Excited Delirium

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Abstract

This paper will discuss several factions with excited delirium. I will discuss what the term excited delirium means, and where it came from. This paper will cover the many different ways excited delirium may be brought on, what happens to the body when it is experiencing excited delirium. Possible ways to decrease the occurrence of excited delirium, and will look into any nexus or correlation between the uses of "tools" in gaining compliance from the subjects, specifically a Taser.

Intro/Literature Review

Excited Delirium, what is this term? What does it mean? Where did it come from? There has been much controversy into what has caused and contributed to unexplained in-custody deaths in the past several years. Within the last few years there have been two primary resources/tools used by law enforcement to gain control and or compliance of suspects. Those two tools are pepper spray and the conducted energy weapon, more commonly known as Taser. In-custody deaths are generally given a cause of death but until recently these causes have been general. For example cocaine psychosis, cardiac, or many other terms that would sound familiar to the trained or untrained person. More recently there has been a new term for many unexplained deaths this term is "Excited Delirium." What is it, how is it brought on, what can be done to decrease its occurrence and is there any nexus to these types of in custody deaths and electro muscular disruption; more commonly known as Taser?

The term excited delirium is a recent name given to a cause of death that may encompass several criteria. You do not need all of the following factors to be a victim of excited delirium, but when one or more of them combine your likeliness to suffer from it are greater. Some things found to be signs of or symptoms of excited delirium are: "…bizarre or aggressive behavior, dilated pupils, high body temperature, incoherent speech, inconsistent breathing patterns, fear, panic, severe sweating, shivering and nakedness." (MDFR, 2007) These are just a few actions by persons that have been documented. According to this same protocol written by Miami Dade Fire Rescue there are also several possible causes of excited delirium. These causes are not limited to but include the following: "Overdose of stimulant or hallucinogenic drug, drug withdrawal, psychiatric patient off medication, illness, low blood sugar, psychosis, and head trauma" (MDFR, 2007). Excited delirium is believed to be a real and diagnosable disorder, and was first seen in the 1980s. In an article by Farnham he defines excited delirium as a "…state of mental and physiological arousal, agitation, hyperpyrexia with epiphora, and hostility" (Farnham & Kennedy, 1997).

While it is still unclear what exactly causes excited delirium there was much talk about this being around but called many different things and only since drug use has come into the picture has it finally started to receive the title or diagnosis of excited delirium. Many of the articles and databases used within this investigative report have stated that most of these types of deaths have occurred while the person is in police custody, or other places where there may be instances where physical confrontation may or may have already occurred. Excited delirium has contributing factors. When a person has a history of heart disease, drug use, and possibly even mental illness and they then get into a physically responsive state this begins the onset of events that lead up to excited delirium. When the person is struggling the body releases chemicals called catecholamines. When this is done and released into the body's circulation the body then reacts by pumping the heart faster, and thus the heart wants more oxygen. The person's potassium levels drop distinctly. When you combine this and many other medical terms together you find the heart beats faster, is not getting enough oxygen, and the arteries to the heart are constricting shutting down the blood flow. Once the person stops the struggle and there is a time of cessation, this is when the heart shuts down. Dr. Vincent DiMaio wrote a letter to a police agency explaining the death of a person. In this letter he states "…Danger time for arrhythmias in individuals with excited delirium is immediately following the cessation of physical activity, when blood catecholamine concentrations continue to rise while potassium levels drop…" (DiMaio, n.d.).

The term excited delirium came around in the early 1980's but was more widely known now in the early 2000's due to media coverage. In a book by Doctors Theresa and Vincent DiMaio they discuss the first references to excited delirium being within literature found in psychiatric books during the mid to late 19th century. This information was found not only in the United States but also in Europe (DiMaio & DiMaio, 2005). There were multiple names given for deaths that occurred during this time, and all seemed to have common attributes and were given the following different names "…acute exhaustive mania, Bell's mania, fatal catatonia, acute exhaustive psychosis, etc" (DiMaio, pg. 7). Physicians finally simplified their multiple diagnoses and started titling these deaths as "Bell's Mania". This diagnosis was given to the newly discovered disease because patients were dying and no one knew why. "Bell goes on to state that there are no residual impairment of mental integrity and the cure is permanent" (DiMaio, pg 8). Throughout the study findings showing death occurring at various time frames; within minutes or even hours after the start of the symptoms.

