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Explaining the Unexplainable: Excited Delirium Syndrome and Its Impact on the Objective Reasonableness Standard for Allegations of Excessive Force

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**EXPLAINING THE UNEXPLAINABLE: EXCITED DELIRIUM
SYNDROME AND ITS IMPACT ON THE OBJECTIVE
REASONABLENESS STANDARD FOR ALLEGATIONS OF
EXCESSIVE FORCE**

INTRODUCTION

A woman frantically dials 9-1-1 and pleads for protection from her boyfriend who has snapped. She explains that he had started yelling incoherently at imaginary people whom he believed were attempting to “get him.”¹ In order to “protect himself,” the woman explains that he had begun continuously flailing and swinging his arms in rage.² At that moment of explanation, her boyfriend, unprovoked, charges, grabs her by the hair, and throws her violently onto the floor.³ Startled by the woman’s screams, the deranged boyfriend flees. Exiting the front door, he begins disrobing, removing his shirt, shorts, and his boxers.⁴

The man, now naked, sprints across the street and begins striking the windshield of his neighbor’s vehicle with his fists. Swinging violently, and seemingly impervious to pain, the man finally succeeds in shattering the glass. Clearly entertained with himself, the man weaves back and forth across the street, ignorant of oncoming vehicles, breaking window after window.⁵ Neighbors, frightened by the man, call the police en masse. With the call center overwhelmed with frantic pleas for help, the responding officers multiply and arrive quickly.

The first responding officer finds the man out of breath, yet clearly agitated, standing in traffic, and sweating profusely.⁶ The officer attempts to establish communication with the man, but he refuses to acknowledge the officer. The officer slowly approaches, when the man suddenly lunges at the officer. The officer quickly retreats and requests backup for an “emotionally

1. See Charles V. Wetli, *Excited Delirium*, in *SUDDEN DEATHS IN CUSTODY* 99, 104 (Darrell L. Ross & Theodore C. Chan eds., 2006) (noting a case of excited delirium where the man hallucinated that people were after him).

2. See THERESA G. DI MAIO & VINCENT J.M. DI MAIO, *EXCITED DELIRIUM SYNDROME: CAUSE OF DEATH AND PREVENTION* 87 (2006) (noting a case of excited delirium where a man wildly flailed his arms).

3. See *id.*

4. See *id.* at 91 (illustrating how excited delirium can result in complete disrobing).

5. See *id.* at 89.

6. See *id.* at 90.

disturbed” suspect.⁷ As backup arrives, five officers cautiously approach the deranged man with guns drawn, ordering him to lay face down. The man, ignoring the commands, suddenly tackles the front officer, slamming her to the ground. The officers holster their guns and a violent five-on-one wrestling match begins. The officers struggle to restrain the average-sized man, who seems to possess super-human strength.⁸ Unable to subdue him through human force, the officers collectively retreat. The deranged man jumps to his feet, mumbles incoherently, and throws punches above his head.

With no progress being made, the officers decide to employ a “non-lethal” electronic control device to put an end to the struggle. Two officers lodge barbs into the naked man’s chest, sending 50,000 volts of electricity through his body. The man crumbles under the shocks and falls face down to the ground. The officers charge the fallen man, place a knee on his neck and use their weight to hold the man down. After handcuffing the man, they force him to stand; however, his submission is only temporary. Without warning, the suspect begins thrashing violently, kicking his legs, and head-butting the officers. The officers once again swarm the man and take him to the ground in an attempt to prevent him from hurting himself and others. At least seven officers pile on the man’s back to prevent him from thrashing. The officers continue to restrain him until one of them realizes that the man is no longer breathing.⁹ With EMTs already on the scene, attempts to resuscitate the man begin instantly. However, the efforts are futile and the man dies.

With the media questioning whether this was police brutality, the public makes it clear that they want an answer.¹⁰ The public assumes the death was “due to the misconduct by police and/or medical personnel.”¹¹ The continued media attention is fueled because the average person cannot conceptualize “the violence with which such individuals can struggle.”¹² Therefore, all other explanations fail to “conform to the present mind-set of many Americans, that

7. See Michael Avery, *Unreasonable Seizures of Unreasonable People: Defining the Totality of Circumstances Relevant to Assessing the Police Use of Force Against Emotionally Disturbed People*, 34 COLUM. HUM. RTS. L. REV. 261, 266 (2003) (discussing how many officers are trained to handle situations involving “emotionally disturbed people”).

8. See Wetli, *supra* note 1, at 101 (listing the common features of Excited Delirium Syndrome, including “[e]xtraordinary strength and endurance”).

9. DI MAIO & DI MAIO, *supra* note 2, at 34 (“Following the cessation of the struggle, the individual is generally ignored until suddenly it is realized that he or she is not breathing.”).

10. *Id.* at 75.

11. *Id.* at 4. This is in part because “[i]n custody deaths draw enormous media attention and can severely raise tensions between police and the public, who often assume the police are at least partially responsible if only because of their proximity.” Daniel Costello, ‘Excited Delirium’ as a Cause of Death, L.A. TIMES (April 23, 2010), <http://articles.latimes.com/2003/apr/21/health/he-delirium21>.

12. DI MAIO & DI MAIO, *supra* note 2, at 34.

anytime tragedy occurs someone must be at fault and they should be punished, or even better, sued.”¹³

Three months later, after much speculation from the media and public alike, the local medical examiner releases the cause of death. According to the report, the man’s cause of death was homicide caused by sudden cardiac arrest due to “cocaine-induced excited delirium syndrome.”¹⁴ Although the death is considered a homicide, the medical examiner’s use of Excited Delirium Syndrome as a cause of death seems to implicitly remove the liability from the hands of the police department.¹⁵ The public, who believes this was an example of excessive force, is outraged and confused by what Excited Delirium Syndrome is and how it killed the victim.¹⁶

Explaining Excited Delirium Syndrome is difficult because most sources describe the symptoms of the condition, but fail to provide an explanation of the cause of death that the average American can understand.¹⁷ The unknown nature of the syndrome adds to the outrage and strengthens the claim of police brutality. For example, the lack of an explanation has led the Executive Director of the Ella Baker Center for Human Rights to label Excited Delirium Syndrome as a “smokescreen.”¹⁸ Additionally, organizations such as the NAACP question whether Excited Delirium Syndrome may simply be a tool to cover cases of racially motivated excessive force.¹⁹ These claims, in part, highlight the mystique of the condition and further the American public’s distrust of its use in highly controversial cases.

In conjunction with the release of the autopsy report, the “victim’s” family files a lawsuit against the city, the police department, and the individual police officers for excessive force under 42 U.S.C § 1983, alleging, among other claims, a violation of the Fourth Amendment.²⁰ In response, the defense argues that the cause of the death was not proximate to the actions of the police

13. *Id.* at 4.

14. John O’Brien, *Death Highlights a Mysterious Condition*, POST-STANDARD, Aug. 27, 2010, at A1.

15. *See id.* (noting that these deaths are often considered “accidental”).

16. “The excited delirium label has drawn mixed acceptance among forensic pathologists” and many believe it is “used as a scapegoat for deaths caused by police.” *Id.*

17. *See What is Excited Delirium (ED)?*, EXCITEDDELIRIUM.ORG, <http://www.exciteddelirium.org/indexwhatisED2.html> (last visited January 2, 2012) (describing the symptoms including “bizarre and/or aggressive behavior, shouting, paranoia, panic, violence toward others, unexpected physical strength, and hyperthermia,” but failing to explain the cause of death other than the unclear explanation that “[h]yperthermia is a harbinger of death in these cases”).

18. Costello, *supra* note 11.

19. *Id.* It should be noted that the available data does not support this claim in any significant manner. *Id.* (noting that a 2001 published study found the cases of excited delirium were evenly divided among whites, Latinos, and African Americans).

20. *See Gregory v. Cnty. of Maui*, 523 F.3d 1103, 1105 (9th Cir. 2008) (exemplifying a typical claim).

officers but was caused by the victim suffering from Excited Delirium Syndrome.²¹ More specifically, the defense argues that under the Fourth Amendment's search and seizure requirements, the actions of the police were objectively reasonable under the standards set out by the United States Supreme Court in *Tennessee v. Garner*²² and *Graham v. Connor*.²³ The district court agrees and grants the defendant's motion for summary judgment, eliminating liability for the city, police department, and officers.²⁴ This decision creates a media firestorm because the public believes the government is using a "fictional" cause of death to make a scapegoat of the actions of violent officers.²⁵

This Comment will function as a two-part analysis: First, is Excited Delirium Syndrome a legitimate cause of death? Second, if so, does the recognition of the symptoms of Excited Delirium Syndrome heighten the "objective reasonableness" standard for federal claims of excessive force? This analysis will establish that Excited Delirium Syndrome is a legitimate cause of death. Furthermore, recognition of, as well as the law enforcement officers training for, Excited Delirium Syndrome should factor into the fact finder's determination of what is objectively reasonable force.

I. WHAT IS EXCITED DELIRIUM SYNDROME?

What is this mysterious syndrome that results in death during altercations with police? According to Dr. Vincent and Theresa Di Maio,²⁶ "[e]xcited 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."²⁷ As this definition suggests, Excited Delirium Syndrome is considered to be a cause of death that explains complex situations where an individual dies during police

21. *See id.*

22. 471 U.S. 1, 7–8 (1985).

23. 490 U.S. 386, 397 (1989).

24. *See, e.g., Gregory*, 523 F.3d at 1106.

25. *See Costello*, *supra* note 11 (stating that police watchdogs and civil rights groups "fear that the condition is being exploited and used as a medical scapegoat for police abuse," and noting that a spokesman for the American Medical Association stated, "We've never heard of it.").

