



eISSN 2282-2054

<https://www.pagepressjournals.org/index.php/ecj/index>

Publisher's Disclaimer. E-publishing ahead of print is increasingly important for the rapid dissemination of science. The **Early Access** service lets users access peer-reviewed articles well before print / regular issue publication, significantly reducing the time it takes for critical findings to reach the research community.

These articles are searchable and citable by their DOI (Digital Object Identifier).

The **Emergency Care Journal** is, therefore, e-publishing PDF files of an early version of manuscripts that undergone a regular peer review and have been accepted for publication, but have not been through the typesetting, pagination and proofreading processes, which may lead to differences between this version and the final one.

The final version of the manuscript will then appear on a regular issue of the journal.

E-publishing of this PDF file has been approved by the authors.

Emerg Care J 2026 [Online ahead of print]

To cite this Article:

Poggiali E, Ghiadoni L, Riccardi A. **Never again: a hard lesson from a tragic, predictable death.** *Emerg Care J* doi: 10.4081/ecj.2026.16097

 ©The Author(s), 2026

Licensee [PAGEPress](#), Italy

Note: The publisher is not responsible for the content or functionality of any supporting information supplied by the authors. Any queries should be directed to the corresponding author for the article.

All claims expressed in this article are solely those of the authors and do not necessarily represent those of their affiliated organizations, or those of the publisher, the editors and the reviewers. Any product that may be evaluated in this article or claim that may be made by its manufacturer is not guaranteed or endorsed by the publisher.

Submitted: 20 August 2026

Accepted: 1 September 2026

Early access: 3 September 2026

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

Erika Poggiali,¹ Lorenzo Ghiadoni,² Alessandro Riccardi³

¹Emergency Department, Guglielmo da Saliceto Hospital, Piacenza; ²Department of Clinical and Experimental Medicine, University of Pisa, Pisa; ³Emergency Medicine, Ospedale Santa Corona, Pietra Ligure, Italy

Correspondence: Erika Poggiali, Emergency Department, “Guglielmo da Saliceto” Hospital, Via Giuseppe Taverna 49, Piacenza, Italy. Tel.: +39 0523 303044. E-mail: E.Poggiali@ausl.pc.it

Key words: hyperactive delirium; severe agitation; ketamine; droperidol; emergency settings; restraints.

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) *Be 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 colleagues⁸ 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.

References

- 1) The Guardian. Video shows death of man in Italy while under police restraint – video. Available from: <https://www.theguardian.com/world/video/2026/jul/22/video-shows-death-of-man-in-italy-while-under-police-restraint-video>
- 2) American College of Emergency Physicians. ACEP reaffirms positions on hyperactive delirium. ACEP website. Published October 10, 2023. Available from: <https://www.acep.org/news/acep-newsroom-articles/aceps-position-on-hyperactive-delirium>
- 3) DeBard ML, Adler J, Bozeman W, et al. White Paper Report on Excited Delirium Syndrome. 2009. Accessed August 14, 2026. Available from: <https://www.prisonlegalnews.org/news/publications/acep-report-on-excited-delirium-syndrome-sept-2009/>
- 4) McGuinness T, Lipsedge M. 'Excited delirium', acute behavioural disturbance, death and diagnosis. *Psychol Med* 2022;52:1601-11.
- 5) Takeuchi A, Ahern TL, Henderson SO. Excited delirium. *West J Emerg Med* 2011;12:77-83.
- 6) American College of Emergency Physicians Hyperactive Delirium Task Force. ACEP task force report on hyperactive delirium with severe agitation in emergency settings. Available from: <https://www.acep.org/siteassets/new-pdfs/education/acep-task-force-report-on-hyperactive-delirium-final.pdf>
- 7) Curato M, Shah K, Reisig C. *Urban emergency medicine*. Cambridge University Press. 2023.
- 8) Isoardi KZ, Cole JB, Hoffman RS, Isbister GK. What is the best approach for parenteral sedation to manage severe acute behavioral disturbance in the emergency department? *Clin Toxicol (Phila)* 2026;64:79-85.
- 9) Lee C. ACEP rejects “excited delirium”. Available from: <https://www.acepnow.com/article/acep-rejects-excited-delirium/4/>

Contributions: all the authors equally contributed to the work, and they approved the final version.

Conflicts of interest: Erika Poggiali and Lorenzo Ghiadoni are members of the editorial board of Emergency Care Journal. This work was not supported by any grant.

Ethics approval and consent to participate: not applicable.

Informed consent: not applicable.

Availability of data and materials: all data underlying the findings are fully available upon reasonable request to Erika Poggiali, E.Poggiali@ausl.pc.it

Acknowledgement: the authors sincerely thank the Italian Emergency Medicine Service for its support in effectively managing this challenging emergency. Erika Poggiali is grateful to Paolo Elisei and Kezia Vigevani for their invaluable help and support.