From the Perspective of the Medical Examiner: Analysis of 2 Cases of Excited Delirium

Dr. Judy Melinek
Assistant Medical Examiner
San Francisco

CONFIDENTIAL

DO NOT DUPLICATE, REPRODUCE OR OTHERWISE DISTRIBUTE THIS PRESENTATION

Pursuant to Section 129 of the California Code of Civil Procedures, no copy, reproduction, or print of the images included in this presentation may be made without the written permission of the Medical Examiner.

The opinions expressed are those of the presenter and do not represent the policies and/or procedures of the San Francisco Office of the Chief Medical Examiner.

Introduction

- 2 cases of Excited Delirium Syndrome
  - Case #1: Person under the influence
  - Case #2: Solitary suspicious death
- Scene & Investigative Findings
- Autopsy
- Final Conclusions & Basis for my opinions
- Take Home Messages

Case #1

- KS was a 43 year old male who went to a concert with his friend "Steve".
- At the start of the concert KS took some "E" and started acting strangely.
- Staff observed him masturbating in public.
- They escorted him to the stairs, but he started flailing him arms and refused to descend.

Case #1

- Four security personnel (off-duty police officers) restrained him, while a nurse got on his back to calm him down.
- They carried him down another set of stairs to a side alley.
- He resisted violently.
- He was held prone on the pavement with his arms handcuffed behind his back when he had a sudden cardiorespiratory arrest.

Case #1

- He was immediately flipped over and CPR initiated.
- Paramedics came, attempted CPR and transported him to the hospital (since he was in public view).
- He was declared dead on arrival to the Emergency Room.

Case #1: Investigator's Report

- Case was immediately referred to Homicide
- The manager of the auditorium had all employees document their actions in writing
- Interview with Father & Friends:
  - No previous medical history except for childhood asthma (father)
  - No mental health history (both)
  - History of previous substance abuse (friends)

Autopsy

Obese: BMI 32.0 lbs/in^2

- Bite mark on tongue
- Blood in oral cavity
- No aspirated blood in:
  - Larynx
  - Pharynx
  - Glottis
  - Lungs

Petechiae & Congestion

Injuries Associated with Medical Therapy

Injuries Associated with Medical Therapy

Rib Fractures: CPR or trauma?

- Right fifth rib x 2
  - Costo-chondral
  - Anterolateral
- Non-displaced
- No injury:
  - Pleura
  - Pericardium
  - Pneumothorax
  - Hemothorax

Handcuffing

Handcuffing

Restraint associated trauma

Restraint associated trauma

Restraint associated trauma

Reflection of the skin

- Incisions made along the back, backs of the legs and arms, and the skin reflected forward to visualize occult injury
- Technicians can suture & body remains viewable.

Anterior Neck Dissection

Reflection of the skin

- Documentation of *negative* findings: the absence of injury.

Reflection of the skin

Reflection of the skin

Full Autopsy: Including spinal cord

Case #1: Autopsy Questions

- Petechiae: Passive congestion or positional/compressive asphyxia?
- Blood on face and in oral cavity: Intubation injury or inflicted trauma?
- Chest trauma and rib fractures: CPR or inflicted injury?
- *What is the cause of death?*

Case #1: Autopsy Findings

- Obesity:
  - BMI (32.0 lbs/in2)
  - Abdominal wall thickness: 1 inch
  - increased internal fat: "fatty liver"
- Heart Disease:
  - Coronary artery arteriosclerosis
- Nutrition/Bone density:
  - Slight osteoporosis

Case #1: Subsequent Investigation

- Police: Discussion with ME guides investigations about who to interview and what to ask
  - Interviews with staff
  - Interviews with paramedics
  - Interview with friend
- *Specific questions:*
  - Height & weight, relative positions, sweating?
  - Difficulty with intubation, CPR, transport
  - Appearance/respiration while prone, drug use

Case #1: Subsequent Investigation

- Medical Examiner:
  - Spoke to the family on a monthly basis to keep them appraised of the progress, or just to "touch base"
  - Personally interviewed girlfriend and father about drug use and medical history
  - Attended interview with paramedic
  - Reviewed 3 volumes of police reports and transcribed interviews

