**The Bill Blackwood**
**Law Enforcement Management Institute of Texas**

---

# Acceptance and Recognition of Excited Delirium by Law Enforcement Agencies

---

**A Leadership White Paper**
**Submitted in Partial Fulfillment**
**Required for Graduation from the**
**Leadership Command College**

---

**By**
**Jeffery R. Daugherty**

**Luling Police Department**
**Luling, Texas**
**July 2012**

# ABSTRACT

Arguably the second most traumatic event that a peace officer is faced with is the death of a person in their custody, the first being the death of a fellow officer. An in-custody death is not only emotionally traumatic for the family of the victim, the officer(s) involved, and their families, it may also be traumatic for the agency and the community. These deaths quite often trigger internal and external reviews of the agency, its training and policies. It is also difficult for one to imagine, in this litigious society, an in-custody death not resulting in a lawsuit. An in-custody death can create extreme financial burdens on the officer(s), agencies, and their governing bodies. In an effort to reduce in-custody deaths and the resulting emotional, financial, departmental, and community trauma that accompanies them, it is incumbent upon law enforcement agencies to accept and recognize that the condition known as excited delirium exists. Information for this leadership white paper was obtained from books, on-line journals and articles, a television program, internet sites, and a personal interview.

In many ways, the cost of an in-custody death cannot be calculated. The cost of human life, the psychological trauma suffered by the officer(s) involved, the loss of trust and cooperation in the community, and even trust within the police agency are all real costs that cannot be calculated in dollars and cents. Some of the costs can be thought of in dollars and cents, and these costs can be extreme. By reaching beyond that which is widely accepted and training officers to recognize the symptoms of excited delirium and obtaining immediate medical aid for that person, the agency administrator may reduce the number of in-custody deaths and, in doing so, many reduce trauma, both

physical and emotional to the individual, their family, the officer(s) involved, and the community as well as save the agency from incurring staggering financial liabilities.

# TABLE OF CONTENTS

Page

# INTRODUCTION

Sergeant R. Gutierrez and the officers on his shift were dispatched to a quiet neighborhood, where a caller reported a man running down the street, knocking on doors and yelling. While the officers were making their way to the call, additional callers informed communications that the man had no shirt on and was yelling that “they” were trying to kill him. Two blocks away, the alarm at a closed convenience store activated. A witness saw a man with no shirt on throwing things into and shattering the store’s windows. When the officers arrived in the area, they found a man with no shirt on running down the street. He was initially unresponsive to the officers or their commands. He appeared to be incoherent and was yelling that “they” were trying to kill him. The officers were able to close in on him and wrestle him to the ground. He continued to yell and did not appear to feel pain. This was evident due to his lack of response to arm or wrist locks and to pressure points. By sheer force of numbers, the officers were able to handcuff the man and place him in a patrol car. This man was not placed in a chokehold, pepper-sprayed, nor was a Taser conducted energy weapon applied to the man (R. Gutierrez, personal communication, April 10, 2002).

When officers attempted to talk to the man, his conversation was rambling, disjointed, and paranoid. The only information gained from him was that he had been using a large amount of cocaine. The man was transported to the county jail and eventually bonded out the next day without further incident (R. Gutierrez, personal communication, April 10, 2002). There was, however, the very distinct possibility that the situation could have taken a turn for the worse. It could have been worse to the

point of the man dying for no apparent reason. Unknown to the officers at the time was that this man may very well have been suffering from Excited Delirium (EXD).

In another case, which was recorded by the television show COPS, an officer responded to a scene and encountered with a subject apparently suffering from EXD (Langley, 2005). When the video clip starts, the time across the top of the video reads 04.45, or four hours and forty-five minutes. As the officer approached the residence, he observed a man with no shirt on running along the roadway. The officer approached the man and ordered him to the ground. The man initially complied with the officers, and he laid on the ground. He spoke about someone being after him. He was sweating profusely and could not keep still; his arms and legs were in constant motion. The man continued his ramblings, continued being unable to stay on the ground, and tried to run into traffic. The officer attempted to restrain the man and eventually forced him to the pavement. The officer did not place his arm around the man's neck but kept the man's throat in the crook of his elbow so as not to restrict his airway. The man began to growl and makes guttural noises and still did not comply with the officer's commands. A second officer arrived and together they placed handcuffs on the man. As soon as the man was cuffed, one of the officers called via radio for the "medics," as it was obvious that the man needed medical attention (Langley, 2005).