26. Theresa Di Maio is a nurse with a Graduate Certificate in Forensic Nursing who lectures to "nurses, police, and the general scientific community on excited delirium syndrome." DI MAIO & DI MAIO, *supra* note 2, at vii. Dr. Vincent Di Maio is a forensic pathologist and Chief Medical Examiner of Bexar County, Texas. *Id.* He is a Pathology Professor at the University of Texas Health Science at San Antonio and is the Editor of the *American Journal of Medicine and Pathology*. *Id.*

27. *Id.* at 69.

contact²⁸ from injuries insufficient to cause death.²⁹ The relevant question becomes if trauma or natural disease did not cause the death, then what did?

According to Dr. Assaad Sayah, Chief of Emergency Medicine at Cambridge Health Alliance, Excited Delirium Syndrome can be best explained as a “physical response to an actual psychological problem resulting in their autonomic systems producing too much adrenaline.”³⁰ Dr. Sayah analogizes it to “having too much nitrous in a car; eventually the engine will blow up.”³¹ In most cases, the cause of death is either “a heart attack or, less frequently, respiratory failure.”³² Dr. Vincent Di Maio estimated that Excited Delirium Syndrome kills 800 people every year in police altercations because the victims “are just overexciting [their] heart from the drugs and from the struggle.”³³ Therefore, in theory, those suffering from symptoms of Excited Delirium Syndrome, as described in the introduction, suffer from increased rates of adrenaline, and ultimately, the anxiety caused by the adrenaline results in a heart attack or a failure of the respiratory system.³⁴

Excited Delirium Syndrome has only recently become a contentious issue. According to Amnesty International:

[I]n the past few years the term has been used increasingly by medical examiners to explain sudden deaths in custody of individuals in a highly agitated state—usually under the influence of drugs or with some form of psychosis—who suffer a surge of adrenaline and collapse after struggle and police restraint.³⁵

The increase in use by medical examiners over the past two decades is, in part, explained by the increased use of cocaine, which is believed to aid the onset of

28. *Id.* at 1 (“In virtually all such cases, the episode of excited delirium is terminated by a struggle with police or medical personnel, and the use of physical restraint.”).

29. Russell Goldman, *Excited Delirium: Police Brutality vs. Sheer Insanity*, ABC NEWS (Mar. 2, 2007), <http://abcnews.go.com/Health/story?id=2919037&page=1> (noting that according to an emergency room doctor, there are often no signs of trauma and therefore the cause of death in excited delirium controversies cannot be said to be due to any trauma related injuries).

30. *Id.*

31. *Id.*

32. Costello, *supra* note 11.

33. Tom Zeller Jr., *Deaths in Custody: Excited Delirium or Excessive Force?*, N.Y. TIMES: THE LEDE (Feb. 2, 2007, 8:46 AM), <http://thelede.blogs.nytimes.com/2007/02/27/deaths-in-custody-excited-delirium-or-excessive-force/>.

34. See Costello, *supra* note 11 (noting that the syndrome mostly results in heart attacks and respiratory failure); Goldman, *supra* note 29 (noting that patients are having a “physical response to an actual psychological problem resulting in their autonomic systems producing too much adrenaline”).

35. AMNESTY INT’L, ‘LESS THAN LETHAL’?: THE USE OF STUN WEAPONS IN US LAW ENFORCEMENT 26 (2008), available at <http://www.amnesty.org/en/library/asset/AMR51/010/2008/en/530be6d6-437e-4c77-851b-9e581197ccf6/amr510102008en.pdf>.

Excited Delirium Syndrome.³⁶ Although its use by medical examiners as a cause of death has only become popular in the past two decades, Excited Delirium Syndrome has been recognized by doctors under various names for over a century.³⁷

A. *Excited Delirium Syndrome's Long History*

Many medical experts believe that Excited Delirium Syndrome has been a diagnosed condition since 1849, when Dr. Luther Bell discovered a condition he coined as "Bell's Mania."³⁸ Dr. Bell used the term to describe a condition in which mentally ill patients died from unexpected causes after an acute onset of specific symptoms.³⁹ In his patients, Dr. Bell noted that death occurred two or three weeks after the acute onset of the following symptoms: mania, violent behavior, need for restraint, refusal of food, inability to sleep, and fatigue deteriorating to exhaustion and circulatory collapse.⁴⁰ These symptoms seem similar to the modern Excited Delirium Syndrome, which increases the validity of the modern diagnosis.⁴¹

However, Dr. Bell's research conclusions were not alone. In the nineteenth century Dr. Emil Kraepelin, a German psychiatrist, discussed a syndrome that he labeled as "dementia praecox."⁴² This chronic predecessor to the modern Excited Delirium Syndrome is described in Dr. Kraepelin's published works as: "Less uncertain is the causation of death by the morbid process itself in those somewhat frequent cases, in which the death of the patients results at the height of severe excitement, accompanied by phenomena of cerebral irritation with convulsions or paralyzes, sometimes with almost continuous seizures."⁴³ Thus, history provides the necessary foundation that "both Dr. Bell in the United States and Dr. Kraepelin, in Munich, were documenting a unique and fatal syndrome involving excited delirium."⁴⁴

The studies and research continued into the 1930s. In 1933, Dr. Irving M. Derby described a condition that he labeled as "maniac-depressive

36. Costello, *supra* note 11 ("Use of cocaine has climbed as much as 20% in the U.S. since 1990, according to the most recent Department of Health and Human Services' National Household Survey on Drug Abuse."). The article notes that the first diagnosis linked to cocaine by a medical examiner was in the 1980s, followed by a medical examiner in San Francisco in the 1990s and then widespread use across the country in the past decade. *Id.*

37. *See infra* Part I.A.

38. *See, e.g.,* Wetli, *supra* note 1, at 100; DI MAIO & DI MAIO, *supra* note 2, at 7–8.

39. DI MAIO & DI MAIO, *supra* note 2, at 7–8.

40. *Id.* at 8.

41. *See id.* at 7. ("The first reports of death in association with excited delirium appear in the psychiatric literature in the mid and late 19th century in both the United States and Europe.")

42. *Id.* at 9.

43. *Id.*

44. DI MAIO & DI MAIO, *supra* note 2, at 9.

exhaustion.”⁴⁵ In 1934, Dr. G.M. Davidson attributed twenty-two deaths to a condition he labeled “acute lethal excitement.”⁴⁶ In 1944, Dr. N.R. Shulack published an article detailing four cases of what he called “excited psychotic furors” and reviewing 376 cases of sudden death in excited psychosis patients from the early 1900s through 1943.⁴⁷ Combining all of the historical cases, it is undeniable that a chronic form of Excited Delirium Syndrome “was not uncommon between 1850 and 1950.”⁴⁸ However, after the first half of the twentieth century and until the 1980s, there was a “temporal pause” in the research and diagnosis of Excited Delirium Syndrome and its related predecessors.⁴⁹

The re-emergence was marked by a significant change; it was no longer just a chronic condition, but rather, it had developed acute symptoms.⁵⁰ According to Dr. Vincent and Theresa Di Maio, this development occurred because of the increased use of illegal stimulant, in particular cocaine, and the advancements in the treatment of chronic mental illnesses.⁵¹ In 1981, Charles V. Wetli and David Fishbain reintroduced Excited Delirium Syndrome to the general medical community,⁵² which ultimately led to the increase in research and literature that has become the knowledge base for what is known today as Excited Delirium Syndrome. Therefore, “[c]ontrary to what many journalists believe (or were told), the brain disorder of excited delirium is not a new label for a sudden death.”⁵³

B. *Causes and Symptoms of Excited Delirium Syndrome*

The emergence of “sudden onslaught” or acute Excited Delirium Syndrome has been directly correlated to the increased use of cocaine in the United States.⁵⁴ Along with cocaine, other drugs have been known to be contributing factors of Excited Delirium Syndrome.⁵⁵ These drugs include:

45. *Id.* at 10.

46. *Id.* at 11.

47. *Id.* at 12.

48. Jami R. Grant et al., *Excited Delirium Deaths in Custody: Past and Present*, 30 AM. J. FORENSIC MED. & PATHOLOGY 1, 1 (2009).

49. *Id.*

50. *Id.*

51. DI MAIO & DI MAIO, *supra* note 2, at 13. *See also* Grant et al., *supra* note 48, at 4 (“Consistent with extant literature, results indicate that acute EDS is a relatively recent phenomenon, first identified during the 1980s, and driven in large part by the increased abuse of stimulants.”).

52. DI MAIO & DI MAIO, *supra* note 2, at 18.

53. John G. Peters, Jr., *Excited Delirium: What Every Chief Needs to Know*, POLICE & SECURITY NEWS, Sept.–Oct. 2007, at 57.

54. *See* DI MAIO & DI MAIO, *supra* note 2, at 55 (describing the significant role drugs play in deaths caused by Excited Delirium Syndrome).

55. *Id.*

amphetamine (meth), Phencyclidine (PCP), alcohol, antidepressants, antipsychotics, diphenhydramine, marijuana, albuterol, promethazine, and epileptic medication.⁵⁶ The Di Maios conclude that “[i]n virtually all deaths due to Excited Delirium Syndrome, drugs, whether illicit or therapeutic, play a role.”⁵⁷

However, not all cases of acute Excited Delirium Syndrome can be attributed solely to drugs. Some cases can be attributed to psychiatric disorders.⁵⁸ An example of this was prevalent in an incident in 2001, in which a sixteen-year-old mentally disabled girl was restrained at school and died from what was attributed to Excited Delirium Syndrome.⁵⁹ Another contributing factor, according to Deborah Mash, a neurology professor at the University of Miami who has studied Excited Delirium Syndrome for twenty years, could be genetics.⁶⁰ It can be difficult to “make any medical assessment to differentiate between the three causes of Excited Delirium,” as causes are multi-factoral.⁶¹ Yet as Dr. Mash explains: “The way I look at this is you’re walking around with a loaded gun That gun may never fire. But if you use drugs, or have these other contributing environmental issues, you’ve cocked that gun, you’ve put the bullet in the chamber.”⁶²

Overall, it is difficult to determine the cause of a particular case of Excited Delirium Syndrome because the symptoms, although numerous, rarely differentiate between the known causes.⁶³ The hypothetical in the introduction provides a “stereotypical” scenario for a victim of Excited Delirium Syndrome.⁶⁴ Many of the bizarre symptoms exhibited by the man are found to occur time and time again in Excited Delirium Syndrome cases. These symptoms can be divided into four basic categories: psychological behaviors, communication behaviors, physical behaviors, and physical characteristics.⁶⁵ These categories are important because the symptoms allow police, emergency

56. *Id.* at 55–65.