Key Findings from Investigations

- No noted hyperthermia.
- When held prone immediately prior to arrest: few minutes, no pressure applied to his back, friend witnessed normal respirations until sudden arrest
- No witnessed beating, dropping while carrying or inflicted head or neck injury
- Friend and police confirm that injury to face was when he was struggling in face-down position on pavement

Key Findings from Investigations

- No respiratory difficulty or airway obstruction by blood
- Intubation difficult: multiple attempts
- While in ER, minutes after KS pronounced dead “Steve” said that he spontaneously saw bloody fluid come out of his nose and mouth and cover his face

Toxicology

- Blood (Cardiac) and Liver
  3,4-Methylenedioxymethamphetamine:
  0.8 mg/L
- Blood cannabinoids and urine cannabinoids
- Urine and Liver cocaine
- Urine MDMA metabolites
- Vitreous electrolytes WNL

Case #1: Cause of Death

- CAUSE OF DEATH:
  - Acute Ecstasy (MDMA) and Cannabinoid Intoxication with Prone Restraint During Physical Struggle
- OTHER CONDITIONS CONTRIBUTING TO DEATH:
  - Arteriosclerotic coronary artery disease, obesity, chronic cocaine abuse.

Case #1: Medical Examiner’s Report

- Documentation: Activities, 104 photographs
- Microscopic sections of injuries
- Microscopic sections of rib, heart + nodal
- Section of brain frozen and preserved for potential neurochemical analysis
- Stock jar: portions of all major organs, entire spinal cord, neck block
- Complete Toxicology: scalp hair saved

Case #1: Autopsy Report

- Opinion:
  - Summary of events (based on investigation)
  - Summary of records reviewed
  - Explanation of cause of death: “In this case, the cause of death was due to the direct effects of acute intoxication with MDMA and cannabinoids combined with the physiologic stress of a violent physical struggle and prone restraint”
  - Explanation of Manner as it pertains to jurisdiction
- Selected References

Case #1: Lessons

- Working together with homicide inspectors to treat all restraint-associated cases as homicides is imperative.
  - You can’t interpret injury accurately without the full story.
- Keeping the family of the deceased informed during what is a months-long investigation is imperative in earning their trust and getting the information you need.

Case #2

- *If a tree falls in the forest and there is no one there to hear it – does it make a sound?*
- Is there such as thing as *Excited Delirium Syndrome* when there is no one there to witness it?

Case #2

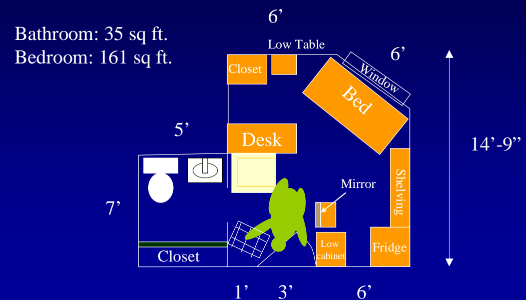
- JN was a 57 year old man who was found deceased in his residence (an SRO/half-way house) by a manager performing a well-being check.
- He hadn't been seen in 3 days and another tenant was concerned.
- The manager could barely open his door, and called 911/Paramedics

Case #2: Scene Investigation

- Body naked, kneeling behind the door.
- To its left a broken mirror.
- Microwave oven on the back: moved by investigators to nearby easy chair.
- Debris and personal property strewn about.
- Cabinets open.
- Only window cracked open: interior crank.

Case #2: Scene Investigation

Bathroom: 35 sq ft.
Bedroom: 161 sq ft.



Case #2: Autopsy Findings

- Lividity:
  - Corresponding to position of body
- Blunt Trauma:
  - Contusions on the back, buttocks and anal area
  - Patterned contusions (grab mark?) on the upper arm
  - Contusions on the face including lacerations of the left frontal scalp (dependant)

Case #2: Grab Mark?

