
	1. Critical call phrases include, "He just freaked out," "just snapped," "flipped out," or a person is "running around naked."[13]
Law Enforcement	
	2. Agitation, screaming, extreme fear response or panic[14-18]
	3. Violence, assault, or aggression towards others[18-21]
	4. Suspicion of impending death. Typical comments include, "I'm dying," "Please save me," or "Don't kill me"[22]
	5. Incoherence or disorganized speech. Grunting or animal sounds[21, 23]
	6. Clothing removal inappropriate for ambient temperature or complete nudity.[18, 24-26]
	7. Disorientation or hallucinations[18, 27-30]
	8. Mania, paranoia, anxiety, or avoidance behavior[14, 18, 31-34]
	9. Constant motion or hyperactivity[14, 30, 35-37]
Capture, Control and Restraint of Subject	
	10. Extreme or "super human" strength[21, 33]
	11. High threshold of or imperviousness to pain[23, 26]
	12. Extreme stamina[38,23]
	13. Brief quiet period before collapse likely corresponding with respiratory arrest[14, 17, 23, 39]

Emergency Medical Services Contact and Intervention	
	14. Presenting rhythm of PEA (pulseless electrical activity) or asystole.[38, 40-43] Also documented by "No shock advised" with automatic external defibrillator[42]
Emergency Department	
	15. High core body temperature.[15, 16, 21, 31, 44, 45]
	16. Acidosis (acidic blood)[23, 46, 47]
	17. Rhabdomyolysis (if suspect is resuscitated).[15, 45, 48]
Law Enforcement/Forensic Investigator Death Investigation	
	18. History of chronic stimulant abuse or mental illness[14, 19, 27, 32, 37, 40, 49-52] History of violence or drug related arrests, mental health histories and treatments, and drug rehabilitation interventions, etc.
	19. Damage to shiny objects such as glass, mirrors and lights.[23] Reported behaviors may include attacking a squad car light bar or charging oncoming traffic at night. Occasionally generalized vandalism.
Pathologist – Medical Examiner Investigation	
	20. Minor injuries from fighting against restraints (e.g. handcuffs, hobbles).
	21. Positive Mash (central nervous system biomarkers) test for dopamine transporter assay and heat shock protein.[15, 31, 32, 53-57]
	22. Positive brain and hair toxicology screen for chronic stimulant abuse.[53, 58-62] Post-incident drug levels may be low to negative.

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Notes:

A syndrome is an aggregate of signs and symptoms that define a medical condition. Not all persons with a certain syndrome have all the same signs and symptoms. Not all cases of a syndrome result from the same cause. For example, some persons with carpal tunnel syndrome will have numbness and tingling, while others will have weakness and pain. Also, some persons with carpal tunnel syndrome will have it because of trauma, while others will have the syndrome because of pregnancy, diabetes, rheumatoid arthritis or thyroid disease.

Persons with the excited delirium syndrome will have various combinations of some of the signs and symptoms listed above. The cause (etiology) of the excited delirium syndrome in any individual may be due to one or more of a number of conditions. The most common conditions are mental illness and illegal stimulant abuse (especially cocaine and methamphetamine).[40]

Because the term "excited delirium syndrome" has not been widely used until recent years, many physicians do not recognize the term even though they may be very familiar with agitation and deaths due to drugs and other conditions.[63] It is important to avoid the distraction of the various terms that have been applied to this syndrome. For example, what is now referred to as excited delirium[14-16, 26, 32, 33, 36, 38-40, 45-48, 51, 54, 55, 64-71] or agitated delirium[41, 57, 72-117] has also been called: Bell's mania,[30] acute exhaustive mania,[118] acute delirious mania,[30] delirium grave,[30] typhoma,[30] acute delirium,[30] manic-depressive exhaustion,[24] excited catatonia,[91] lethal catatonia,[119] and neuroleptic malignant syndrome.[19, 26, 44, 74, 119]

Statistical Confidence:

There must be at least 5 positive criteria to diagnose excite delirium syndrome. For 12 or more positive criteria the confidence level is at least 99.9%. For less than 12 positive criteria the confidence depends on the number of criteria for which information is available.

For example, the brain and hair tests are, unfortunately, typically not done. Often the blood tests for rhabdomyolysis is not done. In this case there will only be information on 19 criteria. If 8 of these 19 criteria were positive then the confidence in the diagnosis would be 93%.

Number of Criteria With Information	Number of Positive Criteria						
	5	6	7	8	9	10	11
10	64%	82%	93%	98%	99%	99.9%	
11	62%	81%	91%	97%	99%	99.8%	99.9%
12	61%	79%	90%	96%	99%	99.6%	99.9%
13	60%	78%	89%	95%	98%	99.4%	99.8%
14	60%	78%	89%	95%	98%	99.2%	99.8%
15	59%	77%	88%	94%	97%	99%	99.7%
16	59%	76%	87%	94%	97%	99%	99.6%
17	58%	76%	87%	93%	97%	99%	99.5%
18	58%	75%	86%	93%	97%	98%	99%
19	57%	75%	86%	93%	96%	98%	99%
20	57%	74%	86%	92%	96%	98%	99%
21	57%	74%	85%	92%	96%	98%	99%
22	57%	74%	85%	92%	96%	94%	99%

References:

1. So EL. What is known about the mechanisms underlying SUDEP? *Epilepsia.* Dec 2008;49 Suppl 9:93-98.
2. So NK, Sperling MR. Ictal asystole and SUDEP. *Neurology.* Jul 31 2007;69(5):423-424.
3. Channa Perera SD, Pollanen MS. Sudden death due to sickle cell crisis during law enforcement restraint. *J Forensic Leg Med.* Jul 2007;14(5):297-300.
4. Yeo KK, Wijetunga M, Ito H, et al. The association of methamphetamine use and cardiomyopathy in young patients. *Am J Med.* Feb 2007;120(2):165-171.
5. Rosenqvist M. Alcohol and cardiac arrhythmias. *Alcohol Clin Exp Res.* Oct 1998;22(7 Suppl):318S-322S.
6. Kupari M, Koskinen P. Alcohol, cardiac arrhythmias and sudden death. *Novartis Found Symp.* 1998;216:68-79; discussion 79-85.
7. Baranchuk A, Johri AM, Simpson CS, Methot M, Redfearn DP. Ventricular fibrillation triggered by marijuana use in a patient with ischemic cardiomyopathy: a case report. *Cases J.* 2008;1(1):373.
8. Aryana A, Williams MA. Marijuana as a trigger of cardiovascular events: speculation or scientific certainty? *Int J Cardiol.* May 31 2007;118(2):141-144.
9. Rezkalla SH, Sharma P, Kloner RA. Coronary no-flow and ventricular tachycardia associated with habitual marijuana use. *Ann Emerg Med.* Sep 2003;42(3):365-369.
10. Akins D, Awdeh MR. Marijuana and second-degree AV block. *South Med J.* Mar 1981;74(3):371-373.
11. Bar KJ, Koschke M, Boettger MK, et al. Acute psychosis leads to increased QT variability in patients suffering from schizophrenia. *Schizophr Res.* Sep 2007;95(1-3):115-123.
12. Ray WA, Chung CP, Murray KT, Hall K, Stein CM. Atypical antipsychotic drugs and the risk of sudden cardiac death. *N Engl J Med.* Jan 15 2009;360(3):225-235.
13. Code 1069 Excited Delirium Dispatch Policy. In: Sheriff's_Office, ed. Jacksonville, FL2006.
14. Pollanen MS, Chiasson DA, Cairns JT, Young JG. Unexpected death related to restraint for excited delirium: a retrospective study of deaths in police custody and in the community. *CMAJ.* Jun 16 1998;158(12):1603-1607.
15. Ruttenber AJ, Lawler-Heavner J, Yin M, Wetli CV, Hearn WL, Mash DC. Fatal excited delirium following cocaine use: epidemiologic findings provide new evidence for mechanisms of cocaine toxicity. *J Forensic Sci.* Jan 1997;42(1):25-31.
16. Blaho K, Winbery S, Park L, Logan B, Karch SB, Barker LA. Cocaine metabolism in hyperthermic patients with excited delirium. *J Clin Forensic Med.* Jun 2000;7(2):71-76.
17. Stefan H. Sudden death of psychiatric patients following great excitation and exhaustion which has no actual anatomic basis. *Dtsch Med Wehnschr.* 1934;60:1550-1558.
18. Shulack N. Sudden "exhaustive" death in excited patients. *Psychiatr Q.* 1944;18:3-12.

19. Kasantikul D, Kanchanatawan B. Neuroleptic malignant syndrome: a review and report of six cases. *J Med Assoc Thai.* Dec 2006;89(12):2155-2160.
20. Bell L. On a form of disease resembling some advanced stages of mania and fever, but so contradistinguished from any ordinary observed or described combination of symptoms as to render it probable that it may be overlooked and hitherto unrecorded malady. . *American Journal of Insanity* 1849;6:97-127.
21. Fishbain DA, Wetli CV. Cocaine intoxication, delirium, and death in a body packer. *Ann Emerg Med.* Oct 1981;10(10):531-532.
22. Karch S, Kroll M. Unpublished observations of 150 excited delirium cases2008.
23. Wetli C. Excited delirium. In: Chan R, ed. *Sudden Deaths in Custody.* Totawa: Humana Press; 2006:99-112.
24. Derby I. Manic-depressive "exhaustion" deaths. *Pyschiatric Q.* 1933;7:436-449.
25. Shulack N. Sudden "exhaustive" death in excited patients. *Psychiatr Q.* 1938;12::282-293.
26. Ross DL. Factors associated with excited delirium deaths in police custody. *Mod Pathol.* Nov 1998;11(11):1127-1137.
27. Stagno D, Gibson C, Breitbart W. The delirium subtypes: a review of prevalence, phenomenology, pathophysiology, and treatment response. *Palliat Support Care.* Jun 2004;2(2):171-179.
28. Ross CA, Peyser CE, Shapiro I, Folstein MF. Delirium: phenomenologic and etiologic subtypes. *Int Psychogeriatr.* Winter 1991;3(2):135-147.
29. Davidson G. Concerning the cause of death in certain cases. *Am J Psychiatry.* 1934;91:41:49.
30. Kraines S. Bell's mania (acute delirium). *Am J Psychiatr.* 1934;91:29-40.
31. Mash DC, Ouyang Q, Pablo J, et al. Cocaine abusers have an overexpression of alpha-synuclein in dopamine neurons. *J Neurosci.* Apr 1 2003;23(7):2564-2571.
32. Mash DC, Pablo J, Ouyang Q, Hearn WL, Izenwasser S. Dopamine transport function is elevated in cocaine users. *J Neurochem.* Apr 2002;81(2):292-300.
33. Wetli CV, Fishbain DA. Cocaine-induced psychosis and sudden death in recreational cocaine users. *J Forensic Sci.* Jul 1985;30(3):873-880.
34. Anglin MD, Burke C, Perrochet B, Stamper E, Dawud-Noursi S. History of the methamphetamine problem. *J Psychoactive Drugs.* Apr-Jun 2000;32(2):137-141.
35. Schroeder U, Schroeder H, Darius J, Grecksch G, Sabel BA. Simulation of psychosis by continuous delivery of phencyclidine from controlled-release polymer implants. *Behav Brain Res.* Dec 1998;97(1-2):59-68.
36. Pedal I, Zimmer G, Mattern R, Mittmeyer HJ, Oehmichen M. [Fatal incidences during arrest of highly agitated persons]. *Arch Kriminol.* Jan-Feb 1999;203(1-2):1-9.
37. Fava M. Psychopharmacologic treatment of pathologic aggression. *Psychiatr Clin North Am.* Jun 1997;20(2):427-451.
38. DiMaio T, VJM D. *Excited delirium syndrome cause of death and prevention.* Boca Raton: Taylor & Francis; 2006.

39. Stratton SJ, Rogers C, Green K. Sudden death in individuals in hobble restraints during paramedic transport. *Ann Emerg Med.* May 1995;25(5):710-712.
40. Stratton SJ, Rogers C, Brickett K, Gruzinski G. Factors associated with sudden death of individuals requiring restraint for excited delirium. *Am J Emerg Med.* May 2001;19(3):187-191.
41. Park KS, Korn CS, Henderson SO. Agitated delirium and sudden death: two case reports. *Prehosp Emerg Care.* Apr-Jun 2001;5(2):214-216.
42. Swerdlow C, Kroll M, Williams H, Biria M, Lakkireddy D, Tchou P. Presenting Rhythm in Sudden Custodial Deaths After Use of TASER® Electronic Control Device. *Heart Rhythm* May 2008;5(5):S44.
43. Escobedo LG, Ruttenber AJ, Agocs MM, Anda RF, Wetli CV. Emerging patterns of cocaine use and the epidemic of cocaine overdose deaths in Dade County, Florida. *Arch Pathol Lab Med.* Sep 1991;115(9):900-905.
44. Nielsen J, Bruhn AM. Atypical neuroleptic malignant syndrome caused by olanzapine. *Acta Psychiatr Scand.* Sep 2005;112(3):238-240; discussion 240.
45. Ruttenber AJ, McAnally HB, Wetli CV. Cocaine-associated rhabdomyolysis and excited delirium: different stages of the same syndrome. *Am J Forensic Med Pathol.* Jun 1999;20(2):120-127.
46. Allam S, Noble JS. Cocaine-excited delirium and severe acidosis. *Anaesthesia.* Apr 2001;56(4):385-386.
47. Brice JH, Pirrallo RG, Racht E, Zachariah BS, Krohmer J. Management of the violent patient. *Prehosp Emerg Care.* Jan-Mar 2003;7(1):48-55.
48. Karch SB. *Karch's Pathology of Drug Abuse* 2002.
49. DiMaio VJ. *Forensic Pathology* 2001.
50. Gray SD, Fatovich DM, McCoubrie DL, Daly FF. Amphetamine-related presentations to an inner-city tertiary emergency department: a prospective evaluation. *Med J Aust.* Apr 2 2007;186(7):336-339.
51. Morrison A, Sadler D. Death of a psychiatric patient during physical restraint. Excited delirium--a case report. *Med Sci Law.* Jan 2001;41(1):46-50.
52. Pearlson GD. Psychiatric and medical syndromes associated with phencyclidine (PCP) abuse. *Johns Hopkins Med J.* Jan 1981;148(1):25-33.
53. Stephens BG, Jentzen JM, Karch S, Mash DC, Wetli CV. Criteria for the interpretation of cocaine levels in human biological samples and their relation to the cause of death. *Am J Forensic Med Pathol.* Mar 2004;25(1):1-10.
54. Mash DC, Staley JK. D3 dopamine and kappa opioid receptor alterations in human brain of cocaine-overdose victims. *Ann N Y Acad Sci.* Jun 29 1999;877:507-522.
55. Mash DC, Staley JK, Izenwasser S, Basile M, Ruttenber AJ. Serotonin transporters upregulate with chronic cocaine use. *J Chem Neuroanat.* Dec 2000;20(3-4):271-280.
56. Stephens BG, Jentzen JM, Karch S, Wetli CV, Mash DC. National Association of Medical Examiners position paper on the certification of cocaine-related deaths. *Am J Forensic Med Pathol.* Mar 2004;25(1):11-13.

57. Chen L, Segal DM, Moraes CT, Mash DC. Dopamine transporter mRNA in autopsy studies of chronic cocaine users. *Brain Res Mol Brain Res.* Nov 10 1999;73(1-2):181-185.
58. Berankova K, Habrdova V, Balikova M, Strejc P. Methamphetamine in hair and interpretation of forensic findings in a fatal case. *Forensic Sci Int.* Oct 4 2005;153(1):93-97.
59. Kimura H, Mukaida M, Mori A. Detection of stimulants in hair by laser microscopy. *J Anal Toxicol.* Nov-Dec 1999;23(7):577-580.
60. Takayama N, Tanaka S, Hayakawa K. Determination of stimulants in a single human hair sample by high-performance liquid chromatographic method with chemiluminescence detection. *Biomed Chromatogr.* Jan-Feb 1997;11(1):25-28.
61. Kintz P, Cirimele V, Tracqui A, Mangin P. Simultaneous determination of amphetamine, methamphetamine, 3,4-methylenedioxyamphetamine and 3,4-methylenedioxymethamphetamine in human hair by gas chromatography-mass spectrometry. *J Chromatogr B Biomed Appl.* Aug 4 1995;670(1):162-166.
62. Nagai T, Kamiyama S, Nagai T. Forensic toxicologic analysis of methamphetamine and amphetamine optical isomers by high performance liquid chromatography. *Z Rechtsmed.* 1988;101(3):151-159.
63. Vilke GM, Debard ML, Chan TC, et al. Excited Delirium Syndrome (ExDS): Defining Based on a Review of the Literature. *J Emerg Med.* Mar 24 2011.
64. Sztajnkrycer MD, Baez AA. Cocaine, excited delirium and sudden unexpected death. *Emerg Med Serv.* Apr 2005;34(4):77-81.
65. O'Halloran RL, Lewman LV. Restraint asphyxiation in excited delirium. *Am J Forensic Med Pathol.* Dec 1993;14(4):289-295.
66. Strote J, Range Hutson H. Taser use in restraint-related deaths. *Prehosp Emerg Care.* Oct-Dec 2006;10(4):447-450.
67. Paquette M. Excited delirium: does it exist? *Perspect Psychiatr Care.* Jul-Sep 2003;39(3):93-94.
68. Gowers WR. *A Manual of diseases of the nervous system* Vol 21896.
69. Nahas GG, Burks TF, Hollister LE. *Drug Abuse in the Decade of the Brain* 1997.
70. Levine B. *Principles of Forensic Toxicology* 2003.
71. Karch SB. *Drug Abuse Handbook*2006.
72. Mets B, Jamdar S, Landry D. The role of catecholamines in cocaine toxicity: a model for cocaine "sudden death". *Life Sci.* 1996;59(24):2021-2031.
73. Karch SB, Wetli CV. Agitated delirium versus positional asphyxia. *Ann Emerg Med.* Dec 1995;26(6):760-761.
74. Wetli CV, Mash D, Karch SB. Cocaine-associated agitated delirium and the neuroleptic malignant syndrome. *Am J Emerg Med.* Jul 1996;14(4):425-428.
75. Mirchandani HG, Rorke LB, Sekula-Perlman A, Hood IC. Cocaine-induced agitated delirium, forceful struggle, and minor head injury. A further definition of sudden death during restraint. *Am J Forensic Med Pathol.* Jun 1994;15(2):95-99.
76. Irwin P, Murray S, Bilinski A, Chern B, Stafford B. Alcohol withdrawal as an underrated cause of agitated delirium and terminal restlessness in

patients with advanced malignancy. *J Pain Symptom Manage.* Jan 2005;29(1):104-108.