By this time, there were numerous officers on the scene, including a patrol supervisor. The man was removed from the street, placed on his side on the sidewalk, and medical services are summoned. The man continued to writhe and move around as much as he could and his incoherent rant continued. At 04.51, four hours and 51 minutes, the man suddenly quieted. The man was released from the leg restraint that

had been placed on him and sat up. At 04.53, the man stopped breathing; he was un-cuffed and CPR was initiated, to no avail. Emergency medical services arrived, and the man was taken to the hospital, but he was dead. In less than ten minutes since first contact with the police, the man died. This man was not struck with an impact weapon, he was not pepper-sprayed, he was not choked, and a Taser was not applied to him (Langley, 2005).

These two episodes are not all that different than ones officers have faced numerous times before. The fact that a person suffering from an EXD event did not die has for all intents and purposes been left to luck. The difference between life and death outcomes for an individual suffering from an EXD event need not rest with luck; it should depend on the recognition of EXD by the officer and the prompt summoning of medical aid. The responding medical aid should then be able to render the proper immediate care to increase the EXD sufferer's chance of survival.

References to excited delirium that caused extreme agitation and aggressiveness can be found in medical literature as far back as the 1840s (Bell, 1849). The use of the term "excited delirium" begins to appear with some regularity in the late 1970s and early 1980s. This modern use of excited delirium refers to a specific set of symptoms that can lead to the death of a person experiencing the excited delirium event (Paquette, 2003). The symptoms include, but are not limited to, paranoia, delusions, extreme agitation and aggressiveness, hyperthermia, profuse sweating, and a lack of pain response (Excited Delirium, n.d.). A person experiencing an EXD event can suddenly develop respiratory arrest, be non-responsive to attempts to resuscitate them, and eventually die. This appears to be especially true after physical exertion, such as

struggling with law enforcement officers attempting to take the subject into custody. It does not appear to matter whether the struggle includes strikes with an impact weapon, the use of pepper spray, or the deployment of a Taser (Excited Delirium, n.d.).

In the past, law enforcement officers who have encountered these subjects treated them primarily as a law enforcement problem, and then secondarily sought out medical treatment for the subject. This approach has tragically led to the deaths of many of these persons. These deaths have, over the years, been blamed on choke holds, positional asphyxiation, pepper spray, Tasers, and the general application of excessive force by the officers (Petty, 2004).

As EXD has become a more studied and understood physiological event, a specific set of medical protocols have been developed in an attempt to reduce deaths from an EXD event. When these protocols are applied in a timely manner, the survivability of the subject greatly increases (Klienman, 2009). The law enforcement officer who encounters a person experiencing an EXD event can initiate a response from medical personnel who, when applying the proper medical protocols, can greatly increase the chances that that person will survive the EXD event. This is obviously an optimal outcome for the person experiencing the event, but it also has very positive ramifications for the officer, the law enforcement agency, the local government, and the community at large.

It is an obvious conclusion that the non-death of a person who has had contact with law enforcement is always preferred to that of their death. The individual benefits and his/her family benefits by their continued presence. The officer benefits in several ways: he/she does not have to deal with the psychological fall out of an in-custody

death, he/she also avoids internal and external investigations, and he/she is not subject to being ostracized by the department or community. These investigations could lead to the loss of the officer's career and freedom. The officer may also suffer financial damage. The law enforcement agency and its controlling governmental body benefit in that they do not incur any financial loss due to lawsuits and it does not erode the public trust in these entities in the manner that an in-custody death would.