No one can say for sure what exactly brings on, or initiates the process within the body for excited delirium to occur. Within the law enforcement field there have been several tools that people have tried to link to this type of death, especially where the death occurs while in custody. There was much criticism of the Taser when it first came out and much more since there have been in custody deaths after the use of a Taser. Taser International Inc. who created and produces the Taser has done extensive research into how the Taser works what within the body it affects, and its safety. In an article written in the Palm Beach Post Taser International has been producing stun gun type devices since the 1990s (Kahn, March 2007). It was not until 2003 that the upward swing started for Taser and many agencies began investing in this new tool. Taser International was begun in 1993 by two brothers Rick and Tom Smith. They initially

started developing a stun gun, and said in their corporate web page they wanted to "…developing a more effective and safer use of force option for citizens and law enforcement" (Corporate History, 2007). The brothers then created an Air Taser in 1994, and this was able to track its deployments/uses thus making persons accountable for when it is used. This is the same time, June 1994, that "…ATF certified that Air Taser was not a firearm and is not subject to the stringent regulations that were placed on the original Taser device developed by Jack Cover" (Corporate History, 2007). Several more years of research product alignment and technology was upgraded which lead us to the more commonly known and most currently used form of Taser, the X-26. This Taser has "…dynamically influenced significant changes in over 11,000 law enforcement agencies worldwide" (Corporate History, 2007). A study was conducted in December of 2001 by the National Institute of Justice on the effects pepper spray may or may not have on a person's ability to breathe. This study focused on positional restraint after exposure to Oleoresin Capsicum (OC) spray. The basis of their findings was suggested there was no significant risk to persons who had inhaled OC even in conjunction with positional restraint. There were findings that it did have some effect on persons elevating their blood pressure. The study looked at several positions including sitting, and restrained. This study measured not only positions but included body weight, size, medical issues such as asthma, and history of smoking. This study was conducted and is included in material relative to excited delirium within literature for an in custody sudden death symposium. There was no significant results found that conclude OC spray causes positional or other asphyxiation. (Chan, et al, 2001). In an article by Lt. Benner for Police Chief Magazine he found there was a main problem when looking at and for excited delirium. It was not as of 1996 listed as a medical or psychiatric condition, and was still in a descriptive phase. He found increased attention was laid upon this new diagnosis for an unexplained death. Researched had realized that cocaine related emergencies had jumped and thus the increase in in-custody deaths associated. Departmental training in recognizing this condition had not been conducted at the levels needed, and there were published symptoms related to excited delirium. They are; bizarre and aggressive behavior, shouting, paranoia, panic, violence towards others, unexpected physical strength, and sudden tranquility. These issued for EDS were discussed at the IACP conference as far back as 1995 (Benner & Isaacs, 1996).

Much of the research found within this topical realm had no conclusive diagnosis or information on how to stop the occurrence of excited delirium. Many of them recognize it, and suggest how to best handle it. In a news report from ABC there is a question of the validity of this new "diagnosis" excited delirium. Many are skeptical, yet most doctors who have had persons that have died from the same set of symptoms and/or circumstances. "They tend to be overweight males, high on drugs, and display extremely erratic and violent behavior." In most cases found to be excited delirium the victims also have been under some sort of stress. The article spoke of the introduction of the term excited delirium starting as far back as 1980, and was introduced along the same time as the start of the cocaine craze. Doctors in this article are stating there is a real clinical diagnosis for this disorder, but the American Medical Association refuses to recognize it. Doctors in this study have linked the adrenalin released by the body during the stressful event in combination with the high levels of cocaine, or some other drugs

to excited delirium deaths (Goldman, 2007). An article published in Police Magazine focused on some very basic concepts for Excited Delirium and officer response to it in the field. As in previous articles this one discusses the many signs of this medical condition, and lists them as violent behavior and incredible strength among others. This study showed no single cause as to what is causing this delirium, and lists deaths attributed to Excited Delirium after contact with pepper spray, Tasers, and some restraint techniques. No one instance has been linked with this type of death. It is suggested that officers upon first realizing they may be encountering a person who is exhibiting some signs of Excited Delirium to call for medical personnel and have them stage down the street, and when given the opportunity have the subject immediately evaluated. It is normally too late when medical personnel are called after the subject has collapsed (Ho, 2007).

