



Medical-Legal Alliances: Encounters with Excited Delirium in Ontario Coronial Law

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ABSTRACT *This theoretical paper analyzes Ontario coroner inquest reports that reference excited delirium from 1996 to 2023. The author argues that coroner inquest reporting engaged medical experts in work to exonerate law enforcement of white supremacist violence. Excited delirium as a racializing assemblage illustrates how the coroner inquest functions as a medico-legal tool that pulls focus from, and in so doing is designed to maintain, the violent institution of policing. To that end the author describes the anti-racist abolitionist theoretical approach driving this paper's analysis, to show the limitations of reliance on what is ultimately a reformist response to death-by-police. Through this lens the author explains the invention and development of excited delirium in medical scholarship. Then in a review of Ontario coroner inquest reporting, the author shows how the causes of death identified and the summaries of death presented come to constitute excited delirium, both by focusing on conditions located in the body-mind of the deceased, and by reframing – and ultimately displacing legal scrutiny away from – restraint use and other patterns of violence found in police encounters. Further, jury recommendations and coroner elaborations related to training and research align with a reformist ethos that enlists medical authorities in the work of keeping institutions of policing intact and beyond meaningful reproach despite the violence they continually enact.*

KEYWORDS assemblage; race and racism; Canadian mental health law; abolition; police

The boot is never the focus of law.

(Razack, 2015, p. 140)

Sherene Razack (2015) offers this insight in her analysis of a coroner's inquest investigating the death of Indigenous man Paul Alphonse – whose gravestone is featured on the cover of her book *Dying from Improvement: Inquests and Inquiries into Indigenous Deaths in Custody*. A member of the Williams Lake Indian Band of British Columbia, Canada, Alphonse died in police custody in 2000, one week after his arrest for intoxication and disorderly conduct.

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Witnesses reported that the arresting officer for the Royal Canadian Mounted Police had kicked and stomped on Alphonse when bringing him into custody. The officer testified that he had used force to subdue Alphonse later at the precinct station. These incidents could explain Alphonse's broken ribs and boot-print-shaped bruising on his chest. The report from a coroner's investigation into the death describes Alphonse's damaged liver in detail, speculating that he may have died by alcohol poisoning. Between the lines of text is a settler colonial, white supremacist history that ties First Nations peoples to alcoholism. The attribution leads to non-white actors being held solely or primarily responsible for the hardships they experience, including death involving state violence. "The boot is never the focus of law" (p. 140) in that medico-legal reporting pulls focus from the police and corrections officers whose violent tactics cause death.

When theorizing coronial work, Razack (2015) references a medical diagnosis that like liver damage draws focus from the boot:

Medical conditions frequently have a connection to legal interests, and it is useful to reconstruct excited delirium as a medico-legal alliance, tracing the apparatus of knowledge production that regulates what we can and cannot know about who is to blame for a death in custody. Specifically, how does excited delirium operate to make undue use of force impossible? (p. 142)

The term she uses here, *excited delirium* surfaced in forensic psychology and medical literature, and consequently in Canadian coroner inquest reporting, to stand in for cause of sudden death in instances involving a constellation of factors, including imposition of restraints, physical exertion, mental distress, and use of a psychostimulant with or without alcohol (Lipsedge, 2015; McGuinness & Lipsedge, 2022). While excited delirium has been a controversial diagnosis, and an uncommon determination in reporting, where invoked it serves as a telling example of the kind of work coronial law can accomplish. In this article, I argue Ontario coroner inquest reports engaged medical professionals – coroners, physicians, psychiatrists, paramedics, researchers – in work to exonerate law enforcement of white supremacist violence. Specifically, excited delirium as a racializing assemblage (Weheliye, 2014) illustrates how the coroner inquest functions as a medico-legal tool that enlists medical professionals in work to exculpate, and in so doing maintain, the violent institution of policing.

To that end, I charted the invention of excited delirium in medical scholarship, then traced its use through coroner inquest reports from the Canadian province of Ontario. This article takes the shape of the inquest report itself, which first identifies how and by what means a person in police custody died, and summarizes the circumstances surrounding death; then enumerates systems-level reforms as recommended by a jury, in a section that includes coroner annotations. I mirror the structure of the report to offer my own annotations in a critical reading of how the causes of death identified, and the summaries of death presented, across reporting come to constitute excited

delirium, both by focusing on conditions located in the body-mind of the deceased, and by reframing – and ultimately displacing legal scrutiny away from – restraint use and other patterns of violence found in police encounters. I next show that jury recommendations and coroner elaborations related to training and research align with a reformist ethos that enlists medical actors in the work of keeping institutions of policing intact and beyond meaningful reproach despite the violence they continually enact.

Inventing Excited Delirium

Despite the idea bleeding from forensics into “emergency medicine, psychiatric, law enforcement, prehospital, and medicolegal literature” (Vilke et al., 2012, p. 897), there has been no consensus in the medical community on excited delirium. The World Health Organization does not list the condition in the International Classification of Diseases, nor does the American Psychiatric Association include it in the Diagnostic and Statistical Manual of Mental Disorders (McGuinness & Lipsedge, 2022; Saadi et al., 2022). Even when taken for granted that it exists, excited delirium cannot stand on its own as an independent explanation of death. Instead, Sandeep Sekhon and colleagues (2023) describe the phenomenon as “multifactorial and secondary to a complex interaction of co-morbid, and acute-on-chronic medical conditions” (para. 2).