57. *Id.* at 55.

58. See DARREN LAUR, CAN. POLICE RESEARCH CTR., EXCITED DELIRIUM AND ITS CORRELATION TO SUDDEN AND UNEXPECTED DEATH PROXIMAL TO RESTRAINT: A REVIEW OF THE CURRENT AND RELEVANT MEDICAL LITERATURE 17 (2004), available at http://www.css.dr dc-rddc.gc.ca/cprc/tr/tr-2005-02_e.pdf (describing psychiatric illness as one of the three specific groups of people most prone to Excited Delirium Syndrome).

59. Costello, *supra* note 11.

60. O’Brien, *supra* note 14.

61. LAUR, *supra* note 58, at 19.

62. O’Brien, *supra* note 14.

63. MARK L. DEBARD ET AL., AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, WHITE PAPER REPORT ON EXCITED DELIRIUM SYNDROME *12 (2009).

64. See *supra* Introduction.

65. Peters, *supra* note 53, at 58, 60.

medical personnel, and doctors to recognize a person who is suffering from Excited Delirium Syndrome.⁶⁶

The psychological behaviors provide one of the most readily detectable characteristics of acute Excited Delirium Syndrome.⁶⁷ The behaviors include: intense paranoia, extreme agitation, rapid emotional changes, altered mental states, delusions, and hallucinations.⁶⁸ For instance, in the hypothetical, the man became instantly agitated and suffered from the delusion that imaginary people were attempting to “get him,” which is common in Excited Delirium Syndrome cases.⁶⁹ The acute nature of the psychotic behavior is easily identified because witnesses will testify that the individual “just snapped” and began acting in bizarre ways.⁷⁰

The second category consists of a variety of communication characteristics. Specifically, the person is often incoherently screaming for no apparent reason, which often involves intermittent grunting.⁷¹ The screaming and yelling is usually bizarre and filled with “religious or racial epithets, pleas for protection (‘don’t let them kill me’), or calls for the police despite the presence of several uniformed officers.”⁷² Due to hallucinations, the communication often involves talking to non-existent people.⁷³

The third category involves distinct physical behavior. In addition to violent and bizarre behavior,⁷⁴ such as striking, kicking, and biting friends, family, and law enforcement officers,⁷⁵ there are four additional peculiar behaviors that seem to occur in most, if not all, Excited Delirium Syndrome cases. The first behavior is aggression on inanimate objects, which often includes breaking glass.⁷⁶ Second, the victim will often run wildly into oncoming traffic.⁷⁷ Third, which occurs extensively and in conjunction with

66. *Id.* at 58 (“Knowing the following psychological, communication, and physical behaviors and characteristics may help the chief and/or PIO to explain that the individual who fought with law enforcement officers demonstrated one or more of these behavioral cues which match the profile of a person who is in an excited delirium state.”).

67. *See* Wetli, *supra* note 1, at 101 (listing the symptoms of Excited Delirium Syndrome).

68. Peters, *supra* note 53, at 58.

69. *See* Wetli, *supra* note 1, at 104.

70. Peters, *supra* note 53, at 58.

71. *Id.*

72. Wetli, *supra* note 1, at 100.

73. Peters, *supra* note 53, at 58.

74. *Id.*

75. *See* Zeller, *supra* note 33 (noting a case where a man almost bit off a fireman’s finger).

76. Peters, *supra* note 53, at 58; *see also* DI MAIO & DI MAIO, *supra* note 2, at 89 (noting a case where an individual was “running down the street smashing the windows of cars”); Wetli, *supra* note 1, at 100 (noting a common behavior of “[j]umping through a closed window” or “smashing glass and mirrors”).

77. Peters, *supra* note 53, at 58.

the other behaviors, is disrobing and nudity.⁷⁸ The last behavior is the acquirement of apparent “superhuman strength,” with seemingly unlimited endurance, while being impervious to pain.⁷⁹ These odd behaviors almost inevitably lead those suffering from Excited Delirium Syndrome to resist arrest violently at all phases of law enforcement interaction.⁸⁰

The fourth, and final, category is easily identifiable physical characteristics. The suspect will often sweat profusely due to a high core body temperature,⁸¹ which explains the high occurrence of disrobing and nudity. Often one’s core temperature can elevate to the dangerously high level of 105 degrees Fahrenheit.⁸² Furthermore, dilated pupils, skin discoloration, foaming at the mouth, and respiratory distress may also be present.⁸³ In fact, these characteristics can be one of the easiest ways of recognizing an Excited Delirium Syndrome case.⁸⁴

The importance of defining and recognizing the common characteristics of Excited Delirium Syndrome cannot be understated. Currently, Excited Delirium Syndrome is not a diagnosis recognized by the American Medical Association or found in the leading diagnostic manuals, which invariably makes it difficult for medical personnel or police officers to identify.⁸⁵ The only way it can be identified is by recognizing its clinical features and characteristics, which makes it extremely difficult to determine true incidents of Excited Delirium Syndrome.⁸⁶

C. *How Does Excited Delirium Syndrome Result in Death?*

The problem many commentators have with Excited Delirium Syndrome is that “[t]he exact mechanism of death is not clear.”⁸⁷ This misconception is

78. *Id.* at 60; *see also* Wetli, *supra* note 1, at 100 (noting that it is common for one to engage in “inappropriate disrobing” and running naked).

79. Peters, *supra* note 53, at 60; *see also* Wetli, *supra* note 1, at 100 (“Bystanders or police officers who attempt to restrain the victim encounter violent, unexpected strength in a person who is totally impervious to pain that may be inflicted with compliance techniques, electric stuns guns, or pepper spray.”).

80. Peters, *supra* note 53, at 60.

81. *Id.*

82. Wetli, *supra* note 1, at 100.

83. Peters, *supra* note 53, at 60. One commentator has stated, “If it is known that the individual was sweating and highly agitated, tell the media,” in reference to when one can determine if a person is experiencing excited delirium. *Id.*

84. *See* Costello, *supra* note 11 (discussing how medical examiners rely on police reports to determine cause of death and often point to a set of physical symptoms common to most cases).

85. *See* Peters, *supra* note 53, at 58 (noting that Excited Delirium Syndrome is not recognized by the American Medical Association and is not a diagnosis found in the *International Classification of Disease* manual or the *Diagnosis and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*).

86. *Id.*

87. Wetli, *supra* note 1, at 101.

fueled by the media who “invent, suggest, or help perpetuate baseless allegations.”⁸⁸ Generally in Excited Delirium Syndrome cases, “death is due to a combination of the normal physiologic changes seen in a struggle, combined with, depending on the case, the use of illicit drugs, medications, and natural disease.”⁸⁹ As suggested earlier, an individual essentially dies from an overdose of adrenaline, which, when combined with drug use and pre-existing medical conditions, can result in systematic organ failure.⁹⁰ Specifically, “[c]ollapse can occur in acute excited states such as mania and catatonic excitement because of a mental state in which agitation is centrally driven regardless of context, leading to physiological exhaustion without subjective fatigue.”⁹¹ In other words, individuals excite themselves to death.

However, the question that constantly arises is: Why does Excited Delirium Syndrome, in particular, when compared to other deliriums and acute excited states, lead to such a high mortality rate? This particular question is answered in detail by the Di Maios in their book *Excited Delirium Syndrome: Cause of Death and Prevention*.⁹² According to the book, death “results from a fatal cardiac arrhythmia due to a hyper-adrenergic state.”⁹³ However, if you are a legal scholar, that explanation of the cause of death might as well be Latin. Therefore, it is essential to breakdown the process the body undergoes when one dies from Excited Delirium Syndrome step by step.

First, with the syndrome the body experiences increasing levels of norepinephrine, which causes high levels of adrenaline.⁹⁴ The increased stimulation caused by the struggle results in the stimulation of the sympathetic nervous system.⁹⁵ This in turn causes the release of more norepinephrine, which increases the heart rate.⁹⁶ Additionally, natural disease or the use of drugs can cause a decrease in the capacity of the arteries thereby decreasing the amount of oxygen dispersed to the body and brain.⁹⁷ During struggle, high amounts of oxygen are required by the body.⁹⁸ However, due to the decreased

88. Peters, *supra* note 53, at 57.

89. DI MAIO & DI MAIO, *supra* note 2, at 45.

90. Goldman, *supra* note 29.

91. Frank R. Farnham & Henry G. Kennedy, *Acute Excited States and Sudden Death*, 315 *BMJ* 1107, 1107 (1997).

92. DI MAIO & DI MAIO, *supra* note 2.

93. *Id.* at 72; *see also* Farnham & Kennedy, *supra* note 91, at 1107 (“High circulating adrenaline concentrations, lactic acidosis, and dehydration contribute to a tendency towards ventricular tachyarrhythmias, while myocardial hypertrophy due to common disorders such as hypertension or diabetes mellitus or cocaine misuse also increases the risk of cardiac arrhythmia.”).

94. DI MAIO & DI MAIO, *supra* note 2, at 51.

95. *Id.*

96. *Id.*

97. *Id.* at 72.

98. *Id.* at 51.

levels of oxygen in the blood, cardiac arrhythmia is possible due to the body's need for oxygen.⁹⁹ In other words, during a struggle, similar to the hypothetical, death can result because of a lack of oxygen. Although the struggle may not be deadly for the average person, an individual in a state of excited delirium cannot afford to lose any oxygen through over exertion.

