PORAC Law Enforcement NEWS

FEBRUARY 2016

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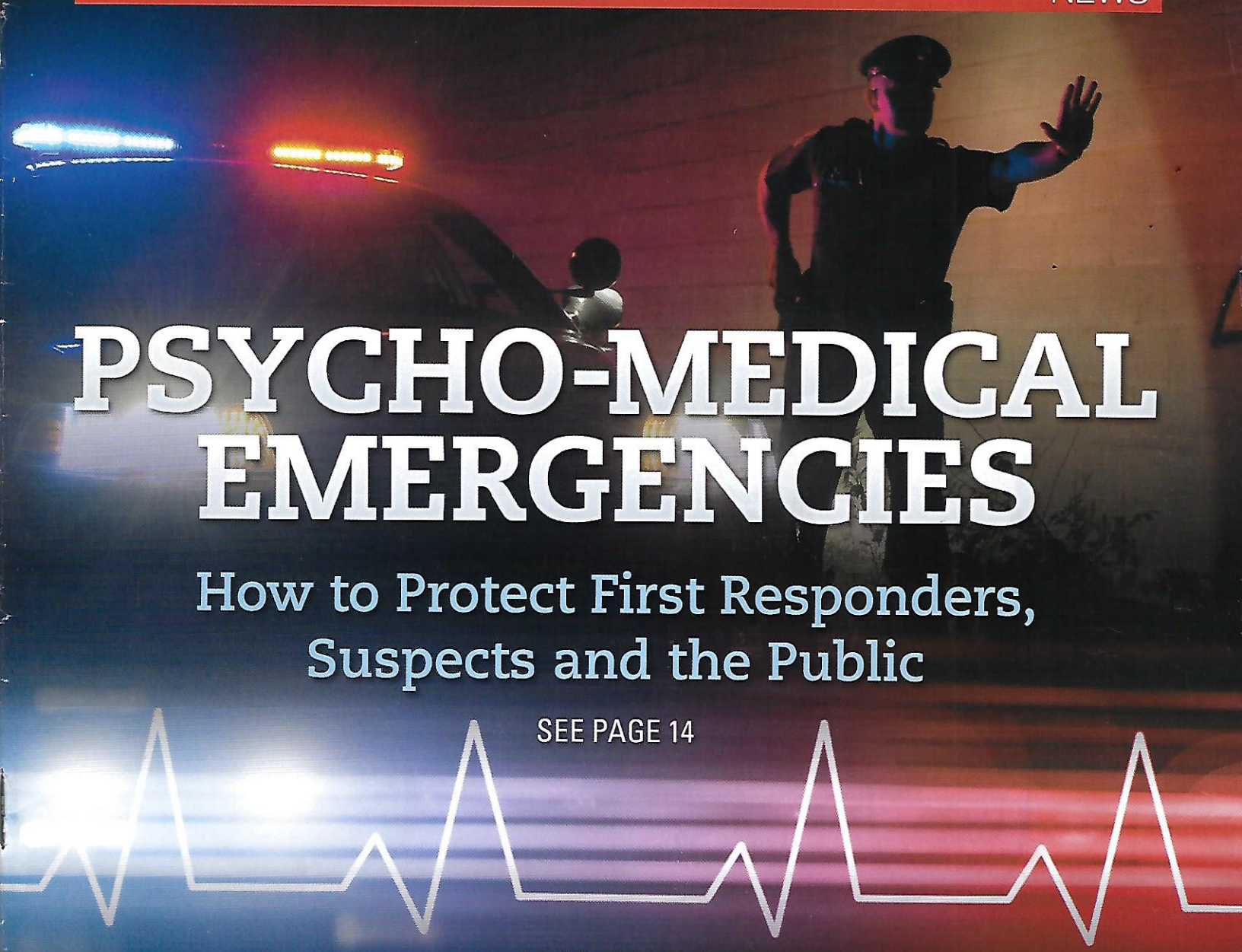

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RESPONDING to Psycho-Medical Emergencies

RON MARTINELLI, PH.D., CMI-V
Forensic Criminologist/
Certified Medical Investigator

On a hot July day, fire and police are called to the home of a 55-year-old man suffering from heat stroke. Police arrive first and find the man sitting on a bench in his front yard. When the officers approach the man and ask him to give them his cane, he becomes agitated and noncompliant. One officer suddenly grabs the cane away from the man, who screams and abruptly stands up. The man is tased, taken to the ground, beaten and handcuffed. He is transported to the hospital, where ER physicians confirm a diagnosis of heat stroke. The man has no criminal history. The numerous moderate injuries he sustained keep him from returning to work for several weeks. The officers and agency are sued and settle out of court.