The University of Miami Medical School has conducted ground breaking research into EXD and concluded that it is a physiological event and identified EXD's symptoms (Excited Delirium, n.d.). Drawing from this and other studies, emergency care protocols for the treatment of EXD have been developed (Klienman, 2009). The American College of Emergency Physicians in 2009 recognized ED and its symptoms. They have also put for a set of protocols for emergency room personnel to adhere to when treating a person experiencing and EXD event (Sztajnkrycer & Baez, 2009). Many pathologists, including the renowned Dr. Vincent Di Maio, recognize EXD as a cause of death (Di Maio & Di Maio, 2005). It would appear that law enforcement agencies should acknowledge and recognize excited delirium in order to reduce the number of in-custody deaths. These agencies, in conjunction with local emergency medical services and hospitals, should create partnerships in education and enactment of protocols in an attempt to mitigate the effects of an EXD event on the individual, the officer(s), agency, governmental body, and the community at large.

# POSITION

The vast majority of law enforcement agencies in this country have some type of mission statement or a statement of agency values. In almost all of these, there will be some verbiage that makes it clear that the law enforcement agency and their officers place a high value on life and are here to help “preserve life.” If this is truly a tenant of law enforcement, then it is incumbent upon these agencies to do all they can to protect life, even if the law enforcement agencies have to push the boundaries beyond the accepted norms that are currently held about EXD. There is, at present, a mechanism available to law enforcement agencies that can and will reduce the number of in-custody deaths. The agencies must accept that the condition known as Excited Delirium exists. They must then train their personnel to recognize the symptoms of EXD and to take the appropriate action(s).

Recently, 44 persons in the Miami-Dade area were identified as suffering an EXD event. All 44 of these people were treated under established EXD emergency treatment protocols, and survived (Klienman, 2009). At present, data is not available on how many persons, during that same time period, were identified as having suffered an EXD event and lived while receiving no treatment or how many received no treatment and died. However, the most important thing to remember is that 44 people survived the EXD event that could have otherwise died. While one cannot state that all of these persons would have died without the emergency protocols, it would appear that the potential for the preservation of life far outweighs any other consideration when EXD may be involved.

When looking beyond the incalculable cost of a human life, a realization is reached that there are other costs involved. A secondary cost that can be incurred by the law enforcement agency in an EXD event is that of the injury to the officer(s) involved. While this cost cannot compare to the loss of a life, it is still a cost that must be considered by every agency. It is very often the fact that a person in the midst of an EXD event must first be restrained for his/her own safety as well as the safety of those that are attempting to help that person. The majority of the time, the restraint of that person falls to the law enforcement officer.

When encountered by law enforcement, the person may be displaying symptoms of extreme agitation, aggressiveness, and paranoia. The person may also be delusional, incoherent, and demonstrate a lack of a pain response (Mash, Pablo, & Basile, n.d.). The agitation, aggressiveness, and paranoia generally indicate that the person will not comply with the requests of the officer nor will they positively respond to the commands of that officer. The person's lack of a pain response means that the officer will not have much success in the use of pressure points or applying a wrist or arm bar. The officer may also meet with limited success with an impact weapon, pepper spray and even a Taser ("Neuromuscular Incapacitation," 2007). When these methods render a marginal or negative result, the officers must then rely on one of the oldest tools available to the officers, the "pig pile." The officers must, in effect, overwhelm the person with sheer mass. The major problem with this sheer mass method is the potential for injury to the officers.

Generally speaking, while officers take care not to injure the person being restrained, a paranoid, delusional, and combative person suffers no such constraints.

This person will strike out with fist, foot and head; they will also bite and perform any other act they can as a means of resistance. These acts generally indicate the potential for some level of injury to the officers. In some instances, while employing sheer mass, the officers may also be injured by their fellow officers. Although the officers are ultimately attempting to help this person, nonetheless, the injury inflicted on the officer will still result in the officer(s) seeking medical aid. This may be the emergency medical services, EMS, on the scene; it may result in a trip to the Emergency Room (ER) or even admittance to the hospital. There also exists the potential for psychological trauma to the officer(s) who must restrain that person.