Additionally, based on data received during brain autopsies, Dr. Deborah Mash concluded that "people with excited delirium have a faulty brain regulation of the heart."¹⁰⁰ She believes it is a neuro-cardiac event and that the "brain chemistry goes chaotic and that leads to a fatal arrhythmia."¹⁰¹ Ultimately, the reality is that Excited Delirium Syndrome can result in death absent police force. According to Dr. Wetli, "there are now numerous studies that indicate the methods of police restraint, with or without pepper spray or pressure on the back, have nothing to do with the death."¹⁰² Therefore, if science seems to indicate that Excited Delirium Syndrome can be the legitimate cause of death, why is the diagnosis of Excited Delirium Syndrome by medical examiners controversial?

II. THE CONTROVERSY OF EXCITED DELIRIUM SYNDROME AND THE CASE FOR ITS LEGITIMACY

Excited Delirium Syndrome is controversial because the disorder "seems to manifest most often when people are in police custody, and is often diagnosed only after the victims die, [which] gives civil libertarians cause for concern."¹⁰³ The involvement of police, force, and death create highly charged situations in which medical examiner reports and hearings become high profile media events.¹⁰⁴ The unsupported theories and myths concerning Excited Delirium Syndrome are propagated by the media because "journalism favours controversy and blame rather than balance and exploration."¹⁰⁵ The high profile nature of Excited Delirium Syndrome cases and the quick-to-blame media create a perfect firestorm for controversy.

One of the most popular criticisms of Excited Delirium Syndrome is that it is not recognized by the American Medical Association ("AMA") and it is "not a diagnostic term formally recognized in the diagnostic schemes of the American Psychiatric Association [(“APA”)] or the World Health

99. DI MAIO & DI MAIO, *supra* note 2, at 51.

100. O'Brien, *supra* note 14.

101. *Id.*

102. Wetli, *supra* note 1, at 101.

103. Goldman, *supra* note 29.

104. Farnham & Kennedy, *supra* note 91, at 1107; *see also* Costello, *supra* note 11 ("In custody deaths draw enormous media attention and can severely raise tensions between police and the public, who often assume the police are at least partially responsible if only because of their proximity.").

105. Farnham & Kennedy, *supra* note 91, at 1108.

Organization [“WHO”].”¹⁰⁶ However, researchers and doctors “say it isn’t unusual that most major medical associations” do not recognize this diagnosis because they do not come across it.¹⁰⁷ Importantly, acute Excited Delirium Syndrome is only diagnosed when trauma or natural causes cannot explain a death. Doctors and psychiatrists therefore do not have interactions with those affected by Excited Delirium Syndrome because the victims of Excited Delirium Syndrome are already dead. Although the AMA, APA, and WHO do not recognize Excited Delirium Syndrome, the National Association of Medical Examiners has recognized it for over a decade.¹⁰⁸ Even though Excited Delirium Syndrome is not listed, “delirium and closely associated diagnoses to ‘excited delirium’ are found in both manuals under terms such as ‘manic excitement,’ ‘psychomotor excitement,’ ‘abnormal excitement,’ etc.”¹⁰⁹ Therefore, although many medical organizations do not officially recognize it, asserting that Excited Delirium Syndrome is not a viable syndrome would be telling an incomplete story.

In response to the growing controversy surrounding Excited Delirium Syndrome, the 2008 Council of the American College of Emergency Physicians convened a special task force to answer the following questions: (1) does Excited Delirium Syndrome exist; (2) what are its characteristics, and; (3) what are the “current and emerging methods of control and treatment?”¹¹⁰ The task force was comprised of nineteen experts; eighteen emergency physicians and one doctoral researcher.¹¹¹

Based on extensive research and analysis the task force came to an uncontroverted consensus that Excited Delirium Syndrome “is a real syndrome of uncertain etiology.”¹¹² This consensus is groundbreaking because it expands the realm of Excited Delirium Syndrome from medical examiners to emergency care practitioners.¹¹³ No longer should Excited Delirium Syndrome be considered an issue that pertains only to medical examiners.

106. AMNESTY INT’L, *supra* note 35, at 26; *see also* Goldman, *supra* note 29 (“It can’t be found in any medical textbooks, and the AMA still doesn’t recognize it as a diagnosis.”); Peters, *supra* note 53, at 58 (“Many journalists may try to put the PIO or administrator on the spot by naïvely pointing out that ‘excited delirium’ is not recognized by the American Medical Association (AMA) and/or is not a diagnosis found in the *International Classification of Disease (ICD)* manual or the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*.”).

107. Costello, *supra* note 11.

108. *Id.*

109. Peters, *supra* note 53, at 58.

110. DEBARD ET AL., *supra* note 63, at *4.

111. *Id.*

112. *Id.* at *18.

113. Mark L. DeBard, *Identifying New Disease as Excited Delirium Syndrome Rejects Idea that Police Brutality Causes Death*, EMERGENCY MED. NEWS, Nov. 2009, at 3.

In addition, the task force published the frequency of certain characteristics that are prevalent in Excited Delirium Syndrome cases.¹¹⁴ This identification of characteristics and features provides much needed assistance to emergency personnel as they attempt to recognize and react to the condition. Emergency personnel should become capable of diagnosing potential Excited Delirium Syndrome cases, and medical professionals should document and publish the results of their examination.¹¹⁵ This will allow the medical community to research and develop “the best strategies for intervention in all environments and identify methodologies to save more lives.”¹¹⁶

The second common criticism is that Excited Delirium Syndrome “is a ‘catch-all’ term which may wrongly exclude other causes or contributory factors, such as dangerous restraint procedures or other inappropriate use of force.”¹¹⁷ Many doubters of the syndrome believe that the term is “used as a scapegoat for deaths caused by police.”¹¹⁸ A potentially troubling criticism has been presented by groups such as the NAACP, which question whether Excited Delirium Syndrome is being proffered as an excuse for excessive force on minorities.¹¹⁹ Despite the seriousness of these claims, it is important to note that the over-application and/or misapplication of Excited Delirium Syndrome does not demonstrate that it is a false syndrome. Despite these criticisms, “[p]sychologists, medical examiners, and perhaps most pointedly, law enforcement officers insist that it’s a real and discrete condition.”¹²⁰ The aforementioned concerns are serious and warrant in-depth discussion, but the presumption should be in favor of the legitimacy of Excited Delirium

114. DEBARD ET AL., *supra* note 63, at *7 (describing the frequencies of potential characteristics with 95% confidence intervals: pain tolerance 100%; tachypnea (rapid breathing) 100%; sweating 95%; tactile hyperthermia 95%; police non-compliance 90%; lack of tiring 90%; unusual strength 90%; inappropriately clothed 70%; mirror/glass attraction 10%).

115. *Id.* at *9.

116. DeBard, *supra* note 113, at 5; *see also* DEBARD ET AL., *supra* note 63, at *18 (“For research and diagnostic purposes, thorough documentation of the patient’s signs and symptoms along with appropriate testing should occur. This includes the presence of sweating or muscle rigidity, temperature, pulse, respiratory rate, blood pressure, venous blood gases, urine and serum toxicology, thyroid functions, and blood and (if fatal) anatomic brain specimens for genetic, heat shock proteins, and neurochemical analyses.”).

117. AMNESTY INT’L, *supra* note 35, at 26.

118. O’Brien, *supra* note 14. “Dr. Werner Spitz, the former medical examiner in Detroit, said these types of cases should be labeled homicides because the officers, not the cocaine, cause the deaths.” *Id.*

119. Costello, *supra* note 11 (According to Frank Berry, a regional director for the NAACP, “[t]his condition reminds me of the argument they gave us 10 years ago about the chokehold. They said black men’s necks were more susceptible to dying in a chokehold, which of course was a lie. This is no different.”). It is important to note that the American College of Emergency Physicians task force report does not mention an increased likelihood for death from excited delirium among minorities. DEBARD ET AL., *supra* note 63.

120. Zeller, *supra* note 33.

Syndrome because only after accepting the condition can medical professionals, first responders, and law enforcement officers be properly trained to effectively handle the syndrome.¹²¹

The third criticism of Excited Delirium Syndrome relates to specific cases that involve death that could have been potentially caused by positional asphyxiation and electronic control devices. In fact, in a majority of early Excited Delirium Syndrome cases, the specific cause of death was often attributed to asphyxiation because the individual was placed in a position that restrained respiration through force.¹²² Shortly after it was developed, the use of this cause of death was expanded to all cases in which an individual died during police restraint.¹²³ This trend was in stark contrast to studies that indicated that the force used by officers on individuals in certain positions often claimed to cause death was clinically irrelevant to the death.¹²⁴ Furthermore, the positions that these individuals were placed in are positions used every day by the police, which indicates that the cause of death goes beyond mere positional asphyxiation.¹²⁵

Recently the controversy has shifted from attributing these deaths to positional asphyxiation to the use of electronic control devices. Amnesty International has become one of the leaders in questioning the use of electronic control devices in Excited Delirium Syndrome cases, believing it is just a convenient excuse to continue the use of such devices.¹²⁶ Yet, the diagnosis of Excited Delirium Syndrome by medical examiners across the county continues to increase.¹²⁷ Although it seems plausible that the 50,000 volt shocks from an electronic control device could kill an individual, less than 10% of the over 300 electronic control device related deaths since 1999 have been ruled to be caused by, or related to, the use of the device.¹²⁸ In other words, over 90% of deaths that were associated with the use of an electronic control device were attributed to causes completely unrelated to the device. Many of these deaths can likely be legitimately traced to Excited Delirium Syndrome because the individual does not die immediately from the shocks of the device but rather minutes later.¹²⁹

121. Goldman, *supra* note 29 (“[P]hysicians all emphasized the importance of training police to properly identify the symptoms and to get suspects medical attention as soon [sic] possible.”).

122. DI MAIO & DI MAIO, *supra* note 2, at 35.

123. *Id.* at 36.