77. Morita T, Tei Y, Inoue S. Agitated terminal delirium and association with partial opioid substitution and hydration. *J Palliat Med.* Aug 2003;6(4):557-563.
78. Morita T, Tei Y, Inoue S. Impaired communication capacity and agitated delirium in the final week of terminally ill cancer patients: prevalence and identification of research focus. *J Pain Symptom Manage.* Sep 2003;26(3):827-834.
79. Vatsavayi V, Malhotra S, Franco K. Agitated delirium with posterior cerebral artery infarction. *J Emerg Med.* Apr 2003;24(3):263-266.
80. Vilke GM, Chan TC. Agitated delirium and sudden death. *Prehosp Emerg Care.* Apr-Jun 2002;6(2):259; author reply 259-260.
81. Frye MA, Coudreaut MF, Hakeman SM, Shah BG, Strouse TB, Skotzko CE. Continuous droperidol infusion for management of agitated delirium in an intensive care unit. *Psychosomatics.* May-Jun 1995;36(3):301-305.
82. Levenson JL. High-dose intravenous haloperidol for agitated delirium following lung transplantation. *Psychosomatics.* Jan-Feb 1995;36(1):66-68.
83. Sanders KM, Murray GB, Cassem NH. High-dose intravenous haloperidol for agitated delirium in a cardiac patient on intra-aortic balloon pump. *J Clin Psychopharmacol.* Apr 1991;11(2):146-147.
84. Verslegers W, De Deyn PP, Saerens J, et al. Slow progressive bilateral posterior artery infarction presenting as agitated delirium, complicated with Anton's syndrome. *Eur Neurol.* 1991;31(4):216-219.
85. Mori E, Yamadori A. Acute confusional state and acute agitated delirium. Occurrence after infarction in the right middle cerebral artery territory. *Arch Neurol.* Nov 1987;44(11):1139-1143.
86. Julien J, Vital C, Vallat JM, Bourgoin B. Epilepsy and agitated delirium caused by an astrocytoma of the amygdala. *Eur Neurol.* 1979;18(6):387-390.
87. Medina JL, Chokroverty S, Rubino FA. Syndrome of agitated delirium and visual impairment: a manifestation of medial temporo-occipital infarction. *J Neurol Neurosurg Psychiatry.* Sep 1977;40(9):861-864.
88. Medina JL, Rubino FA, Ross E. Agitated delirium caused by infarctions of the hippocampal formation and fusiform and lingual gyri: a case report. *Neurology.* Dec 1974;24(12):1181-1183.
89. Horenstein S, Chamberlin W, Conomy J. Infarction of the fusiform and calcarine regions: agitated delirium and hemianopia. *Trans Am Neurol Assoc.* 1967;92:85-89.
90. Spiller JA, Keen JC. Hypoactive delirium: assessing the extent of the problem for inpatient specialist palliative care. *Palliat Med.* Jan 2006;20(1):17-23.
91. Pruett JR, Rizvi ST. A16-year-old girl with excited catatonia treated with low-dose oral Lorazepam. *J Child Adolesc Psychopharmacol.* Dec 2005;15(6):1005-1010.
92. Kusne S, Smilack J. Transmission of rabies virus from an organ donor to four transplant recipients. *Liver Transpl.* Oct 2005;11(10):1295-1297.
93. Duggal MK, Singh A, Arunabh, Lolis JD, Guzik HJ. Olanzapine-induced vasculitis. *Am J Geriatr Pharmacother.* Mar 2005;3(1):21-24.

94. Ogasawara K, Komoribayashi N, Kobayashi M, et al. Neural damage caused by cerebral hyperperfusion after arterial bypass surgery in a patient with moyamoya disease: case report. *Neurosurgery.* Jun 2005;56(6):E1380; discussion E1380.

95. Srinivasan A, Burton EC, Kuehnert MJ, et al. Transmission of rabies virus from an organ donor to four transplant recipients. *N Engl J Med.* Mar 17 2005;352(11):1103-1111.

96. Cameron D, Bridge D, Blitz-Lindeque J. Use of sedation to relieve refractory symptoms in dying patients. *S Afr Med J.* Jun 2004;94(6):445-449.

97. Muller-Busch HC, Andres I, Jehser T. Sedation in palliative care - a critical analysis of 7 years experience. *BMC Palliat Care.* May 13 2003;2(1):2.

98. Cowan JD, Palmer TW. Practical guide to palliative sedation. *Curr Oncol Rep.* May 2002;4(3):242-249.

99. Cheng C, Roemer-Becuwe C, Pereira J. When midazolam fails. *J Pain Symptom Manage.* Mar 2002;23(3):256-265.

100. Morita T, Tsunoda J, Inoue S, Chihara S. Terminal sedation for existential distress. *Am J Hosp Palliat Care.* May-Jun 2000;17(3):189-195.

101. Travis SS, Conway J, Daly M, Larsen P. Terminal restlessness in the nursing facility: assessment, palliation, and symptom management. *Geriatr Nurs.* Nov-Dec 2001;22(6):308-312.

102. Chiu TY, Hu WY, Lue BH, Cheng SY, Chen CY. Sedation for refractory symptoms of terminal cancer patients in Taiwan. *J Pain Symptom Manage.* Jun 2001;21(6):467-472.

103. Ogasawara K, Ogawa A, Okuguchi T, Kobayashi M, Suzuki M, Yoshimoto T. Postoperative hyperperfusion syndrome in elderly patients with chronic subdural hematoma. *Surg Neurol.* Aug 2000;54(2):155-159.

104. Dunlop RJ, Campbell CW. Cytokines and advanced cancer. *J Pain Symptom Manage.* Sep 2000;20(3):214-232.

105. Wein S. Sedation in the imminently dying patient. *Oncology (Williston Park).* Apr 2000;14(4):585-592; discussion 592, 597-588, 601.

106. Fainsinger RL, Bruera E. When to treat dehydration in a terminally ill patient? *Support Care Cancer.* May 1997;5(3):205-211.

107. Black KJ, Perlmutter JS. Septuagenarian Sydenham's with secondary hypomania. *Neuropsychiatry Neuropsychol Behav Neurol.* Apr 1997;10(2):147-150.

108. Vaphiades MS, Celesia GG, Brigell MG. Positive spontaneous visual phenomena limited to the hemianopic field in lesions of central visual pathways. *Neurology.* Aug 1996;47(2):408-417.

109. Moyle J. The use of propofol in palliative medicine. *J Pain Symptom Manage.* Nov 1995;10(8):643-646.

110. Di Salvo TG, O'Gara PT. Torsade de pointes caused by high-dose intravenous haloperidol in cardiac patients. *Clin Cardiol.* May 1995;18(5):285-290.

111. Nicolai A, Lazzarino LG. Acute confusional states secondary to infarctions in the territory of the posterior cerebral artery in elderly patients. *Ital J Neurol Sci.* Mar 1994;15(2):91-96.

112. Sanders KM, Stern TA. Management of delirium associated with use of the intra-aortic balloon pump. *Am J Crit Care.* Sep 1993;2(5):371-377.
113. Fernandez F, Holmes VF, Adams F, Kavanaugh JJ. Treatment of severe, refractory agitation with a haloperidol drip. *J Clin Psychiatry.* Jun 1988;49(6):239-241.
114. Swedlow DB, Schreiner MS. Management of Reye's syndrome. *Crit Care Clin.* Jul 1985;1(2):285-311.
115. Price J, Whitlock FA, Hall RT. The psychiatry of vertebro-basilar insufficiency with the report of a case. *Psychiatr Clin (Basel).* 1983;16(1):26-44.
116. Steinhart MJ. Treatment of delirium--a reappraisal. *Int J Psychiatry Med.* 1978;9(2):191-197.
117. Brenner WI, Lieberman AN. Acute clonidine withdrawal syndrome following open-heart operation. *Ann Thorac Surg.* Jul 1977;24(1):80-82.
118. Wendkos M. Acute Exhaustive Mania. *Sudden death and psychiatric illness.* New York: Medical & Scientific Books division of Spectrum Publications; 1979:Chapter 10.
119. Mann SC, Caroff SN, Bleier HR, Welz WK, Kling MA, Hayashida M. Lethal catatonia. *Am J Psychiatry.* Nov 1986;143(11):1374-1381.

Excited delirium

From Wikipedia, the free encyclopedia

Excited delirium is a condition that manifests as a combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent and bizarre behavior, insensitivity to pain, elevated body temperature, and superhuman strength.[1][2] Excited delirium is sometimes called **excited delirium syndrome** if it results in sudden death (usually via cardiac or respiratory arrest), an outcome that is sometimes associated with the use of physical control measures, including police restraint and tasers.[1][2] Excited delirium arises most commonly in male subjects with a history of serious mental illness and/or acute or chronic drug abuse, particularly stimulant drugs such as cocaine.[1][3] Alcohol withdrawal or head trauma may also contribute to the condition.[4]

The diagnosis of excited delirium has been controversial.[5][6] Excited delirium has been listed as a cause of death by some medical examiners for several years,[7][8] mainly as a diagnosis of exclusion established on autopsy.[1] Additionally, academic discussion of excited delirium has been largely confined to forensic science literature, providing limited documentation about patients that survive the condition.[1] These circumstances have led some civil liberties groups to question the cause of death diagnosis, claiming that excited delirium has been used to "excuse and exonerate" law enforcement authorities following the death of detained subjects, a possible "conspiracy or cover-up for brutality" when restraining agitated individuals.[1][5][6] Also contributing to the controversy is the role of taser use in excited delirium deaths.[3][9] The American College of Emergency Physicians has officially recognized excited delirium as a unique syndrome[10] and "rejects the theory" that excited delirium is an "invented syndrome" used to excuse or cover-up the use of excessive force by law enforcement.[11]

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Introduction

Over the past decade, increased attention has been paid to the sudden and seemingly inexplicable deaths of some highly agitated subjects being held in police custody. In most of these cases, the force required to restrain or incapacitate the suspect was not sufficient to cause death.

Our colleagues in Miami-Dade County, Florida, first described the syndrome of excited delirium associated with cocaine abuse. The symptoms of excited delirium include bizarre and/or aggressive behavior, shouting, paranoia, panic, violence towards other people, unexpected physical strength, and hyperthermia. Throughout the United States and Canada, these cases are frequently associated with psychostimulant abuse, representing the extreme end of a psychiatric continuum of drug abuse effects. However, reports of acute exhaustive mania, physical restraint, Pepper Spray or TASER and sudden death also have been reported that are not related to abused drugs, suggesting further that an underlying central nervous system disorder was the precipitating cause of lethality. Such victims of excited delirium have provoked allegations of police misconduct, unnecessary force and improper TASER deployment.

Medical examiners often have extreme difficulty in identifying the cause of death, but frequently drug intoxication is considered as a contributing factor or cause of death. While the precise cause and mechanism of these deaths remain controversial, we have demonstrated abnormalities in brain that define and confirm the occurrence of the excited delirium syndrome.

What to Know

Fact: ED is a medical emergency that presents itself as a law enforcement problem.
- Early and advanced coordination with EMS is key.

Fact: ED is not easy to recognize.
- Training is important so that dispatch or other personnel recognize behavioral signs.

Fact: ED containment requires backup personnel.
- Do not approach until it is safe to do so and always ensure several officers are present.

Fact: ED victims exhibit superhuman strength and are impervious to pain.
- Restraint positions and use of electronic control devices (TASER®) to override the CNS.

Fact: ED is a life-threatening emergency.
- Get the subject into acute medical care quickly.

Headlines

Death by Excited Delirium: Diagnosis or Coverup? full story...

Coroner Rules Cocaine, Not Taser, Killed Prisoner full story...

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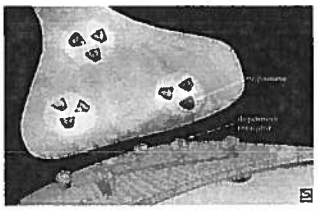
What is Excited Delirium (ED)?

Excited delirium is a brain disorder.



This disorder is usually drug-related (cocaine or "crack", PCP or "angel dust", methamphetamine, amphetamine), but can occur in non-drug users as well.

The presentation of excited delirium occurs with a sudden onset, with symptoms of bizarre and/or aggressive behavior, shouting, paranoia, panic, violence toward others, unexpected physical strength, and hyperthermia. Hyperthermia is a harbinger of death in these cases.

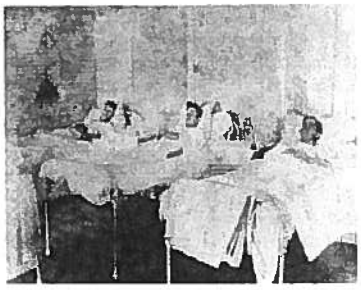
Neurochemical systems in the brain are abnormal in this disorder. At the molecular level, excited delirium is characterized by dysregulated dopamine transporters (hyperdopaminergic state), elevated heat shock proteins (hyperthermia), and immediate early gene activation as a marker of paranoid aggression (c-fos protein). These molecular changes serve as biomarkers of the disorder.

While many factors are associated with sudden death in individuals requiring restraint for excited delirium, these individuals develop a disturbance in thought, behavior and mood, and become agitated and violent. This abnormal behavioral state is due to CNS mechanisms which are the cause of lethality. The brain controls the heart and respiration. Abnormal brain activity leads to the psychosis and sudden death.

History of Excited Delirium

While excited delirium is best characterized in cocaine users, medical examiners and forensic scientists have noted a similarity in psychiatric presentation between sudden unexplained deaths in custody and psychiatric states associated with or without drug abuse. This seminal work was first described by Dr. Charles Wetli and his collaborator David Fishbain in the mid 1980s, when the "crack" cocaine epidemic first hit the streets of Miami, Florida (Wetli and Fishbain, 1985). But this disorder was known more than a decade earlier.

In 1849, Dr. Luther Bell first described a "disease" resembling some advanced stage of mania and fever, distinguished as an overlooked and often unrecorded malady (Bell, 1849). This "exhaustive mania" was described in 40 cases by Dr. Bell where "exhaustion due to mental excitement" caused three quarters of these patients to die.



Similarly, a condition called neuroleptic malignant syndrome (NMS) was described in the 1960s as a potentially fatal complication of antipsychotic drugs. This highly lethal disorder is seen in patients taking dopamine (DA) antagonists or following abrupt withdrawal from DAergic agonists (Caroff et al., 2007; Friedman et al., 1985; Kosten and Kleber, 1988; Levenson, 1985; Strawn et al., 2007).

In their seminal 1985 paper, Wetli and Fishbain reported excited delirium in a cocaine body packer, and within the next few years, the syndrome was recognized in cocaine abusers as well. NMS is usually associated with muscle rigidity, while the cocaine variant of the syndrome presents with brief onset of rigidity immediately prior to respiratory collapse (Kosten and Kleber, 1988). In 1988, Kosten and Kleber proposed that cocaine-induced excited delirium was a variant of NMS. Alternatively, NMS may be an attenuated version of acute exhaustive mania/excited delirium. There is no doubt that these three disorders represent a common brain disease that likely has a genetic risk for certain individuals.

Neurochemical Biomarkes of Excited Delirium

Recent studies by our group supporting the hypothesis that NMS and cocaine-induced excited delirium are related and due to a brain disorder, involves dysregulated dopamine transport (Staley et al., 1994, 1995b; Wetli et al., 1996; Mash et al., 2002; Mash et al, 2008).

Cocaine blocks the dopamine transporter (DAT,red plugs in the presynaptic membrane) which leads to an elevation of the neurotransmitter in the synaptic cleft (shown above). An elevation of DA activates postsynaptic receptors (blue plugs in the synaptic membrane) on receiving cells. Pathologic levels of DA in the synapse causes the paranoia, delusions and psychosis. Too much DA in the synapse causes a dysregulation in the centers of the brain that controls temperature. DA is known to be linked to the central command centers in brain

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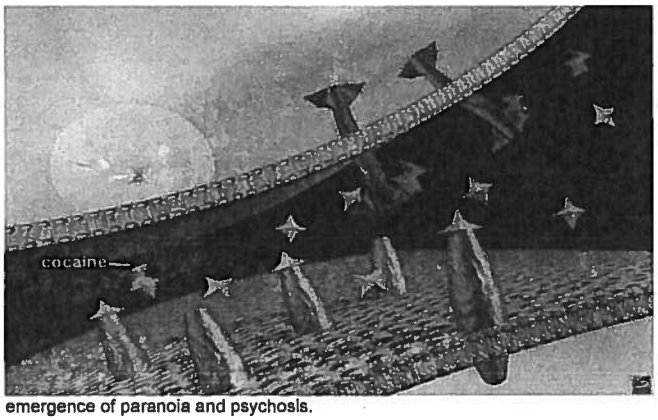

that controls the heart. Chaotic DA signaling in the brain underlies the emergence of paranoia and psychosis.

Cocaine-related excited delirium is always seen in chronic abusers. The brain on cocaine is "not the same" and has adapted to a new state. Many neurochemical systems are dysregulated, but the final common pathway is most likely linked to DA. Excited Delirum is characterized as a ***hyperdopaminergic state.***

What is Excited Delirium ?

Wetli suggests that there are three related syndromes: (1) acute exhaustive mania, as described by Bell in psychiatric patients, (2) excited delirium, due to psychostimulants (cocaine, methamphetamine, MDMA) and psychiatric illness; and (3) the attenuated variant - NMS (Wetli, 2005; Wetli and Natarjajan, 2005).

With advances in molecular genetics, the gene or genes and environment interactions that cause Excited Delirium will be identified. This will only be possible if the biospecimens are made available to fully characterize excited delirium as a brain disease.

Good Video - Sad DOA

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For Law Enforcement

Individuals suffering from ED should be viewed as psychiatric patients and require immediate medical attention. ***ED is a medical emergency***. The video below illustrates a prime example of an excited delirium case.