The medical treatment sought by the officer(s) results in a financial obligation placed on the employing agency. It does not matter whether the officer is treated on an outpatient basis at the ER, which may result in a hefty bill or a stay in the hospital, which will result in an even greater cost to the agency, the agency will have to pay the outstanding medical costs as well as any workman's compensation that is incurred if the officer cannot immediately return to work. There is also the cost of the loss of that officer's service during the period of medical care. In many agencies, there is also the cost of shift coverage by another officer(s) until the injured officer returns to work. All in all, the direct and indirect costs of an officer injury related to the restraint of a person experiencing an EXD event may be quite substantial.

A physically healed officer may return to work in short order, but one that sustains a psychological trauma may require more treatment, may return as a less effective officer, and may require more recovery time, if they return at all. The mental breakdown that an officer may suffer need not hinge on a single event; it may be the

culmination of a series of stresses during a career (Miller, 2006). The cost of counseling through a psychologist or psychiatrist may be greater as more visits may be required when compared to most minor on the job injuries. The cost of covering missed shifts then increases as does workman's compensation payments. The financial liability of an agency may be greatly increased when the trauma is psychological and not physical. The cost of recruiting and training a new officer may also be incurred if the affected officer does not return to work.

If the same officer(s) mentioned above were to have immediately recognized the EXD event for the medical problem that it is, this scenario could have a very different outcome. By summoning EMS to the scene as soon as possible they can then administer Versed, via a nasal mist. Versed is midazolam, a strong sedative, generally used prior to surgery. This sedative will reduce the time the officer(s) have to spend physically restraining the person, and this reduces the probability of injury to the officer (Sztajnkrycer & Baez, 2009). The law enforcement officer encountering a person suffering from an EXD event should then treat the situation as a medical problem and obtain the proper medical treatment for that person as soon as is possible. If a crime has been committed by the person suffering from EXD, charges can be pursued after the officer is assured that the person will not die as a result of the EXD event. The preservation of that life must be the paramount concern.

The Miami-Dade model provides law enforcement with a tool to greatly reduce potential excessive use of force complaints, excessive use of force lawsuits, internal investigations, investigations from the media, the local District Attorney, and the Federal Department of Justice. Each one of these events mentioned represents a financial

liability to the agency and local government. In some cases, the financial liability is very large. The cost of a single large settlement can, in effect, cripple smaller jurisdictions. In addition, each one of these events costs the agency and the local government in the form of trust in the community. A dollar value cannot be placed on that loss of that trust.

The agency that avoids excessive force or wrongful death complaints as a result of an EXD event also avoids the cost of the internal and/or external review of their hiring and training practices. Any reviews of this type, along with the changes that are implemented as a result of the review, place a financial burden on the agency and the local government. Along with these types of reviews comes the accompanying loss of confidence in the agency by the public. This lack of confidence in the agency may also extend to the officers of that agency. When a lack of confidence in the agency occurs, it is quite often followed by high turnover. A high turnover rate costs the agency in recruiting new officers, pre-employment investigations, equipment, and training (Orrick, 2005). The agency may also incur overtime costs until the departing officer's position is filled by a fully trained officer. While these dollar amounts can be calculated, the loss of experience both in police knowledge and in the officer's understanding of the community that each officer takes with him cannot be calculated in dollars and cents.

Law enforcement agencies may be able to greatly reduce agency and local government financial liability, maintain and build the trust with their communities, reduce officer injuries, maintain officer's confidence in the agency, and, most importantly, reduce the number of in-custody deaths by accepting that EXD exists. The costs incurred by training officers to recognize the symptoms of an EXD event and treating

that situation as a situation that requires prompt medical intervention are extremely small when compared to the financial obligation that can be placed on an agency when an EXD event has a negative outcome.

## COUNTER POSITION

The term excited delirium is often used when the more medically precise term of sudden unexpected death should actually be used (Mash, Duque, Pablo, Qin, & Adi, 2009). Sudden unexpected death is quite often associated with an undetected, underlying medical condition (Shaw, 2009). The manifestation of the medical condition quite often presents after some form of physical exertion resulting in the death of the person (Shaw, 2009). Although there has been a great deal of discussion of EXD as a cause of death, EXD is not recognized as a disease or mental disorder in either the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders. It appears too many that EXD is being used as a way to cover up or mitigate the deaths of those who die in police custody (Hart, 2010). It is then reasoned that they died as a result of police misconduct.