Head

- Laceration
- Contusion
- Lividity

Case #2: Subsequent Investigation

- Police
  - Interviews with:
    - Neighbor: “he would re-arrange his room”
    - Other tenants: last saw him
    - Friends and family: liked “rough sex”
    - Social workers and staff at building
  - 60 hours of videotape of hallway leading to door and elevator: *Thank you Insp. Delahunty!*

Case #2: Subsequent Investigation

- Medical Examiner
  - Interviews with:
    - Family
    - Social worker: medications, previous episodes
  - Review of Medical Records
  - Returned to scene and viewed videotape of hall and elevator
  - Toxicology: drugs of abuse & medications

Case #2: Excited Delirium Syndrome

- Psychostimulant drugs (methamphetamine)
- Psychiatric illness
- History of previous violent/paranoid events
- Naked
- Broken glass
- Physical exertion and blunt force trauma
- Prone restraint and airway obstruction

Case #2: Cause of Death

- CAUSE OF DEATH:
  - Probable excited delirium due to acute methamphetamine intoxication
- OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH:
  - Asphyxia with torso compression and blunt force trauma; panic disorder, anxiety disorder, bipolar disorder.
- MANNER: Accident.

Case #2: Lessons

- Working together with homicide inspectors to treat some suspicious deaths as homicides is imperative.
  - You can’t interpret injury without the full story.
- Cooperation leads to more effective investigation: what could have been an undetermined death, was instead closed as an accident: closure for the family.

Take Home Messages: Law Enforcement

- Treat *every* in-custody death as a potential homicide: preserve scene, photograph, document, witness interrogation & statements
- Be open to sharing information about the police investigation in an in-custody death
- Know your local pathologist:
  - They have a lot of experience in interpreting injury.
  - Understand their background: credibility.

Take Home Messages: Forensic Pathologists

- Keep up on the literature.
- Respect the high-profile nature of in-custody deaths: public relations and family dialogue
- Be open to challenges up front:
  - Demand additional investigative information
- Be wary of interpreting injury before you have all the information:
  - CPR vs. Blunt Trauma from assault
  - Self-inflicted vs. Inflicted by others
  - Inflicted prior to/during/after arrest

Take Home Messages: Coroners

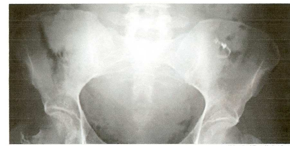
- Make sure your pathologists are qualified:
  - Certified in forensic pathology by the American Board of Pathology
- Make sure in-custody deaths and all suspicious deaths get the attention they deserve:
  - Full autopsy & toxicology
  - Pathologist has access to police & medical records
  - Pathologist needs proper equipment and storage
- Public relations: prepare the family for the complexity and length of the investigation

Take Home Messages: Attorneys & Risk Managers

- In some jurisdictions, the real investigation into an in-custody death occurs after the ME's report is finished.
- Be aware that severely traumatized bodies sway juries, even when trauma is not the cause of death.
- Engaging the deceased's family may decrease litigation and minimize financial penalties.

New York Times: May 18, 2008

"What often transforms a reasonable patient into an indignant plaintiff is less an error than its concealment, and the victim's concern that it will happen again."



Doctors Say 'I'm Sorry' Before 'See You in Court'

University of Illinois Medical Center

An electrode, at right in X-ray, was left inside Maria Del Rosario Valdez when her son was delivered by Caesarean section.

By KEVIN SACK
Published: May 18, 2008

CHICAGO — In 40 years as a highly regarded cancer surgeon, Dr. Tapas K. Das Gupta had never made a mistake like this.

Carlos Ortiz for The New York Times

When an electrode was left inside Maria Del Rosario Valdez after her son was delivered by Caesarean section, she was gratified that the hospital quickly acknowledged its mistake and corrected it without charge.

As with any doctor, there had been occasional errors in diagnosis or judgment. But never, he said, had he opened up a patient and removed the wrong sliver of tissue, in this case a segment of the eighth rib instead of the ninth.

Once an X-ray provided proof in black and white, Dr. Das Gupta, the 74-year-old chairman of surgical oncology at the University of Illinois Medical Center at Chicago, did something that normally would make hospital lawyers cringe: he acknowledged his mistake to his patient's face, and told her he was deeply sorry.

"After all these years, I cannot give you any excuse whatsoever," Dr. Das Gupta, now 76, said he told the woman and her husband. "It is just one of those things that occurred. I have to some extent harmed you."