The aggressiveness, hyperactivity, incoherent shouting, and extreme paranoia exhibited by the suspect in the video are always associated with ED. This suspicion is confirmed by the fact that the suspect was found to be hyperthermic as indicated by not wearing a shirt. Individuals often disrobe or are found naked. This person had an eventual cardiorespiratory collapse in the absence of lethal force. With a completed brain autospy showing the biological signature of ED, it can be concluded that excited delirium played a role in this man's death. In order for police officers to avoid situations like the one shown, it is essential to understand and recognize excited delirium when it presents itself.

Signs and Symptoms

Victims of excited delirium display sudden onset of paranoia and alternate between calm behavior and extreme agitation. When confronted by police, who are invariably called to the scene, the victim intensifies the violence and paranoia. An intense struggle ensues, when the victim exhibits incredible "superhuman" strength and is impervious to the usual police techniques of pain control, including pepper spray, peroneal baton strikes, and in certain cases, TASER deployment. The intense struggle requires the efforts of many police officers, who are finally able to restrain the victim and apply ankle and/or wrist restraints. Usually, within minutes of being restrained, the victim loses all vital signs. Core body temperatures average 105 degrees. . Resuscitation of these cases often results in a failed course of hospital treatment, characterized by a fatal sequence of rhabdomyolysis and renal failure.

Things to look for:
-Aggressiveness
-Combativeness
-Hyperactivity
-Extreme paranoia
-Unexpected Strength
-Incoherent shouting

Investigators must document what occured at the scene. Record or note body temperature. Ask for EMS personnel to record the temperature of the person. Attention to details may help medical examiners in determining the cause and manner of death.

Treatments

Excited delirum is a medical emergency.

Patients exhibiting signs of excited delirium require supportive care immediately:
- Sedation with benzodiazepines

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- External cooling
- Intravenous fluids
- Maintain on cardiac and respiratory monitor
- ER treatment of rhabdomyolysis and hyperkalemia

More Video Examples of Excited Delirium

October 14, 2005

Destroying Myths & Discovering Cold Facts
with The Force Science Research Center

10 training tips for handling "excited delirium"

DIRECTOR'S NOTE: One of the missions of the Force Science Research Center is to bring the latest research (ours and others) to the law enforcement community. Excited Delirium is a very high profile, significant social problem that although rare in occurrence has been very costly to the LE in terms of the health and safety of all concerned, reputation of the profession and certainly financially in terms of lawsuits against officers, departments and community.

It is our hope that this newsletter, which combines the latest research with the resulting suggested policy and procedures, stimulates thoughtful discussion in the areas of policy, practice and training.

--Dr. Bill Lewinski, executive director, Force Science Research Center

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A representative of a large insurer of law enforcement agencies advises that new criteria are evolving for dealing with a special type of EDP-the person in the violent throes of Excited Delirium.

Attorney William Everett, a former police officer, offers 10 recommendations he believes will help patrol officers better manage high-risk ED confrontations. He presented these last month [9/05] in Utah at a conference of LE administrators and government risk managers and elaborated on them recently in an interview with Force Science News.

Litigation stemming from in-custody deaths is not uncommon.

"In minimizing risk," Everett says, "agencies and officers should be aware of the latest developments in medical and scientific research and use those findings to develop protocols for dealing with ED."

Everett is associate administrator for the League of Minnesota Cities Insurance Trust, which provides liability coverage for more than 800 communities, and is also a member of the National Advisory Board of the Force Science Research Center at Minnesota State University-Mankato.

"Studies estimate that ED may be a factor in 50 to 125 in-custody deaths a year in the United States alone," Everett says. "Part of the problem seems to be that officers tend to see the bizarre and alarming behavior of a subject experiencing this condition as strictly a control-and-arrest situation rather than as a serious medical emergency that can be fatal.

"Fifteen to 20 years ago, it became important for officers and trainers to start thinking about distinguishing the difference between a combative drunk and a person in a diabetic crisis. Even though they may share some common behaviors, one needs to go to jail and the other needs to go to a hospital.

"Now, with the research that has been done on ED in the last few years, there's a need to distinguish between people who are just choosing to act in a violent criminal way and those who are doing so because of an underlying medical condition that is affecting them mentally and physically.

"When you put the latter subject in jail without proper medical attention and he dies, you have both a tragedy and a liability problem."

Excited Delirium has been described as "a state of extreme mental and physiological excitement," characterized by exceptional agitation and hyperactivity, overheating, excessive tearing of the eyes, hostility, superhuman strength, aggression, acute paranoia, and "endurance without apparent fatigue."

Officers' encounter this condition under "very consistent" circumstances, according to Chris Lawrence, defensive tactics coordinator at the Ontario Police College in Aylmer (ON) and a member of FSRC's Technical Advisory Board. Lawrence is recognized as a leading LE authority on ED. He will soon debut a column on ED and other LE issues for FSRC's strategic partner, PoliceOne at www.policeone.com.

The subject officers confront, often on a property damage or unusual behavior call, will be "acting in a bizarre manner, often partially clothed or naked," Lawrence reports. He will likely be incoherent or speaking in gibberish or what seems to be another language. He'll be yelling or screaming loudly, seem to

be disoriented or hallucinating and may be foaming at the mouth or drooling. He may be sweating profusely or the opposite, his body temperature soaring and uncooled by perspiration. Glass often will somehow be involved in the encounter, reason unknown.

Usually ED symptoms are well underway when officers arrive, but lately Lawrence has found instances in which a subject is speaking calmly and rationally with officers and then suddenly explodes into ED. However the onset occurs, the condition, while relatively rare, is always high-risk, he stresses.

As officers try to gain physical control of the subject, his "extraordinary strength" will be "a central feature of the struggle." Several officers will be needed to overcome his determined resistance and immunity to pain.

"During the restraint process, the subject will often be grunting and making animal-like noises."

The biggest problem may come after he is controlled - when, after struggling against restraint, there may come "a period of sudden tranquility." At this point, Lawrence says, "the officers realize the subject has stopped breathing. Invariably resuscitation efforts fail."

At autopsy, "the pathologist is typically unable to determine the exact cause of death," but the police, of course, generally end up being blamed.

ED episodes most likely occur between Thursday and Sunday, with Sunday the most common day, Lawrence has found. The hot months, May through September, are the most common time of year. Male subjects in their early 30s are most frequently afflicted, with subjects under 20 or over 50 least likely; female ED subjects are "extremely rare." Of illegal substances potentially involved, cocaine is most common (more than half the cases). Alcohol is common, too. About one-third of the time, the subject will have a diagnosed mental illness, schizophrenia most likely.

During his 15 years as a street cop, Everett says he saw "all kinds of people with mental impairments," but he believes he encountered only one memorable subject exhibiting ED - a young man pounding furiously on a plate glass window, then jumping on the hood of a car, trying to gain entry to a bar on a Sunday night when it was closed.

The melee with officers that ensued was "the closest I ever got to an unarmed life-and-death confrontation," Everett recalls.

The difference between that subject and the multitude of other EDPs he encountered in his career he likens to, "the difference between a Tyrannosaurus and a tabby cat. There's no subtlety about the intensity of energy, the physicality. It doesn't seem like you're dealing with anything human."

Seemingly invulnerable physically, the subject, in fact, may be experiencing a cluster of life-threatening physiological stresses, including hyperthermia, a change in blood acidity, electrolyte imbalances, a breakdown of muscle cells, and a leaching of cellular contents into the blood stream, all of which put his heart at significant risk.

With more research desperately needed, identifying "definitive, scientifically validated 'best practices'" for dealing with dangerous and difficult ED subjects may be impossible at present, Everett concedes. But based on his review of available data, he believes that "the overarching operational objective" when these individuals are confronted must be to bring them under control in a manner that does not unnecessarily aggravate their affliction and to get them immediate medical treatment.

Everett adds that ED is rare and that agencies may have other more prominent life and safety concerns to deal with. Based on what is known about ED now, he makes these recommendations:

1. Coordinate in advance with EMS. "ED is a medical emergency that presents itself as a law enforcement problem." Police and medical communities should strive to develop a coordinated approach for dealing with these incidents, with everyone involved understanding "what ED is and what their roles are"
   when dealing with an episode.
2. If feasible, train dispatchers to recognize and question for indicators of ED so that responding officers can be cautioned before reaching the scene. When ED is suspected, EMS personnel and any available crisis intervention teams should be promptly notified.
3. Where ED seems probable, EMS should be dispatched and stand by at a safe distance until the individual is restrained. "EMS involvement is warranted as early as possible."
4. "Unless there is an immediate public safety threat, the first responding officers should focus on containing the subject" in an environment that offers him maximum possible safety and protects others as well. Unless there are compelling reasons to do otherwise, officers should not approach the individual until substantial backup and medical personnel are on the scene.
5. As soon as the first responding officers believe they are dealing with ED, "they should ensure that SEVERAL officers are sent as backup." If physical restraint becomes necessary, they'll be needed for the protection of everyone involved. "Backing off until help is there makes sense and rushing to intervene alone, unless there is a compelling public safety threat, is foolhardy."
6. Once sufficient numbers are on hand, including medical personnel, then "police efforts should be focused on getting the subject under control as quickly and safely as possible." He needs medical treatment, but there can be no treatment until he has been brought under control.
7. In considering tactics, keep in mind that "ED is often characterized by superhuman strength and imperviousness to pain. Thus, control through empty-hand, mechanical techniques may be more difficult to achieve, and pain-based techniques may be relatively ineffective." The subject is typically "unresponsive to verbal direction."

   The effectiveness of pepper spray and impact techniques (baton strikes and beanbag rounds) "will likely be diminished with individuals who are unresponsive to pain."
   If empty-hand techniques are to be tried, "then the officers should be trained in advance to function as part of a multiple-officer takedown team."

   A better choice may be Conducted Energy Devices (Tasers). However, current research cautions about a possible link "between MULTIPLE such applications and death in persons with symptoms of ED. To mitigate this risk, a SINGLE Taser application should be made before the subject has been exhausted."
   (The Taser should be used not in the hope of gaining compliance but to create a window of disablement during which officers can establish physical control of the subject.)

One Taser firing in the probe mode, "followed by a restraint technique that does not impair respiration, may provide the optimum outcome." NOTE: "The Taser should not be used in the pain-distraction (push/stun) mode in dealing with ED individuals," since that is primarily a pain-reliant technique.

Whatever the tactical approach, "without a common plan and without training and practice in working together in multi-officer techniques, officers may very likely end up working against each other."

8. Adjust your restraint tactics. "People are designed to fight what is in front of them, and officers are almost universally trained to place individuals into a prone position because of safety and control advantages. This position may make it more difficult for the person to breathe, and this concern is heightened when dealing with ED."

   Therefore, once control is achieved, "the subject should be placed on his side if this can be done without creating an unreasonable risk to officers or others. As soon as he is controlled, hand him off to the medics."

9. The goal is to get the subject into the hands of Advanced Life Support personnel or into a hospital as quickly as possible. Ideally, do not transport ED subjects in a police car. "They should be transported to a hospital in an ambulance," unless waiting for an ambulance would cause unreasonable delay. Officers should train in advance with EMS on how these individuals should best be placed on and secured to a stretcher.

10. Medical personnel should have protocols for dealing with ED cases, including the possibility of considering the prompt use of "chemical restraint" (powerful tranquilizing agents) to bring them down from their state of extreme agitation and violence. "At the very least, medical personnel are better equipped to intervene than police officers would be if there is a cardiac event."

Lawrence characterizes Everett's recommendations as "a forward-thinking attempt to advance our understanding and response" to ED. But he stresses that there are still many mysteries about this syndrome and that these suggestions should not all be regarded as guaranteed lifesavers.

For example, delaying physical control attempts until more officers and medical personnel are on hand may, in fact, permit a subject's condition to worsen, although Lawrence agrees that waiting will likely be more prudent from an officer-safety standpoint.

Similarly, rolling a subject onto his side after he is controlled in the prone position will not necessarily prevent his dying, "since we don't really know what is killing these people," Lawrence says.

However, he agrees with relieving pressure on the subject's respiratory system in that manner, provided that his legs are securely restrained to prevent him from kicking officers. Also, he reminds, the subject needs constant monitoring after being "controlled," given the ability of many suspects to defeat seemingly secure behind-the-back handcuffing.

(Although some medical critics of police tactics object to using the prone position to gain control because of its potential restriction on breathing, Lawrence says he has never found a critic who could suggest an effective alternative. Even the premise that prone positioning is related to ED deaths continues to be debated.)

Also, Lawrence points out, in remote locations where distance and lack of ready availability may delay the arrival of paramedics, it may be safer to quickly transport an ED subject by squad car to a hospital than to wait at the scene for an ambulance and field medical personnel. "Officers need to assess the circumstances and do what they think is most appropriate," he advises.

Everett agrees that his recommendations should be considered only "starting points" and that officers, trainers and agencies are "well advised to continue monitoring ED research for further developments and insights.

"As more research is done, the best practices will become clearer, and over time these will become the basis against which the profession is measured. Agencies that don't keep their training current will inevitably be compared with those that do when there's a lawsuit."

To assist in understanding and preparing for ED intervention, you may want to view a video training program developed by the Las Vegas Metro P.D. and posted on the Internet at http://www.southernnevadahealthdistrict.org/ems/ems_excited_delirium.htm.

This presentation includes vivid recreations of ED encounters, plus a post-training test.

Also a comprehensive report on ED, prepared by Sgt. Darren Laur of the Victoria (BC) P.D., is available through the Canadian Police Research Centre at:

http://www.cprc.org/tr/tr-2005-02_e.pdf

Chris Lawrence has published an article on the proper protocol for investigating sudden in-custody deaths, available from the archives of The Police Chief magazine at:

http://policechiefmagazine.org/magazine/index.cfm?fuseaction=display_arch&article_id=191&issue_id=12004

FSN readers can contact Lawrence directly at elginsci@execulink.com for a copy of a form he has designed to guide such investigations. He is currently designing another form which will aid first responders in capturing "transient evidence" of ED episodes at the scene. This is expected to be published and posted by the Canadian Police Research Centre by the end of this month [10/05].

The CPRC also features a significant section on ED in a report of a year-old study of Taser use. This report can be viewed at www.cprc.org/tr/tr-2006-01.pdf

An information bulletin called "Law Enforcement Responses to Excited Delirium," which contains Everett's recommendations and background on the ED phenomenon, is scheduled to be accessible: www.lmnc.org by the end of the week of October 10.

"Sudden Deaths in Custody," a book that deals with ED, is scheduled to be published next January ['06] by Humana Press. Authors are Darrell Ross of East Carolina University and Ted Chan of the University of California-San Diego.

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About the author

The FSRC was launched in 2004 by Executive Director Bill Lewinski, PhD. - a specialist in police psychology -- to conduct unique lethal-force experiments. The non-profit FSRC, 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.

For more information, visit www.forcescience.org or e-mail info@forcescience.org. If you would benefit from receiving updates on the FSRC's findings as well as a variety of other use-of-force related articles, please visit www.forcesciencenews.com and click on the "Please sign up for our newsletter" link at the front of the site. Subscriptions are free.

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Does 'Excited Delirium' Kill Taser Victims?

By David Hambling ✉ August 12, 2009 | 5:35 pm | Categories: Bizarro, Less-lethal

Even when supposedly "non-lethal" weapons are used to subdue a suspect, people can still die. Many blame the weapons used; Amnesty International report that at least 334 people have died in the USA after being Tasered. But a new study suggests that a condition known as Excited Delirium may be

responsible in many cases.

The University of Miami's official website on the condition says that the condition, which are frequently associated with drug abuse, include "bizarre and/or aggressive behavior, shouting, paranoia, panic, violence towards other people, unexpected physical strength, and hyperthermia."These symptoms are often noted in suspects who are subdued apparently without harm, either by physical force, pepper spray or Taser, but who die shortly afterwards."

The condition has always been hugely controversial since it was described in 1985. It is not recognized by the American Medical Association, and some critics, like the Excited Delirium blog , regard it as a "flimsy excuse" used to cover up police brutality.

Police psychologist Mike Webster, testifying on Taser deaths, said that excited delirium was a "dubious disorder" used by Taser International in its training of police. Certainly a page on the company's website suggests that excited delirium suggests it is the real cause of deaths blamed on Tasers by "certain anti-police groups."

A 2005 book Excited Delirium Syndrome: Cause of Death and Prevention cast doubt on the traditional explanations on how such deaths occur (such as asphyxia) and argued that it was a form of sudden cardiac arrest brought on by stressors, but this had remained controversial.

The new study, carried out by Deborah Mash and colleagues at the University of Miami in Florida , is published in Forensic Science International (abstract only without subscription) and reported in New Scientist. The researchers looked at samples of brain tissue for ninety individuals who has apparently died of excited delirium.

They found the signatures of two distinctive "biomarker" proteins which were common to all ninety cases. One the one hand there were abnormally low levels of a dopamine transporter. This is a substance that would normally clear up excess dopamine produce by stress or drugs; a low level

means that the body could be overwhelmed by dopamine, leading to either cardiac problems or severe overheating.

A second biomarker is a "heat shock" protein called HSPA1B which is an indicator that body temperature was raised. This is not surprising, as the average core body temperature was 40.4 C, but it does give a forensic way of demonstrating that a person was overheating at the time of death.

So, if the research stands up, excited delirium is a real condition. But that doesn't necessarily mean that the weapons are not a factor. The RCMP have adopted a policy which acknowledges that there is a risk of death when using Tasers on "acutely agitated" suspects and restricts their use to cases where there is a threat to officers or the public. If the excited delirium is aggravated by a struggle with the police, then clearly their actions are a factor. And in any case there is clearly a need to supervise victims rather than leaving them unattended in a police cell or vehicle where they may die.

The new study is unlikely to settle the matter, but perhaps it will prompt more research into the question of exactly how you should treat someone with excited delirium to minimize the risk of harm to them without endangering anyone else.

Photo: Taser International

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Tasers Implicated in Excited Delirium Deaths

by LAURA SULLIVAN

This is the second of two reports on excited delirium.

Google Video

A still from a video shot by police shows efforts to revive Frederick Williams at the Gwinnett County Detention Center in a suburb of Atlanta in May 2004. Williams stopped breathing shortly after being stunned with a Taser; he died a few hours later. His family is suing the county and Taser International; the company has made it clear that it plans to argue Williams died of excited delirium.