There have been efforts on the part of private industries, which rely on sales of their products to law enforcement, to fund research to bolster the claim of the existence of EXD (Anglen, 2005). Many of these studies, some 280 cited by one company alone, are viewed with skepticism as many were funded by the very entities the studies hold blameless (http://www.taser.com/press-kit). This approach is thought to be somewhat akin to having the fox guard the hen house.

One reason there may be an elevated level of conversation about EXD is the growing number of in-custody deaths in this country. Between 2003 and 2005, there

were a reported 2,002 deaths of persons while in police custody, according to a review by Justice Department's Bureau of Justice Statistics (Mumola, 2007). The review further found that a staggering 55% of those deaths were ruled as homicides committed by the police (Mumola, 2007). By introducing EXD into the conversation about in-custody deaths, those responsible for the deaths, directly or indirectly, hope to reduce the number of homicides attributed to law enforcement.

If, indeed, EXD is responsible for a percentage of in-custody deaths, then the police agencies escape scrutiny. The deaths that are ruled EXD will not generate a microscopic look into the officer's conduct or the agency and its policies and procedures. If the death was a result of EXD, then no criminal action is forthcoming against the officer(s), and the police agency and its governing body cannot be held financial responsible (Amnesty International, 2004). By blaming EXD for an in-custody death, it is, in effect, blaming the person that died for their own death. According to the experts that support the theory of EXD, one of the major factors leading up to an EXD event is a history of prolonged drug use (Di Miao & Di Miao, 2005). EXD is a factor that the police clearly had no control over, and the victim ultimately had control of. Therefore, there is a shift in the focus of the cause of death away from excessive force being used by officers. It would then not matter whether the person was struck repeatedly, placed in a chokehold, pepper-sprayed, or shocked with a Taser.

Whenever officers encounter a person who may have a mental disorder or may be under the influence of an illegal substance, or a combination of both, they can feel free to use force on the person, short of deadly force. If the person sustains some

major injuries or suffers death, the officers and the agency may simply point to EXD as the actual cause of death and not their own misconduct.

Although EXD cannot currently be found in either the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders, many in the medical profession, including pathologists, emergency room physicians, and medical universities, believe that EXD exists. (Institute for Non-Lethal Defense Technologies, 2011) Not only does it exist, but can be identified by a specific set of symptoms and treated by a specific set of protocols (Di Miao & Di Miao, 2005). EXD can also be identified post mortem by examination of the brain for particular changes and/or abnormalities (Mash et al., 2009). Di Maio & Di Maio (2005) stated, "Excited delirium syndrome involves the sudden death of an individual, during or following an episode of excited delirium, in which an autopsy fails to reveal evidence of sufficient trauma or natural disease to explain the death" (p.1). In addition to Di Maio, the National Association of Medical Examiners has recognized EXD for more than a decade (Costello, 2003)

Whenever a person dies in police custody there is, of course, the possibility of that death having been caused by police misconduct. There is, however, also the possibility that the death was not a result of police misconduct. There are cases of in-custody deaths in which the autopsy revealed no traumatic injuries that could have caused death (Di Miao & Di Miao, 2005). Hospital emergency rooms have also been witness to persons presenting with EXD symptoms and then suddenly dying (Vilke et al., 2011). In the cases where post-mortems revealed no traumatic injuries or the subjects died in the ER, the case for police misconduct cannot be made. The set of

symptoms that lead to a conclusion that a person has died from an EXD event do not necessarily include the application of force. The conclusion must then be that if the person who died exhibited the symptoms of EXD and did not receive life threatening injuries from police, then they died from something other than the excessive use of force by the police. The only sound explanation left is Excited Delirium.

