Office of the

YATES COUNTY SHERIFF

FRANCIS E. RYAN

Public Safety Building • 227 Main Street
Penn Yan, New York 14527-1720
Telephone: 315-536-4438

Web site: www.yatescountysheriff.gov **Email: sheriff@yatescounty.org**

Brandon C. Jensen, Undersheriff

PHONES: (315) area code

Emergency	**911**
Fax	536-5191
Administration	536-5172
Animal Control	694-6077
Civil Division	536-5174
Court Security	536-5107
Criminal Division	536-5176
Dispatcher	536-4439
Jail Division	536-5175
Juvenile Division	536-5177
Marine Division	536-5526
P.S. Comm. Div.	531-3214
Records Division	536-5178
Coroner	536-5172
STOP-DWI	536-5182
Tip Hotline	536-5558
Text Tip "Yates"	847411

November 13, 2024

Jenny Wadhwa
MuckRock
175171-50644719@muckrock.com

FOIL CR# 2024-10492

Dear Ms. Wadhwa:

This letter is in response to your Freedom of Information Law (FOIL) request that we received on November 1, 2024.

A departmental check has been completed per your request. Attached please find the delirium training materials.

This search is for Yates County Sheriff's Office records only.

For Sheriff Ryan, I am,

Sincerely yours,

Joy E. Jensen
C.A.T.S.
Records Access Officer

JEJ: jkh
XC: Records Division

ACCREDITED AGENCY

YATES COUNTY SHERIFF'S OFFICE LAW ENFORCEMENT PERSONNEL		CODE: LE-1-21 NUMBER:
POLICY AND PROCEDURE MANUAL		SUPERCEDES NR: NEW
SUBJECT: EXCITED DELIRIUM		PAGE 1 OF 4 PAGES DISTRIBUTION: ALL AUTHORIZED MANUALS

REFERENCES: NYSLEAP *******

AUTHORITY: SHERIFF RONALD G. SPIKE

DATE:

CHECKED
JUN - 4 2021
OFFICE OF
YATES COUNTY SHERIFF

POLICY:

This policy provides for the safe and appropriate response to individuals suffering from Excited Delirium (ED). The purpose is not to confine deputies into a particular response, but rather to recognize the dangers to all parties involved, and to give deputies an opportunity to have necessary resources on hand.

DEFINITION:

1. **EXCITED DELIRIUM:** Excited Delirium is described as "a state of extreme mental and physiological excitement sometimes associated with drug use characterized by exceptional agitation, hyperactivity, overheating, and excessive tearing of the eyes, hostility, superhuman strength, high pain tolerance, aggression, acute paranoia and endurance without apparent fatigue."
2. **MEDICAL RESTRAINT:** A restraint is any method that limits a person's ability to move around freely or reach normal body parts. There are two different types of restraints.
    a. **Chemical restraints** are medicine used to help a patient calm down and relax when they may hurt themselves or others. This medicine is not the regular medicines someone may take every day for your medical or emotional problems and can only be authorized by licensed medical personnel.
    b. **Physical restraints** are when a person is forced to stay in a chair or bed. This is done with special kinds of restraints placed on or near a person's body. These restraints cannot be easily removed by them.

PROCEDURES:

1. Identifying Excited Delirium:

    Although the describable symptoms of an individual suffering from ED vary, the following are the most common:

    - The individual may be sweating profusely and stripping off clothing

- The individual may be sweating profusely and stripping off clothing
- The individual may be destroying property, especially reflective objects or glass
- Individuals may show superhuman strength and high pain tolerance
- Acute Onset: You are told or observed that the individual "just snapped"
- The individual may be confused as to who they are or where they are
- The individual may not follow verbal commands to stop their behavior
- The individual may be incoherent and shouting unintelligible or bizarre content
- The individual may have a history of drug abuse

2. Dispatch Responsibility

   a. Although there are many different ways law enforcement can come into contact with individuals suffering from ED, the most common is being dispatched to an incident after a 911 call has been made to the Dispatch Center. Therefore, it is imperative that Dispatch Center personnel screen calls for indicators that the incident may involve someone experiencing ED.

      (a) It will not be the dispatcher's responsibility to identify that an individual is showing symptoms of ED, only to recognize that possibility and relay to responding deputies the symptoms/behavior that they are aware of.

   b. Questions may include, but are not limited to:

      1. Does the individual have a history of mental illness?
      2. Does the individual have a history of drug use/abuse?
      3. Has the individual recently stopped taking any prescription drugs?
      4. Is the individual destroying items and/or acting violently?
      5. Has the individual removed clothing and/or complaining of being hot?
      6. is the individual sweating profusely or are their eyes tearing excessively?
      7. Is the individual speaking, what are they saying?
      8. Finally the dispatcher should use available databases to check for prior law enforcement contacts with the individual or at the location of the incident.