Methods

Present research was conducted by utilizing three different means. Research surveys were distributed to all accredited agencies with in the State of Florida utilizing a Florida Police Accreditation Coalition web based bulk e-mailer. This allowed access to approximately 160 accredited agencies throughout the State of Florida. These types of agencies were selected as they meet the requirements set forth by the Commission for Florida Accreditation to which my agency is also accredited. This means all agencies responding to the survey will meet, and adhere to the same set of criteria and standards as the Fort Pierce Police Department. There was no set methodology set forth such as size, geographic location. The surveys were sent out randomly. The survey consisted of 13 questions that were based upon yes or no answers. Some answers required a bit of explanation. There was no need for any Lykert scales or quotients.

The second form of research for empirical data is personal interviews. Interviews with Dr. Garavaglia and Dr. Mittleman were conducted. Both doctors are forensic pathologists. Dr. Mittleman is the Chief Medical Examiner for the 19th Judicial Circuit, and Dr. Garavaglia for Orange County. Both have had multiple dealings with excited delirium.

The final means of gathering data will be from personal/own agency, Fort Pierce Police Department, information and case file review. Our agency has had the misfortune to experience two deaths that were attributed to excited delirium. Review of coroner reports and facts surrounding the incidents and information leading up to the time of death were considered, and then filtered into this paper.

Results

Tabulation of survey information reflected a return rate of 33 responses equating to 21%. 14 of these agencies have had in custody deaths. Of these deaths three were self termination. The remaining eleven deaths can be connected to abnormal behavior, combative actions, and aggressiveness in general. The time frames for distress to death were all under 5 minutes with the exception of one being 10-20 minutes. All

agencies performed CPR and requested the response of medical personnel. All parties had narcotics in their system, and the most pronounced of these was cocaine.

In speaking with M.E. Dr. Mittleman he noted behavior of people while experiencing excited delirium is "unreal" almost super human strength. Dr. Mittleman stated "…like running down the street after jumping out of a two story window". I asked Dr. Mittleman if he had any experience with persons being affected by excited delirium who have not been on drugs. Dr. Mittleman reported he has no information relating excited delirium to anyone who has no history and no drugs in their system. That all deaths affiliated with excited delirium as he recalls have had drugs in their system. I asked Dr. Mittleman if he can attribute excited delirium to one specific drug, and he could not. Dr. Mittleman stated there are many different drugs he has seen in the system of a person effected with excited delirium ranging from cocaine to psychiatric medications that were prescribed. I asked Dr. Mittleman when he recalled his first diagnosis of excited delirium and he stated it was in the early 1980's in Miami Dade Florida. Dr. Mittleman added that these types of deaths were happening farther back than this, but persons did not realize what it was, and had no name for it. Dr. Mittleman offered that through his research on the topic this has been happening all the way back to times when it was legal to use cocaine, and that these types of unexplainable deaths, and irrational behaviors are what instigated the illegalization of cocaine, which is still law today. I asked Dr. Mittleman if he knows of a way to prevent excited delirium, and he did not. Dr. Mittleman stated that his experience with it is once the process starts there is no way to deviate from the course that the body takes. I asked Dr. Mittleman if he saw any correlation between the use of an electro muscular device, more commonly know as a Taser, and he did not. Dr. Mittleman stated he has had to rule on two cases here in St. Lucie County recently. Both of these cases involved the use of a Taser on drive stun. Dr. Mittleman stated these deaths were not related to the use of the Taser; "…if they were as a result of the application of the Taser the persons would have died when the Taser was applied". Dr. Mittleman did rule these deaths as a homicide which may confuse some people until they review the literal term of homicide. The killing of one human being by another. Homicide is of three kinds: justifiable, as when the killing is performed in the exercise of a right or performance of a duty; excusable, as when done, although not as duty or right, yet without culpable or criminal intent; and felonious, or involving what the law terms malice; the latter may be either manslaughter or murder. Dr. Mittleman stated that both deaths were ruled this, by clinical definition.

Dr. Garavaglia was interviewed by phone, and offered similar if not the same information as Dr. Mittleman. Dr. Garavaglia had heard of the processes spoken of earlier in this paper of trying to lessen/decrease the possibility of excited delirium by cooling the body, and calling for medical personnel when in doubt, but also did not know if any of this would work. Dr. Garavaglia was called away to an emergency autopsy and we were unable to make further contact as of the writing of this paper.

After reviewing both incidents occurring within the Fort Pierce Police Department and their in custody deaths none of the officers involved were found to have acted outside of their prescribed and appropriate responses and levels. All officer involved actions in these cases were found to be legal proper and just. The 19th Judicial Circuit also reviewed the files and did nor pursue criminal action. Moreover the medical examiner revealed both deaths were attributed/caused by excited delirium. Both

persons were of different cultural and socioeconomic lifestyles and areas of the country. But both persons had several attributes listed above in this paper such as drug use, and medical conditions.