Excited delirium has become part of the dialogue about in-custody deaths in large part due to the use of Tasers by over 14,000 law enforcement agencies (http://www.taser.com/press-kit). The Taser is a conductive energy weapon (CEW), which causes incapacitation by electro muscular disruption ("Neuromuscular Incapacitation," 2012). The Taser accomplishes this by passing a charge of up to 50,000 volts through the body. The claim put forth by the manufacturer of Tasers, Taser International, is that this causes no permanent harm and does not otherwise interfere with the body's electrical system. Taser International maintains that their weapon does not cause death, yet in a great number of in-custody deaths involve the application of a Taser (http://www.taser.com/press-kit).

The logic then follows that if EXD is the cause of death and not the application of a CEW, like a Taser, then the company that makes the CEW is blameless in the deaths. The financial implications for the companies that manufacture CEWs are enormous. Without its law enforcement customer base, the CEW manufacturers would, in all likelihood, cease to exist. They also stand to face severe financial penalties in civil court and may face charges in criminal court as well.

CEWs have been deployed thousands of times with no permanent effect on the person who received the shock (http://www.taser.com/press-kit). The vast majority of

police officers that carry a CEW have themselves felt the effects of the weapon. There are deployments against sober and intoxicated persons. There are deployments against persons that are under the influence of some type of narcotic or dangerous drug. None of these thousands of deployments per year result in the death of the person. The majority of the time, a death is associated with a CEW when the person also appears to be suffering from an EXD event (Williams, 2008).

## RECOMMENDATION

The act of accepting the existence of Excited Delirium is perhaps one of the simplest and most direct ways an agency administrator can cause a positive impact on their officers, governing body, and the community at large. In one change in policy, the administrator can move toward maintaining, if not actually increasing, the level of trust and cooperation that exists between his agency and the community it serves. He can implement a plan that will result in the reduction of officer injuries. This will result in more productivity, less cost in time off for injuries, less direct medical costs, a reduction in overtime to cover the injured officer's shifts, and less worker's compensation. This will, of course, render a positive effect on the administrator's budget. The higher productivity will also positively impact the public. As the officer continues to work his shift in his assigned area, he gains knowledge, not only knowledge of the law and procedures, but he gains experience in interacting with the people he serves. The most important outcome of this decision will be the reduction of in-custody deaths when officers encounter a person in the midst of an EXD event.

The policy and procedure that agencies enact should be done so after consultation with the local EMS provider, the hospitals that serve the area, and the

mental health authority. The policy should include training in the recognition of ED for the officers who will encounter the person with EXD, the EMS personnel who will have to administer aid to the person, and the staff of the ERs who will have to care for the person. Of course the exact medical protocols and procedures would be a matter for the medical professionals to determine. The officers should be trained to recognize EXD and to realize that EXD is a medical event requiring immediate medical intervention and not a law enforcement matter. However, quite often, the officers may be the first people to encounter the person and will have to assist in actually restraining the person for medical personnel.

The premise that EXD does not exist because it is not recognized by the American Medical Association and cannot be found in the American Psychiatric Association's handbook of mental disorders should not affect the effort to reduce the number of in-custody deaths (Layton, 2007). A growing number of medical professionals and professional organizations accept and recognize EXD. The American College of Emergency Physicians, the National Association of Medical Examiners and the Excited Delirium.org group, headed by Dr. Mash all recognize EXD as an event that can cause death (Mash et al., 2009.) By accepting that EXD does exist and that it can cause the death of people in-custody, positive steps should then be taken to prevent these deaths.

The argument as to the validity of EXD will continue in the medical, legal, and civil rights communities. The law enforcement professional should not concern himself with the minutia of these continuing debates; he should instead take positive, proactive steps to acknowledge and prepare for an EXD event. The law enforcement

administrator can in this way, reduce injuries to his officers, reduce the liability exposure of his officers, department, and governing body, and maintain and build the trust that exists between the agency and the community.  Most importantly, the number of in-custody deaths can be reduced.