While there is no clarity in the research on diagnostic criteria or physical symptoms (Saadi et al., 2022; Whitehead, 2023), forensic pathologists, medical examiners, and emergency physicians turned to excited delirium when they encountered a collection – or put another way, an assemblage – of features and could not otherwise identify a straightforward cause of death. Those defining features start with a person, usually a young man, dying in police custody or some form of detention; he is in restraints, often put or left there in a prone position, following an instance of physical exertion, and he is in distress; he may have cocaine, amphetamines, or psychostimulants in his system, potentially mixed with alcohol (Lipsedge, 2015; McGuinness & Lipsedge, 2022; Pollanen et al., 1998).

The term dates back to the 1980s, first coined by forensic pathologist Charles V. Wetli and psychiatrist David A. Fishbain (1981, 1985). *Excited delirium* builds upon the technical term *delirium*, which refers to an acute confused state (Lipsedge, 2015), or disorganized thought processes leading to altered cognition or consciousness (Byard, 2017). The *excited* part drew on Zbigniew J. Lipowsky’s (1979) theory that there are two kinds of delirium, hypoactive-hypoaalert (or the absence of activity and alertness, which looks like apathy), and hyperactive-hyperalert (the version refashioned as excited). Wetli and Fishbain (1985) posited that cocaine induced at least hyperactivity, or agitation, even if “the defining features of delirium (i.e. a fluctuating disturbance of consciousness with reduced ability to focus, sustain or shift

attention, together with altered cognition or perceptual disturbance) were not present” (Lipsedge, 2015, p. 124; see also Strommer et al., 2020).

Fishbain and Wetli (1981, 1985) were writing through the height of the North American “war on drugs,” as cocaine and especially its criminalization was decimating Black communities. They collaborated on an article for the *Annals of Emergency Medicine* wherein they considered the case history of one man, described in their work as a Colombian drug smuggler who had been restrained by six hospital attendants in response to a violent episode and who had died six hours later (Fishbain & Wetli, 1981). They called the man’s cocaine intoxication excited delirium. Four years later they published an analysis of the deaths of seven recreational cocaine users who had experienced drug-induced psychosis though intoxication levels at time of death were below lethal amounts (Wetli & Fishbain, 1985). All seven men were described as engaging in paranoid, erratic, and violent behaviours leading to restraints, and four of the seven had been hog-tied. Wetli and Fishbain’s (1985) analysis landed on the conclusion that “police and emergency paramedical personnel should be aware of the potential for sudden death in association with excited delirium” (p. 879), signaling that the origins of the term can be found in scholarly work that seeks to dialogue with law enforcement. In 1988, Wetli returned to his and Fishbain’s theory for an investigation into the deaths of 12 Black women presumed to be sex workers (da Silva Bhatia et al., 2022). He speculated that cocaine induced lethal psychosis in men and sex-related death in women, and that Black people may be more genetically predisposed to contracting excited delirium; but all the women in his investigation were eventually found to have died of asphyxiation at the hands of a serial killer (da Silva Bhatia et al., 2022; Doherty, 2024).

Following its invention, psychiatric nurse Theresa Di Maio and pathologist Vincent Di Maio (2005) popularized the term in their book *Excited Delirium: Cause of Death and Prevention*, which they dedicated to “all law enforcement and medical personnel who have been wrongfully accused of misconduct in deaths due to excited delirium syndrome” (p. v). This dedication was rooted in their work delivering expert testimony to aid court prosecutions (Razack, 2015). In this widely cited, influential book (see e.g., Mash, 2016; Sekhon et al., 2023; Takeuchi et al., 2011; Vilke et al., 2012), the Di Maios (2005) described the syndrome as a delirium that “involves combative and/or violent behaviour” (p. 1). They identified aggression and agitation as the defining features in the 22 examples they used for their study. The authors hung so much on behaviour that they dismissed restraint use as a causal condition. The evidence presented in these sources is not necessarily neutral – its arrangement, context, and presentation all bear markings of political intention, and cannot escape histories of racial relations (da Silva Bhatia et al., 2022; Paquette, 2003; Ranson, 2012). As this article turns to usage in legal reporting, there is value in acknowledging: this brief accounting of key scholarly contributions demonstrates that in order for excited delirium to come together as a legitimate

diagnosis, medical authorities package some circumstances and symptoms, and actively ignore or absolve the role of state actors in death events.

Describing Death in the Racializing Assemblage

Not confined to medical textbooks, the diagnosis found its way into legal reporting. Under Ontario's *Coroners Act* (1990), the Provincial Legislature appoints medical practitioners as coroners to investigate (among other incidents) the circumstances of deaths that occur in the custody of law enforcement due to unknown, violent, or unnatural causes. The coroner's investigative powers include examining or taking possession of the body of the deceased, as well as entering and inspecting any place associated with the circumstances of the death. Where mandated by law or deemed by the coroner to be justified, their investigation leads to an inquest or public hearing, after which they prepare written reports that in Ontario are publicly available.