3. Deputy Responsibility

   a. If a Deputy receives information leading them to believe the incident they are involved in has an individual experiencing ED they should:

      1. Request to have a supervisor respond to their location.

3. Deputy should ensure his / her action(s) and those of others on scene are recorded by the deputy's body worn camera. (BWC)
4. If possible, secure the scene to keep others from entering the location and evacuate the building the individual is located in.
5. If time permits, deputies should put on gloves before attempting to physically control an ED subject.
6. Whenever possible, when trying to physically restrain an individual suffering from ED, a reasonable amount of force should be employed.
7. Generally speaking, individuals experiencing ED have a high pain tolerance, therefore pain compliance methods (O.C. Spray, etc.) **can be ineffective.**
8. If possible, at least one deputy should be armed with a Taser. The device should not be used to gain compliance, but to create a window of disablement during which deputies can gain physical control of the subject. Additionally, using the Taser in "stun" mode **can be ineffective as this primarily is a pain compliance technique**.
9. As soon as the suspect is safely restrained and has been searched for weapons, EMS personnel should evaluate the subject and determine whether any "medical restraint" is necessary for the patients' medical management. If a medical restraint is utilized, the subject **shall** be transported to a hospital by ambulance. EMS personnel will determine what medical treatment the individual receives.
10. If possible, a deputy shall follow the ambulance to the hospital and brief medical personnel at the hospital regarding the subject's behavior.
11. The deputy will document the incident as they would under normal circumstances (Criminal Act, Use of Force, SMRR, or weapon deployment, etc.).
11. Although those individuals suffering from ED have been described as being in a "medical crisis", this should never deter personnel from taking appropriate measures to ensure their safety and the safety of others.

4. Supervisor Responsibility
   a. A supervisor who becomes aware of an incident involving an individual experiencing Excited Delirium:
      1. Shall acknowledge that they are aware of the call and are enroute.
      2. While it is desirous that a supervisor be on scene before deputies attempt to physically take control of the subject, it is not necessary. Supervisors should not stop deputies on scene from taking action unless they feel that an unresolved safety issue exists.

3. The supervisor will notify the Lieutenant of the incident as soon as practical if any injuries occurred and after the incident is under control.
4. The supervisor will review reports keeping in mind that the detail of the report should be comparable to that of a critical incident. Reports will be forwarded to the LE Lieutenant.

REFERENCES:

1. Force Science (https://www.forcesceience.org)
2. Lexipol (https://www.lexipol/resources)
3. FBI (https://www/fbi.gov)

ADMINSTRATIVE REVIEW:

June 2021

12
OCT
2021

Sidestepping the Excited Delirium Debate

BY VON KLIEM, JD, LL.M / FORCE SCIENCE NEWS / 3

Depending on who you ask, excited delirium syndrome (ExDS) is either a group of symptoms that warn of a life-threatening medical condition or it is a diagnosis invented by racist and abusive police to excuse murder.[1,2]

Among those that use the term ExDS, the medical consensus is that ExDS is not a unique disease but a group of symptoms with uncertain and varied causes.[3] Although drug intoxication is a common cause of ExDS, the World Health Organization includes in the ICD-10 more than 30 separate conditions that can lead to symptoms associated with ExDS.

As mentioned in a previous article, and it's worth repeating here, "The varied causes of ExD, the overlap of its symptoms with other conditions, and its rare occurrence are just some of the reasons first responders are not expected to diagnose ExD. Even so, the absence of a specific diagnosis does not negate the seriousness of the behavioral and physical symptoms."[4]

Fortunately, first responders are not trained to wait for a specific medical diagnosis before responding to potentially life-threatening symptoms. Whether ExDS proves to be a valid diagnosis or not, the need for containment, rapid de-escalation, and medical intervention for people in an agitated state of delirium is well-settled.

Trying to Pull Focus

Law enforcement and EMS training continues to focus on the latest de-escalation strategies, physical restraint techniques, and chemical sedation options to get suspected ExDS patients to advanced medical care safely. Ideally, this training is informed by professional medical groups like the American Medical Association, the National Association of EMS Physicians, and the American College of Emergency Physicians.

Unfortunately, discussions that should be aimed at identifying the best emergency response protocols for suspected ExDS cases have instead become racialized and

response protocols for suspected ExDS cases have instead become racialized and hyper-politicized. Conversations around ExDS have become volatile, divisive, and no longer reflect purely physiological or psychological considerations.[5]

Instead, added to the "excited delirium" discussion is the theory that ExDS was invented by "racist" police and corrupt medical organizations *for the purpose* of helping officers avoid accountability for excessive force and murder.[6] Proponents of this ahistorical and racialized view of ExDS must still contend with reports that observe, "By itself, ExDS carries an extremely high mortality risk, with approximately 2/3 of ExDS patients dying in the prehospital setting in the absence of any major trauma, physical restraint, *or police intervention* [emphasis added]."[7]

Staying Focused: The American College of Emergency Physicians

Despite the distractions caused by injecting political and social justice theories into ExDS discussions, first responders and emergency medical personnel still needed to know how to treat delirious, agitated, and combative patients effectively and safely.