Deputies are dispatched to a residence after their emergency 9-1-1 center receives a number of hang-up calls where the caller sounds agitated. They contact the parents and brother of a subject in his 30s who is agitated, chaotic and possibly under the influence of drugs. After being assured that the family will handle him, the deputies begin to leave, but then observe the son pulling his mother back into the house. The deputies re-enter the home and confront the son, who is clearly acting bizarrely. When the paranoid man hides behind his mother and hugs her from behind, the deputies decide to tase him. A violent struggle ensues to capture and restrain him, which results in the use of pepper spray and repeated hard baton strikes. The man becomes unresponsive and dies at the scene. The deputies and agency are sued. A civil trial jury finds that the deputies were poorly trained and used excessive force. The damages verdict is in the millions, the largest in the county's history.

On a warm early September morning, police receive numerous calls of a naked man running into the street, yelling that he is God and pounding on passing vehicles. The first officer to arrive on scene observes the subject walking out from behind a building and standing quietly on the curb. Without waiting for backup to arrive, the officer approaches and engages the man while yelling at him to put his hands up. The subject immediately becomes agitated. He yells at the lone officer and then rapidly approaches him while swinging a closed fist. The officer responds by tasing the man, who falls to the ground, disoriented. He sits up and is ordered to lie on his stomach while still being tased. Despite the presence of two more officers who could have physically controlled the subject, he is tased four more times before officers handcuff him. The man experiences respiratory distress and agonal breathing, then suffers a cardiac arrest and dies in custody. An autopsy finds no drugs in his system. The cause of death is classified as "natural" and listed as "agitated-excited delirium in concert with psychosis." The use of an electronic control weapon that delivered 21 seconds of electrical load in the upper chest within a 23-second time span is not even listed as a contributing cause of death. The officers and agency are sued for wrongful death and excessive force.

These are serious, life-threatening events that can rapidly degrade to sudden in-custody death incidents if not handled properly.

Hyperthermia, agitated-chaotic events, excited delirium syndrome, seizures, drug influence, mental health disorders and psychosis — all of these are classified as psycho-medical emergencies (PMEs). They are serious, life-threatening events that can rapidly degrade to sudden in-custody death (ICD) incidents if not handled properly. PME incidents are on the rise, as are the statistics for ICDs. As the high-profile ICD cases in West Palm Beach, Fla.; Kern County, California; and Baltimore, Maryland — to name just a few — demonstrate, PMEs are some of the most dangerous and challenging critical-incident circumstances that officers face. They are also an increasing area of criminal prosecution and civil litigation for officers, agencies and municipalities.

BEST PRACTICES FOR RESPONSE

Any response to a PME should be integrated and involve all of the first-responder role players: dispatchers, police, medical services directors, EMS and ER physicians. This cannot happen without first developing and implanting a solid training platform that teaches how to recognize the cues of a classic psycho-medical emergency, and then the best protocol of response, intervention and mitigation.

The best-practice multidisciplinary PME response protocol involves identification; pre-contact threat and assessment; isolation/containment; communication; capture, control and restraint; sedation; medical intervention and transport to hospital for treatment. All role players should have defined areas of responsibility and should understand that the ultimate objective is the safety of the public, themselves and the subject.

While officers and dispatchers are not physicians equipped to diagnose, they should be properly trained to assess and evaluate subjects to determine whether they might be experiencing a psycho-medical emergency. Training should involve recognition of four basic signs of psycho-medical distress, which are categorized as verbal, physical, behavioral and psychological. Responders need to quickly determine whether the subject's cues indicate that they are gravely disabled, in need of immediate medical intervention or a danger to themselves and/or others sufficient to justify an involuntary commitment to a hospital or psychiatric facility for evaluation.