# REFERENCES

Amnesty International. (2004, November 29). *USA: Excessive and lethal force? Amnesty international's concerns about deaths and ill-treatment involving police use of tasers*. Retrieved from http://www.amnestyusa.org/node/55449

Anglen, R. (2005, July 30). Taser shocks ruled cause of death. Retrieved from http://www.azcentral.com/arizonarepublic/news/articles/0730taser30.html

Bell, L. D. (1849). A new form of disease. *American Journal of Insanity*.

Costello, D. (2003, April 21). Excited delirium as a cause of death. *Los Angeles Times.* pp. 1A, 4A.

Di Maio, T. & Di Maio, V. (2005). *Excited delirium syndrome*. Boca Raton, FL: Taylor & Francis.

Excited Delirium. (n.d.) *What is excited delirium?* Retrieved from http://exciteddelirium.org/indexwhatisED2.html

Hart, J. (2010, July 10). What is 'excited delirium'? Is it real? [Blog post]. Retrieved from http://blogs.kansascity.com/crime_scene/2010/07/what-is-excited-delirium.html

Institute for Non-Lethal Defense Technologies, Less-Lethal Devices Technology Working Group. (2011). *Special panel review of excited delirium*. Retrieved from https://www.justnet.org/pdf/ExDS-Panel-Report-FINAL.pdf

Klienman, D. (2009, April 15). *Excited delirium.* Retrieved from http://www.emsworld.com/article/10320570/excited-delirium

Langley, J. (Producer). (2005). *Cops* (Television series). Los Angeles: Fox Broadcasting Company.

Layton, J. (2007, March 1). Are people in police custody dying of excited delirium? Retrieved from http://people.howstuffworks.com/excited-delirium.htm

Mash, D.C., Duque, L., Pablo, J., Qin, Y., & Adi, N. (2009, September 10). *Brain biomarkers for identifying excited delirium as a cause of sudden death*. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19541436?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum

Mash, D.C., Pablo, J., & Basile, M. (n.d.). Excited delirium education: Research and information. Retrieved from http://exciteddelirium.org/indexFacultyandstaff.html

Miller, A. (2006). *Law enforcement traumatic stress: Clinical syndromes and intervention strategies.* Retrieved from http://www.aaets.org/article87.htm

Mumola, C. (2007, October). Arrest-related deaths in the United States*, 2003-2005.* Retrieved from http://bjs.ojp.usdoj.gov/content/pub/pdf/ardus05.pdf

Neuromuscular Incapacitation (NMI). (2012, March). Retrieved from http://www.taser.com/images/press-room/taser%20ecd%20press%20kit%20master%2003%2015%2012.pdf

Orrick, D. (2005, September). Police turnover. *The Police Chief, 72*(9). Retrieved from http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display_arch&article_id=697&issue_id=92005

Paquette, M. P. (2003, July). Excited delirium: Does it exist? *Perspectives in Psychiatric Care*, *39*(3), 93-94.

Petty, C. (2004, February). *Deaths in police confrontations when oleoresin capsicum is used*. Retrieved from http://www.ncjrs.gov/pdffiles1/nij/grants/204029.pdf

Shaw, E.B. (2009, May 2). *Sudden Unexpected Death: Causes and Contributing Factors.* Retrieved from http://poptop.hypermart.net/sudden.html

Sztajnkrycer, M., & Baez, A. (2009). *Excited delirium and sudden unexpected death*. Retrieved from http://www.acep.org/ACEPmembership.aspx?id=31850

Vilke, G.M., DeBard, M.L., Chan, T.C., Ho, J.D., Dawes, D.M., Hall, C., Curtis,M.D., Costello, M. W., Mash, D.C., Coffman, S.R., McMullen, M.J., Metzger, J.C., Roberts, J., Sztajnkrcer, M.D., Henderson, S.O., Adler, J., Czarnecki, F., Heck, J., Bozeman, W.P. (2011). Excited delirium syndrome (ExDS): Defining based on a review of literature [Abstract]. *The Journal of Emergency Medicine.* Retrieved from http://www.jem-journal.com/article/S0736-4679(11)00196-X/abstract

Williams, H. (2008). *Taser Electronic Control Devices and Sudden In-Custody Death.* Springfield, IL:Charles C. Thomas.