February 27, 2007

The medical diagnosis called excited delirium is the subject of intense debate among doctors, law-enforcement officers and civil libertarians. They don't even all agree on whether the condition exists. But to Senior Cpl. Herb Cotner of the Dallas Police Department, there's no question that it's real.

"This is when you have someone doing push-ups with two 150-pound officers on their back," Cotner says, describing how the condition can manifest itself.

Excited delirium is a term more medical examiners are using to explain why people — often high on drugs or alcohol — die suddenly while in police custody. Symptoms are said to include extreme agitation, aggressive, violent behavior and incoherence.

Cotner had to subdue several men. One man smashed through a plate-glass window, fell from a fence, broke his leg several times and still walked two blocks to fight with police.

"[I] had a guy that was handicapped, with a bad leg and a bad arm," Cotner said about another man. '[He] dragged us across a parking lot, and we had him half-controlled."

"These fights leave us exhausted," he adds. "There is no one thing that simply describes this. It's a totality of characteristics that you can't explain."

One minute, a person is fighting and screaming; the next minute, he's dead, Cotner says.

Hear Part 1 of This Report

Death by Excited Delirium: Diagnosis or Coverup?
Feb. 26, 2007

Recent Cases

Below are some recent instances in which excited delirium was cited to explain the deaths of people in police custody. In each case, the deceased had also been stunned with a Taser:

June 13, 2005 – Shawn C. Pirolozzi, 30, of Canton, Ohio, dies after police tried to subdue him with a Taser. His death certificate listed excited delirium as the cause of death. The

Taser was not listed as a contributing factor.

April 21, 2006 — Alvin Itula, 35, dies after a struggle with Salt Lake City police. Itula led officers on a foot chase, then fought with them when the officers caught up, according to police. Officers tased Itula and also used pepper spray and a baton. Itula stopped breathing soon after. The medical examiner found that Itula died of excited delirium brought on by methamphetamine and cocaine.

April 24, 2006 — Jose Romero, 23, dies in Dallas police custody. He was in his underwear, screaming and holding a knife on his neighbor's porch. Police tased him multiple times. He died shortly thereafter. The Dallas County medical examiner ruled Romero died of excited delirium.

Sept. 5, 2006 — Larry Noles, 52, dies in Louisville, Ky., after a struggle with police. Noles, an ex-Marine, was standing naked in the middle of a street when police were called. Police said he was agitated. They tased him two or three times. He died a few minutes later. The Jefferson County medical examiner ruled Noles died because of excited delirium and not the Taser.

Oct. 29, 2006 — Roger Holyfield, 17, dies after police in Jerseyville, Ill., shocked him twice with a Taser. Holyfield had been walking down a street, holding a phone in one hand and a Bible in the other, yelling that he wanted Jesus. After policed shot him with the stun gun, Holyfield

Cotner trains officers to give the person space and try to calm them — unless the person poses a danger to someone else. In those cases, a fight often results.

And in a growing number of cases, police officers end up reaching for their Tasers. That is where the debate over excited delirium becomes more complicated.

Medical Condition or Legal Cover?

Civil-liberties groups fear that the diagnosis is being used to cover up police abuse — and to protect companies like Taser International from lawsuits.

Taser International, the company that makes stun guns, says its product helps police deal with people suspected of having excited delirium. A company spokesman told NPR that Tasers could be the only way to subdue a person fast enough to get medical attention.

But according to civil-liberties groups and legal filings, Taser may have financial reasons to support — and even encourage — the use of the excited delirium diagnosis.

Take the case of Frederick Williams. On a grainy video, Williams is screaming, 'Don't kill me! I have a family to support. I've calmed down!" as several officers carry him into the Gwinnett County Detention Center in a suburb of Atlanta. One officer takes out his Taser and fires it directly onto Williams' chest.

The officer yells, "Relax! Stop resisting!" But the shock keeps jerking Williams' chest upward. As several officers hold Williams down, he is stunned six more times. A few minutes later, the officers realize Williams is not breathing. Williams died a few hours later.

Williams' family is now suing the county and Taser International. The company has made it clear in proceedings so far that it intends to argue Williams died of excited delirium — not because

went into a coma; he died the following day. A medical examiner ruled the death was probably a result of excited delirium.

Dec. 17, 2006 — Terill Enard, 29, dies following a disturbance at a Waffle house in Lafayette, La. He was naked and yelling, with a broken leg bone piercing his skin. Police stunned Enard with a Taser; he died several hours later. Police said the forensic report from the Lafayette Parish coroner's office found Enard died as a result of "cocaine-induced excited delirium."

— Laura Sullivan

of the Taser or excessive force. The medical examiner could not determine the exact cause of death.

Williams, a deacon in his church and father of four, had no drugs or alcohol in his system.

Publicizing the Diagnosis

Excited delirium has helped Taser International in the past. In recent years, the company has successfully defended itself against at least eight lawsuits involving people who died in police custody, arguing that the cause of death was excited delirium, not the Taser.

Taser International spokesman Steve Tuttle acknowledges that each year, his company sends hundreds of pamphlets to medical examiners explaining how to detect excited delirium. Taser also holds seminars across the country, which hundreds of law-enforcement officials attend. But Tuttle says his company is only providing information that has been vetted by researchers.

"We're not telling departments [that] excited delirium is always the cause of death following a Taser application," Tuttle said. "We're simply pointing out the facts: that excited delirium is an issue out there, and they need to treat this as a medical emergency if they see these signs."

Taser is also reaching out to the medical community.

John Peters is president of the Institute for the Prevention of In-Custody Deaths, a prominent consulting company in Henderson, Nev. His firm specializes in training law-enforcement officers, coroners, emergency-room physicians and others in the medical community about sudden death from excited delirium.

A Conflict of Interest?

Peters is also one of Taser International's star witnesses against claims that the weapon kills people. He and his staff were paid by Taser for a year and a half to instruct at the company's training academy.

Peters says that training law enforcement to embrace excited delirium does not affect his impartiality on the stand.

"Some people would say, 'Well, obviously you're on their side,'" Peters said. "But the Taser is just one piece of this. I'm not a Taser instructor. I don't hold stock in Taser. So we try to maintain a distance or separation."

But Eric Balaban, a staff attorney with the American Civil Liberties Union, worries that the messages police receive about excited delirium may actually exacerbate confrontations with people in custody.

"If police officers are being trained about this condition known as excited delirium, and are being told the people suffering from it have superhuman strength, and [these people] are being treated as if they are somehow not human, it can lead officers to escalate situations," he said.

Balaban says the fear is not just that excited delirium may not exist, but that it is already being overused — in lawsuits and on the streets.

Related NPR Stories

Georgia Protesters Angry over Use of Tasers Nov. 12, 2005

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The Debate over Tasers and Police Dec. 7, 2004

the windows of the vehicle. The police subsequently restrained his ankles and attached the ankle restraints and handcuffs together. He was then transported to a local hospital. While en route, the police officers noted he became tranquil (about 45 minutes after the onset of the disturbance). Upon arrival at the hospital a few minutes later, the subject was discovered to be in a respiratory arrest. Resuscitative attempts were futile. A postmortem examination was performed 1 hour and 45 minutes later (about 3 hours after the onset of the disturbance), and a rectal temperature of 41°C (106°F) was recorded. He had needle marks typical of intravenous drug abuse and pulmonary and cerebral edema. Abrasions and contusions of the ankles and wrists were also evident from his struggling against the restraints. Toxicologic analysis of postmortem blood disclosed 52.3 mg/L of lidocaine and 0.8 mg/L of cocaine. No lidocaine was administered to the victim during resuscitative attempts.

1.12.2.12.2 Neurochemistry of excited delirium. The cellular and molecular changes resulting in this stereotyped set of symptoms are now reasonably well understood. Using ligand binding and autoradiographic methods, researchers have identified a series of neurochemical abnormalities in the brains of excited delirium victims, as well as the interactions between the mesolimbic areas of the brain, where dopamine is the principle neurotransmitter, and endogenous opioids (Mash and Staley, 1999). The abnormalities have to do with the number and type of dopamine receptors, the number of sites where cocaine can bind with brain tissue, and the ability of cocaine and dopamine to interact with κ-type opiate receptors located primarily in the amygdala, but also in the nucleus accumbens and other corticolimbic zones.

Dopamine receptors were initially classified into two main groups, but with advances in molecular biology, these main groups have been further subdivided into five different recognizable subtypes of receptors, although for practical purposes they are still considered as two groups: the "D1-like receptors" (dopamine receptors D1 and D5), and the "D2-like receptors" (dopamine receptors D2, D3, and D4) (Seeman and Van Tol, 1994). The situation is somewhat confusing, largely because of the nomenclature used to describe dopamine receptors. Most antipsychotic drugs block the D2 receptors in direct correlation to their clinical potency, except clozapine, which preferentially binds the D4 receptor. D1 and D2 receptors can interact with each other and enhance the actions of each other, possibly through subunits of G proteins. In schizophrenia, D2 and D3 receptor density is elevated by 10% while the D4 receptor density is elevated by 600%. It has been suggested that cocaine craving may be the result of marked D3 receptor elevation over the limbic sectors of the striatum (Strange, 1998; Mash and Staley, 1999).

Cocaine use alters the number of brain D1, D2, and D3 dopamine receptors (Seeman and Van Tol, 1994; Staley et al., 1994; Mash and Staley, 1999). When compared to the brains of drug-free trauma victims, the cocaine recognition sites on the striatal dopamine transporter are elevated in the brains of most cocaine users (i.e., the nonpsychotic ones). No such increase is seen in patients with excited delirium. The fact that psychotic cocaine users fail to demonstrate this compensatory increase means that they cannot clear excess dopamine from their synapses. At the same time, chronic cocaine abuse leads to striking decreases in the density of the D1 receptor subtype throughout the striatal reward centers, probably as a result of receptor downregulation (Staley and Mash, 1996). This type of downregulation is not seen in excited delirium.

The fact that cocaine users quickly become tolerant to the euphoriant effects of the drug is probably explained by the change in the number of dopamine binding sites. D2 receptors in nonpsychotic cocaine abusers are unchanged. However, in the psychotic subgroup, marked reductions in the number of D2 receptors in the hypothalamus have been observed. Because these receptors are known to mediate temperature control, decreased numbers of D2 receptors may explain the occurrence of malignant hyperthermia in the psychotic patients. With fewer D2 receptors available, D1-mediated temperature increases would be unopposed (Staley et al., 1994). Obviously, the occurrence of hyperthermia, and its severity, depend on the absolute decrease in D2 receptors; if it is not very great, then hyperthermia may or may not occur.

The significance of changes in the D3 receptor has only recently become apparent (Mash and Staley, 1999). Compared to drug-free controls, the brains of nonpsychotic cocaine users contain an increased number of D3 binding sites, with a one- to threefold increase measurable in the nucleus accumbens and in the ventromedial sectors of the caudate and putamen. Nucleus accumbens is a collection of brainstem neurons deeply implicated in the process of addiction to all drugs. Within this nucleus, cocaine exposure also causes increased production of D3 receptor mRNA.

By mechanisms yet to be determined, the increase in D3 receptors is in some way related to an increase in the number of κ-opioid receptors. Nonpsychotic cocaine users, when compared to drug-free controls, have twice the number of κ receptors in the nucleus accumbens and other corticolimbic areas. Unlike the nonpsychotic cocaine users, cocaine users who die of excited delirium have a selective upregulation of κ receptors in the amygdala (Staley et al., 1997; Mash and Staley, 1999). The observation almost certainly explains the paranoid nature of the psychotic episodes experienced by these patients. Although it would have been an unthinkable undertaking just a few years ago, PET scanning has been used to map the functional neuroanatomy of psychosis (Epstein et al., 1999).

The amygdala and other portions of the striatum play a very significant role in controlling our emotional response to external stimuli. Studies of schizophrenic patients, with or without hallucinations and paranoid delusions, have shown marked increases in mesolimbic activity, particularly when there is a perceived threat (Goodwin, 1996; Fudge et al., 1998). Of particular interest is the observation that, in drug-free patients with schizophrenia, projections from the amygdala to the frontal area of the brain may be involved. Decreased frontal lobe blood flow and glucose uptake are known concomitants of chronic cocaine abuse (Volkow et al., 1993).

Some of the neurochemical effects of cocaine seem to be gender related. Studies utilizing proton magnetic resonance spectroscopy have shown that the brains of cocaine users, when compared to those of non-drug-using controls, contain decreased amounts of *N*-acetyl compounds, an indicator of neuronal damage. Production of myoinositol, an indicator of glial activation, is increased. Both of these alterations are most prominent in the frontal lobes, and both changes are much more pronounced in men than in women. Whether these neurochemical alterations explain why nearly all excited delirium victims are men is not known (Chang et al., 1999).

As Bell first observed in the 1840s, excited delirium can occur in conjunction with many different medical disorders, not just cocaine or stimulant toxicity. It has been suggested that this constellation of symptoms is actually a variant of neuroleptic malignant syndrome (Kosten and Kleber, 1987, 1988). Neuroleptic malignant syndrome (NMS) is a highly lethal disorder seen in patients taking dopamine antagonists and in individuals who have been withdrawn from dopaminergic agents, such as bromocriptine and levodopa (Friedman et

al., 1985; Levinson, 1985). NMS is usually associated with muscle rigidity, though variants of the syndrome without rigidity are also recognized. Whether the same set of abnormalities underlie both excited delirium and NMS is unclear, but given that schizophrenic patients and patients suffering from bipolar disorder can also develop excited delirium, even when they are not taking dopaminergic agents, it seems likely that two different processes are at work (O'Halloran and Lewman, 1993).

1.12.2.12.3 Medico-legal considerations. Not uncommonly, patients with excited delirium find themselves "hog-tied," with their wrists and ankles bound together behind their backs while they lie prone (Reay et al., 1988, 1992; O'Halloran and Lewman, 1993; Reay, 1993; Pollanen et al., 1998; O'Halloran and Frank, 2000). Based on some early studies and anecdotal case reports, the cause for death in these individuals was said to be an entity called "positional asphyxia," a term originally used to describe what happens when alcoholics or otherwise infirm individuals fall into a confined space and are unaware that their respiratory status has been compromised and that their chests are not expanding adequately (DiMaio and DiMaio, 1989; Purdue, 2000).

In all such cases, autopsy will disclose marked congestion, cyanosis, and petechiae. However, the term is now applied to agitated psychotics, transported prone, who die suddenly, and in whom autopsy is said to be unrevealing (Reay et al., 1992). Or, as a 1995 publication from the U.S. Department of Justice puts it, "positional asphyxia" occurs as "a result of a body position that interferes with one's ability to breathe — as it occurs within a confrontational situation involving law enforcement officers" (Petty and McDonough, 1995). This same report goes on to state that such deaths are more likely to occur when there is either "cocaine-induced bizarre or frenzied behavior … or drugs and alcohol intoxication" or a "violent struggle extreme enough to require the officers to employ some type of restraint technique."

There is no question that intoxicated, massively obese individuals trapped in confined spaces may not be able to expand their own chests, and the term "positional asphyxia" is appropriately used in such cases. But, this new definition, as defined by the Justice Department, was formulated before the neurochemical changes in excited delirium had been characterized (Staley et al., 1994, 1997; Mash and Staley, 1999), before it was apparent that stimulant abusers have enlarged hearts (Karch et al., 1995), before it was widely recognized by pathologists that myocardial hypertrophy was an independent and potent risk predictor for sudden cardiac death (Frohlich, 1999; Zipes and Wellens, 1998), and before it was demonstrated that "hog-tying," at least of normal-sized individuals (body mass index [BMI] < 30), has no significant effect on respiratory function (Chan et al., 1997, 1998; Schmidt and Snowden, 1999; Elfawal, 2000), at least not those with normal hearts.

Failure to recognize these anatomic and histochemical changes, coupled with incomplete autopsies (no heart weights or heart weight not normalized) and minimal scene investigation, has led to a flood of litigation (Table 1.12.2.12.3.1). Much of the confusion stems from the failure of those involved to properly document what occurred. For example, paramedics, and even medical examiners, more often than not fail to record a victim's temperature, either at the scene or at the time of postmortem examination. If the temperature has not been recorded, proving that a decedent suffered from excited delirium becomes that much more difficult. Similarly, unless strangulation is specifically ruled out at autopsy, considerable liability may result. Meticulous neck dissection is required, and the findings need to be documented photographically. Efforts made during prehospital care require equally precise documentation. Attempts at endotracheal intubation and cardiopulmonary resuscitation may produce petechiae, contusion, and even damage to

Table 1.12.2.12.3.1 Protocol for Excited (Agitated) Delirium Deaths

1. *Training:* Establish protocols that:

   Do not use pepper spray when excited delirium is suspected. It will not subdue the individual, and will only create needless liability.
   Do not hog-tie the victim. If the heart is abnormal, doing so may hasten death.
   Make every effort to transport the patient by ambulance, not police car.
   Never transport an excited delirium patient unattended in a police van.
   Always take excited delirium victims to a hospital, never to a jail.
   Notify the medical examiner immediately of any excited-delirium-like death.
   Document that each officer has learned the protocol.

2. *Neurochemical testing:* Make arrangements with a local university or medical school to process the brain. The University of Miami brain endowment bank has done extensive research in this area and can always be consulted (1-800-UMBRAIN).

3. *Temperature:* Take and record the core temperature of the deceased at the scene. Take and record the ambient air temperature.

4. Interview all witnesses; verify the method of restraint and time to loss of consciousness.

5. If the deceased was transported by ambulance, review paramedic records for temperature and oxygen-saturation measurements.

6. If pepper spray was used, confiscate the unit and weigh it to estimate the amount remaining (as an indication of how much was used).

7. Autopsy protocol to be completed within 24 hours of death:

   a. Remove brain, place 1-cm slices on baking sheet, rinse with saline, freeze with dry ice, and ship to neurochemistry reference lab.

   b. Remove heart and fix prior to examination. Consider consultation with a university-based cardiac pathologist.

   c. Obtain urine, blood samples from right heart, and also brain tissue for toxicologic testing; record sites of sampling

8. Always remove the brain and thoracic organs *before* performing and photographing the neck dissection (prevents artifacts simulating neck trauma).

9. Consider asking family of decedent to designate a forensic pathologist to be present at time of autopsy.

the tracheal mucosa and strap muscles of the neck (Raven et al., 1999). Any one of these artifactual changes could mistakenly be attributed to the effects of neck compression or choke hold. If the resuscitative attempts go undocumented, false accusations of brutality may result.