In 2009, The American College of Emergency Physicians (ACEP) took the lead in therapeutic options and best practices for ExDS patient care and survival. Although not the first medical organization to formally recognize ExDS, ACEP has been at the forefront of ExDS discussions since publishing the *White Paper Report on Excited Delirium Syndrome*.[8]

In its 2009 paper, the ACEP Task Force identified the features of ExDS and those characteristics that were present in cases where the subject died. They provided expert insight into developing ExDS response protocols, including prioritizing verbal calming and de-escalation techniques. If those techniques failed, ACEP recommended rapid physical control measures that minimized the time patients spent struggling. When medically justified, ACEP recommended aggressive chemical sedation to facilitate evaluation and transport to advanced medical care.

Allegations of Bias, Conflict of Interest

Following ACEP's publication of their ExDS report, police critics continued to question the existence of ExDS and predictably started to question the motives of ACEP itself.

For context, ACEP represents tens of thousands of physicians from 53 chapters, including all 50 states, Puerto Rico, the District of Columbia, and Government Services. The 2009 ACEP Task Force consisted of 19 members who reported to the Board of Directors and Council, with Council members representing all 53 chapters. The Board of Directors and Council approved the report for publication.

Still, concerns about bias in the report were raised when critics learned that 3 of the Task Force members provided expert medical consultation and litigation support to Axon (manufacturer of TASERs). Two of these medical consultants were also employed as part-time police officers, relationships that were disclosed in the 2009 report.

Bias is certainly a fair question to investigate. However, critics of ExDS were still forced to contend with the scholarly research and experience of ACEP and its highly credentialed Task Force members. ACEP had convincingly argued that ExDS was a medical emergency and that response protocols were critically needed.

Sidestepping the Debate: The American College of Emergency Physicians

In 2021, ACEP returned to the ExDS conversation. Responding to questions from "its membership, the scientific community at large, community leaders, media, and governmental agencies," ACEP published another Task Force Report. This June 2021 report again focused on the prehospital evaluation, treatment, and management of patients who are delirious and agitated to the point where they cannot be safely or reliably evaluated.[9]

To sidestep the ExDS debate, ACEP took several important steps. First, their most recent study was conducted *de novo*, meaning they took a fresh look at the evidence. They were informed by the 2009 paper but did not approach their latest study as an update or refutation of the previous research.

Next, ACEP executed what they described as a "robust global conflict of interest

policy." This policy was intended to identify, disclose, and avoid conflicts or potential bias in its members. The conflict-of-interest policy was "not a direct response to critics of the 2009 white paper nor with specific concerns regarding the content of that paper." Even so, the persuasive impact from executing the conflict-of-interest policy was bolstered by the fact that none of the 2009 Task Force members were members of the 2021 Task Force or review panel.

Finally, ACEP publicly recognized the political controversy surrounding the term "Excited Delirium Syndrome." To avoid potential distractions and maintain focus on patient care and survival, ACEP chose to sidestep the issue again and simply refer to ExDS by the more descriptive terminology, "hyperactive delirium with severe agitation."

Problem solved.

The Task Force Report

Behind the brilliant ACEP pivot is an important report: *The ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings, June 23, 2021*.

The full report focuses on the evaluation, initial treatment, and effective medical interventions (chemical sedation options). Although the report was expressly written for EMS professionals and medical staff, law enforcement and other first responders will undoubtedly benefit from the insights.

Highlights from the report:

- "[A patient experiencing hyperactive delirium with severe agitation] needs rapid de-escalation and calming to allow for definitive medical evaluation and ongoing treatment, in order to avoid preventable fatality due to failure to manage the potential causative life threats, and to treat the danger inherent to the presenting condition."

- "Hyperactive delirium with severe agitation is a life-threatening constellation of signs and symptoms with numerous causes .... The combination of [symptoms] raises serious concerns for rapid physiologic deterioration and

death particularly in patients with underlying comorbidities (e.g., coronary artery disease, obesity, asthma)."

- "There are risks associated with empiric treatment [experience-based treatments] for a presumptive diagnosis in all aspects of medicine; nevertheless, such an approach is required when the patient's clinical condition necessitates the need for resuscitative interventions prior to a definitive diagnosis.

- "We strongly recommend that the urgency of intervention not inadvertently exclude simple, effective therapies. In a recent large, preliminary analysis of patients in law enforcement custody who were documented as combative and required an EMS response, non-pharmacologic intervention was all that was required in over 80% of cases. In nearly all cases, non-pharmacologic interventions may be attempted, *even if in parallel with preparations for pharmaceutical administration* [emphasis added]."