124. *Id.* (citing Theodore C. Chan et al., *Restraint Position and Positional Asphyxia*, 30 ANNALS EMERGENCY MED. 578, 578–86 (1997)).

125. *Id.* at 37.

126. AMNESTY INT’L, *supra* note 35, at 26.

127. Robert Anglen, *Taser’s Lawsuits Challenge Coroners*, ARIZ. REPUBLIC, May 3, 2008, at A1.

128. *Id.*

129. DI MAIO & DI MAIO, *supra* note 2, at 42.

An example of the interaction between Excited Delirium Syndrome and electronic control devices is found in *Mann v. Taser International*.¹³⁰ In *Mann*, Melinda Fairbanks became agitated and delusional after smoking methamphetamine.¹³¹ When the police arrived, Ms. Fairbanks was combative, screaming, and attempting to kick the officers.¹³² She screamed about how demons and devils had taken her drugs and she had begun ransacking a neighbor's house.¹³³ After being cuffed and placed in the vehicle she kicked out the rear driver's side window of the cruiser and was banging her head against the door violently.¹³⁴ After several warnings, the officer deployed his Taser and discharged it three times.¹³⁵ The EMS personnel determined that she was not "in any immediate medical distress since she was talking, breathing and responding."¹³⁶ However, she went into cardiac arrest more than an hour later and died with a body temperature in excess of 107 degrees Fahrenheit.¹³⁷ The Eleventh Circuit held that the plaintiffs failed to show that the Taser had caused Ms. Fairbank's death, noting that the plaintiffs' own expert suggested that the death was caused by Excited Delirium Syndrome.¹³⁸ Presumably, the length of time between the use of the Taser and the death of the individual was considered, as well as the litany of Excited Delirium Syndrome symptoms including, but not limited to, the extremely high core body temperature.

In response to the controversy, the media attention, and the potential civil litigation, "[l]arge numbers of officers are being trained to recognize the syndrome."¹³⁹ For instance, the Dallas police force has been "trained to call for an ambulance any time a suspect fits the description, and to defuse encounters with mentally ill suspects by slowing things down, using suspects' first names and trying to avoid the use of force."¹⁴⁰ Additionally, the University of Florida and its police department recently settled a lawsuit concerning a doctoral student, who was allegedly suffering from Excited Delirium Syndrome when the police officers shot the student in the face and hand for threatening the officers.¹⁴¹ After the incident, the school's

130. 588 F.3d 1291, 1304 (11th Cir. 2009).

131. *Id.* at 1298–99.

132. *Id.* at 1299.

133. *Id.*

134. *Id.* at 1300.

135. *Mann*, 588 F.3d at 1300.

136. *Id.*

137. *Id.* at 1301.

138. *Id.* at 1304.

139. Goldman, *supra* note 29.

140. Zeller, *supra* note 33.

141. Nathan Crabbe, *Despite UF Settlement, Controversy Still Remains*, GAINESVILLE SUN, Sept. 9, 2010, at 1B.

commissioned investigation suggested additional Excited Delirium Syndrome training despite the schools already “extensive” training prior to the incident.¹⁴²

In order to prevent and decrease the number of deaths associated with Excited Delirium Syndrome, training for police officers and first responders is necessary.¹⁴³ Police officers and their departments must remember, first and foremost, that “an excited delirium state creates a medical emergency.”¹⁴⁴ Therefore, the first goal of police training should be to prevent the deaths from Excited Delirium Syndrome, which will in turn help eliminate media scrutiny and civil suits.¹⁴⁵

Although police training has increased, there is a “serious deficiency in the training of police officers who often face such individuals daily in communities.”¹⁴⁶ In order to prevent death, police officers must be trained to: “Identify individuals in excited delirium; [a]ttempt to de-escalate the situation and calm them down; [u]se overwhelming force if restraint must be used; [a]fter individuals are restrained, monitor them at the scene and during transport; [and] [i]mmediately transport them to a hospital for treatment and/or observation.”¹⁴⁷ It should be stressed that physical force should only be used as a last resort and, if force is used, the officers “must be prepared for the potential for death to occur.”¹⁴⁸

As part of the study by the 2008 Council of the American College of Emergency Physicians, training for law enforcement officers and emergency service personnel was suggested.¹⁴⁹ The task force stressed that it is critical for law enforcement officers to recognize Excited Delirium Syndrome suspects because it is a dangerous medical situation in which normal interaction skills may fail to eliminate the risks associated with the situation.¹⁵⁰ Very similarly to the training already suggested, the task force offered three general goals that law enforcement officers should be trained to accomplish.¹⁵¹ First, officers should be able to recognize Excited Delirium Syndrome and then successfully contain the subject, while calling for emergency medical services.¹⁵² Second, the officers must quickly, safely, and efficiently take the subject into

142. *Id.*

143. DI MAIO & DI MAIO, *supra* note 2, at 102.

144. Peters, *supra* note 53, at 58; *see also* Avery, *supra* note 7, at 293 (“Many of the deficiencies in police responses to mentally disturbed people result from officers treating such calls as criminal incidents rather than mental health emergencies.”).

145. DI MAIO & DI MAIO, *supra* note 2, at 98.

146. *Id.* at 100.

147. *Id.* at 102.

148. *Id.*

149. DEBARD ET AL., *supra* note 63, at *9.

150. *Id.* at *8.

151. *Id.* at *9.

152. *Id.*

custody.¹⁵³ Third, the officers must “then immediately turn the care of the subject over to EMS personnel when they arrive for treatment and transport to definitive medical care.”¹⁵⁴

In recognition of the seriousness of Excited Delirium Syndrome cases, police departments across the country offer training programs. Reports suggest that the police must be trained to handle these situations in order to protect themselves and those suffering from Excited Delirium Syndrome; yet, it is clear that the training needs to be improved. With training available, should the standards for use of force against individuals suffering from Excited Delirium Syndrome be changed to reflect the individual’s condition?

III. DETERMINING WHAT IS OBJECTIVELY REASONABLE FORCE

In the hypothetical, the deceased’s family would likely file a civil suit against the law enforcement officer and the local police department for the use of excessive force under 42 U.S.C § 1983.¹⁵⁵ The excessive force claim would be based on the use of the electric stun guns and the subsequent use of force to restrain the man. The question becomes whether the deceased’s condition of Excited Delirium Syndrome should alter the objectively reasonable standard for excessive force under the Fourth Amendment?

In *Tennessee v. Garner*, the United States Supreme Court held that, in the context of arresting or restraining a citizen, the constitutionality of the use of force is to be determined under the Fourth Amendment.¹⁵⁶ The Fourth Amendment guarantees:

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.¹⁵⁷

153. *Id.*

154. DEBARD ET AL., *supra* note 63, at *9.

155. 42 U.S.C. § 1983 (2006).

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or 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, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer’s judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable.

Id.

156. 471 U.S. 1, 7 (1985).

157. U.S. CONST. amend. IV.

The Court in *Garner* determined that excessive force claims fall under the Fourth Amendment because “[w]henver an officer restrains the freedom of a person to walk away, he has seized that person.”¹⁵⁸ Therefore, in cases where law enforcement officers are attempting to restrain or arrest an individual suffering from Excited Delirium Syndrome, the Fourth Amendment’s protection from unreasonable seizure is the controlling constitutional standard.

In *Graham v. Connor*, the Supreme Court expanded on its holding in *Garner* and held that to determine whether the force used by the officers was excessive under the Fourth Amendment, we must assess whether “the officers’ actions are ‘objectively reasonable’ in light of the facts and circumstances confronting them, without regard to their underlying intent or motivation.”¹⁵⁹ Furthermore, the Court concluded “[d]etermining whether the force used to effect a particular seizure is ‘reasonable’ under the Fourth Amendment requires a careful balancing of ‘the nature and quality of the intrusion on the individual’s Fourth Amendment interests’ against the countervailing governmental interests at stake.”¹⁶⁰

In *Graham*, Dethorne Graham brought an action under 42 U.S.C. § 1983 for injuries sustained from law enforcement officers during an investigative stop.¹⁶¹ That day Mr. Graham, a diabetic, asked his friend to drive him to a local convenience store because he felt the “onset of an insulin reaction.”¹⁶² Once inside the store, he realized that the checkout line was too long and left the store quickly with the intent to go to a nearby friend’s house.¹⁶³ Officer Connor observed Graham hastily leave the store and became suspicious.¹⁶⁴ He followed the car and then executed an “investigative stop.”¹⁶⁵ The driver explained that Mr. Graham was suffering from a “sugar reaction,” but Officer Connor required them to wait until he investigated what had happened at the store.¹⁶⁶ While Officer Connor investigated, Mr. Graham exited the vehicle and ran two laps around his vehicle before passing out briefly.¹⁶⁷ An arriving law enforcement officer rolled Mr. Graham over and handcuffed him tightly.¹⁶⁸ A third officer stated, “I’ve seen a lot of people with sugar diabetes that never

158. *Garner*, 471 U.S. at 7 (citing *United States v. Brignoni-Ponce*, 422 U.S. 873, 878 (1975)).

159. 490 U.S. 386, 397 (1989).

160. *Id.* at 396. (quoting *United States v. Place*, 462 U.S. 696, 703 (1983)).

161. *Id.* at 388.

162. *Id.*

163. *Id.* at 388–89.

164. *Graham*, 490 U.S. at 389.