The presence of petechiae is often cited as proof of death from "positional asphyxia" (Reay et al., 1992), but petechiae around the eyes are not infrequently seen in individuals with heart failure, for whom there is no question of drug abuse or strangulation having occurred (Rao and Wetli, 1988). Petechiae can, and do, occur as a result of resuscitative attempts (Maxeiner and Winklhofer, 1999; Raven et al., 1999), and they may not be apparent until some time has elapsed after death (Kondo et al., 1997; Burke et al., 1998). That being the case, photographic documentation of the absence of petechiae is just as important as documentation of their presence.

The mean cocaine concentration in 45 cases seen by the Miami–Dade County Medical Examiner was 1.32 mg/L (range .05–11.8 mg/L, $n = 34$), while the benzoylecgonine level was 3.78 mg/L (range .08–14.75 mg/L, $n = 38$). In these same deceased individuals, the mean brain cocaine concentration was 1.90 mg/kg (range .05–4 mg/kg, $n = 10$), while the mean benzoylecgonine concentration was 2.69 mg/kg (range .85–3.5 mg/kg, $n = 6$) (Wetli et al., 1996). By comparison, cocaine blood concentrations in a group of 51 trauma victims, where the presence of cocaine was an incidental finding, were not much lower than in victims of excited delirium (Karch et al., 1998).

Questions as to whether the death of these individuals is centrally mediated or a consequence of unrecognized heart disease, and whether either possibility is increased by the process of restraint remain unanswered. In experimental animals, the stress of restraint makes fatal outcomes more likely. Rats injected daily with moderate doses of cocaine (30 mg/kg) and then restrained are three times more likely to die from seizures than rats injected with the same amount of drug and allowed free access to their cages (Pudiak and Bozarth, 1994). However, because seizure activity in actual patients with this syndrome is extremely rare, the relevance of this experimental model is doubtful. It has also been suggested that the mechanism of death may involve a surge of catecholamines released by the stress response, acting upon a myocardium already sensitized by cocaine (Mirchandani et al., 1994).

This last explanation seems to be increasingly probable. As discussed in Section 1.12.2.6, myocardial hypertrophy, even in individuals who are not drug users, is associated with structural changes that increase the risk for arrhythmia and sudden death. Some of these structural changes are clearly related to catecholamine toxicity, while others are the result of myocardial hypertrophy, which can almost always be detected in chronic cocaine users (but only if the heart is weighed and compared to the standard nomogram). Surges in catecholamines produce myocyte damage (contraction band necrosis and damage to vessel walls) and, at the same time, lower the threshold for ventricular fibrillation. The microvasculature changes seen in the hearts of excited delirium patients are highly reminiscent of those seen in hypertensive individuals — a decrease in the lumen of arteriole, as a direct consequence of either vasoconstriction or wall thickening (O'Halloran and Lewman, 1993; Gavin et al., 1998), and these changes also favor ischemia, which lowers the fibrillatory threshold.

Whatever the cause, the syndrome is occurring with some regularity. And, because violent behavior is part of the syndrome, the police are almost inevitably involved, which means that patients with this disease often die in police custody or en route to the hospital (Mirchandani et al., 1994). In some jurisdictions, "Tasers" are used to subdue the violently agitated. This device produces an electrical charge sufficient to produce immobilization. Virtually all fatalities associated with "Taser" use have been patients with excited delirium (Kornblum and Reddy, 1991). It may be that the device activates a stress response similar to being "hog-tied." On the other hand, death and use of the "Taser" could have been purely coincidental.

Similar considerations apply to the pepper sprays used by some police departments. All of the adult deaths associated with pepper spray use have been in individuals with excited delirium, usually in cocaine users. In the absence of laryngeal edema, it is difficult to conceive of a mechanism, or any connection at all, other than that violently psychotic individuals are more likely to be exposed to pepper spray than people who are not psychotic. However, because of low cocaine blood levels at autopsy, because of general misunderstandings about cocaine blood concentrations and the probability of death because of core temperatures generally not being taken, because of heart weights not being normalized, and because hearts are not examined microscopically, it is hardly surprising

that death is often attributed to use of a choke hold or pepper spray or hog-tying. The other alternative, attributing death to a trivial head injury (minor cerebral contusions or subdural hematomas), is still another obvious temptation best avoided (Mirchandani et al., 1994).

In some cities in the U.S., medical examiners have taken the sensible approach of contacting the deceased's family and asking them to retain their own pathologist to witness the autopsy. In the U.K., this is standard practice. But even the presence of an independent observer may not be enough to prevent litigation or to prevent individuals from confusing temporal proximity of an action, such as hog-tying, with causality. Aristotle identified this type of logical error more than 2000 years ago. One would hope that, in the interim, pathologists would have learned to avoid this mistake and base their decisions on factual analysis, not flawed reasoning.

References

Bell, L. (1849). On a form of disease resembling some advanced stages of mania and fever, but so contradistinguished from any ordinarily observed or described combination of symptoms as to render it probable that it may be an overlooked and hitherto unrecorded malady, *Am. J. Insanity*, 6, pp. 97–127.

Burke, M. P., Olumbe, A. K. et al. (1998). Postmortem extravasation of blood potentially simulating antemortem bruising, *Am. J. Forensic Med. Pathol.*, 19(1), pp. 46–49.

Chan, T. C., Vilke, G. M. et al. (1997). Restraint position and positional asphyxia, *Ann. Emerg. Med.*, 30(5), pp. 578–586.

Chan, T. C., Vilke, G. M. et al. (1998). Reexamination of custody restraint position and positional asphyxia, *Am. J. Forensic Med. Pathol.*, 19(3), pp. 201–205.

Chang, L., Thomas, E. et al. (1999). Gender effects of persistent cerebral metabolite changes in the frontal lobes of abstinent cocaine users, *Am. J. Psychiatry*, 156(5), pp. 716–721.

Di Maio, D. J. and M. Di Maio, V. J. (1989). *Forensic Pathology*, Elsevier, New York.

Elfawal, M. A. (2000). Sudden unexplained death syndrome, *Med. Sci. Law*, 40(1), pp. 45–51.

Epstein, J., Stern, E. et al. (1999). Mesolimbic activity associated with psychosis in schizophr enia. Symptom-specific PET studies, *Ann. N.Y. Acad. Sci.*, 877, pp. 562–574.

Friedman, J., Feinberg, S. et al. (1985). A neuroleptic malignant like syndrome due to levodopa therapy withdrawal, *JAMA*, 254, pp. 2792–2795.

Frohlich, E. D. (1999). State of the art lecture. Risk mechanisms in hypertensive heart disease, *Hypertension*, 34(4, part 2), pp. 782–789.

Fudge, J. L., Powers, J. M. et al. (1998). Considering the role of the amygdala in psychotic illness: a clinicopathological correlation, *J. Neuropsychiatry Clin. Neurosci.*, 10(4), pp. 383–394.

Gavin, J. B., Maxwell, L. et al. (1998). Microvascular involvement in cardiac pathology, *J. Mol. Cell. Cardiol.*, 30(12), pp. 2531–2540.

Goodwin, G. M. (1996). Functional imaging, affective disorder and dementia, *Br. Med. Bull.*, 52(3), pp. 495–512.

Karch, S. B. and Stephens, B. G. (1999). Drug abusers who die during arrest or in custody, *J. R. Soc. Med.*, 92(3), pp. 110–113.

Karch, S. B., Green, G. S. et al. (1995). Myocardial hypertrophy and coronary artery disease in male cocaine users, *J. Forensic Sci.*, 40(4), pp. 591–595.

Karch, S. B., Stephens, B. G. et al. (1998). Relating cocaine blood concentrations to toxicity: an autopsy study of 99 cases, *J. Forensic Sci.*, 43(1), pp. 41–45.

Knopf, S. (1924). The one million drug addicts in the United States. A defense of, and suggestion to, the medical profession, *Med. J. Rec.*, 119, pp. 135–139.

Kondo, T., Betz, P. et al. (1997). Retrospective study on skin reddening and petechiae in the eyelids and the conjunctivae in forensic physical examinations, *Int. J. Legal Med.*, 110(4), pp. 204–207.

May 27, 2011

DOJ releases controversial study on so-called 'stun guns'

The study released by NIJ concludes that it's appropriate for officers to use stun guns to subdue unruly or uncooperative suspects

By Dave Collins
Associated Press

HARTFORD, Conn. — Police officers using stun guns should avoid shooting suspects multiple times or for prolonged periods to reduce the risk of potential injury or death, according to a new U.S. Justice Department study prompted by hundreds of police-involved deaths across the country.

Coroners and other medical experts on the study panel concluded that while the effects of prolonged and repeated stun gun use on the body are not fully understood, most deaths officially attributed to Tasers and similar devices are from multiple or lengthy discharges of the weapons.

The panel reviewed nearly 300 cases in which people died from 1999 to 2005 after police shot them with stun guns, but found that most of the deaths were caused by underlying health problems and other issues. Of those cases, the experts examined 22 in which the use of stun guns was listed as an official cause of death.

The study released Tuesday by the department's research arm, the National Institute of Justice, concludes that it's appropriate for officers to use stun guns to subdue unruly or uncooperative suspects, as long as police adhere to "accepted national guidelines and appropriate use-of-force policy." It also makes several recommendations, including medical screenings for all people shot with stun guns.

The experts also noted that evidence shows the risk of death from a stun gun related incident is less than 0.25 percent, and there's no conclusive evidence that stun guns cause permanent health problems.

"What this study suggests is, indeed, less-than-lethal technologies ... can be effectively used by law enforcement," said John Laub, director of the National Institute of Justice.

Justice Department officials said the study began more than six years ago after Amnesty International and other groups blamed many death of suspects in police custody on stun gun. Both Amnesty International and the United Nations Committee Against Torture have called the use of stuns guns a form of torture in some cases.

More than 12,000 law enforcement agencies nationwide had issued about 260,000 stun guns to officers as of spring of last year, the study said. Of the more than 600 arrest-related deaths in the U.S. each year, there are very few cases in which stun guns are cited the cause or contributory factor, the report said.

Officials at Taser International, the maker of the leading stun guns, said Thursday that there are no peer-reviewed medical studies that have found that prolonged or repeated use of Tasers cause death. In 2009, however, the company advised Taser users to try to avoid shooting people in the chest, because of a very low risk of a health problem.

Alvaro Garzon, a 46-year-old drug and alcohol addiction counselor from New Haven, said the study's cautions about firing stun guns multiple times make sense. Garzon has filed a brutality complaint with New Haven police saying a city officer shot him with a stun gun four times last year during a domestic disturbance call.

"After two times it should be enough," Garzon said in Spanish on Thursday while his daughter, Lina, interpreted for him. "You don't feel good after the second shot. I felt like I was burning inside."

Garzon, who was accepted into a probation program on a charge of assault on a police officer, said he was treated at a hospital for lung problems, and he continues to suffer from the trauma. The status of Garzon's police complaint wasn't immediately clear Thursday night.

Police across the country have faced heated criticism for stun gun deaths.

Connecticut state police are investigating the May 1 death of 26-year-old Marcus Brown, who authorities say was shot with a stun gun by Waterbury police while he was in the back of a police cruiser and handcuffed. Brown's family is calling for federal authorities to investigate; the official cause of death is still pending.

Waterbury police say Brown, who was about 5 feet 6 inches tall and 125 pounds, became combative. The officer who shot Brown, Adrian Sanchez, had been placed on administrative duty under normal procedures.

Earlier this month, Connecticut state police released an investigation report that showed how Middletown police last year shot 35-year-old Efrain Carrion 34 times with stun guns to subdue him while responding to a report that he was despondent and violent. Carrion died later that day.

The medical examiner concluded Carrion died of "excited delirium," a cause of death not recognized by many medical groups but one the Justice Department says is well documented. Several officers were cleared of wrongdoing in the incident.

Last year, a jury in Louisiana acquitted former Winnfield officer Scott Nugent, who was accused of shooting handcuffed suspect Baron Pikes eight times with a Taser gun and charged with manslaughter. Pikes later died.

In 2006, police in Green Cove Springs, Fla., shot a 56-year-old woman in a wheelchair 10 times with a stun gun and she died. Police say Emily Marie Delafield was swinging knives and a hammer at relative and police, and officers had tried to talk her into dropping the weapons before they were forced to subdue her. The officers' actions were found to be justified.

Lt. J. Paul Vance, a spokesman for Connecticut state police, said police officers never want to get into a situation where they're forced to fire Tasers or other weapons.

"Certainly you're looking for voluntary compliance from a suspect ... but unfortunately that's not always achievable," Vance said.

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7 Member Comments

The comments below are member-generated and do not necessarily reflect the opinions of PoliceOne or its staff.

Page 1

Posted by **fatman16@hotmail.com** on Saturday, May 28, 2011 09:11 AM Pacific Report Abuse

Why does anyone even listen to people like Amnesty International anymore? They complain no matter what we do, or what we don't do. And who is that moron counselor? He got arrested during a domestic, and didn't like that he had to be tased so many times. Then maybe he should have complied after the second ride on the taser, and he wouldn't have needed 4...

Posted by **lumpy193** on Saturday, May 28, 2011 07:02 AM Pacific Report Abuse

The Taser is a very effective tool; it drops me like a sack of potatos. That said, although I continue to qualify with the Taser, I do not carry one. Our training staff asked me why and I gave the following policically incorrect answer: I spent a lot of time, energy and money learning how to effectively use my hands, elbows, knees, legs, feet, ASP and a wide varity of other implements of chaos. I advised I prefer to get my money's worth by utilizing the above when necessary. Before the comments start, I am not some arrogant fool who thinks I am indestructible. I simply prefer to rely on my own abilities to defend myself rather than an electronic device. Too many instances where Taser has failed stop a suspect and then the Individual who deployed the Taser now does not know what to do because they have come to rely on the Taser too much.

Posted by **nathanhayes** on Saturday, May 28, 2011 05:40 AM Pacific Report Abuse

My department has a medical review check requirement (except for officers hit in training). I have carried a Tazer for about a year now and haven't used it yet. One of the main reasons is the hospital visit. If someone is being combative they belong in jail, not the hospital.

Posted by **HRPufnstuf** on Saturday, May 28, 2011 04:43 AM Pacific Report Abuse

So the perp says that two time should be enough. I agree. If two zaps doesn't stop them, step back and "insert" a couple of .45 rounds into them. That should stop them.

Posted by **wmccarty** on Saturday, May 28, 2011 03:33 AM Pacific Report Abuse

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Another pile of crap from the " Associated Depressed."

Posted by **jjackson110@hotmail.com** on Saturday, May 28, 2011 00:42 AM Pacific Report Abuse

There is so much BS in this article it's ridiculous. I knew it was an AP article before I even looked.

Posted by **nichow** on Friday, May 27, 2011 08:52 PM Pacific Report Abuse

I guess overall this study works in our favor by saying tazers are a good tool when "accepted national guidlines" are used. I have no idea what they are talking about "national guidlines" unless they are talking about case law on the use of force.

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Excited Delirium *Education, Research and Information*

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Introduction

Over the past decade, increased attention has been paid to the sudden and seemingly inexplicable deaths of some highly agitated subjects being held in police custody. In most of these cases, the force required to restrain or incapacitate the suspect was not sufficient to cause death.

Our colleagues in Miami-Dade County, Florida, first described the syndrome of excited delirium associated with cocaine abuse. The symptoms of excited delirium include bizarre and/or aggressive behavior, shouting, paranoia, panic, violence towards other people, unexpected physical strength, and hyperthermia. Throughout the United States and Canada, these cases are frequently associated with psychostimulant abuse, representing the extreme end of a psychiatric continuum of drug abuse effects. However, reports of acute exhaustive mania, physical restraint, Pepper Spray or TASER and sudden death also have been reported that are not related to abused drugs, suggesting further that an underlying central nervous system disorder was the precipitating cause of lethality. Such victims of excited delirium have provoked allegations of police misconduct, unnecessary force and improper TASER deployment.

Medical examiners often have extreme difficulty in identifying the cause of death, but frequently drug intoxication is considered as a contributing factor or cause of death. While the precise cause and mechanism of these deaths remain controversial, we have demonstrated abnormalities in brain that define and confirm the occurrence of the excited delirium syndrome.

What to Know

Fact: ED is a medical emergency that presents itself as a law enforcement problem.
- Early and advanced coordination with EMS is key.

Fact: ED is not easy to recognize.
- Training is important so that dispatch or other personnel recognize behavioral signs.

Fact: ED containment requires backup personnel.
- Do not approach until it is safe to do so and always ensure several officers are present.

Fact: ED victims exhibit superhuman strength and are impervious to pain.
- Restraint positions and use of electronic control devices (TASER®) to override the CNS.

Fact: ED is a life-threatening emergency.
- Get the subject into acute medical care quickly.

Headlines

Death by Excited Delirium: Diagnosis or Coverup? full story...

Coroner Rules Cocaine, Not Taser, Killed Prisoner full story...

Detained man's 'drug delirium' full story ..

Top chef died after cocaine reaction full story...

Better training 'prevents custody deaths' full story...

Cocaine, Excited Delirium and Sudden Unexpected Death full story...

Excited Delirium

The usual presentation in such deaths is that of individuals in **excited delirium.** They are confused, irrational, hyperactive, and usually violent. In an attempt to restrain them from injuring themselves or others, a violent struggle ensues. Immediately after the struggle ends, the individual abruptly becomes unresponsive, develops cardiopulmonary arrest, and does not respond to cardiopulmonary resuscitation. In cases involving the police, individuals usually become unresponsive after being handcuffed and placed or wrestled to the ground. In some instances, this occurs as they are being transported to jail or a hospital. At autopsy, there is no anatomical cause for the death, though minor injuries, e.g., abrasions, may be present. In the cases involving the police, toxicologic testing will usually reveal drugs such as cocaine or methamphetamine. It is the cocaine or another stimulant that is presumably causing the excited delirium. The authors would like to reiterate that the lapse into unresponsiveness and development of cardiopulmonary arrest almost invariably occurs after the struggle has ended.

