

**REPORT TO THE ATTORNEY GENERAL  
PUBLIC INQUIRY  
THE FATALITY INQUIRIES ACT**

CANADA  
PROVINCE OF ALBERTA

WHEREAS a Public Inquiry was held at the Court House  
in the City of Lethbridge  
(City, Town, etc.) (Name of City, Town, etc.)  
on the 2nd day of November, 1995 (and by adjournment  
on the 3rd day of November, 1995), before  
The Honourable Timothy G. Hironaka, a Provincial Court Judge.

A jury  was  was not summoned and an Inquiry was held into the death of  
DALE MOODY 38  
(Name in Full) (Age)  
of Raymond, Alberta and the following findings were made:  
(Residence)

Date and Time of Death March 17th, 1995 at 12:10 a.m.  
Place Lethbridge Regional Hospital, 960 - 10th Street South, Lethbridge

Medical Cause of Death ("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization — The Fatality Inquiries Act, Section 1(d))

Patient deceased as a result of cardio pulmonary arrest brought on  
by the combined toxicity of clorpromazine and amobarbital.

Manner of Death ("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable — The Fatality Inquiries Act, Section 1(g))

Undeterminable

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CIRCUMSTANCES UNDER WHICH DEATH OCCURRED

See attached page

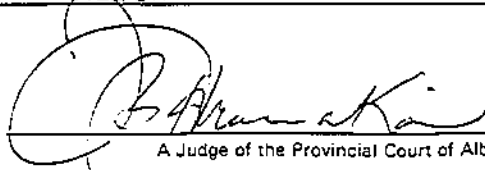
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RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

No recommendations for the prevention of similar deaths could be made as a result of the findings of the inquiry.

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DATED this 21st day of March, 1996

  
A Judge of the Provincial Court of Alberta

## FATALITY INQUIRY - DALE MOODY

### Background

The decedent had been transferred from the Raymond Care Centre to the Lethbridge Regional Hospital on March 10th, 1995. The reason for his transfer was described as "exacerbation of chronic schizophrenia" characterized by increasing agitation, hostility, delusions of religious persecutuion and refusal to take prescribed medications.

The patient was placed in the Psychiatric Unit of the Lethbridge Regional Hospital where he was kept under close observation from March 10th through March 12th, 1995. On March 13th the patient was involved in an incident where he became verbally and physically abusive resulting in minor injury to a staff member. As a result of that incident, the patient was placed on constant observation and that status continued until the time of his death on March 17th, 1995.

### Circumstances under which death occurred:

On March 17th, 1995, the patient was in a room within the secure area in the east portion of the Psychiatric Unit. He was noted to be restless, unsteady on his feet, and somewhat congested. Nursing staff also noted slurred speech and impairment of fine motor control. At 1015 hours the patient asked for and was given some toast, cheese and apple juice to eat. At 1125 hours the patient was noted to be sleeping on his side snoring loudly. Respirations were deep and regular, although he was noted to be mumbling in his sleep. At 1145 hours the patient was noted to be asleep on his side with respirations deep and regular. At 1150 hours nursing staff noted that the patient was no longer snoring and that he had rolled onto his stomach. On examination, he was found to be apneic, cyanotic and pulseless. CPR was begun immediately and an emergency code was called. Efforts to resuscitate were unsuccessful and Mr. Moody was pronounced dead at 1210 hours March 17th, 1995.