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Never again: a hard lesson from a tragic, predictable death

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The recent tragic death of a young man experiencing hyperactive delirium with severe agitation in Bologna (Italy), on July 19, 2026,[1] should serve as a crucial reminder of the importance of effective management of this challenging emergency. While it is a tragic event, the shock of such an episode forces us to draw a core lesson for clinical practice, system design, and medical culture.

Hyperactive delirium with severe agitation is indeed a true medical emergency.[2] Individuals usually experience extreme agitation characterized by unexpected strength, panic, violence, disorientation, hallucinations, hyperthermia, and an accelerated autonomic nervous system. These symptoms can quickly escalate and lead to cardiopulmonary arrest, often resulting in the patient's death, frequently occurring in a pre-hospital care setting.

The American Society of Emergency Physicians (ACEP) recommends using the right definition "hyperactive delirium with severe agitation" instead of the old term "excited delirium", stating that it is scientifically baseless and outdated.[3] ACEP strongly dictates that the phrase should never be used as a diagnosis or listed as a cause of death and recommends that emergency physicians to always consider "hyperactive delirium with severe agitation" as a distinct, life-threatening medical emergency that requires a specific clinical and pharmacological approach.[3]

A timely and accurate diagnosis, along with appropriate pharmacological intervention, are the two critical points in preventing medical errors that can turn hyperactive delirium into a life-threatening condition. Death can be avoided if at least three primary medical errors are considered, as follows: i) *The use of prone physical* restraints: the choice to put the patient face-down (sometimes with a weight on the patient's back) or to use "hog-tie" restraints to control agitation is the cause of positional asphyxia. Indeed, hyperactive delirium increases oxygen demand and causes metabolic acidosis, which are the primary drivers of death, combined with positional asphyxia;[4] ii) *Pharmacological mismanagement:* a patient with hyperactive delirium needs immediate emergency care and always requires continuous monitoring of heart rate and oxygen saturation. It is essential to use a well-defined pharmacological sedation protocol to manage symptoms effectively and rapidly. This helps to avoid the use of inappropriate sedatives, such as high doses of benzodiazepines, which can lead to over-sedation and increase the risk of respiratory depression; iii) *Failure to recognize and treat the root cause*: hyperactive delirium is not a "simple behavioural problem". It is a symptom of a severe and life-threatening condition that can include metabolic diseases (*i.e.*, severe hypoglycemia, hypoxia, or electrolyte imbalances), acute infections (sepsis, meningitis, or severe urinary tract infections in the elderly), and severe drug toxicity (cocaine, methamphetamine, and cathinones).[5]

Consequently, emergency physicians must: i) *Never prone the patient:* the ACEP guidelines mandate that, as soon as a patient is handcuffed or restrained, they must be immediately flipped onto their side (safety position) or on their back (supine position);[2] ii) B*e prepared for a rapid chemical de-escalation using a standardized medication protocol and avoiding physical struggle:* this is the primary goal in treating hyperactive delirium to protect both the patient and staff while ensuring that the patient's ability to breathe is never compromised. The choice and dose of medication are strictly medical decisions. The ACEP strongly recommends fast-acting drugs to safely calm the patient and alleviate toxic metabolic stress, with minimal impact on the patient's respiratory drive.[6] Ketamine is a dissociative anesthetic that can be administered intramuscularly or intravenously for ultra-fast de-escalation (onset < 5 minutes), whilst preserving the patient's natural airway reflexes and supporting blood pressure. Droperidol is a rapid-acting antipsychotic that can be combined with ketamine for fast-acting sedation aimed at reducing agitation.[7] Midazolam is the first-line choice if the delirium is triggered by alcohol withdrawal or toxicity from stimulants such as cocaine, but it can lead to silent respiratory arrest. In a recent perspective, Isoardi and colleagues[8] recommend a standardized approach for managing severe acute behavioural disturbances, using intramuscular droperidol (or olanzapine if droperidol is not available) as first-line therapy. If rescue sedation is required or in extremely dangerous scenarios where immediate control is needed, they recommend ketamine. No advice is given on the use of benzodiazepines as first-line therapy, unless the situation specifically warrants it, such as in cases of alcohol withdrawal, sedative-hypnotic withdrawal or stimulant intoxication. Furthermore, the combination of antipsychotics and benzodiazepines is not recommended. The choice of medication and route of administration (IV vs IM) depend on the patient's condition, the availability of intravenous access, and the severity of the agitation. In all cases, patients must be rolled onto their back or side immediately after the injection. Law enforcement should loosen physical restraints to allow medical personnel to monitor the patient's airway using a pulse oximeter and heart rate with a cardiac monitor; iii) *Consider hyperactive delirium like a cardiac arrest event:* the absolute clinical priority is to assess for severe metabolic acidosis

and extreme hyperthermia (body temperature above 40 °C / 104 °F). These two factors are the strongest predictors of an imminent cardiac arrest in an agitated patient. In addition, hypovolemia, hypoglycemia, and electrolyte disturbances (most often hyperkalaemia) must be immediately corrected; iv) *Never forget the diagnosis:* writing off a patient suffering from severe hypoglycemia, hypoxia, or meningitis as just a "violent psychiatric case" until they lapse into a coma represents gross medical negligence due to a failure to perform a basic diagnostic workup.

In conclusion, the death of an individual experiencing hyperactive delirium with severe agitation reflects the failure of the entire system, including Emergency Medical Services (EMS) and law enforcement.

We fully support the position of the ACEP experts indicating that there is no evidence to support "excited delirium" as a natural cause of death on its own. On the contrary, when a highly agitated patient dies whilst being forcefully restrained, the actual culprit is usually restraint-related positional asphyxia.[9]

This tragic event must serve as an opportunity to reevaluate how to correctly and effectively manage this medical emergency. It is essential to adopt a standardized approach based on specific clinical protocols, alongside a structured strategy involving collaboration between law enforcement and EMS. Handcuffs, tasers, and prone restraints are not effective solutions for hyperactive delirium, which is a life-threatening medical emergency rather than a behavioural issue, as clearly defined by the ACEP. The role of law enforcement should be limited to securing the scene, so that EMS can promptly administer medical treatment. Once the patient has been chemically sedated, medical resuscitation takes precedence over custody, and any restraints should be removed.

Finally, we acknowledge that the EMS bears a significant responsibility in managing patients experiencing hyperactive delirium with severe agitation. Effective management includes administering the appropriate medication at the right time and creating a supportive environment with the assistance of law enforcement. This combined approach is the only safe way to save a life.

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