Discussion

The Fort Pierce Police Department has had two in custody deaths within the last five years. The first case involved Law Enforcement On February 21, 2006, working a detail at Lawnwood ER. Officers were trying to remove an individual who had become disorderly and was causing a disturbance in the emergency room waiting/triage area. The individual refused to leave when asked several times to do so by Officers. Officers warned the individual that if he continued to be combative and refuse to leave he would be Tased. The individual continued to refuse to leave, and became more combative and threatening, at which time he was drive stunned. The individual continued, after being drive stunned 2 times, to refuse commands, and was forcefully handcuffed. Additional Officers arrived during this commotion and assisted the original officers with the handcuffing process. The individual still refused to cooperate by not walking out of the waiting room area on his own accord, and had to be placed onto a gurney, involuntarily, and wheeled out of the hospital. Between the time he was wheeled out of the hospital and the officers made it to their vehicles, it was noticed by one of the Officer that the individual did not appear to be breathing. Officers checked the individual for breathing and pulse. Finding none, an officer was sent ahead to inform E.R. staff of the situation. Officers raced the individual back into the E.R., where staff immediately tended to his needs. The following is a step-by-step description of the incident:

The second case occurred when officers were summoned to a disturbance in the parking lot of the Pilot Travel Center on Okeechobee Rd. in Ft. Pierce. Prior to officer arrival, several individuals had witnessed the subject acting in a manner which had been variously described as bizarre, paranoid and out of control. The subject was initially observed driving a large Budget Rental truck while following two of the witnesses into the Pilot parking lot. The subject was seen by several people throwing things from his truck acting irrationally. Driven by concern some of the witnesses went to the front of the Pilot Travel Center where they had seen the officer's vehicle in the front. Officers responded to the rear of the Pilot Travel Center and observed the subject running around his truck. The subject was observed throwing oil at or around his truck while yelling that someone was trying to kill him or steal his belongings. Officers made contact with the subject and tried to calm him. This did not work, and officers felt it necessary for the safety of the subject and those in the immediate area to place the subject in restraints. The first officer was able to do this after a brief struggle, and placed him in the rear of his patrol vehicle. The subject continued his bizarre behavior and actually even asked the officer to call the police. The officer was in full police uniform and had arrived in a marked patrol vehicle. The originating officer had also requested an additional unit be sent to him. The additional officer arrived on scene after the subject had been secured in the back of the patrol car. While on scene, the second officer stated he observed the subject thrashing about in the back of the patrol car. Both officers then patted the subject down as it had been too risky before the arrival of

the back up unit to conduct the search alone. The subject was then taken from the back of the car where he attempted to flee from the officers and was subsequently taken to the ground. While on the ground the subject resisted officers and was thrashing and kicking at the officers. The subject began to violently resist the officers. Both officers continued to verbally direct the subject to stop resisting and to calm down. The subject's resistance grew to a level necessary to escalate the level of force, and he was then warned several times if he did not stop resisting, and calm down he would be Tased. The subject did not calm down and officers elected to resort to pain compliance and not full deployment of the Taser. The subject was then given a drive stun to the rear shoulder area for the 5 second pre-programmed cycle. The effects of the Taser were not evident, and the subject continued to struggle and the officer then applied two additional Taser drive stuns to the subject, but did not administer the full 5 second application, and was unsure, given the subject's level of resistance, whether the Taser even came into contact with the subject as he continued to thrash about during this attempt to subdue him. Shortly after the third and final Taser deployment, the subject stopped resisting the officers. Noticing that the subject did not appear to be breathing, the officers checked for the subject's pulse. Detecting only a weak pulse, the officers initiated lifesaving measures/CPR. The officers requested emergency medical providers (rescue) be dispatched to the scene. The subject never regained consciousness and was declared dead upon arrival at the hospital.

In both of these cases there were drugs found in the system of the subject persons. Both persons were acting irrationally, yet there were separate and different actions also. This lends credence to the claim of not needing a specific set of criteria for this excited delirium to occur. One subject had a long medical history and the other did not. One was physically fit, not obese, and the other was obese, and not physically fit. Both subjects did not receive the full effects of a Taser deployment, and only felt pain compliance. The Taser when not fully deployed does not affect any of the muscles within the body.