165. *Id.*

166. *Id.*

167. *Id.*

168. *Id.*

acted like this. Ain't nothing wrong with the M. F., but drunk."¹⁶⁹ Once he gained consciousness, Mr. Graham offered to show the officers his diabetic decal that he carried, but the officers refused and shoved him face down on the hood and threw him headfirst into the backseat of the patrol car.¹⁷⁰ Moments later, the officers received a report that no crime was committed and released Mr. Graham at his home.¹⁷¹ During the altercation Mr. Graham suffered a broken foot, cuts on his wrist, a bruised forehead, and an injured shoulder.¹⁷²

The district court granted the officers' motion for directed verdict, finding that under the circumstances the force was appropriate, there was no injury inflicted and the force was used in a good faith effort.¹⁷³ The Court of Appeals for the Fourth Circuit was split, but affirmed the district court's decision, specifically upholding the district court's use of a four-part test.¹⁷⁴ The United States Supreme Court granted certiorari and held:

Today we make explicit what was implicit in *Garner*'s analysis, and hold that all claims that law enforcement officers have used excessive force—deadly or not—in the course of an arrest, investigatory stop, or other 'seizure' of a free citizen should be analyzed under the Fourth Amendment and its 'reasonableness' standard¹⁷⁵

Therefore, *Graham v. Connor* stands for the proposition that "the use of force during an arrest, an investigatory stop, or any other 'seizure' of a person at liberty is to be judged by Fourth Amendment standards"¹⁷⁶ that had "dominated federal cases involving the reasonableness of police uses of force since 1989."¹⁷⁷

The most recent seminal Supreme Court case involving the Fourth Amendment's objectively reasonable standard is *Scott v. Harris*.¹⁷⁸ In *Scott*, an officer had permission to use a "Precision Intervention Technique" to stop a vehicle by spinning it out during a high-speed chase.¹⁷⁹ Instead, the officer

169. *Graham*, 490 U.S. at 389.

170. *Id.*

171. *Id.*

172. *Id.* at 390.

173. *Id.* at 390–91.

174. *Graham*, 490 U.S. at 391. The four factors used by the district court were:

(1) the need for the application of force; (2) the relationship between that need and the amount of force that was used; (3) the extent of the injury inflicted; and (4) "[w]hether the force was applied in a good faith effort to maintain and restore discipline or maliciously and sadistically for the very purpose of causing harm."

Id. at 390 (citing *Graham v. City of Charlotte*, 644 F. Supp. 246, 248 (W.D.N.C. 1986)).

175. *Id.* at 395.

176. Avery, *supra* note 7, at 268.

177. Rachel A. Harmon, *When Is Police Violence Justified?*, 102 NW. U. L. REV. 1119, 1130 (2008).

178. 550 U.S. 372 (2007).

179. *Id.* at 375.

“applied his push bumper to the rear of respondent’s vehicle” causing the driver to lose control and violently crash.¹⁸⁰ Respondent was seriously injured and became a quadriplegic.¹⁸¹ Respondent sued the individual law enforcement officer under 42 U.S.C. § 1983.¹⁸²

The Supreme Court reaffirmed the use of the “objectively reasonable” standard under the Fourth Amendment for cases involving excessive force.¹⁸³ The Court stated that to determine an “easy-to-apply legal test” is futile because “we must still slosh our way through the factbound morass of ‘reasonableness.’”¹⁸⁴ In an 8–1 decision, the Supreme Court held that the officer’s termination of a high speed chase, which threatened the lives of innocent bystanders, was not unreasonable under the Fourth Amendment even though it risked serious injury or death to the driver of the fleeing vehicle.¹⁸⁵ This ruling was a significant change from *Graham* and *Connor* in respect to the Fourth Amendment’s objective reasonableness analysis because it creates a rule that provides little guidance on how to evaluate excessive force cases.¹⁸⁶ Although the United States Supreme Court has failed to provide a clear test, we can look at specific circuit court rulings to give guidance on how Excited Delirium Syndrome changes the analysis under the objective reasonableness test.

In 2001, the Ninth Circuit, in *Deorle v. Rutherford*, held “that where it is or should be apparent to the officers that the individual involved is emotionally disturbed, that is a factor that must be considered in determining, under *Graham*, the reasonableness of the force employed.”¹⁸⁷ In *Deorle*, Richard Deorle was upset and consumed a half-pint of vodka and legal prescription pills, which caused him to “los[e] control of himself” according to Mrs. Deorle.¹⁸⁸ Mrs. Deorle called 9-1-1 for assistance with her distressed husband.¹⁸⁹ After the first responding officer called for backup, at least thirteen officers responded, including a Special Incident Response Team.¹⁹⁰ Although Mr. Deorle was clearly agitated and verbally abusive, he was

180. *Id.*

181. *Id.*

182. *Id.*

183. *Scott*, 550 U.S. at 381 (“It is also conceded, by both sides, that a claim of ‘excessive force in the course of making [a] . . . “seizure” of [the] person . . . [is] properly analyzed under the Fourth Amendment’s “objective reasonableness” standard.’” (citing *Graham v. Conner*, 490 U.S. 386, 388 (1989))).

184. *Id.* at 383.

185. *Id.* at 383–86.

186. Harmon, *supra* note 177, at 1135–37.

187. 272 F.3d 1272, 1283 (9th Cir. 2001).

188. *Id.* at 1275–76.

189. *Id.* at 1276.

190. *Id.*

physically compliant.¹⁹¹ Officer Rutherford had observed Mr. Deorle's actions for thirty to forty minutes from behind a tree before he shot Mr. Deorle with a bean-bag deployed from his twelve-gauge shotgun.¹⁹² Mr. Deorle was not threatening Officer Rutherford nor did Officer Rutherford warn Mr. Deorle or ask him to halt.¹⁹³ Mr. Deorle brought suit after he had sustained serious injuries from the bean bag striking him in the face.¹⁹⁴ The district court granted summary judgment for Officer Rutherford and Mr. Deorle appealed.¹⁹⁵ The Ninth Circuit reversed the grant of summary judgment, finding that Officer Rutherford's use of force was excessive.¹⁹⁶

In its opinion, the Ninth Circuit explicitly refused to establish a per se rule that distinguishes between mentally disabled persons and serious criminals.¹⁹⁷ However, the court stressed that the mental condition, especially when the officer had a considerable amount of time to observe, must be considered under *Graham*.¹⁹⁸ This is because "[t]he problems posed by, and thus the tactics to be employed against, an unarmed, emotionally distraught individual who is creating a disturbance or resisting arrest are ordinarily different from those involved in law enforcement efforts to subdue an armed and dangerous criminal who has recently committed a serious offense."¹⁹⁹ This distinction explicitly recognizes that an officer who is fully aware of a suspect's mental instability should take the mental condition under consideration when determining whether or not to use force.²⁰⁰ The court created this requirement to be consistent with current law enforcement training and the training objectives suggested by doctors and mental health experts.

The Ninth Circuit is not alone; both the Eighth Circuit and Tenth Circuit have held that emotional disturbances are relevant to determining objective reasonableness. In *Ludwig v. Anderson*, the Eighth Circuit held that a petitioner's "emotionally disturbed status may be relevant to the trial court's determination of objective reasonableness."²⁰¹ The court, in part, justified the

191. *Id.* (noting that although Mr. Deorle brandished two weapons, a wooden board and a hatchet, he complied when told to put the weapons down).

192. *Deorle*, 272 F.3d at 1276–78. The court also noted that the bean-bag "rounds 'could have lethal capabilities' at thirty feet, and are potentially lethal at up to fifty feet." *Id.* at 1277.

193. *Id.* at 1278.

194. *Id.* ("The cloth-cased shot struck Deorle in the face, knocked him off his feet, and lodged 'half out of his eye.' Deorle suffered multiple fractures to his cranium, loss of his left eye, and lead shot embedded in his skull.").

195. *Id.*

196. *Id.* at 1286.

197. *Deorle*, 272 F.3d at 1283.

198. *Id.*

199. *Id.* at 1282–83.

200. *Id.* at 1283 (noting that, in instances of mental disturbance, "a heightened use of less-than-lethal force will usually be helpful in bringing a dangerous situation to a swift end").

201. 54 F.3d 465, 472 (8th Cir. 1995).

decision based on St. Paul's law enforcement training manual.²⁰² The manual set out in detail when it was reasonable for an officer to use force to control a situation, but more importantly it provided instructions on how to handle mentally ill persons.²⁰³ If the suspect was clearly suffering from a mental episode and not yet violent, the officer was instructed to "'reduce fear, anxiety and tension in the patient' by avoiding 'any show of force.'"²⁰⁴ The court noted that both of the law enforcement officers had been trained to handle emotionally distraught persons, and it was conceded that the petitioner was clearly emotionally disturbed.²⁰⁵ Therefore, the court held that the petitioner's emotional disturbance was material to the reasonableness of the officers' actions.²⁰⁶

Two Tenth Circuit cases are particularly helpful. In 2001, the Tenth Circuit, in *Cruz v. City of Laramie*, held that hog-tie restraint techniques when applied to an individual with diminished capacity is a constitutional violation under the Fourth Amendment.²⁰⁷ The court explained that diminished capacity can be the result of severe intoxication, drug abuse, a discernable mental illness, or "*any other* condition, apparent to the officers at the time, which would make the application of a hog-tie restraint likely to result in any significant risk to the individual's health or well-being."²⁰⁸ Although the court did not conclude that Mr. Cruz was suffering from excited delirium, the court did mention that the appellee provided articles and materials discussing "sudden custody death syndrome" and the dangers of positional asphyxia.²⁰⁹

When the officers arrived, Mr. Cruz was naked, swatting at invisible objects and yelling about swarming insects.²¹⁰ Without labeling the condition, the court held that it was beyond a doubt that Mr. Cruz's diminished capacity was apparent to both officers during the entire interaction; therefore, the officers violated the Fourth Amendment's protection against excessive force.²¹¹ Based on the limited facts, it seems plausible that Mr. Cruz was in fact suffering from Excited Delirium Syndrome. If so, the Tenth Circuit's holding suggests that Excited Delirium Syndrome and related law enforcement training are relevant circumstances for determining if excessive force was used.

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.*

206. *Ludwig*, 54 F.3d at 472.

207. 239 F.3d 1183, 1188 (10th Cir. 2001).

208. *Id.* (emphasis added).

209. *Id.* at 1189.