I collected Ontario coroner inquest reports that reference excited delirium, as well as positional asphyxia (a condition which shares characteristics in common with excited delirium and tends to be paired with the diagnosis). Not all reports identify excited delirium as cause of death; in several, coroners and juries consider excited delirium as a possible cause of death only to dismiss it, or they reference it in their recommendations despite citing some other cause of death. There are in total 46 reports that fit such search criteria, dated from 1996 to 2024. The size of the dataset is consistent with the findings in similarly structured studies, nearly matching that found in Baldwin (2014) and McNeilly (2017) – at least up until their respective publication dates. In what follows in this article I engage in critical discourse analysis (modeled after Rebecca Bromwich's [2017] analysis of Ashley Smith's inquest), presenting the specific wording used to describe excited delirium in the reporting, and more broadly the patterns cutting across descriptors; then I show the words carry force, inasmuch as the diagnostic soup they generate functions as a racializing assemblage, a tool that legitimizes death by state violence. I provide in-text citations when the lists of findings are manageable sizes. Where findings include numbers that would make citation listings unwieldy, I provide counts instead. For supplemental information on these counts, I built Appendix 1 with shaded boxes indicating when a term is used in cause of death and summary reporting.

Inquest invocations of excited delirium first followed a 1995 Ontario Coroner's Office Memorandum to police, corrections, ambulance, and security services as well as hospitals, psychiatric facilities, and group homes (referenced in Lamonday, 2005; Varona, 1998). The memo identified signs and symptoms of excited delirium and risks of restraint use, with the purpose of standardizing communication between police and medical workers. Following the memorandum, the first Ontario inquest to reference excited delirium was published the year later, in 1996, investigating the death of Winston Grosvenor.

Specifically, the Grosvenor inquest identified as cause of death: “excited delirium precipitated by cocaine intoxication, made worse by positional asphyxia” (p. 2). From 1996 to 2014, a total of 18 inquests identified excited delirium when determining cause of death. While the 2000 Ingraham inquest does not fall within this data subset, excited delirium can be found in its summary, and is tied explicitly to medical expertise: “the pathologist found that the clinical history was consistent with the syndrome of ‘excited delirium’, a drug-related phenomenon in which persons exhibit extreme violence and strength, and which can terminate in sudden death” (p. 6). Consistent with how the diagnosis encompasses mix-and-match symptoms, many cause of death determinations in this set of 18 attach the diagnostic term directly to other events.

These rotating elements are worth unpacking in turn. Consistent with the history of the diagnosis, the most popular circumstance associated with excited delirium is drug or alcohol toxicity, referenced in 27 of the 46 cause of death determinations from 1996 to 2024 (and additionally found in 2 summaries of the circumstances surrounding death). Its relationship with excited delirium shifts across reporting: as examples, cocaine intoxication “precipitates” (Grosvenor, 1996) and “induces” (Davidson, 2005; Knight, 2008; Lamonday, 2005) excited delirium, excited delirium materializes “due to” cocaine intoxication (Gourley, 2008), cocaine intoxication “leads to” excited delirium (Foldi, 2009; Padda, 2004), and cocaine intoxication exists alongside – or, “with” – excited delirium (Reilly, 2011). In 12 reports, cocaine toxicity stands in as the primary cause of death and is connected to other elements associated with excited delirium without citing the diagnosis itself. This means that excited delirium haunts the reporting even when it is not outright invoked as death’s cause.

Psychiatric descriptions also appear in the cause of death and summary sections of the dataset. Descriptions include psychosis (Coffey, 2014; Kolisnyk, 2006; Pucec, 1996), psychological problems (Shand, 2004), psychiatric illness (Blentzas, 2005; Robinson, 2008), disoriented state (Davidson, 2005), paranoia (Kolisnyk, 2006; Lamonday, 2005; McIntosh, 2008), acute mania (Vass, 2006), and emotional disturbance (Walker, 2008). Schizophrenia (Bocksei, 2011; Firman, 2013; Schlaht, 1999) and schizoaffective disorder with delusional features (Michaud, 2007) are specifically cited, but conditions are otherwise broadly conceived or attributed to drug toxicity. Addiction is itself a psychiatric condition, and toxicity can be linked to mental health crisis, so coroner inquest reporting commits firmly in this dataset to a pattern of connecting cause of death to psychopathology.

What makes psychiatric conditions fatal? Coroner reporting frequently refers to the dead as agitated (Allen, 1999; Wesley, 2017), aggressive (Bocksei, 2011; Coffey, 2014; Davidson, 2005; Raamat, 2000; Schaafsma, 2012), combative (Gourley, 2008; Spurn, 2005), and uncooperative (Bocksei, 2011; Marreel, 2010), all suggesting antagonism that threatens the safety of the general public, law enforcement on scene, even the safety of the deceased from self-harm.