DISPATCHERS

Dispatchers should be trained to recognize the cues of agitated, chaotic, abnormal, bizarre and under-the-influence behavior from 9-1-1 callers, reporting persons and witnesses. These should be accurately documented in the computer-aided dispatch log and thoroughly described to responding officers, supervisors and EMS personnel, who should be dispatched at the same time as officers. Dispatchers should be trained to provide as much information as possible so that responding officers and EMS personnel can develop tactical plans and make decisions regarding staging plans while en route to the call.

OFFICERS

Officers should be trained to handle every potential PME call as a high-risk critical incident. In the absence of a supervisor, officers should immediately engage the trained PME protocol. A critical component of the arrival protocol once the suspected PME subject is located is to conduct a pre-contact threat and PME assessment.

In the case of subjects presenting with agitated-chaotic behavior, it is extremely important that officers not compress distance in approaching the subject unless exigent circumstances exist. Case histories have clearly shown that distance compression with delirious and/or paranoid subjects significantly increases agitation, which in turn can exacerbate their psycho-medical condition. Getting too close too quickly also compromises the reactionary gap of officer action-reaction lag time in controlling and defending against violent subjects. This scenario rarely ends well for officers and subjects.

Whenever safe and practical to do so, officers should make sure that all components and resources are marshaled and immediately available to engage and complete the capture/control, sedation and medical intervention of the PME subject. EMS should be staged at a safe location proximate to the scene to allow for a rapid response.

EMS should be equipped to administer sedatives such as Versed nasally or ketamine intramuscularly, as needed. It is critical for officers to understand that most agitated-chaotic subjects are hyperthermic (overheated) and may be presenting with agitated-excited delirium syndrome (ExDS), which is often fatal during or immediately following police uses of force. Therefore, it is important that these subjects be medically sedated as soon as possible to reduce cardiovascular stressors that lead to respiratory and cardiac failures, which are major causes of sudden in-custody death.

The best engagement with an agitated-chaotic PME subject is one that avoids unnecessary uses of force. Always have a studied response, rather than an emotional reaction, to perceived or actual resistance. If the subject is not presenting with extreme agitation, delirium or hallucinations, attempt to calmly and patiently converse with them to assuage them and calm them down. Try not to yell orders, directions or commands. Maintain distance and continue to assess the subject's ability to comprehend and comply. If force is anticipated and must be used, make sure that your arrest/restraint team is ready. Have a plan and move quickly with commitment. If you use an electronic control weapon (ECW), remember to minimize load cycles and cuff the subject under load. While ECWs or body compression alone rarely cause death, they most certainly exacerbate the factors that caused the subject's psycho-medical emergency, and can significantly increase respiratory and cardiovascular stressors.

SUPERVISORS

Supervisors should be trained to immediately respond to the scene to manage personnel, provide direction and logistical support, and assist in managing any potential crime scene that might result from a major use of force. Remember that evidence collection at the scene is critical.

Supervisors should always be present at the hospital to provide ER staff with an immediate medical history of the PME subject's cues at the scene and all force that was used. If the supervisor does not know this information, radio for one of the involved officers to provide these important details.

Evidence collection at the hospital is every bit as critical as at the scene, because ER staff are concerned with saving lives, not collecting evidence. Photograph and video the subject to capture any verbal, physical, behavioral and/or psychological cues. It is critical to have the ER staff capture and document internal body core temperatures to confirm hyperthermia.

MEDICAL DIRECTORS

Medical directors need to work with law enforcement to establish medical response and intervention protocols for handling PMEs, as well as forensic investigation protocols for the proper identification, documentation and collection of medical evidence to diagnose subjects who die in custody and determine the accurate cause of death, manner of death, contributing causes of death and any mechanisms of injury associated with an ICD.

SUMMARY

Psycho-medical emergencies have become one of the most serious, challenging and risky scenarios that law enforcement and medical professionals face today. They often result in serious injury and in-custody death to the PME subject and will most likely be heavily scrutinized by the media and litigated as either a civil rights or criminal case. It is imperative that all responders to a PME incident know their roles and follow the PME response and evidence collection protocols when dealing with subjects in distress. ✪