210. *Id.*

211. *Id.*

In 2008, the Tenth Circuit revisited the standards for excessive force and in-custody death with its decision in *Weigel v. Broad*.²¹² Bruce Weigel died due to what appeared to be cardiac arrest after a struggle with a law enforcement officer.²¹³ Witnesses described his behavior while resisting arrest as “bizarre,” “odd,” and “strange.”²¹⁴ The medical examiner’s autopsy labeled the cause of death as “mechanical asphyxiation caused by inhibition of respiration by weight applied to the upper back.”²¹⁵ The court, in determining the reasonableness of the trooper’s use of force, specifically noted the training of the trooper, which included extensive training on the “dangers of Sudden Custody Death Syndrome and positional asphyxiation.”²¹⁶ The Tenth Circuit held that the reasonableness of the trooper’s actions must be determined in light of his training for Sudden Custody Death Syndrome (which is synonymous with Excited Delirium Syndrome) and the mental capacity of the suspect.²¹⁷

Additionally, in 2008, the Ninth Circuit held that the status of someone suffering from a mental illness is relevant to the determination of what is an objectively reasonable use of force, but the court ultimately found the use of force reasonable.²¹⁸ In *Gregory v. County of Maui*, Richard Gregory lost his cool among friends and became violent.²¹⁹ Mr. Gregory began frantically pacing around the room, stating “we’re all going to hell” and that the devil was among them.²²⁰ When the law enforcement officers arrived, they found Mr. Gregory “high strung, excitable and jumpy;” loudly declaring God was with him; and “holding a pen with its tip pointed at them.”²²¹ Mr. Gregory refused to comply with the officers’ demands to drop the pen.²²² After a third refusal, the officers pinned Mr. Gregory to the ground and held his arms as he struggled.²²³ The officers also used a hold around Mr. Gregory’s neck and head, which the officers later insisted was not a chokehold, causing Mr.

212. 544 F.3d 1143 (10th Cir. 2008).

213. *Id.* at 1148–49.

214. *Id.* at 1148.

215. *Id.* at 1149.

216. *Id.* at 1150.

217. *Weigel*, 544 F.3d at 1155. It is important to note that what the court calls “Sudden Custody Death Syndrome” is synonymous with excited delirium. This is clear from the court’s description of the syndrome: “[I]n-custody deaths ‘tend to share elements which occur in a basic sequence: subjects display bizarre or frenzied behavior[;] almost always, subjects are intoxicated by drugs and/or alcohol[;] [there is a] violent struggle with police[;] and police use force and employ a type of restraint.’” *Id.* at 1150.

218. *Gregory v. Cnty. of Maui*, 523 F.3d 1103, 1109 (9th Cir. 2008).

219. *Id.* at 1104 (threatening “Don’t make me hit you.”).

220. *Id.*

221. *Id.* at 1105.

222. *Id.*

223. *Gregory*, 523 F.3d at 1105.

Gregory to repeatedly shout that he could not breathe.²²⁴ Once handcuffed, Mr. Gregory stopped breathing and efforts to resuscitate him failed.²²⁵ Mr. Gregory's estate sued under 42 U.S.C. § 1983, alleging, that the supposed chokehold constituted excessive force.²²⁶ The district court granted the defendants' motion for summary judgment, concluding the use of force was proportionate and reasonable.²²⁷

In its response to the motion for summary judgment, the estate offered the deposition of Dr. Vincent Di Maio, M.D., who stated that Mr. Gregory's death was caused by Excited Delirium Syndrome, which triggered cardiac arrest.²²⁸ The plaintiffs argued that reasonable officers should have recognized the Excited Delirium Syndrome, and thus the force used in physically restraining him was excessive.²²⁹

Ultimately, the Ninth Circuit held that "even accepting that Gregory was in such a state and that the officers should have recognized it, the officers' response to the threat Gregory posed—first confronting him verbally, and only then attempting to disarm and to restrain him—still was objectively reasonable."²³⁰ Although the court found this force to be objectively reasonable, the court recognized the reasoning in *Deorle* that the defendant's mental condition, which in this case was arguably influenced by Excited Delirium Syndrome, was relevant to the determination of excessive force.²³¹

In 2009, the Eleventh Circuit built upon the *Gregory* decision in *Mann v. Taser International, Inc.* by holding that Excited Delirium Syndrome presented a "serious medical need."²³² The court analyzed whether there was deliberate indifference under the Eighth Amendment which requires plaintiffs to show "(1) a serious medical need; (2) the defendants' deliberate indifference to that need; and (3) causation between that indifference and the plaintiff's injury."²³³ The court found that Excited Delirium Syndrome posed a serious medical need because a layperson would recognize that a delay in treatment would worsen the condition and would pose a significant risk of serious harm.²³⁴ However, the court found that the second requirement for deliberate indifference was not met because the record did demonstrate that the deputies were aware of

224. *Id.*

225. *Id.*

226. *Id.*

227. *Id.* at 1106.

228. *Gregory*, 523 F.3d at 1105.

229. *Id.* at 1106.

230. *Id.* at 1108.

231. *Id.* at 1109.

232. 588 F.3d 1291, 1307 (11th Cir. 2009).

233. *Id.* at 1306–07 (citing *Goebert v. Lee Cnty.*, 510 F.3d 1312, 1326 (11th Cir. 2007)).

234. *Id.* at 1307.

Excited Delirium Syndrome.²³⁵ Although the tests for excessive force (Fourth Amendment) and deliberate indifference (Eighth Amendment) are different, this case serves as implicit recognition of Excited Delirium Syndrome as a recognizable condition that could require alternative actions by law enforcement officers. The court suggested that if the Plaintiff presented evidence that indicated prior knowledge or training when dealing with Excited Delirium Syndrome, the officers' actions could have been considered to meet the element of the deliberate indifference.²³⁶ The Eleventh Circuit's analysis is consistent with the Fifth Circuit's 1998 decision in *Gutierrez v. City of San Antonio*, which established that training materials for law enforcement officers are relevant for sudden in-custody deaths, under the Fourth Amendment.²³⁷

In light of the uncertainty caused by the United States Supreme Court's holding in *Scott v. Harris*, no less than four circuit courts²³⁸ have begun to develop promising case law for what is objectively reasonable under the Fourth Amendment. Using these precedents, how should courts evaluate the recognition of and the training for Excited Delirium Syndrome in 42 U.S.C. § 1983 claims for excessive force?

IV. HOW SHOULD COURTS EVALUATE EXCESSIVE FORCE CLAIMS INVOLVING EXCITED DELIRIUM SYNDROME?

Although the Supreme Court has adopted the "totality of the circumstances" for what is objectively reasonable force, it has yet to determine whether or not being emotionally disturbed is a relevant circumstance.²³⁹ This is despite the growing controversy surrounding police interaction with emotionally disturbed persons, including cases involving Excited Delirium Syndrome.²⁴⁰ The failure to address the issue goes beyond the courts, as it has received "surprisingly little theoretical analysis," even in the world of academia.²⁴¹ This lack of coherent analysis has resulted in lower court hesitancy on whether the use of force should be altered when interacting with

235. *Id.*

236. *Id.* at 1308.

237. 139 F.3d 441, 447 (5th Cir. 1998).

238. The Eighth, Ninth, Tenth, and Eleventh Circuits have in some way recognized that either Excited Delirium Syndrome, or more generally mental disturbances, alter what is objectively reasonable.

239. Avery, *supra* note 7, at 331.

240. See Harmon, *supra* note 177, at 1186 (discussing the need for a workable doctrine to provide guidance for police officers and judges and help the public understand cases of alleged police violence).

241. *Id.* at 1183.

someone suffering from an emotional disturbance.²⁴² Furthermore, what is the relevance of training and accepted police practices in determining the reasonableness of force?²⁴³ The lack of court rulings and academic research undermines “both the evolution of a principled case law defining clear requirements for the legitimate use of police force and the development of an accessible and transparent framework that the public may use to analyze highly publicized uses of police force.”²⁴⁴ This Comment seeks to establish that Excited Delirium Syndrome should alter the totality of the circumstances if the officer is trained in handling Excited Delirium Syndrome and if the suspect is demonstrating symptoms and actions that would allow a reasonably observant officer to ascertain that the suspect has Excited Delirium Syndrome. First, the analysis will apply Excited Delirium Syndrome directly to the seminal Supreme Court cases on excessive force. Second, the analysis will apply the reasoning behind various circuit court decisions to Excited Delirium Syndrome.

In *Graham v. Connor*, Mr. Graham was suffering from a diabetic episode when police used, what appeared to be, excessive force.²⁴⁵ The Supreme Court remanded the case in order to determine whether the force was reasonable in light of all circumstances, likely including the diabetic state of Mr. Graham.²⁴⁶ *Graham* appears to stand for the proposition that courts must “balance the intrusion on the individual’s interests with the government’s competing interests, and [*Graham*] specified that courts must do so under ‘the facts and circumstances of each particular case.’”²⁴⁷ Specifically, *Graham* noted that these facts include, but are not limited to, “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 is actively resisting arrest or attempting to evade arrest by flight.”²⁴⁸ Although the Supreme Court does not explicitly state that Mr. Graham’s diabetic condition was a relevant circumstance, the opinion does seem to implicitly suggest that his diabetes could be relevant under the totality of circumstances analysis.²⁴⁹ If diabetes is relevant to explaining the actions of

242. See *Avery*, *supra* note 7, at 331 (noting that the Supreme Court’s failure to decide what circumstances are relevant to excessive force claims has led to inconsistent lower court decisions).

243. *Id.*

244. Harmon, *supra* note 177, at 1183.

245. 490 U.S. 386, 389 (1989).

246. *Id.* at 397, 399.

247. Harmon, *supra* note 177, at 1129.

248. *Graham*, 490 U.S. at 396.