Other terms imply the behaviours of the deceased were difficult to anticipate or constrain, including the words erratic (Marreel, 2010), irrational (Coffey, 2014; Knight, 2008), and bizarre (Bocksei, 2011; Gourley, 2008; Knight, 2008; Lamonday, 2005; Webster, 2003). A subset of the reporting that cites drug toxicity and/or psychosis describes the deceased as menacing or growling like a wild animal (Firman, 2013; Lamonday, 2005), and displaying supernatural or considerable strength (Knight, 2008; Michaud, 2007; Reilly, 2011); some text describes the deceased as “somewhat impervious to the painful blows that were being inflicted” (Vass, 2006), or experiencing “no apparent effect” (Firman, 2013; Foldi, 2009; Knight, 2008; Reilly, 2011; Walker, 2008) to use of pepper spray or conducted energy weapons (also known as Tasers). These versions of excitation function as reasons for the repeated intervention of law enforcement but also explain sudden or spontaneous death – death by exhaustion or exertion, regardless of whatever police did.

Reporting also presents pre-existing physiological conditions as contributors to cardiac events, to show how exhaustion could prove fatal. Specifically, cause of death determinations and report summaries reference “cardiorespiratory arrest due to moderate coronary artery disease” (Ambeault, 1996); “cardiovascular stress resulting from violent struggle and morbid obesity” (Vass, 2006); “sickle cell crisis” (Robinson, 2008), referring to blood cell blockage (a genetic condition that especially impacts Black people); “hypertensive cardiovascular disease” (Manon, 2012) meaning high blood pressure; “contributing factors of cardiomegaly (Firman, 2013) or an enlarged heart; “cardiac arrhythmia [or an irregular heartbeat] in the presence of hypertensive heart disease” (Prescod, 2013); and “in the setting of...hypertensive heart disease” (Hassan, 2023).

The same collection of symptoms that produces a diagnosis of excited delirium can be found in reporting that names positional or restraint asphyxia, a condition where the body’s positioning obstructs adequate breathing. A total of 11 inquest reports uses the term in cause of death determinations. Within this set, four identify both asphyxia and excited delirium together, starting with Grosvenor in 1996. In the 1997 Fox inquest, the summary text cites the investigating coroner as an expert witness who “testified at length to the medical aspects of severe alcohol intoxication” and considered “the possibility of contributing factors being positioning of the intoxicated person in a cell relative to the possibility of aspiration or positional asphyxia, tolerance levels to chronic alcohol... and possible significance of the heavy snoring contributing to upper airway collapse” (pp. 2-3). This passage offers a variation on the excited delirium narrative, where toxicity (in this case alcohol) and physical deficit (including snoring) meet in the restrained position that obstructs breathing.

This relation of restraint cannot be overlooked, with explicit references to police application of restraint found in no fewer than 31 inquests that reference either excited delirium or asphyxia. Of the 31 reports, only six include restraint under cause of death; otherwise, incidents involving restraint appear in

summaries. In this subset, reporting specifically describes police placing the deceased in prone positions (referenced 13 times); handcuffing, typically behind their back (referenced 15 times); applying weight (e.g., a knee) to the back (referenced four times); hog-tying or applying both handcuffs and leg irons (referenced four times); and administering a sedative injection (referenced three times). Restraint is an inherently violent act, a form of force that brings a person into physical contact with police. Beyond restraint, inquests reference a range of techniques to subdue individuals, including pepper spray (referenced seven times), conducted energy weapons (referenced six times), neck compressions and headlocks (referenced three times), baton strikes (referenced three times), and blows and kicks to the chest or ribs (referenced three times) Variations of “struggle to subdue” are otherwise widely and broadly referenced across the data.

Despite violence surfacing as the most common theme across reports, coroners overwhelmingly determine that the deaths they investigated are accidental, natural, or undetermined – a pattern made possible because excited delirium operates as a racializing assemblage. Alexander G. Weheliye (2014) defines racializing assemblage as the visual and discursive “modalities in which dehumanization is practiced and lived” (p. x). *Assemblage* is a Deleuzoguattarian (2007) concept, French for arrangement, which describes a “series of dispersed but mutually implicated and messy networks” (p. 201), or entities-as-events that stabilize shifting meanings, at least for a time. The observations coroners make in each report about the body-minds of the dead operate *in assemblage* with the violent acts of law enforcement, for these configurations frame a person as more susceptible to death by violence. Over-excitation or a weak heart, as examples from the text, contribute to narratives of death-by-deficit, framing the subject as constitutionally incapable of surviving police intervention. The assemblage found in inquests also *necessitates* the engagement of law enforcement, presented as a response to a person whose agitation or aggression poses a safety risk.

Weheliye (2014) characterizes the *racializing* force of these processes as not a “biological or cultural descriptor but... a conglomerate of sociopolitical relations [responsible for designating] unequal power structures that apportion and delimit which humans can lay claim to full human status and which humans cannot” (p. x). Processes of racialization arrange subjectivities to be deserving of violence. One way the racializing assemblage justifies violence is by gathering into itself psychiatric diagnosis and disability, given disability itself makes up assemblage, or constitutes an “historically contingent network of force relations” (Tremain, 2017, p. 22; for examples see Blackstock, 2024; Hylton, 2024; Segrest, 2020). La Marr Jurelle Bruce (2021) explains that processes of associating race with pathology date back to chattel slavery, and he points to historical examples (both of which were “discovered” by antebellum-era physician Samuel Cartwright): *drapetomania*, where an enslaved person’s efforts toward self-emancipation signaled a disease of the mind, cured by the whip; and *dysaesthesia aethiopica*, an affliction that

impaired the health of Black people who were “constitutionally unfit for freedom, sickened by it” (p. 18). These racializing assemblages implicated medical practitioners in work to legitimize the violences of enslavement. Drapetomania and dysaesthesia aethiopica may have been discredited long ago, no longer considered appropriate collections of attributes to organize into medical diagnoses, but force relations continue to gather in ways that legitimize current institutions of racial capture.