Catecholamine Release

In cases such as the aforementioned, most deaths are caused by the combine effect of the physiological consequences of violent physical activity and th effects of the drugs. During high intensity exercise, e.g., a struggle, there i release of catecholamines (norepinephrine and epinephrine) from th adrenals into the circulation. The effects of these substances are to increas the rate and force of contraction of the heart, the conduction velocity and th blood pressure. This results in an increase in demand for oxygen by the hea The highest levels of catecholamines occur not during physical activity struggle in this case) but approximately 3 min after cessation of the activity.

Potassium

During the struggle, not only do the levels of the catecholamines increase the blood but so do blood potassium concentrations.[2–4] The increase may as much as 5 mEq/l or more in some individuals.[4] Following cessation exercise, there is an immediate, rapid drop in blood potassium to conc trations that approach 2 mEq/l.[3-5] Five minutes after cessation of the exerc potassium levels may be lower than when they were at rest. There may b pronged hypokalemia lasting 90 min or more.[3,5] These extremes in potassi concentrations can have cardiac arrhythmogenic effects. The arrhythmoge effects of the hyperkalemia, however, are neutralized by the cardioprotec effect of the elevated levels of catecholamines.[6] Thus, the danger time arrhythmias is immediately following cessation of physical activity, w blood catecholamine concentrations continue to rise while potassium le

drop dramatically to hypokalemic levels. This period has been referred to by Dimsdale et al. as the time of **post-exercise peril**, in that there is a risk of cardiac arrhythmias during this period.[1]

Effects of Catecholamines on the Heart

Upon commencement of high-intensity physical activity (a struggle in these cases), the adrenal glands secrete epinephrine and norepinephrine into the blood. Most of the alpha adrenergic receptors on effector organs (cardiac muscle, smooth muscle) are alpha-1 receptors. Stimulation results in smooth muscle contraction of blood vessels, with resultant vasospasm. The beta-1 receptors are primarily in the heart; the beta-2 receptors in the heart and peripherally. Stimulation of the beta-1 receptors causes an increase in heart rate, contractility and conduction velocity. Beta-2 stimulation results in smooth muscle relaxation. Epinephrine reacts with alpha and beta receptors both peripherally and in the cardiovascular system. Norepinephrine has its predominant effect on the cardiovascular system, reacting with the alpha-1 and beta-1 receptors in the effector cells of the heart. Thus, both epinephrine and norepinephrine react with beta-1 receptors with resultant increase in heart rate, contractility and conduction velocity. Coronary arteries have in their walls both beta-2 and alpha-1 receptors, with the beta-2 more plentiful. Norepinephrine interacting only with the alpha-1 receptors causes vasoconstriction, thus decreasing the amount of oxygenated blood being supplied to the myocardium by the coronary arteries. Therefore, any drug that causes increased exposure of receptor sites to norepinephrine predisposes to coronary artery constriction at the time the heart needs more — not less — oxygen. At the same time that changes in catecholamine concentrations are occurring, the aforementioned changes in blood potassium levels also occur.

Actions of Drugs

Following cessation of a violent struggle, the levels of catecholamine continue to increase for approximately three minutes, while the level of potassium drops dramatically.[1–5] These two factors predispose to the development of an arrhythmia. This is the time of "**post exercise peril**" described by Dimsdale.[1] Stimulants such as cocaine and methamphetamine can cause excited delirium. If the individual has taken amphetamine, cocaine or another stimulant, the physiologic effects of the struggle can be magnified by the drugs and a fatal arrhythmia more readily ensue. Cocaine has a double effect. It causes increased release of catecholamines from the adrenals and inhibits norepinephrine reuptake. The latter action causes norepinephrine to accumulate at the neuroeffector junction, intensifying its effect. Thus, by these actions, cocaine works on the beta-1 receptors to increase heart rate, force of contraction and

conduction velocity, while, at the same time, acting on the alpha receptors in the coronary arteries to cause contraction, reducing myocardial perfusion. Thus, as the myocardium needs increasing amounts of oxygen, due to the stimulation of the beta-1 receptors, the amount of blood perfusing the myocardium is reduced by constriction of the coronary arteries. Amphetamine has the same effect as cocaine, but, instead of blocking the reuptake of norepinephrine, it causes release of norepinephrine from the sympathetic fibers.

Alcohol

Sudden death of an individual with a history of alcohol abuse and in whom only alcohol may be present also occurs during a struggle. Alcohol is a recognized cause of a variety of atrial and ventricular arrhythmias.[7–9] In addition, chronic alcoholics have been found to have a prolonged QT interval, an affliction associated with sudden death, as well as increased levels of norepinephrine.[10–12] All these predispositions to arrhythmias can be aggravated by catecholamines released during a violent struggle. Thus, if the heart is predisposed to fatal arrhythmias by the action of alcohol, then, under conditions such as a violent struggle, the released catecholamines can produce a fatal arrhythmia.

Endogenous Mental Disease: Acute Psychotic Episodes

Excited delirium may also occur in the absence of stimulant drugs such as cocaine, methamphetamine or alcohol in individuals with endogenous mental disease. Clinically, these are usually referred to as acute psychotic episodes, and tend to occur in individuals with schizophrenia, schizoaffective disorders or delusional disorders. Acute psychotic episodes happen both in and out of mental facilities. They may occur because of the patient's discontinuance of medications or development of tolerance to the medications. If the episode occurs outside a mental health facility, the police are usually called on to deal with the individual; if inside the facility, it is nursing or support personnel. Sudden death can be caused by either the physiological effects of catecholamine and hypokalemia following the struggle or a combination of these effects and the effects of the medications the patient is or was on. Many patients, nowadays, are on medications, some of which have a cardiotoxic potential. The tricyclic antidepressants, just like cocaine, block reuptake of norepinepnrine. The action of these drugs can predispose an individual to a cardiac arrhythmia.

Natural Disease without Anatomical Manifestations

In some instances, sudden death during or following a struggle can be caused by natural disease that is not diagnosable anatomically. In such instances, a

medical history is absolutely necessary to make the diagnosis. Some examples are Wolfe-Parkinson-White syndrome, the prolonged Q-T syndrome, etc. In one case, an interview with the family revealed a history of "fluttering" or "pounding" heartbeats, a "funny pulse," suggestive that the individual had an underlying physiological lesion of the conduction system of the heart predisposing him to develop an arrhythmia.

Most medical professionals, including forensic pathologists, have no experience with individuals who are in the throes of excited delirium. They do not comprehend the violence or the intensity of the struggle. Thus, to restrain a 12-yr-old child during an acute psychotic episode may take four large adults, one to each extremity, while a fifth administers a tranquilizing injection. Nursing articles recommend that, when attempting to physically restrain a violent individual experiencing an acute psychotic episode, at least six individuals be used.[13]

When someone dies during a struggle, the natural question is why. An explanation involving catecholamines, alpha and beta receptors, and potassium levels, is difficult for most people to understand. Choke holds and positional asphyxia can be demonstrated and are simple to understand, therefore, it is normal to gravitate to this simpler explanation for a death. Even if there is absolutely no evidence of use of a choke hold or positional asphyxia, and the law enforcement or medical personnel deny using either, the denials are sometimes dismissed as a cover-up. The concept of death caused by a choke hold is very popular because, when no evidence of trauma to the neck is found, this would seem to "prove" that the choke hold was "expertly" applied. Of course, use of a choke hold is just a form of manual strangulation. It always amazes me when a 200-lb adult male is allegedly killed with a choke hold without a mark on the throat and no petechiae in the eyes, while a 100-lb woman, manually strangled by an individual twice her weight, is able to put up sufficient struggle so as to have bruises on the neck and petechiae of the conjunctivae and sclerae. Since use of a choke hold is manual strangulation, the individual applying the choke hold must maintain it for close to 2 min to cause cessation of respiration.

Deaths Ascribed to Positional Asphyxia

For respiration, one has to have an open airway; lungs capable of gas exchange and the ability to ventilate the lungs. In deaths ascribed to positional asphyxia, it is alleged that there is interference with ventilation of the lungs. Ventilation involves movement of the chest wall, diaphragm and abdominal wall. Positional asphyxia occurs when an individual is placed in or somehow gets into a position where there is interference with his ventilatory efforts (Figure 8.12). A number of deaths occurring after episodes of manic delirium have been ascribed to positional asphyxia.

Law enforcement personnel routinely employ physical restraints to control prisoners. The most common of these are handcuffs. When the prisoner is violent, there may be escalation to ankle shackles, restraint chairs, etc. Until the mid-1990s, use of "hogtie" restraints was common. In the hogtie position, the prisoner is placed face down on the ground, his wrists and ankles bound behind his back and then tied together by a rope or cord. This type of restraint began to fall in disuse when it was alleged that sudden death could be produced utilizing this position and type of restraint. Numerous civil suits were filed in regard to prisoners dying while hogtied. It was alleged that securing an individual in this position caused hypoventilatory respiratory failure, i.e., positional asphyxia. Studies by Chan et al. refuted these contentions.[14] In experiments involving high-intensity physical activity followed by hogtie restraint, Chan et al. demonstrated that, while there was impairment in respiratory activity, it "did not result in clinically relevant changes in oxygenation or ventilation." Eisele et al. continued this line of research, with the addition of placing 25- and 50-lb weights between the shoulder blades while the subjects were prone and hogtied, to simulate an individual pressing down on the back of someone hogtied. The tests showed no significant effect on oxygen saturation of the blood. [15]

While virtually all deaths in manic delirium are probably caused by the physiological reactions to a violent struggle (with or without interaction with drugs), in occasional cases, positional asphyxia may play a role in a death. Thus, if individuals are placed in hogtie restraint and put in the back of a vehicle so that their abdomens lie over the transmission hump, a reasonable argument for positional asphyxia can be made. There is also the problem with massively obese individuals. There is a potential for positional asphyxia if a hogtie is applied and they are left face down. In both situations, pressure on the abdomen would impair the abdominal component of respiration as well as forcing the diaphragm up, reducing its capacity for excursion.

Certification of Death

In the aforementioned cases, the authors suggest two ways of certifying the cause of death. First is to sign out the cause of death as "excited delirium" and then list "struggle," "cocaine intoxication," etc., as contributory causes. The other way is to sign out the cause of death in a descriptive manner, e.g. "Cardiopulmonary arrest during violent struggle in individual under influence of cocaine, alcohol, etc." In individuals with psychoses, this is listed either as a contributory cause or incorporated in the descriptive diagnosis.

The greater difficulty is designating a manner of death. Because of the effects of the violent struggle, one cannot classify such a case as a natural death. The choice then is either homicide or accident. Since a violent struggle has occurred with interaction between two or more individuals, the best

Section E

RPD Policy & Procedure 4.8 (Rev. 5, 10/20/08)

Investigations of Officer Involved Shootings and Incidents Where Death or Serious Likelihood of Death Results

Effective Date: 10/84
Revision 1 Date: 10/6/97
Revision 2 Date: 1/30/2002
Revision 3 Date: 4/5/2002
Revision 4 Date: 5/9/2005
Revision 5 Date: 10/20/2008
Approval:

Russ Leach
Chief of Police

4.8 INVESTIGATIONS OF OFFICER INVOLVED SHOOTINGS AND INCIDENTS WHERE DEATH OR SERIOUS LIKELIHOOD OF DEATH RESULTS:

A. POLICY:

The following procedures shall be followed when a member of this Department, whether on or off duty, or any member of any law enforcement agency, uses, or attempts to use, deadly force through the intentional or accidental use of a firearm or any other instrument in the performance of his/her duties or is otherwise involved as a principal in an incident where death or serious likelihood of death results. A member is considered a principal for the purposes of this policy if he/she participates in and/or is otherwise physically involved in the incident. Such incidents include, but are not limited to:

1. Intentional and accidental shootings;

2. Intentional and accidental use of any other deadly or dangerous weapon;

3. Attempts to affect an arrest or otherwise gain physical control over a person for a law enforcement purpose; and,

4. Deaths of persons while in police custody or under police control following a use of force.

B. PROCEDURES:

1. Whenever an employee of this Department uses, or attempts to use, deadly force through the intentional or accidental use of a firearm or any other instrument in the performance of his/her duties, or is otherwise involved in an incident where death or serious likelihood of death results as defined above, he/she shall immediately notify his/her supervising officer.

2. The supervisor shall notify the Watch Commander without unreasonable delay.

3. The Watch Commander shall notify the on-call General Investigations Sergeant. The on-call General Investigations Sergeant shall notify the General Investigations Lieutenant (or Captain in his/her absence). The General Investigations Lieutenant will determine if a response by the Officer Involved Shooting Team (OIS Team) is necessary. If so, the General Investigations Lieutenant will notify the Crimes Against Persons Sergeant who will respond the OIS Team.

4. If an employee discharges a firearm, or uses other deadly force, or is otherwise involved in an incident where death or serious likelihood of death results outside the Riverside City limits, the employee shall immediately notify the local law enforcement agency having jurisdiction where the incident occurred. As soon as possible, the employee shall notify the Riverside Police Department Watch Commander. The Watch Commander will notify the on-call General

Investigations Sergeant and other personnel as designated in this policy. The on-call General Investigations Sergeant shall make the notification as above in B3. If the incident occurs within Riverside County, the use of deadly force shall be investigated pursuant to the Riverside County Law Enforcement Administrator's protocol. In those cases outside the City of Riverside, the involved employee shall notify the Riverside Police Department Watch Commander as soon as possible and a written memorandum shall be filed with the Watch Commander without delay.

C. ROLES AND RESPONSIBILITIES

Personnel responding to an officer involved shooting or other deadly use of force incident or officer involved incident where death or serious likelihood of death results should recognize and adhere to the roles and responsibilities as listed below.

1. Roles:

a. The Investigations Bureau will focus on all criminal aspects of the incident.

b. The Riverside County District Attorney may be present to oversee the focus on all criminal aspects of the investigation and may conduct a parallel investigation.

c. The Riverside Police Office of Internal Affairs may be present to review training, procedural, and policy matters connected with the incident.

d. The Riverside City Attorney may respond to the scene to review the case with regard to any potential civil liability to the City of Riverside and its officers.

e. Peer Support Officers shall be called to provide employee(s) support and assistance in understanding the investigative process and to attend to the officer(s)' personal needs. The Watch Commander or General Investigations Lieutenant will determine the appropriate time and place for peer support to respond. Although confidentiality within the Peer Support Program is provided under the Evidence Code, and the Riverside Police Department will not require Peer Support Officers to reveal confidential conversations with involved employees, Peer Support Officers are cautioned that a court may determine no privilege exists regarding immunity or communication between the Peer Support Counselor and the involved employee(s).

f. Psychological Services shall be called to assist the employee(s) involved with information on coping with psychological changes which can occur as a result of being involved in a critical incident. A licensed mental health professional afforded psychotherapist-patient privilege under the Evidence Code shall interview the officers involved. The Watch Commander or General Investigations Lieutenant will determine the appropriate time and place for post-incident psychological counseling. Involved employees may decline to discuss the specific facts of the critical incident with the psychological counselor.

g. The Press Information Officer shall be summoned to the scene if necessary to act as a single source of information to the news media. The Investigations Lieutenant or his/her designee will brief the PIO as to information deemed appropriate for release. The PIO shall provide regular updates and a written press release to the news media when appropriate.

h. The Riverside Police Officers Association (RPOA) shall be notified of the critical incident and its Representative(s) permitted access to the involved officers at the scene and at the General Investigations Bureau. RPOA will designate which representative(s) will respond. RPOA Representatives on duty shall be relieved of further duty with pay unless they are witnesses to or directly involved in the critical incident. RPOA Representatives will not unreasonably be denied access to the officers they are representing. No report will be required of Representatives. While the Police Department will not require RPOA Representatives to reveal communications with member officers they are representing, a court may determine that no privilege exists in criminal matters. Accordingly, officers are encouraged to obtain legal representation.

2. Responsibilities:

a. Involved/Witnessing Employee Shall:

1. Provide care for all injured persons.

2. Request supervision and suitable assistance.

3. Secure the scene of the incident and protect it from alteration and contamination.

4. Apprehend offenders.

5. Brief the responding supervisor, providing a public safety statement to assist in identifying and/or locating the suspect, number of rounds fired, trajectory of rounds fired, information necessary to protect the crime scene, or information to protect the public and other officers from continuing harm of a fleeing suspect.

6. Ensure witnesses and/or other involved persons (including police personnel) do not discuss the incident prior to being interviewed by the OIS Team.

7. Prepare an accurate and complete police report of the incident and have it approved by a supervisor. The report may be prepared by the involved employee(s) by dictating the report for transcription, furnishing a complete and accurate statement to police investigators, or by submitting a complete and accurate written report. Such report should be prepared as soon as possible after the incident unless the employee is injured or emotionally unable to promptly make a police report. The Investigations Lieutenant will determine when the report will be

prepared or the employee interviewed. When making their reports, involved officers shall not be considered as having waived their rights under the Public Safety Officers Procedural Bill of Rights Act, the federal and California Constitutions, and other relevant statutory protections.

8. Unless approval is granted by the Chief of Police or his/her designee, the involved employee(s) shall not talk to the news media or anyone else regarding the incident or investigation until the entire criminal investigation is completed. Exceptions are: the interviewing detective and/or supervision from the OIS Team, legal representatives, RPOA representative, Peer Counselor, a member of the clergy, or a psychological services provider.

9. Provide a blood or urine sample as appropriate pursuant to this policy.

b. **Field Supervision Shall**:

1. Provide medical aid to any injured parties.

2. Take immediate charge of the scene. Establish a crime scene perimeter with a single point of entry and exit. Assign an officer to restrict access only to necessary police and/or medical personnel and to maintain a log of persons entering and exiting the crime scene.

3. Ensure preservation of the scene for investigators. Supervise Field Operations personnel and ensure they carry out assigned duties.

4. Make immediate inquiry into issues of public safety and scene security, i.e., including number of rounds fired, trajectories of rounds after discharge, and the description, location, or direction of travel of any outstanding suspects. No further questions will be asked of the involved employee(s).

5. Ensure that no items of evidence are handled or moved unless contamination or loss of evidence is imminent. If contamination or loss of evidence is likely, notation (or preferably a photograph) must be made of its location and condition before it is moved. Photographs will only be taken upon the express direction of a member of the shooting team or the Field Supervisor.

6. Assign an officer to accompany any injured persons to the hospital to:

a. Recover and secure any item of physical evidence.

b. Place suspect in custody if appropriate.

c. Record any spontaneous or other unsolicited statements.

d. Record information regarding medical condition and personnel treating the injured person.