- "[T]he circumstances in which severely agitated patients are encountered may require immediate utilization of pharmacologic and physical interventions, but in many scenarios, it is still feasible to attempt verbal and non-verbal de-escalation initially.

- "It appears [verbal and non-verbal de-escalation] may be most effective when provided within a structured format, likely enhanced by assignment of specialized teams. The failure of these de-escalation techniques may indicate a much more severe form of agitation only amenable to treatment with sedating medications."

Sedation Not Recommended for Purely Law Enforcement Purposes

It is expected that law enforcement officers may be the first to arrive in cases involving patients experiencing hyperactive delirium with severe agitation. Even so

involving patients experiencing hyperactive delirium with severe agitation. Even so, a dual LEO/EMS response is ideal, with de-escalation and restraint efforts conducted in consultation with on-scene emergency medical personnel.

It's worth repeating, to increase patient survivability, ACEP recommends that physical control measures be selected to minimize the patient's exertion and time spent struggling. Physical control should be immediately followed by continuous medical assessment and treatment—including chemical sedation when medically justified.

Both the 2009 and the 2021 ACEP reports support sedation *when justified for medical reasons and to facilitate medical treatment.*

The 2009 report recommends sedation when necessary for medical assessments and intervention. It further recommends that chemical sedation "proceed concurrently with evaluation for precipitating causes or additional pathology."

The 2021 report recommends that medical treatment of hyperactive delirium with severe agitation be led by a physician board-certified in EMS Medicine or Emergency Medicine and that appropriately trained medical professionals on a physician-led care team decide prehospital medical treatments.

Neither report should be read to justify sedation for purely law enforcement purposes.

Read the Full ACEP 2021 Report Below.

VIEW FULL REPORT

Research Force Science News Excited Delirium Articles Below.

VIEW ARTICLES

1. See Byju, A.S., *Excited Delirium: How Cops Invented a Disease*, Current Affairs, April 13, 2021.

Accessed at https://www.currentaffairs.org/2021/04/excited-delirium-how-cops-invented-a-disease [↩]

2. See Kasha Bornstein, Tim Montrief, MD, Mehruba Anwar Parris, MD. Excited Delirium: Acute Management in the ED Setting. Emer. Mgmt. Resident. April 8, 2019, last accessed at https://www.emra.org/emresident/article/excited-delirium/ [↩]
3. Id. [↩]
4. Kliem, L.V., "I am concerned about excited delirium..." Force Science News, August 25, 2020, at https://www.forcescience.org/2020/08/i-am-concerned-about-excited-delirium/ [↩]
5. See Martin, L., *Agree to Disagree: Excited Delirium Syndrome as Volatile as the Term Itself*, Psychiatric Times, May 13, 2021. Accessed at https://www.psychiatrictimes.com/view/borderline-personality-disorder-3-things-you-need-to-do-for-patients [↩]
6. See note 1. See also, REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (June 2021), Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings, (Reference Committee E [↩]
7. DeBard ML, Adler J, Bozeman W, Chan T, et al: ACEP Excited Delirium Task Force White Paper Report on Excited Delirium Syndrome, September 10, 2009, last accessed on June 24, 2020, at https://www.prisonlegalnews.org/media/publications/acep_report_on_excited_delirium_syndrome_sept_2009.pdf [↩]
8. Note 2. [↩]
9. Hatten BW, Bonney C, Dunne RB, Hail SL, et al: ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings, June 23, 2021, last accessed on October 7, 2021, at https://www.acep.org/globalassets/new-pdfs/education/acep-task-force-report-on-hyperactive-delirium-final.pdf [↩]

AMA APA EMS Excited Delirium Excited Delirium Syndrome In Custody Death

PREVIOUS POST

New Study: Grip Strength and Shooting Performance

NEXT POST

New Research on Vision and Emotional Regulation for Effective Performance

3 RESPONSES

Morrell Sipe REPLY

October 13, 2021 at 7:40 am

Thank you for this insightful article.

LEO Round Table REPLY

October 21, 2021 at 3:25 pm

[…] https://www.forcescience.org/2021/10/sidestepping-the-excited-delirium-debate/ […]

Malcolm Field REPLY

December 24, 2022 at 2:41 pm

This is not a syndrome when you involve science, calling it an excited delirium or other title INCIDENT would be more apt and prevent bias in its assessment and management, and prevent future deaths or injury.
Medicine and psychiatric clinicians and law enforcement have over complicated this subject for many years and need address this!

LEAVE A REPLY

Comment*

Name*

Email*

Website

☐ Save my name, email, and website in this browser for the next time I comment.

Post Comment

1-800-526-9444

help@forcescience.com