Case and point, the excited delirium assemblage has racializing force when coroners cite under cause of death attributes that distance incidents of police violence from their direct causal relationship to death. While the dataset does not consistently provide the demographic characteristics of the deceased (and indeed, Canada’s longstanding failure to track race-based data related to deaths in police custody has been subject to scathing critique; see *Tracking (In)Justice*, 2023), the diagnosis of excited delirium links psychiatric terminology to socially and historically fixed racial attributes, such that regardless of individual cases the overall citational pattern is predicated on racial hierarchy (for more on this see Mack, 2014b; Meerai et al., 2016; Pickens, 2019). For example, the criminalization of illicit drug possession and distribution has historically targeted racialized and particularly Black populations, as seen in the legal response to cocaine use starting in the 1980s. Criminalization drives drug use into underground markets, and leads to the devastation of socioeconomically segregated neighbourhoods that come to serve as carceral space for warehousing and pipe-lining populations – trapping non-white minorities on a continuum with prison systems (Wacquant, 2001, 2009). The diagnosis of excited delirium first surfaced as criminal justice approaches to cocaine use brought police into contact with predominantly Black communities. Toxicity, or drug-induced psychosis, could wrap around the behaviours referenced in police testimony when justifying use of force. Coroner reporting therefore functions as defence of police escalation as the appropriate response to pathologically noncompliant conduct.

The defences of repeated interventions further dehumanize the dead where a person is described as animalistic, having superhuman strength, or being impervious to pain (Anais, 2014; Whitehead, 2023). These attributes have long historical associations with Blackness dating back to justifications of enslavement (Maynard, 2017; Washington, 2006). In Razack’s (2015) words: “the inquest arranges our understanding of these geographies of violence so that we come to see [death by police] as the destiny of a people, the end point for those who refuse to be improved” (p. 191). While she is referencing death by freezing in the Prairie winter following an infamous Starlight Tour (i.e., when police drive Indigenous people outside city boundaries and abandon them in the night), the Black neighbourhood relentlessly targeted by a police force focused on “broken windows” and “cleaning up” the streets can itself operate as a geography of violence. Describing death by drug use is one way of claiming a person was destined to die from refusing treatment or forcing an officer’s hand.

Marking the Limits of Reformist Recommendations

Excited delirium surfaces elsewhere in the reporting, where a community-sourced five-member jury panel exercises its authority to enumerate recommendations for institutional reforms that would prevent future deaths, and the presiding coroner incorporates written notations to connect recommendations to their investigation. Recall that excited delirium as a racializing assemblage brings violent police methods into a cocktail of other causes all otherwise rooted in the embodiment of the deceased – displacing that boot as the focus of law. This translates into tempered recommendations for reform that miss the roots to death-by-police. In their role as coroners and in the wider fields of forensic research and clinical practice, medical professionals conduct the diagnostic work that informs coroner report recommendations; recommendations also bring medical actors into collaborative relations with law enforcement in ways that sustain racializing assemblages. Across the reporting then, cause of death and reformist recommendations become mutually constitutive, each calibrating the definitive limits of the other. Therefore, in this section I extend Bromwich’s (2017) critical discourse analysis to the recommendation sections of inquest reporting in order to argue that excited delirium as a racializing assemblage shapes the limits to reform. In Appendix 2 shaded boxes track report recommendations.

The most popular recommendation for how to deal with excited delirium – found in a total of 24 reports – is training. Recommendations for regular and refresher training target medical personnel including paramedics (referenced in eight reports), and most frequently officers and correctional staff (referenced as the recipients of training in 23 reports). These reports recommend that training should cover excited delirium’s symptoms (Ambeault, 1996; Lamonday, 2005; McIntosh, 2008; Reilly, 2011), its risks and hazards (Bocksei, 2011; Knight, 2008; Manon, 2012; Shand, 2004;), positional asphyxia associated with excited delirium (Nairne, 2001; Varona, 1998; Webster, 2003), restraint use associated with excited delirium (Lamonday, 2005; McIntosh, 2008; Padda, 2004), management of excited delirium (Marreel, 2010; McGillivray, 2014), and mental distress (with excited delirium then referenced in coroner comments; for examples see Oruitemeka, 2023; Prescod, 2013). A subset of training recommendations (found in five reports) identified the investigated deaths as classic examples to re-enact in videos and simulations, the death-event conjuring the arrangement of excited delirium again and again. The diagnosis becomes real not just in the field, but in successive rehearsals that re-engage and constantly re-substantiate the circumstances surrounding death.