7. Notify the Watch Commander.

8. Establish an appropriate command post.

9. Ensure that the weapons used are not handled by anyone at the scene. Safety should be paramount. Weapons in possession of the involved employee(s) should be left with the employee(s) until requested by the OIS Team.

10. Transportation of the involved employee(s) from the scene to the Investigations station shall be arranged using uninvolved, on-duty personnel or peer counselors.

11. Assign an on-duty, non-involved officer to accompany the involved and/or witness employee(s) to the station to ensure that they are not allowed to discuss the incident with other officers or employees. Exceptions are: the interviewing detective and/or supervision from the OIS Team, legal representatives, RPOA representative, Peer Counselor, a member of the clergy, or a psychological services provider.

12. All witnesses should be located and documented, including hostile witnesses.

13. Ensure that each employee present, excluding those directly involved in the incident, peer officers and RPOA representatives, completes a supplemental report before the end of shift. The report should include the employee's name, identification number, unit number, and specific actions at the scene. The completed report is to be submitted directly to the Officer Involved Shooting Team Supervisor.

14. Brief the responding OIS Team.

15. Notify the Press Information Officer if necessary. Provide an initial press release to the news media present if necessary. The information released shall be brief and generalized with absolutely no names released or confirmed. The PIO shall also prepare a written press release covering the same information previously released. Any subsequent media contact shall be the responsibility of the PIO or Investigations Lieutenant or his/her designee.

c. Watch Commander Shall:

1. Notify the General Investigations on-call Sergeant.

2. Notify the employee's Division Commander.

3. Notify the Deputy Chief of Police.

4. Notify on-call Peer Support personnel and RPOA representative, and coordinate the response of the Psychological Services provider with the General Investigations Lieutenant.

5. Ensure the presence of sufficient personnel to control the scene and to allow adequate police services for the remainder of the city.

6. Maintain or cause to be maintained an accurate account of police personnel involved in the incident and any employee(s) called to assist in providing basic police services.

7. Unless directed otherwise, conduct a debriefing of the incident and prepare the after action report as required by Riverside Police Department Manual of Policy and Procedures Section 4.58, Debriefing of Critical Incidents.

8. Ensure that the necessary reports are completed in compliance with Riverside Police Department Manual of Policy and Procedures Section 4.30, Use of Force.

d. General investigations Lieutenant Shall:

1. Notify and assign Crimes Against Persons Sergeant(s) to the investigation.

2. Notify the Investigations Division Commander of the investigation.

3. Notify the City Attorney.

4. Notify the Internal Affairs Lieutenant or appropriate Internal Affairs Sergeant in his/her absence.

5. Respond to the scene to assume command of the investigation and serve as liaison with Area Commanders, Division Commanders, Office of Internal Affairs, City Attorney, and the District Attorney's Office.

6. Provide the Press Information Officer with updated information that can be released to the media. In the absence of the PIO, the Investigations Lieutenant or his/her designee shall be the single release point for all press information and be responsible for preparing and distributing the written press release.

7. Ensure that public information concerning the findings and conclusions of the criminal investigation are not disclosed until the involved employee(s) have been first notified.

8. Schedule a debriefing at the conclusion of the initial investigation to ensure all aspects have been covered and to discuss considerations for improvement.

9. Submit the completed investigation to the District Attorney's Office and attend the DA staffing of the investigation with the OIS Sergeant and the case agent.

10. Ensure that the involved employee(s) meets with the Psychological Services provider.

11. Ensure that the OIS Team, including supervisors, complies with this Policy and that involved officers are afforded their procedural rights under the Public Safety Officers Procedural Bill of Rights and related laws.

e. **Officer Involved Shooting Team Shall**:

1. Conduct a thorough and accurate criminal investigation of the incident, including:

a. Documenting, photographing, and collecting all evidence at the scene. Photographs taken after the arrival of the shooting team will be at their direction only.

b. Interviewing all victims, witnesses, suspects, or other involved persons. All interviews will be tape recorded unless impractical or the circumstances prevent it.

c. Advise the involved employee(s) of their Constitutional rights if there is a possibility of a criminal violation on the part of the employee(s) and when it is anticipated the case will be submitted to the District Attorney's Office for review or filing. Rights advisals are not required for employees who are solely witnesses and criminal prosecution will not occur.

d. If the involved employee(s) is advised of his/her Constitutional rights prior to writing or dictating a report or being questioned, and the employee declines to waive those rights, no further questioning will occur, unless the OIS Team supervisor determines that ordering the employee to answer questions or write/dictate a report is necessary to complete the investigation. Otherwise, the investigation will continue without the employee's statements.

e. Advise the involved or witness employee(s) that they may consult with a department representative or attorney prior to the interview taking place, and this department representative or attorney may be present during the interview.

f. No member of the Officer Involved Shooting Team shall order, or in any way compel an involved employee to make a statement, unless approved by the OIS Team supervisor.

g. The involved employee(s) will be requested by the Investigation Team to voluntarily provide up to two (2) samples of his/her blood or urine when such sample request is permitted under department policy or law. If the request is refused, and no probable cause exists to seize the samples for criminal evidence, and when sample collection is permissible under department policy or law, the involved employee(s) will be administratively ordered to provide a sample by the representative from the Office of Internal Affairs. If so ordered, the employee shall provide a sample in conformance with the Alcohol and Drug Testing Policy and Procedures. The sample may then only be utilized in an administrative action. An employee who refuses to provide a sample when lawfully ordered or otherwise refuses to comply with the Alcohol and Drug Testing Policy and Procedures may be disciplined for misconduct or unsatisfactory job performance, up to and including termination.

h. Interviews or questioning of involved officers shall whenever possible take place in an office or room not regularly used to interview suspects or civilian witnesses. Officers shall not be interviewed in a suspect interview room or a room equipped to remotely monitor (audio and/or video) interviews. Injured officers shall not be interviewed at a hospital or medical care center unless circumstances require an emergency interview before the officer is released.

i. Notify and consult with the Deputy District Attorney concerning legal issues connected to the investigation.

j. Ensure all reports have been written and submitted in a timely manner.

k. Take custody of involved employee's weapon(s) for submission to DOJ and range inspection.

l. Ensure involved employee(s) have replacement weapons.

m. The Officer Involved Shooting Team Sergeant will complete a synopsis of the incident, forwarding a copy to the affected Division Commander and Chief of Police within twenty-four hours of the incident.

n. Ensure the investigation is completed in a timely manner and submitted to the General Investigations Lieutenant for review.

o. Attend the District Attorney's Office staffing of the investigation with the OIS Sergeant and General Investigations Lieutenant. Staffing to be arranged by the Lieutenant.

p. The case agent and investigations supervisor will be responsible for the collection of all police reports and related documents. These documents will remain under their control until the investigation concludes and is submitted to the General Investigations Lieutenant.

q. Prior to the conclusion of the investigation, police reports, photographs, and other related documents will be released only with the approval of the General Investigations Lieutenant.

2. The OIS Sergeant and team members, including their supervisors, shall never threaten, coerce, intimidate, or harass an involved officer or his representative for: 1) exercising their rights under this Policy, the Public Safety Officers Procedural Bill of Rights Act, and any other protections afforded peace officers under the law; or 2) choosing to write or dictate a report rather than being interviewed. Violations of such rights or failing to comply with or afford the officer his rights and elections under this Policy shall be grounds for disciplinary action.

f. Internal Affairs Shall:

1. The Internal Affairs Lieutenant shall be responsible for conducting an independent administrative investigation.

2. Inform the Chief of Police or his/her designee with regard to the information obtained in the course of their investigation.

3. All Internal Affairs Investigations shall be separate from the investigation conducted by the Officer Involved Shooting Team. Information obtained from the Officer Involved Shooting Team will be used to aid the Internal Affairs investigation. No information obtained from a compelled interview will be disclosed to the Officer Involved Shooting Team.

4. Interviews with witnesses, suspect(s) or involved employee(s) will not be conducted until after they have been interviewed by the Officer Involved Shooting Team, or a determination made that the officer will not be interviewed, or the officer declines to make a voluntary statement.

g. Public Information Officer and Press Releases:

1. Refer to the Riverside Police Department Policy and Procedures Manual Section 5.4, News Release and Media Relations and Access Policy.

D. RELIEF FROM DUTY

1. In the best interest of the community, the Department and the involved employee(s), the employee(s) shall, as soon as practical, be relieved from active

duty by the Watch or Division Commander. The involved employee(s) may be placed on paid Administrative Leave status for a minimum of one day, during which time he/she shall be provided full salary and benefits.

2. At the discretion of the Chief of Police or his/her designee, those employees who witnessed the traumatic incident or otherwise assisted the involved employee(s) may also be placed on paid Administrative Leave status.

Section F

RPD Policy & Procedure 4.30 (Rev. 7, 11/1/04)

Use of Force Policy

Effective Date: 8/93
Revision 1 Date: 7/26/96
Revision 2 Date: 5/21/97
Revision 3 Date: 6/1/99
Revision 4 Date: 1/5/00
Revision 5 Date: 5/9/2002
Revision 6 Date: 2/2/04
Revision 7 Date: 11/1/04
Approval:

_____
Russ Leach
Chief of Police

4.30 USE OF FORCE POLICY:

A. PURPOSE:

The Police Department's primary function is to protect the rights of all persons within its jurisdiction to be free from criminal attack, secure in their possessions, and to live in a peaceful atmosphere. In order for the Department to carry out this function, police officers may be required to use physical force. **It is in the public interest that this Department's officers be guided by a Use of Force Policy which is fair, appropriate, and creates public confidence in the law enforcement profession.** The application of physical force, and the type of force employed, depends on the situation as perceived by the officer. The purpose of this policy is to provide guidance as to when physical force may be employed, and the type of physical force that the law will permit. However, policy cannot cover every possible situation presented to officers. Therefore, officers must be reasonable in their actions.

B. PHILOSOPHY:

The use of force by law enforcement personnel is a matter of critical concern both to the public and the law enforcement community. Officers are involved on a daily basis in numerous and varied human encounters, and when warranted to do so, may use force in carrying out their duties.

Officers must have an understanding of, and true appreciation for, the limitations on their authority, particularly with respect to overcoming resistance from those with whom they come in official contact.

This Department recognizes and respects the sanctity of human life and dignity. Vesting officers with authority to use force to protect the public welfare requires a very careful balancing of the rights of all human beings and the interests involved in a particular situation.

C. POLICY:

The Department's Use of Force Policy is as follows:

In a complex urban society, officers are confronted daily with situations where control must be exercised to effect arrests and to protect the public safety. Control may be achieved through verbalization techniques such as advice, warnings, and persuasion, or by the use of physical force. Officers are permitted to use whatever force that is reasonable to protect others or themselves from bodily harm. The Department's Use of Force Policy must comply with applicable California and federal law. California Penal Code Section 835a states that an officer who has reasonable cause to believe that a person to be arrested has committed a public offense may use reasonable force to effect the arrest, prevent escape, or overcome resistance. **A peace officer who makes or attempts to make an arrest need not retreat or desist from his or her efforts by reason of resistance or threatened resistance of the person being arrested; nor shall such officer be deemed an aggressor or lose his or her right to self-**

defense by the use of reasonable force to effect the arrest or to prevent escape or to overcome resistance.

Each situation explicitly requires the use of force to be reasonable and only that force which reasonably appears to be necessary may be used to gain control or resist attack. Mere verbal threats of violence, verbal abuse, or hesitancy by the suspect in following commands do not, in and of themselves, justify the use of physical force **without** additional facts or circumstances which, taken together, pose a threat of harm to the officer or others. Officers must be prudent when applying any of the use of force techniques. **Unreasonable** application of physical force is a violation of California and federal law which may result in criminal prosecution and/or civil liability for the officer. A violation of the Department's use of force policy may also subject the officer to Departmental discipline. Officers should clearly understand that the standard for determining whether or not the force applied was reasonable is that conduct which a reasonable peace officer would exercise based upon the information the officer had when the conduct occurred. Officers must pay careful attention to the facts and circumstances of each particular case, including the severity of the crime at issue, whether the suspect poses an immediate threat to the safety of the officers or others, and whether he/she is actively resisting arrest or attempting to evade arrest by flight.

Furthermore, the Department expects officer(s) to use the most appropriate force option given the circumstances. The decision should take into account the situation facing the officer as well as his/her training and experience.

D. ESCALATION/DE-ESCALATION OF FORCE:

The primary objective of the application of force is to ensure the control of a suspect with such force as is objectively reasonable under the circumstances. Ideally, officers should attempt to control a suspect through advice, warning, or persuasion, but be prepared for the use of physical force. The types of force an officer may utilize will vary, depending on the aggressive behavior or degree of resistance used by a suspect and the tactical practicability of a particular use of force technique. In situations when physical force is applied, an officer must escalate or de-escalate to the amount of force which reasonably appears to be necessary to overcome the suspect's resistance and to gain control.

The concept of escalation and de-escalation of physical force must be put into a proper perspective so that officers can effectively handle all types of resistant suspects. There are three key points regarding the concept of escalation and de-escalation of physical force.

1. Physical force is used to control a suspect;

2. Whenever force is used, the officer's defensive reactions must be in response to the suspect's actions;

NOTE: This does not mean that an officer has to wait until a suspect attacks. Based on the circumstances, an officer may be justified in using reasonable force to prevent an attack.

3. An officer may use only the amount of force which reasonably appears to be necessary to control the suspect. **The Fourth Amendment of the United States Constitution requires that police officers use only such force as is objectively reasonable under the circumstances. Officers need not avail themselves of the least intrusive means of responding to an exigent situation; they need only act within that range of conduct identified as reasonable.**

E. USE OF FORCE TECHNIQUES:

The ability to successfully execute the proper control technique when attempting to control a suspect is essential for officer safety. The following use of force techniques are described in general indicating the six (6) approved levels of force to control suspects under increasing resistant actions. Each technique is fully described in a separate training bulletin.

Level 1: Presence:

California Penal Code Section 834a states that if a person has knowledge, or by the exercise of reasonable care, should have knowledge that they are being arrested by a peace officer, it is the duty of such person to refrain from using force or any weapon to resist such arrest. In addition, Section 148 makes it a crime to willfully resist, delay, or obstruct a peace officer in the performance of their duties.

Consequently, the mere presence of a uniformed or other appropriately identified officer, coupled with good verbal communication, will generally gain the willful submission necessary to avoid a further escalation of force.

Level 2: Verbalization:

Verbalization, "talking a suspect to jail," is the most commonly used technique to effect the arrest of a suspect. Verbalization may be advising, warning, or persuading. Actual field experience demonstrates that certain techniques of verbalization, coupled with an advantageous position, and a mature, professional attitude can prevent further escalation of a situation. These techniques include:

- explaining any actions about to be taken;
- allowing a suspect to save face in front of his/her peers;
- recognizing a suspect's remarks are not a personal attack against the officer; and
- allowing a suspect to retain dignity whenever possible.

Officers should attempt to de-escalate confrontations by utilizing verbalization techniques prior to, during, and after any use of physical force.

Level 3: Empty Hand Control:

Empty hand control is generally used to counter a weaponless suspect's passive or active resistance to an officer's verbal commands. Firm grip and control techniques were designed to safely initiate physical contact and gain control of an uncooperative suspect. When verbalization proves ineffective, a firm grip may be all that is necessary to overcome resistance. If the use of a firm grip is unsuccessful, an officer may decide to utilize a control technique as a restraint or come-a-long hold.

When the suspect's physical actions become actively resistant to a point which prevents the officer from gaining control or effecting an arrest, more aggressive countermeasures may become necessary. At this level of force, these techniques consist of:

- avoidance,
- blocks,

- empty hand control holds such as: wrist lock, twist lock, finger flex, arm bar and escort position,

- pressure points,

- controlled take downs such as: leg sweep, hip throw, front leg wrap, front and rear take downs, figure four and wrist turn-out,

- and ground tactics (using the officer's body weight and/or any combination of empty hand control holds to control the subject),

and are designed to create a temporary dysfunction of the suspect and allow the officer the opportunity to gain the advantage.

Level 4: <u>Chemical Irritant/Electrical Control Devices/Team Take Down/ Carotid Restraint</u>:

Officers should remain mindful that the use of force options described in Level 4, below, are described in order of preference where time and circumstances allow the officer to consider various options. This is based on the affected officer(s) having the time and ability to weigh the circumstances and avoid direct physical engagement (team take downs and carotid restraints.) Whenever possible and where practical, officers are encouraged to employ those techniques that do not require them to directly physically engage the subject so as to minimize risk to both the officer and the subject.

Chemical irritant may be used to overcome and control a suspect's aggressive actions when verbalization is unsuccessful. Verbal threats of violence by a suspect do not alone justify the use of chemical irritants. Chemical irritant may be used if the officer reasonably believes that it would be unsafe to approach and control the suspect. When it is tactically unwise to entangle with the suspect, and it is desirous to maintain a distance, chemical irritant may prove to be useful.

Currently, the only Electrical Control Device which is departmentally approved is the Taser. The Taser is a non-lethal control device which may be used to control violent or potentially violent suspects when an officer reasonably believes the following conditions exist:

- Deadly force does not appear to be justifiable and/or necessary, and

- There is a reasonable expectation that it will be unsafe for officers to approach and place themselves within range of the suspect.

The team takedown is another intermediate force tool utilized to reduce risk of injury to officers and arrestees while achieving maximum control. Two or three man takedown teams under the direction of one leader move as a unit and make contact with the arrestee simultaneously. Contact should not be made until all other lesser levels of control have been exhausted and sufficient officers are present to minimize risk of injury to the officers and arrestee.

<u>The Carotid Restraint Control Hold offers peace officers a method for controlling violently resisting suspects when higher levels of force may not be justified.</u>

<u>The Carotid Restraint Control Hold should not be confused with the bar-arm choke hold or any other form of choke hold where pressure is applied to restrict the flow of air into the body by compression of the airway at the front of the throat.</u>

<u>Choke holds are considered ineffective and create the potential for a suspect to panic and react with greater resistence when pressure is applied in this manner by a peace officer. Also, there</u>

is greater risk of serious injury to the suspect. Choke holds shall not be used by any member of this department.