As you can see from the results portion there is no systematic analysis that may be done to find out a specific cause and correlation of excited delirium. The results of the survey conducted shows less than half of the respondents have had an incident involving in custody deaths; finding that not all of these deaths were a result of excited delirium lessened these numbers also. Within the research gathered, there was no direct specific link to excited delirium. There was a large proportion of the population surveyed that did have similar behavior. Most of the persons who died were acting abnormal, were resisting law enforcement efforts, and were aggressively active. All subjects had drugs in their systems, with the largest number of persons having ingested cocaine. Ten of the eleven relative deaths occurred in less than five minutes after the struggle/incident had stopped. Five of these occurred in less than thirty seconds. Several of these deaths did utilize "tools of the trade". Some of these were pepper spray, handcuffs, Tasers, and leg restraints. Ten of the eleven relative in custody deaths surveyed did occur within the last five years.

Within the survey questions agencies were asked what training has been implemented in reference to excited delirium. Most of the agencies have introduced additional training on recognizing some "warning signs" of excited delirium, amended policy, and included Taser training for all personnel. This study was limited to that

information gleaned from agencies who responded. In the future I suggest doing a specific agency mailing, or e-mailing, and not using a bulk mailer. The idea of this group e-mailing was good in the number of agencies available to contact, but the response rate was low. I also suggest making the survey accessible on line. There are limitations to this study as the specific parameters of information are unable to be maintained. There are many different causes or contributors to excited delirium and not one thing can be pin pointed, which gave way to conduct this research in the first place. Finding through this process that there is no direct nexus to a specific event, tool, or drug limits the scope of research.

Recommendations

There are some recommendations that may be made based upon information gathered. New protocol and teaching is recommended for those employees who deal with the public in general, and in our detention facilities. I recommend law enforcement personnel be made aware of this syndrome, and its symptoms. I recommend when able, law enforcement notify medical personnel of the situation, and possibility of excited delirium, and request their response. I recommend all personnel monitor subjects closely after incidents of aggressive behavior until they have deescalated safely.

Commander Katherine “Kitty” England has been employed with the Fort Pierce Police Department since 1991. She has worked in several divisions to include Patrol, Criminal Investigations, Traffic and the Office of Professional Standards. She was Detective of the Year in 1991 and Manager of the Year in 2006 & 2007. Kitty was the first female SWAT member and is only the second female Lieutenant at her agency. Kitty is a graduate of Leadership St. Lucie Class #25 and a member of the National Association of Women Law Enforcement Executives (NAWLEE). Kitty has a bachelor’s degree in Business from Nova Southeastern University and a Master’s degree in Public Administration from Troy State University.

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Appendix A

Interview Questions for Doctors Mittleman and Garavaglia

1. What is excited delirium?
2. What causes excited delirium?
3. Can excited delirium be prevented?
4. Have all excited delirium cases been related to drugs?
5. When do you recall seeing the first diagnosis of excited delirium?
6. Is there any correlation between the use of an EMD with excited delirium?

Appendix B

In-Custody Death Survey

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Senior Leadership Class #12

1. Has your agency had any in custody deaths?
   Yes_____ No_____ (If no please skip to number 12.)

2. Did any of those deaths occur within the last 5 years?
   Yes_____ No_____

3. Was pepper spray used in any of the in custody death cases?
   Yes_____ No_____

4. Was an electro muscular disruption device, more commonly known as a Taser used in any of the in custody deaths?
   Yes_____ No_____ If yes, how many? _____

5. Was there a different tool or restraint device utilized during the incident leading up to the in-custody death? If so what was it and how was it utilized?
   _____
   _____
   _____

6. What were the circumstances surrounding the death?
   (Please include any actions before, during and after death)
   _____
   _____
   _____
   _____
   _____
   _____

7. Was there a struggle with officers or others before the death?
   Yes_____ No_____

8. At what point did the person show signs of distress?
   During struggle_____ 0-30 seconds after struggle_____
   31-60 seconds after struggle_____ One minute to 5 minutes after struggle_____
   Other_____

9. What actions did officers take upon recognition of this distress?
   _____
   _____
   _____

10. Were any toxicological effects found during autopsy?
Yes_____ No_____ If yes what were they?
_____
_____

11. If any what drugs were being utilized by the person?
Cocaine_____ Heroine_____ Methamphetamine_____ Other_____

12. Did that person have a *history* of drug use, violence, and/or medical problems?
Yes_____ No_____

13. What training have you found and or implemented to inform your personnel about excited delirium?
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

14. Agency Name_____

Results Tabulated Below.