Medical authorities play a role in training recommendations not only as trainees, for the content of training requires up-to-date research that keeps the racializing assemblage alive. Research is outright recommended in 11 reports from the dataset, with the inquest reports on the deaths of Osvaldo Aldamo Varona (1998) and Jerry Knight (2008) generally calling for the forensic study

of excited delirium and the pathophysiology of sudden death. Reports recommend that policing and emergency medical services (Foldi, 2009; Ingraham, 2000; Nabico, 2020; Walker, 2008) and the provincial office of the chief coroner (Gourley, 2008; Ingraham, 2000; Nabico, 2020; Walker, 2008) study excited delirium directly and share in up-to-date information. The Canadian Institutes of Health Research, Canadian Police Research Centre, National Research Council, and Ontario Ministry of Community Safety and Correctional Services are all called upon to fund the study of sudden death in police custody including excited delirium causes and symptoms, associated restraint use, and the advisability of conducted energy weapon use (Lamonday, 2005; Michaud, 2007; Nabico, 2020; Reilly, 2011; Vass, 2006). The coroner who reports on the death of Peter Lamonday (2005) reasons that national and provincial bodies should fund research because “sudden unexpected death” in police custody is “a public trust issue” (p. 4), meaning research is needed to restore the public legitimacy of law enforcement when they happen to be brought into proximity to sudden death. These recommendations call for the funding and production of research that involves forensic experts like Wetli and Fishbain (1981, 1985) and the Di Maios (2005), and other modern-day Cartwrights.

It is worth noting that some coroner reports reference research that is *critical* of excited delirium. The coroner presiding over the 1998 Varona inquest report observes “the jury heard that studies to date have not exactly reproduced the circumstances that would be present when an individual is experiencing excited delirium,” attributed to the subjects being “healthy, drug-free and exercising moderately” (p. 2). He comments that a study that reproduces the conditions of excited delirium may be difficult to conduct ethically, yet “the jury was impressed that further research into the matter is warranted, in an attempt to differentiate and understand the factors that may contribute to death” (p. 3). The 2012 report on the death of Junior Alexander Manon similarly seeks diagnostic clarity, noting that Toronto Police Service procedure on risks to prone restraint misaligns with evidence used in current police training modules that suggests “prone restraint may represent a risk for positional asphyxia independent of whether or not the subject exhibits signs of excited delirium” (p. 5). This recommendation separates out positional asphyxia from excited delirium, scrutinizing the tight weaving together of the two phenomena.

Later reporting even recommends research with the intention of calling the diagnosis into question – which would mean that research can serve to challenge, not just to reinforce, excited delirium. In the 2017 report on the death of Romeo Wesley, the coroner recommends that the Ontario Police College and Nishnawbe-Aski Police Service train officers to practice skepticism over whether excited delirium is a recognized medical or psychiatric condition. The coroner reasons that the “unfortunate result” of excited delirium’s associations with aggression, violence, and superhuman strength “is that it makes police, when approaching someone they have been told has excited delirium, expect violence and also expect de-escalation not to

work” (p. 12). Similarly, in the 2023 report on the death of Abdurahman Hassan, the jury recommends that the Ontario Police College ensure current training is “consistent with the latest medical and scientific research concerning the risk of sudden death in cases of police restraint of persons experiencing extreme agitation,” stating explicitly that “the term ‘excited delirium’ should no longer be used to describe the risks associated with restraining an agitated individual” (p. 3). The final report of this dataset, investigating the death of Nicholas Taylor (2024), recommends that training avoids use of terms like excited delirium in light of research that does not recognize the diagnosis. A review of report recommendations, then, charts when the racializing assemblage comes apart through discreditation (in alignment with the BC Braidwood Commission on Conducted Energy Weapon Use [2009] which is beyond the scope of this Ontario-based dataset).

The arrangement of factors explaining death in a way that exonerates police may be slipping with research and by extension training moving away from the excited delirium diagnosis, but still stabilizes as recently as the 2023 report on the death of Emmanuel Oruitemeka – a report focused on recommending training to improve police interactions with Black people. Oruitemeka was found to have died from lack of oxygen to the brain, due to cardiovascular collapse, as a consequence of cocaine ingestion. The arresting officer testified that he did not administer emergency care on transport to the precinct because he suspected Oruitemeka was faking an excited state, and booking officers at the precinct said the same (see also Law, 2023). A now-retired officer was quoted in local news defending their assumptions: “These guys crash very, very fast. For a person to get their head around it or thinking it’s excited delirium from cocaine ingestion or thinking it’s anything else, this stuff happens extremely fast” (as quoted in Diaczuk, 2023, para. 10). This inquest illustrates how the features that previously added up to excited delirium still flow through coroner reporting, shifting the calculation of cause and the valuation of the dead. This soup of symptoms finding new configurations still curtails juries’ collective imagination for institutional reform, for as long as the dead shoulder fault for their own deaths then report recommendations will not exceed the limits to reformism.

What is reformism? Dylan Rodriguez (2021) is critical of reform when it offers “an approach to institutional change that sustains existing social, economic, political, and/or legal systems” (p. 154). While not all reforms do this, an ideological commitment to reform, or *reformism*, defers necessary transformation. For Rodriguez (2021), “reformism limits the horizon of political possibility to what is seen as achievable within the limits of existing institutional structures” (pp. 158-159). Reformism can even invite carceral investments, or the allocation of state resources toward solutions that continue to criminalize and cage people, and that continue to bring people into direct contact with police. As Maya Schenwar and Victoria Law (2020) caution: “what does it mean to reform – to improve – a system that, at its core, relies on captivity and control?” (p. 27).