SIGN IN TO E-MAIL OR SAVE THIS
PRINT
SINGLE PAGE
REPRINTS
SHARE

New York Times: August 7, 2008

"The interesting thing about it is the errors the defendants make are much more costly."

Study Finds Settling Is Better Than Going to Trial

By JONATHAN D. GLATER
Published: August 7, 2008

Note to victims of accidents, medical malpractice, broken contracts and the like: When you sue, make a deal.

Jim Wilson/The New York Times

Avoid a trial, Randall Kiser advises.

That is the clear lesson of a soon-to-be-released study of civil lawsuits that has found that most of the plaintiffs who decided to pass up a settlement offer and went to trial ended up getting less money than if they had taken that offer.

"The lesson for plaintiffs is, in the vast majority of cases, they are perceiving the defendant's offer to be half a loaf when in fact it is an entire loaf or more," said Randall L. Kiser, a co-author of the study and principal analyst at DecisionSet, a consulting firm that advises clients on litigation decisions.

Defendants made the wrong decision by proceeding to trial far less often, in 24 percent of cases, according to the study; plaintiffs were wrong in 61 percent of cases. In just 15 percent of cases, both sides were right to go to trial — meaning that the defendant paid less than the plaintiff had wanted but the plaintiff got more than the defendant had offered.

Multimedia

Graphic
The Cost of Going to Trial

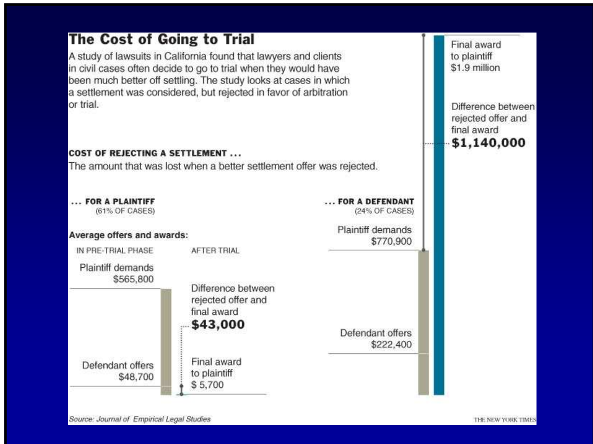
Readers' Comments
Readers shared their thoughts on this article.
Read All Comments (153) »

The vast majority of cases do settle — from 80 to 92 percent by some estimates, Mr. Kiser said — and there is no way to know whether either side in those cases could have done better at trial. But the findings, based on a study of 2,054 cases that went to trial from 2002 to 2005, raise provocative questions about how lawyers and clients make decisions, the quality of legal advice and lawyers' motives.

Critics of the profession have long argued that lawyers have an incentive to try to collect fees that are contingent on winning in court or simply to bill for all the hours required to prepare and go to trial.

"What I would want them to look at was whether or not the lawyers had a strong financial incentive to go to trial," said Cristina C. Arguedas, a criminal defense lawyer in Berkeley, Calif., when told of the study. "I'm not suggesting the answer, because I don't know, but

COMMENTS (153)
E-MAIL
PRINT
REPRINTS
SAVE
SHARE


The Cost of Going to Trial
A study of lawsuits in California found that lawyers and clients in civil cases often decide to go to trial when they would have been much better off settling. The study looks at cases in which a settlement was considered, but rejected in favor of arbitration or trial.
COST OF REJECTING A SETTLEMENT ...
The amount that was lost when a better settlement offer was rejected.
... FOR A PLAINTIFF
(61% OF CASES)
Average offers and awards:
IN PRE-TRIAL PHASE
AFTER TRIAL
Plaintiff demands $565,800
Difference between rejected offer and final award
$43,000
Defendant offers $48,700
Final award to plaintiff $ 5,700
... FOR A DEFENDANT
(24% OF CASES)
Plaintiff demands $770,900
Defendant offers $222,400
Final award to plaintiff $1.9 million
Difference between rejected offer and final award
$1,140,000
Source: Journal of Empirical Legal Studies
THE NEW YORK TIMES

KES
"I see a beautiful young woman. You're naked, she's leaning over you. Oh, wait. She's performing your autopsy! "