Appendix C

Agencies with history of In Custody Death	W/in 5 yrs	Pepper Spray	EMD	Other Tool	Synopsis	Struggle	Distress Time	Ofc. Action	Drugs if any	History	Training Implemented
Altamont Springs Police Department	N	N	N	Cuffs	W/M acting abnormal, physical restraint hands on - 10/15	Y	1-5 min	CPR	Cocaine	Y	General, CPR, PPE, Roll Call
Boca Raton Corrections	N	N	N	N	Self Termination	N	N/A	N/A	Alcohol	N	In Service Training on E/D
Collier County Sheriff's Office	Y	Y	Y	N	Pursuit, resisting arrest with violence, cardiac arr. In water	Y	0-During struggle	CPR, called EMS	Cocaine	Y	Taser training includes E/D
Collier County Sheriff's Office	Y	Y	Y	N	Pursuit, Resisting arrest with Violence, Cardiac arr. On land	Y	0-During struggle	CPR, called EMS	Cocaine		Taser training includes E/D
Collier County Sheriff's Corrections	Y	N	N	N	Inmates Self Terminated	N	N/A	CPR	N/A	Y	In Service Training on E/D
Department of Corrections Orlando	Y	N	Y	N	Acting abnormal, screaming thrashing	Y	10-20 MIN	Called EMS	Y	Unknown	Training on symptoms of E/D
Hollywood Police Department	Y	N	Y	N	Aggressive action-fight between two subjects	Y	0-30 Sec	EMS	Y	Y	Changed Taser SOP
Lakeland Police Department	N	N	N	N	Self Termination	N	N/A	Contact EMS	Y	Y	Taser training includes E/D
Lee County Sheriff's Office	Y	N	Y	N	Disorderly combative, resisted arrest	Y	1-5 min	First Aid, called EMS	Y	Y	Monitor and look for E/D
Martin County Sheriff's Office	Y	N	Y	Cuffs	Pursuit, Hallucinating, incoherent resisting arrest.	Y		EMS on scene	Y	Y	Taser training includes E/D
Melbourne Police Department	Y	N	Y	N	Burglary, subject armed with broom	Y	1-5 min	Called EMS	Y	Y	E/D training, New E/D policy

Agencies with history of In Custody Death	W/in 5 yrs	Pepper Spray	EMD	Other Tool	Synopsis	Struggle	Distress Time	Ofc. Action	Drugs if any	History	Training Implemented
Okaloosa County Sheriff's Office	Y	N	Y	N	Agitated, aggressive, armed with flashlight	Y	0-30 Sec	Called EMS	Y	Y	Medical treatment for subject
Polk County Sheriff's Office	Y	Y	Y	Leg restraint	Combative, secured in vehicle	Y	31-60 sec	CPR		Y	
Saint Petersburg Police Department	Y	N	N	Cuffs	Acting erratically, restrained	Y	5 Min	CPR EMS	Y	Y	Taser training includes E/D
Agencies without history of In Custody Death	**W/in 5 yrs**	**Pepper Spray**	**EMD**	**Other Tool**	**Synopsis**	**Struggle**	**Distress Time**	**Ofc. Action**	**Drugs if any**	**Hisotry**	**Training Implemented**
Aventura Police Department					N/A						E/D-annual ECD training
Boca Police Department					N/A						In Service E/D Training
City of Atlantis Police Department					N/A						Training
Department of Environmental Protection					N/A						No formal training on E/D
Department of environmental Protection - Florida Wildlife Comm.					N/A						No formal training on E/D
Department of Transportation					N/A						OCAT format
Agencies without history of In Custody Death	**W/in 5 yrs**	**Pepper Spray**	**EMD**	**Other Tool**	**Synopsis**	**Struggle**	**Distress Time**	**Ofc. Action**	**Drugs if any**	**Hisotry**	**Training Implemented**

Florida Highway Patrol Fort Walton Beach	-	-	-	-	N/A N/A	-	-	-	-	-	-
Gulf Port Police Department					N/A						CJSTC defensive tactics
Hernando Sheriff's Office					N/A						Annual E/D training
Jacksonville Police Department					N/A						Training and Formal Policy
Jupiter Police Department					N/A						Positional asphyxia training
Manalapan Police Department					N/A						
Ocala Police Department					N/A						Taser X26 training
Palm Bay Police Department					N/A						Taser & defensive tactics
Plantation Police Department					N/A						Positional asphyxia, & E/D
Punta Gorda Police Department					N/A						E/D in ECD training
Sebastian Police Department					N/A						