The function of a coroner inquest, in this light, would be to defend the institutions under investigation, to produce reforms that would improve those institutions rather than dismantle them. Whether implemented or not, the recommendations made in inquest reporting do not fundamentally shift institutional purposes and power, not as long as reports continue to re-produce what Razack (2015, p. 142) in a passage quoted earlier called “medico-legal alliances” – marriages of medical condition with legal interest. She was referring to the excited delirium diagnosis – its discursive power, the way force relations pulse through it, how excited delirium forms at this point of interaction. But the diagnosis and iterations also risk bringing medical practitioners into literal alliance with law enforcement. Training and research are opportunities for collaboration, predicated on the presumption that systems of policing are fixable.

Conclusions

This article presents a critical discourse analysis of nearly 30 years of Ontario coroner inquest reporting, 46 reports in total, to show how excited delirium and its constituent features move, activating the medical field in the work of police legitimation. In my analysis I first reviewed cause of death determinations that brought violent police encounters into conversation with psychiatric and physiological conditions, in effect framing the violence as necessary and the victim as predisposed to dying. Next, I found inquest report recommendations for training and research may be limited at best, reformist at worst, as long as law enforcement is not held fully and radically accountable for the deaths they cause.

My argument in this article is not meant to lead to a full indictment of the inquest as a legal mechanism, for there is a place in law for tools designed to motivate institutional reform. Coroners and juries have shining moments across the dataset of defending the dead and taking law enforcement to task for systemic and direct racism. I only mean for this paper to push against the limits to the tool, because coroner reporting is insufficient in the work to end police violence. Scholarship at least points to ways to improve coronial law, with some excellent suggestions. Tess Sheldon (2023), for instance, identifies examples in the Ontario context where institutions fail to implement jury recommendations given recommendations are neither binding nor enforceable. Framing “open, public and transparent inquests [as] crucial to the proper execution of justice as they allow the public to oversee the actions of publicly funded organizations” (p. 38), Tracy Mack (2014a) argues their circumscribed scope limits their effectiveness, particularly when coroners determine deaths to be natural, at which point inquests are discretionary. She and Myles Leslie (2013) (in their respective works) also take issue with the quasi-legality of inquests, where legal procedure constrains investigations and presentations of

violence. This literature is all predicated on the idea that the inquest has value and is not beyond repair.

This article offers a word of caution particularly for medical researchers and practitioners: the inquest is not only ineffective but can also deploy medical expertise to continue violence work. Ultimately policing is irredeemable for its role in enforcing racial hierarchy (Davis et al., 2022; Kaba & Ritchie, 2022), so medical professionals need to consider what role *they* serve in relation to law. Ontario – and more widely the country of Canada – is already seeing an incredibly harmful diagnosis breaking down, losing its power to reframe police encounters; in this generative space there is an opportunity for medical actors to realign in the direction of the communities they are meant to serve. This could include committing to research that is designed with intention, in recognition that medical knowledge can be politically contingent, even weaponized. Medical actors can protect their research by resisting invitations and recommendations to collaborate with law enforcement, given such alliances produce knowledge that is tied to legal intention.

Participation in or facilitation of training modules – their design, delivery, and updates – also requires careful consideration. It is clear in the dataset that contemporary police officers are holding onto excited delirium even as the diagnosis faces discreditation in medical research. They would therefore certainly benefit from retraining, if only so they use restraints in the field less frequently and less forcefully. Nonetheless, there are constraints to what training can accomplish given officers have legally entrenched powers to apply force, and even inquest reporting that dropped excited delirium still largely landed on causes of death that did not implicate police. In which case, the involvement of medical professionals in police training is complicated where training operates as reformism – a band-aid applied to a grievous and untreated wound.

Finally, coroners themselves have power when they prepare inquest reports. They can track racial data in their reporting, and acknowledge racism affects police interactions with the public. Further, they can ensure descriptions of death do not lose sight of Razack's (2015) boot. In cause of death determinations, they can hold officers at fault, and these decisions would offer direction to the jury panel crafting recommendations for systemic reform. Even as excited delirium falls away (marking this dataset as a potentially complete sampling, this case study contained), force relations will continue to move through inquest reporting. It may be possible to harness those relations, to align with a legal intent that serves as the ostensible mandate to inquests: to prevent future death.

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Dataset

Note on citations: In every citation, the style of cause, also understood to be the decision's name, refers (hence Re) to the surname of the person whose death was investigated (hence "Re"). The acronym LNOCI in most citations represents the legal database used in my search (LN for LexisNexis), the province where the decision was rendered (O for Ontario), and the source type (CI for Coroner Inquest), followed with a unique number assigned to the decision based on decision order that year. There are some anomalies to this formatting. Specifically, the three earliest decisions, rendered in 1996 (Grosvenor, 1996; Ambeault, 1996; Pukec, 1996), are not available in this published form, but are described in detail in the McNeilly report (2017) as well as later coroner inquests. Two decisions (Robinson, 2008; Marreel, 2010) can be found on the LexisNexis database, but only as rough coroner notes. The five most recent decisions rendered after 2020 (Nabico, 2020; Couvrette, 2022; Hassan, 2023; Oruitemeka, 2023; Taylor, 2024) are currently available not on LexisNexis but on Ontario's Chief Coroner Office website. For these 10 decisions in total, I cite the Office of the Chief Coroner for Ontario (OCCO) that originally released the reports.