249. *Id.* at 396–97 (emphasizing the necessity of a fact specific analysis to determine objectively reasonable actions for purposes of the Fourth Amendment). Additionally, the recognition of diabetes has empirically resulted in a change in law enforcement procedure due to increased civil liability. See Bill Lewinski, *10 Training Tips for Handling “Excited Delirium,”*

Mr. Graham, it seems quite plausible to hold that Excited Delirium Syndrome—which can be readily recognized by a trained officer—is a condition that, if present, is relevant in determining excessive force. In fact, according to one commentator, “[t]he most fundamental error that courts can make in these cases is to analyze the use of force against emotionally disturbed persons without factoring the person’s mental state into the calculation of whether the officer’s actions were reasonable.”²⁵⁰

However, the rule set out by the Court in *Graham* was undermined by the Court in *Harris*. Essentially:

[T]he Court rid itself of the clear rule of *Garner*, establishing instead a much narrower rule for most high speed chase cases; deemphasized, if not eliminated, any significant instruction to lower courts facing future cases about what to consider in evaluating police violence; and remained near silent about how to balance the interests of officers, suspects, and others.²⁵¹

Therefore, Supreme Court precedent can only create a framework for determining whether or not force was reasonable and likely fails to provide an answer.

The Ninth Circuit in *Deorle* made it clear that the mental condition of the suspect must be taken into consideration when determining excessive force.²⁵² This bold statement is justified because “[t]here is no principled basis for excluding from the calculus of constitutional reasonableness those actions of officers that contribute to an escalation of tensions that results in a violent outcome when they encounter an emotionally disturbed person.”²⁵³ Due to the high rates of mortality involving Excited Delirium Syndrome, the balancing of the suspect’s interest should weigh heavily because of the often-severe consequences inflicted upon the suspect. Instead of viewing people with Excited Delirium Syndrome solely as threats to society, it is imperative—as noted by many officers, doctors, and psychologists—that these situations be

POLICEONE.COM (Oct. 14, 2005), <http://www.policeone.com/columnists/Force-Science/articles/119828-10-training-tips-for-handling-excited-delirium> (“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.”).

250. Avery, *supra* note 7, at 299. According to William Everett, a member of the National Advisory Board of the Force Science Research Center, “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.” Lewinski, *supra* note 249. He went on to conclude that “[w]hen you put the latter subject in jail without proper medical attention and he dies, you have both a tragedy and a liability problem.” *Id.*

251. Harmon, *supra* note 177, at 1139 (citation omitted).

252. *Deorle v. Rutherford*, 272 F.3d 1272, 1283 (9th Cir. 2001).

253. Avery, *supra* note 7, at 332.

viewed as a “medical emergency.” Although, undoubtedly in many cases the person suffering from Excited Delirium Syndrome is a threat to physically harm others and themselves, there are methods that have been taught to police officers across the county to lessen those dangers without using force.

In 1995, the Eighth Circuit in *Ludwig v. Anderson* held that a suspect’s mental disturbance was relevant because of the extensive training for mental illness that the St. Paul Police Department received.²⁵⁴ Similarly, the Tenth Circuit in *Cruz v. City of Laramie*²⁵⁵ and *Weigel v. Broad*²⁵⁶ considered diminished mental capacity similar to Excited Delirium Syndrome—which the court refers to as Sudden Custody Death Syndrome—and the officers’ training in analyzing the reasonableness of the law enforcement officers’ use of force. Furthermore, although the Ninth Circuit in *Gregory v. County of Maui* found that the force used against an individual that was possibly suffering from Excited Delirium Syndrome was objectively reasonable, the court recognized that the syndrome was properly evaluated within the “totality of the circumstances.”²⁵⁷ In sum, the Eighth, Ninth, and Tenth Circuits have clearly stated that mental disturbances similar to Excited Delirium Syndrome and the associated law enforcement training are relevant in the evaluation of objectively reasonable force. Therefore, as Excited Delirium Syndrome training increases, it should be the precedent for the courts to enforce a higher standard of care for officers who choose to use force against individuals suffering from Excited Delirium Syndrome.²⁵⁸

Thus, a court faced with Excited Delirium Syndrome should look at the entirety of all the circumstances, including the condition of the suspect and the relevant training of the police officer, in determining whether or not the officer’s actions constituted excessive force.

254. 54 F.3d 465, 472 (8th Cir. 1995). Furthermore, “[a]lthough these ‘police department guidelines do not create a constitutional right’ . . . they are relevant to the analysis of constitutionally excessive force.” *Id.* at 472 (citation omitted) (quoting *Cole v. Bone*, 993 F.2d 1328, 1334 (8th Cir. 1993) & citing *Tennessee v. Garner*, 471 U.S. 1, 18–19 (1985)).

255. 239 F.3d 1183, 1189 (10th Cir. 2001).

256. 544 F.3d 1143, 1154 (10th Cir. 2001).

257. *Gregory v. Cnty. of Maui*, 523 F.3d 1103, 1109 (9th Cir. 2008).

258. As further proof, the Eleventh Circuit in *Mann v. International Taser, Inc.*, found that Excited Delirium Syndrome is a medical need and that it should be considered relevant *if* the officers have received training. 588 F.3d 1291, 1307 (11th Cir. 2009). Additionally, according to Dr. Vincent and Theresa Di Maio, early identification by police and emergency personnel is possible because of the obvious, and distinct, behavioral and cognitive indicators associated with excited delirium. This early identification of Excited Delirium Syndrome is essential because “[e]arly identification and intervention equates to death prevention from excited delirium syndrome.” DI MAIO & DI MAIO, *supra* note 2, at 105.

CONCLUSION

This is an interesting time in the understanding of how the diagnosis and treatment of Excited Delirium Syndrome alters what is “objectively reasonable” for allegations of excessive force. Although it appears a consensus is developing in recognizing the legitimacy of the condition, Excited Delirium Syndrome is relatively unknown and susceptible to skepticism. To better understand Excited Delirium Syndrome, the Council of the American College of Emergency Physicians task force briefly analogized Excited Delirium Syndrome to “the decades-long controversy over the causes of Sudden Infant Death Syndrome.”²⁵⁹

Although the task force is brief in its analogy, the comparison between Sudden Infant Death Syndrome (“SIDS”) and Excited Delirium Syndrome unveils striking similarities. Although accepted today as a legitimate cause of death, SIDS was, and in some respects is still today, a highly controversial topic.²⁶⁰ First described by Dr. J. Bruce Beckwith in 1969, SIDS, much like the definition of excited delirium, was described as follows: “[T]he sudden and unexpected death of an apparently healthy infant, typically occurring between the ages of three weeks and five months, and not explained by careful postmortem studies.”²⁶¹ Due to the unknown cause of death, many believed that the syndrome served as a scapegoat for parental negligence and, even worse, murder.²⁶² But over the years medical research has focused on determining characteristics that identify at-risk infants, as well as preventative measures to safeguard against SIDS.²⁶³ No longer is SIDS an unknown syndrome, and through years of medical research, parents are now more aware of the dangers and are trained by medical professionals to mitigate risks.²⁶⁴ Excited Delirium Syndrome, much like SIDS in the 1970s, is a largely unknown syndrome and is looked upon with great skepticism. However, like SIDS, recent research is indicating that Excited Delirium Syndrome is a verifiable syndrome, which can be easily identified and thus can be mitigated through specialized training for law enforcement and emergency service personnel. Only through acceptance of Excited Delirium Syndrome as a

259. DEBARD ET AL., *supra* note 63, at *4–5.

260. See Catherine L. Goldenberg, Comment, *Sudden Infant Death Syndrome as a Mask for Murder: Investigating and Prosecuting Infanticide*, 28 SW. U. L. REV. 599, 602 (1999) (describing SIDS as a label to “describe an infant death that cannot be explained”).

261. *Id.* at 601 (citing DORLAND’S ILLUSTRATED MEDICAL DICTIONARY 1644–45 (27th ed. 1988)). The definition of SIDS looks similar to excited delirium as Excited Delirium Syndrome is defined as “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.” DI MAIO & DI MAIO, *supra* note 2, at 69.

262. Goldenberg, *supra* note 260, at 603.

263. *Id.* at 606.

264. *Id.*

legitimate syndrome can the medical and legal professions develop standards of care for excited delirium—developments that will help save lives.

Although many questions surrounding Excited Delirium Syndrome remain unanswered, the existence of Excited Delirium Syndrome is becoming undeniable. As the diagnosis of the syndrome becomes more and more popular among medical examiners for in-custody deaths, the media scrutiny and public outrage will continue to grow. Courts in the near future will be faced with high profile cases involving Excited Delirium Syndrome and will be looked upon to establish sound case law on the standards of objective reasonableness under the Fourth Amendment.²⁶⁵ The development of such standards will rely on the continuing medical, academic, and legal research, as well as the evolving training for law enforcement officers.

The function of this Comment is to increase knowledge of Excited Delirium Syndrome in hopes of encouraging further research into methods of mitigating risks of in-custody deaths. As part of this movement, police departments across the country need to increase the training of its law enforcement officers to safely handle suspects suffering from Excited Delirium Syndrome. Furthermore, emergency medical personnel need to be trained in recognizing Excited Delirium Syndrome in order to increase the research data available. And finally, courts need to enforce the evolving standard of care by recognizing that Excited Delirium Syndrome, and the associated training of officers and medical personnel, is a relevant factor in analyzing the totality of circumstances for determining what is “objectively reasonable.” Only through this progression can the unexplainable deaths be explained and can future deaths be prevented.

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265. The development of case law will create pressure on law enforcement agencies and emergency service providers to provide better training on the dangers of excited delirium. See *Weigel v. Broad*, 544 F.3d 1143, 1155 (10th Cir. 2008) (“If Cruz had not been handed down, perhaps Wyoming troopers would not have received training on positional asphyxia and would be uninformed about the danger. But the reasonableness of an officer’s actions must be assessed in light of the officer’s training. The defendants’ training informed them that the force they used upon Mr. Weigel produced a substantial risk of death.”).

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