The carotid restraint may be utilized to control a violently resisting suspect, and allows for control against varying degrees of resistance. Once the technique is applied, the officer has the capability of restraining the subject by using only that degree of force **which is reasonable** to control the suspect. Caution should be exercised to prevent a disadvantageous position which might expose the officer's baton and/or firearm to the suspect. Any time a carotid restraint is applied, whether or not the suspect is rendered unconscious, an O.K. to Book shall be obtained as soon as practical and prior to booking.

Level 5: Intermediate Weapons:

Intermediate weapons are utilized to immediately impede the threatening actions of an **aggressive** suspect. They consist of:

- personal body weapons such as palm heel strike, common fist, bottom fist strike, elbow strike, knee strike, front kick, side kick, roundhouse kick,
- impact weapons such as PR-24, expandable baton, mid-range baton, short billy, riot baton and flashlight,
- less lethal munitions
- improvised weapons
- and other self-defense techniques designed to protect the officer and/or innocent citizens from bodily harm.

These weapons are generally used when lethal force is not justified and lesser levels of force have been, or will likely be, ineffective in the situation.

The baton may be appropriately displayed as a show of force if verbalization techniques appear to be ineffective when used on an aggressive suspect. A decision to draw or exhibit a baton must be based on the tactical situation. For example, the drawing of a baton may be reasonable in a situation of an officer entering a bar or other location of prior disturbance calls, or exhibiting the baton in a situation where there is an escalating risk to the officer's safety. If the situation continues to escalate, the baton can provide a viable method of controlling the suspect. The baton was designed as an impact weapon and should be used for striking movements and blocks. **Caution shall be used to avoid striking those areas such as the head, throat, neck, spine or groin which may cause serious injury to the suspect.**

In situations when use of the baton is applicable, the front, side, rear, and round house kicks can be applied as alternate use of force techniques when attempting control of **an aggressive** suspect.

Another alternative to the use of the baton as an impact weapon is the flashlight. While certainly not preferred over the baton in most situations, the flashlight is usually readily available, especially at night, and may be appropriate at times when the baton is not accessible or too cumbersome. Nevertheless, should this choice be made within an intermediate use of force situation, caution shall be used to avoid striking those areas such as the **head, throat, neck**, spine or groin which may cause serious injury to the suspect.

Generally, the deployment of less lethal munitions should have the goal to restore order and/or reduce the risk of more serious injury. Incidents where deployment may be an option include, but are not limited to, the following:

- **!** Restoration or maintenance of order during a jail or civil disturbance.

- **!** Safely controlling violent persons.

- **!** Subduing vicious animals.

- **!** Situations wherein the authorizing person deems their use necessary to safely resolve the incident.

Depending on circumstances, less lethal weapons can be used to safely control violent or potentially violent suspects when the officer reasonably believes the following conditions exist:

- **!** Attempts to control the incident with lesser force options have been, or will likely be ineffective in the situation, and

- **!** There is a reasonable expectation that it would be tactically unwise for officers to approach or place themselves in range of the suspect.

Level 6: <u>Lethal Force</u>:

If the situation becomes life threatening, the officer would be compelled to escalate to the ultimate level of force. The use of lethal force is a last resort dictated by the actions of a suspect **where the officer has reasonable cause to believe that the suspect poses a significant threat of death or serious physical injury to the officer or others.** The weapon of choice in these situations is generally one of the various departmentally approved firearms. However, this does not preclude officers from using **any reasonable means** to protect themselves or other persons from this immediate and significant threat of **death or serious physical injury**. Furthermore, where the officer has reasonable cause to believe that the suspect poses a threat of serious physical harm, either to the officer or to others, it is reasonable to prevent escape by using lethal force. Thus, if the suspect threatens the officer with a weapon or there is reasonable cause to believe that the suspect has committed a crime involving the infliction or threatened infliction of serious physical harm, lethal force may be used if necessary to prevent escape, and if, where feasible, some warning has been given.
The use of less lethal munitions is neither encouraged nor discouraged in deadly force situations. Officers must evaluate each situation by the facts and circumstances confronting them. Less lethal force should not be considered a substitute for deadly force in lethal situations.

<u>USE OF FIREARMS</u>

Firearms shall be used only when an officer believes his/her life or the life of another is in imminent danger, or in danger of great bodily harm, or when all other reasonable means of apprehension have failed to prevent the escape of a felony suspect whom the officer has reason to believe presents a serious danger to others where the felonious conduct includes the use or threatened use of deadly force.

1. **<u>Drawing Firearm</u>:** Officers shall only draw their sidearm or shotgun when there is likelihood of danger to the officer or other persons.

2. **<u>Discharge of Firearm</u>:** An officer of this Department shall not discharge a firearm or use any other type of deadly force in the performance of his/her duties, except under the following circumstances:

    a. In the necessary defense of himself/herself or any other person who is in imminent danger of death or great bodily harm.

b. Where the officer has reasonable cause to believe that the suspect poses a threat of serious physical harm, either to the officer or to others, it is reasonable to prevent escape by using lethal force. Thus, if the suspect threatens the officer with a weapon or there is reasonable cause to believe that the suspect has committed a crime involving the infliction or threatened infliction of serious physical harm, lethal force may be used if necessary to prevent escape, and if, where feasible, some warning has been given.

c. To kill a dangerous animal that is attacking the officer or another person or persons, or which if allowed to escape, presents a danger to the public.

d. When humanity requires the destruction of an animal to save it from further suffering, and other disposition is not possible.

e. For target practice at an approved range or in unrestricted areas.

f. To give an alarm or call assistance for an important purpose when no other means are available.

3. Display and Discharge of Firearms Prohibited:

a. Officers shall not display their firearms or draw them in any public place except for inspection or use, nor shall officers handle their weapons in a careless manner which could result in an accidental discharge of the firearm.

b. A member of the Department shall not discharge a firearm as a warning shot.

c. Generally, a member of the department should not discharge a firearm at or from a moving vehicle unless in the necessary defense of himself/herself or any other person who is in imminent danger of death or great bodily harm. If an officer has reasonable cause to believe the suspect poses a threat of serious physical harm, either to the officer or to others, it is reasonable to prevent escape by using lethal force. If the suspect threatens the officer with a weapon or there is reasonable cause to believe that the suspect has committed a serious crime involving the infliction or threatened infliction of serious physical harm, lethal force may be used if necessary to prevent escape, and if, where feasible, some warning has been given.

4. Juvenile Felony Suspects: An officer generally should not shoot at a fleeing felon whom he has reasonable grounds to believe is a juvenile.

This section does not limit an officer's right of self-defense or his defense of others whose lives he reasonably believes are in imminent peril, except as provided in paragraph 2 a or b above.

5. Acting as a Peace Officer While Off Duty or in Other Jurisdictions: Officers are reminded that as employees of this Department, the policies set forth here are in force whether or not officers are on duty in this City or on special or casual assignment in another legal jurisdiction or when off duty, but acting as a police officer.

F. OVERVIEW OF TECHNIQUES:

When a suspect physically attacks an officer, the officer must act in self defense using one or more of the previously mentioned control techniques within approved use of force standards. Consider a situation wherein a suspect assumes a clenched fists fighting stance some distance

from the officer. The officer counters by drawing his baton as a show of force. At this time, the suspect drops his hands, resumes a normal posture, and submits to arrest. Although an officer must proceed with extreme caution, maintaining an advantageous position and ensuring that no additional threat exists, they should de-escalate all the way back to verbalization. Therefore, since the suspect is now cooperating, the officer reacts accordingly by advising, warning, and persuading.

The increased amount of force used by a suspect requires an officer to escalate the degree of force needed to maintain control of the situation. **Note, however, that an officer is permitted by law to not only use the level of force used by the suspect but to use reasonable force to overcome the resistance.** As a suspect's use of force declines, the officer's reaction must also decline. The reasonable amount of force needed to control a suspect may vary from one officer to another.

G. SITUATION-BASED USE OF FORCE CONTINUUM:

The Department recognizes that building flexibility into an officer's determination of the appropriate use of force is advisable and acceptable - if not essential - given that the standard for evaluating an officer's use of force claims is reasonableness under the facts and circumstances known to the officer at the time. This is an affirmative stance by the Department designed to provide additional confidence and needed support to officers in making their decisions regarding use of force in the field.

A number of factors are taken into consideration when an officer selects force options, and when evaluating whether an officer has used reasonable force. The Department recognizes that officers are expected to make split-second decisions and that the amount of time available to evaluate and respond to a situation may impact the officer's decisions. By establishing a policy that includes a use of force continuum the Department hopes to provide additional guidance to officers in making those split-second decision. Examples of facts which may affect an officer's force option selection include, but are not limited to:

- Officer/subject factors (age, size, relative strength, skill level, injury/exhaustion, number of officers versus number of subjects)
- Influence of drugs or alcohol
- Proximity to weapons
- Availability of other options
- Seriousness of the offense in question
- Other exigent circumstances

Finally, it is important to note that an officer need not attempt to gain control over an individual by use of the lowest level of force on the continuum when reason dictates and the officer can articulate that a higher level of force is reasonable. Likewise, the skipping of steps may be appropriate given the resistance encountered.

Simply put, this continuum should be viewed as an elevator, not a ladder - an officer may go directly to any level of the continuum provided that the force selected is reasonable.

H. MENTAL ATTITUDE:

Officers must realize that emotional involvement is also a factor in the escalation or de-escalation of force. In order to react to every situation with the **reasonable** amount of force, an

officer must be in good physical condition, possess self defense and verbalization skills, and have a mature, professional attitude. Additionally, officers must have self confidence in their training and ability to control the situation.

I. REPORTABLE USE OF FORCE INCIDENTS:

1. A reportable use of force incident is defined as an incident in which any on-duty Department employee, or off duty employee whose occupation as a Department employee is a factor, uses a less lethal control device or any physical force to:

- **!** Compel a person to comply with the employee's directions; or
- **!** Overcome resistance by a suspect during an arrest or a detention; or
- **!** Defend themselves or any person from an aggressive action by a suspect.

Reportable Use of Force does not include:

- **!** The mere presence and identification of police officer status; or
- **!** The use of a firm grip hold which does not result in an injury, complaint of injury, or complaint of pain; or
- **!** That force necessary to overcome passive resistance due to physical disability or intoxication which does not result in injury, complaint of injury, or complaint of pain; or
- **!** Control holds utilized in conjunction with handcuffing and searching techniques which do not result in injury, complaint of injury, or complaint of pain, and did not require any other reportable use of force; or
- **!** Injuries sustained by a subject as a sole consequence of his/her actions such as, but not limited to, falling while fleeing from officer(s); or
- **!** Shooting of an animal as otherwise permitted by the Riverside Police Department Policy and Procedures Manual; or
- **!** Use of Departmentally approved diversion or entry devices, deployed to gain entry into a structure.

2. Employee Responsibilities:

Any member who becomes involved in a reportable use of force incident or discharges a firearm, Taser, or chemical irritant control device for any reason, other than an approved training exercise, shall:

- **a.** Summon medical aid, as needed;
- **b.** Immediately notify a supervisor that they have been involved in a use of force incident;
- **c.** If the force used falls within Level 6 and/or results in death or serious likelihood of death, the employee shall adhere to the provisions of Section 4.8 of the Riverside Police Department Policy and Procedures Manual.
- **d.** Report the full details of the use of force incident in the related Department arrest or crime report;

e. Use a Department "memorandum" form to report the full details of the use of force incident when a crime or arrest report is not required;

f. When off duty, notify the Watch Commander immediately.

3. Supervisor Responsibilities:

The notified or designated supervisor shall:

a. Confirm medical aid has been summoned, as needed.

b. Respond to the scene, independently investigate the use of force and make a report of the incident.

c. If the force used falls within Level 6 and/or results in death or serious likelihood of death, the supervisor shall notify the Watch Commander immediately and adhere to the provisions of Section 4.8 of the Riverside Police Department Policy and Procedures Manual. The Watch Commander shall make additional notifications in accordance with Section 4.8.

d. Photographs shall be taken in all reportable use of force incidents that result in an injury, or a complaint of injury. If practicable, photographs of the subject and the injury should be taken after the injury or wound is cleansed by medical personnel and before medical treatment, if any is necessary. Care should be taken to protect the subject's personal privacy interests. Any possible concerns should be discussed with a field supervisor prior to taking the photographs.

e. The investigating supervisor shall report the incident as follows:

1. A “Supervisor Use of Force Report” form shall be completed within twenty four (24) hours and forwarded to the Office of Internal Affairs, when the force used was within Level 3, 4, or 5 of this policy.

   - **!** The “Supervisor Use of Force Report” form shall be sufficient documentation of a Use of Force incident when the force used did not result in an injury or complaint of injury. A simple complaint of pain, without evidence of underlying injury, may properly be documented on the “Supervisor Use of Force Report” form.

   - **!** The supervisor shall complete a separate “Supervisor Use of Force Report” form for each subject upon whom force was used. Each report shall include the force levels used by each officer involved in the incident.

2. A “Use of Force Investigation Memorandum” shall be completed within ten (10) days to supplement the “Supervisor Use of Force Report” form and forwarded to the Office of Internal Affairs when:

   - **!** The force used was the direct cause of injury or complaint of injury, beyond a simple complaint of pain.

   - **!** The force used involved the application of a carotid restraint, chemical irritant, electrical control device or similar control technique/device.

- **!** The force used falls within Level 5.

f. Internal Affairs shall have the responsibility to prepare all administrative reports of incidents wherein the force used falls within Level 6 and/or death or serious likelihood of death results. Field supervisors shall not prepare any administrative reports of such incidents unless directed by Internal Affairs.

g. Use of force reports will be designated for inclusion into the Early Warning System (EWS) in accordance with the provisions of section 4.55 of the Riverside Police Department Policy and Procedures Manual.

h. Alternative methods of reporting uses of force may be utilized during incidents of civil unrest. The incident commander shall make this determination and specify the reporting method to be utilized.

J. CONCLUSION:

The decision to use physical force places a tremendous responsibility on the officer. There is no one capable of advising an officer on how to react in every situation that may occur. Ideally, all situations would require only verbalization. While the control of a suspect through advice, warning, or persuasion is preferable, the use of physical force to control a suspect is sometimes unavoidable. Officers must be able to escalate or de-escalate the amount of force which reasonably appears to be necessary to control a situation as the suspect's resistance increases or decreases. Force should only be used as a **reasonable** means to secure control of a suspect.

Section G

RPD Policy & Procedure
4.31F (Rev. 1, 1/8/96)

Searching, Handcuffing and Prisoner Transportation:

Total Appendage Restraint Methods and Equipment

F. TOTAL APPENDAGE RESTRAINT METHODS AND EQUIPMENT:

1. PURPOSE:

The purpose of this policy is to provide police officers with guidelines in the use of total appendage restraining methods. Total appendage restraining methods are designed to be used in various situations that require the restraint of a violent or uncooperative suspect, preventing or limiting injury to officers and/or the suspect and/or damage to property.

2. DEFINITIONS:

a. **HOBBLE** - A restraining device used primarily to secure the legs and ankles of a subject.

b. **"RIPP" HOBBLE** - A restraining device made of one-inch wide polypropylene webbed belting with a tested strength of 700 pounds, equipped with a one-inch wide steel, alligator-jawed, friction-locking clip, and bronze swivel.

c. **"TARP" - Total Appendage Restraint Position -** The method employed by officers to restrain handcuffed suspects in a seated position, using RIPP or similar type equipment.

3. POLICY:

a. Officers shall only use department approved restraining methods, when such use appears warranted under the circumstances. Currently, only restraining hobbles that are of the "RIPP" design or similar are approved. This does not preclude officers from using other restraining devices if the" RIPP" or similar type hobbles are not immediately available. However, the use of other devices or systems is discouraged, unless absolutely necessary.

b. Officers shall not restrain or transport suspects in a "Hog-Tied" position. For the purpose of this policy, Hog-Tied refers to the method of restraining the hands and feet together behind the suspects back while the suspect is lying in a face down position. The T.A.R.P. is not a hog-tie position. If it is necessary to control and restrain a suspect by the use of two or more officers transferring their body weight onto the suspect while the suspect is positioned face down on the ground, officers shall immediately, upon restraining the suspect, reposition the suspect into a sitting or face-up position. Officers shall continually monitor the suspect for signs of Cocaine Psychosis (Cocaine Overdose) or Excited Delirium ("Other" Drugs Overdose). If in doubt, officers should arrange to have the suspect transported to the hospital prior to booking. (Refer to training bulletin 96-02.)

4. APPROVED USES OF THE RIPP HOBBLE:

a. To secure the feet and legs of a suspect to control running, kicking, and fighting.

b. To prevent a suspect from standing.

c. To secure a violent and/or uncooperative suspect in a total appendage restraint (T.A.R.P.) position.

d. To secure a suspect's feet in the police unit to prevent self injury, injury to

officers, and/or damage to police units.

e. As approved by a supervisory officer.

5. PROCEDURE:

When the hobble is used on a suspect who meets the listed criteria for use, the following procedures will be employed as they apply:

a. When transporting a suspect in the rear of the unit with the suspect's ankles secured with the hobble, officers will attempt to seat suspect in an upright position in the passenger side, back seat. After seat belting the suspect, the loose end of the hobble will be secured to the front seat area in a manner which prevents the suspect from kicking. In no circumstances will the loose end of the hobble be left outside of the back or front door.

b. A suspect who is continually combative and/or uncooperative may be restrained in the T.A.R.P. position. **A suspect restrained in this position shall not be transported face down on their chest.** The suspect can be placed on his/her side and his/her feet secured as above. When a suspect is transported in this position, the transporting unit will consist of two officers. The second officer will continuously monitor the suspect's condition. Medical attention shall be sought if the suspect appears to be having difficulties in breathing, lapse in consciousness, or other medical problems.

c. A suspect may be kept in the T.A.R.P. position for as long as it appears necessary under the circumstances of each particular situation. The suspect should be released from the feet to handcuff (T.A.R.P.) position when it reasonably appears that the suspect is cooperative and non-combative.

d. The use of the "RIPP" or other approved hobble devices shall be fully documented in the arrest reports. This documentation shall include the observable symptoms and specific actions of the suspect which required the use of a restraint device.

e. Officers who use the hobble restraint on a suspect, shall immediately notify a supervisory officer when the hobble restraint device is used in incidents as outlined in the Use of Force Guidelines, Section 4.30 (I).