- Allen (Re)* 1999 LNONCI 94.
Ambeault (Re) OCCO 1996.
Blentzas (Re) 2005 LNONCI 19.
Bocksei (Re) 2011 LNONCI 3.
Cameron (Re) 2003 LNONCI 43.
Coffey (Re) 2014 LNONCI 41.
Couvrette (Re) OCCO 2022.
Davidson (Re) 2005 LNONCI 22.

Firman (Re) 2013 LNONCI 19
Foldi (Re) 2009 LNONCI 39.
Fox (Re) 1997 LNONCI 14990.
Gourley (Re) 2008 LNONCI 58.
Grosvenor (Re) OCCO 1996.
Hassan (Re) OCCO 2023.
Ingraham (Re) 2000 LNONCI 44.
Jeanveau (Re) 2008 LNONCI 44.
Knight (Re) 2008 LNONCI 34.
Kolisnyk (Re) 2006 LNONCI 25.
Lamonday (Re) 2005 LNONCI 37.
Manon (Re) 2012 LNONCI 11.
Marreel (Re) OCCO 2010.
McGillivary (Re) 2014 LNONCI 8.
McIntosh (Re) 2008 LNONCI 16.
Michaud (Re) 2007 LNONCI 44.
Nabico (Re) OCCO 2020.
Nairne (Re) 2001 LNONCI 17.
Oruitemeka (Re) OCCO 2023.
Padda (Re) 2004 LNONCI 4.
Prescod (Re) 2013 LNONCI 28.
Pukec (Re) OCCO 1996.
Raamat (Re) 2000 LNONCI 66.
Reilly (Re) 2011 LNONCI 14.
Rioux (Re) 1998 LNONCI 15017.
Robinson (Re) OCCO 2008.
Schaafsma (Re) 2012 LNONCI 28.
Schlaht (Re) 1999 LNONCI 66.
Shand (Re) 2004 LNONCI 16.
Smith (Re) LNONCI 32.
Spurn (Re) 2005 LNONCI 38.
Taylor (Re) OCCO 2024.
Varona (Re) 1998 LNONCI 14997.
Vass (Re) 2006 LNONCI 47.
Walker (Re) 2008 LNONCI 2.
Webster (Re) 2003 LNONCI 49.
Wesley (Re) 2017 LNONCI 24.
Yim (Re) 2010 LNONCI 14.

Appendix 1: Factors Referenced in Cause of Death or Summary Related to Excited Delirium

Inquest	Excited Delirium	Asphyxia	Drug/Alcohol Toxicity	Mental Crisis	Physical Condition	Restraint	Other Use of Force
Grosvenor, 1996							
Ambeault, 1996							
Pucek, 1996							
Fox, 1997							
Varona, 1998							
Rioux, 1998							
Schlaht, 1999							
Allen, 1999							
Ingraham, 2000							
Raamat, 2000							
Nairne, 2001							
Cameron, 2003							
Webster, 2003							
Padda, 2004							
Shand, 2004							
Blentzas, 2005							
Davidson, 2005							
Lamonday, 2005							
Spurn, 2005							
Kolisnyk, 2006							
Vass, 2006							
Michaud, 2007							
Walker, 2008							
McIntosh, 2008							
Knight, 2008							
Jeanveau, 2008							
Gourley, 2008							
Robinson, 2008							
Foldi, 2009							
Yim, 2010							
Marreel, 2010							
Bocksei, 2011							
Reilly, 2011							
Manon, 2012							
Schaafsma, 2012							
Firman, 2013							
Prescod, 2013							
Smith, 2013							

Appendix 1: Factors Referenced in Cause of Death or Summary Related to Excited Delirium (cont.)

Inquest	Excited Delirium	Asphyxia	Drug/Alcohol Toxicity	Mental Crisis	Physical Condition	Restraint	Other Use of Force
McGillivray, 2014							
Coffey, 2014							
Wesley, 2017							
Nabico, 2020							
Couvrette, 2022							
Hassan, 2023							
Oruitemeka, 2023							
Taylor, 2024							

Appendix 2: Recommendations in Coroner Inquest Reporting Related to Excited Delirium

Inquest	Training			Research			
	For Police/ Correctional Staff	For Medical Personnel	Simulation	Federal Research Body	Ministry/ Coroner Office	Police Force/ Division	Forensic Study/ Medical
Grosvenor, 1996							
Ambeault, 1996							
Varona, 1998							
Schlaht, 1999							
Ingraham, 2000							
Nairne, 2001							
Webster, 2003							
Padda, 2004							
Shand, 2004							
Blentzas, 2005							
Lamonday, 2005							
Vass, 2006							
Michaud, 2007							
Walker, 2008							
McIntosh, 2008							
Knight, 2008							
Gourley, 2008							
Foldi, 2009							
Marreel, 2010							
Bocksei, 2011							
Reilly, 2011							
Manon, 2012							
Prescod, 2013							
McGillivray, 2014							
Coffey, 2014							
Wesley, 2017							
Nabico, 2020							
Hassan, 2023							
Oruitemeka, 2023							
Taylor, 2024							