MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Madeleine Wilson, Coroner, having investigated the death of Judith Mary Dodd

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Judith Mary Dodd, date of birth 4 June 1938.

b) Mrs Dodd (nee Barnes) was believed to have been born on King Island, the eldest of three children. She married Geoffrey Thomas Dodd in about 1957 and they had four children, Carol (b. 1958), Ian (b. 1960), Wayne (b1962) and Lorraine (b. 1964). They were married for 62 years until Mr Dodd's death in about 2019. Mrs Dodd worked in a milk bar while her eldest children were little. Later, Mrs Dodd worked at Joyce's Jewellers in Wilson Street, Burnie until she retired when she was about 60 years old.

Mr and Mrs Dodd raised their children on a cattle farm on Mooreville Road, Burnie. Following Mr Dodd's retirement, they moved to Turnbull Avenue, Burnie, before later relocating to a unit on Mooreville Road.

Mrs Dodd's medical history included a suspected stroke in 2019, for which she refused treatment; double incontinence; chronic lung disease; hypertension; anaemia; hiatal hernia; osteoarthritis/osteopenia (with limited mobility); chronic pain and a past leg ulcer.[1]

In addition, Mrs Dodd developed dementia in about 2010 with associated behavioural disturbances including irritability, anger, and aggression, requiring psychotropic medication. Her husband found it difficult to care for her at home and a placement was found for her at Yaraandoo Nursing Home in Somerset in May 2016.

[1] Forensic Pathology Report.

Mrs Dodd's son, Ian, reported that her personality and demeanour deteriorated further after she entered the nursing home. She had limited mobility and often used a wheelchair. Mrs Dodd was a heavy smoker and frequently prevailed upon the staff and visitors to assist her to go outside so she could smoke.

Ian Dodd reported that he was sometimes present at mealtimes and noticed that Mrs Dodd would eat very quickly and often ignored his advice, and that of the staff to slow down.

Mrs Dodd was in the habit of eating her meals in her room sitting in her wheelchair with her tray sitting on a little table that she could move around. After eating she would put her tray on the bed and "be straight out to have a cigarette." He recalled occasions when, while eating, she would be saying "I need a cigarette" and "be shovelling the food in her mouth and hurrying so she could have a cigarette."[2]

On 4 August 2024 Ian visited Mrs Dodd after lunch. He took her outside for a cigarette and everything appeared "fine and relatively normal."

At approximately 4.00pm one of the carers took Mrs Dodd outside for a cigarette in her wheelchair and returned her to the corridor outside her room, where it was her practice to return to the room herself.

At approximately 5.25pm a carer delivered her evening meal to her in her room. The meal consisted of curried egg sandwiches. A short time later another carer noticed that Mrs Dodd hadn't come out of her room to have her after dinner cigarette, as was her custom. He checked on her and found Mrs Dodd seated in her wheelchair slumped slightly to the left; she appeared to be unconscious. The carer activated the emergency alarm.[3] Mrs Dodd's food tray was in front of her on her bed and there was still some food left on it. A nurse attended the room and conducted a mouth sweep to clear her mouth of obstructions. Her dentures were removed, emergency services were called and cardiopulmonary resuscitation (CPR) was commenced.

On arrival Ambulance Tasmania continued CPR. The ambulance officers observed that Mrs Dodd was not responsive, was not breathing and no

[2] Affidavit of Ian Dodd sworn 17/10/2024
[3] Affidavit of Manish Thapa sworn on 26/8/2024.

pulse could be detected. Mrs Dodd was found to be in asystole. Her airway was observed to be full of bread and egg. Several attempts were made to clear her airway but it could not be fully cleared and despite repeated efforts paramedics were unable to ventilate her and resuscitation attempts were ceased.[4] Mrs Dodd was declared deceased at 5.55pm.

External postmortem examination revealed the presence of food in her oral cavity (including the back of her throat). A forensic pathologist concluded that her cause of death was foreign body airway obstruction (bolus of food), with dementia being the most significant risk factor in this case. I accept this opinion.

c) Mrs Dodd's cause of death was foreign body airway obstruction (bolus of food).

d) Mrs Dodd died on 4 August 2024 at Somerset, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mrs Dodd's death which includes:

- the Police Report of Death for the Coroner;
- affidavits confirming identity;
- the affidavit of Mrs Dodd's son;
- affidavits of staff of Yaraandoo Registered Aged Care Facility;
- a review of Ambulance Tasmania records;
- the opinion of the forensic pathologist as to the cause of death; and
- the report of Sarah Rooke, Coronial Nurse Consultant.

Review of care and treatment provided by residential aged care facility

Sarah Rooke, Coronial Clinical Nurse Consultant reviewed the coronial records in this case, which included documents provided by Yaraandoo Nursing Care pursuant to an order under s59 *Coroners Act* 1995*,* authorising the taking of all records, reports, notes and correspondence, in particular records from the iCare, and any notations relating to diet and/or supervision at meal times.

The records documented a witnessed choking episode on 21 June 2024 during lunch, while Mrs Dodd was eating chips. The Extended Care Assistant (ECA) administered back thrusts, which resolved the choking episode. The Registered Nurse (RN)

[4]VACIS electronic Patient Care Record.

subsequently reviewed Mrs Dodd, who declined assistance and requested that she be left alone.

The terminal choking event was recorded as occurring on 4 August 2024. In addition to providing details consistent with these findings, the records indicated that prior to the arrival of Ambulance Tasmania, the Nurse in Charge was called to confirm Mrs Dodd's resuscitation status, who advised that it could not be confirmed and therefore CPR was commenced.

The documents revealed that Mrs Dodd had numerous appropriate assessments related to swallowing function and oral intake whilst a resident and that the associated risks and concerns were identified and documented, however a review of the available records disclosed that follow up and reassessment were not consistently undertaken in accordance with facility policy.

Ms Rooke identified that a dietician assessment[5] was carried out on 26 November 2021, which identified concerns surrounding poor appetite and low mood, resulting in recommendations about the size and frequency of meals. A review was recommended in one to two months' time[6] however, based on the documents provided, no review was documented.

A speech pathology review[7] was scheduled for 8 June 2022, however Mrs Dodd refused to undertake the review. Nonetheless the reviewer was able to observe Mrs Dodd eating during lunch. A diagnosis of mild oral dysphagia was made and it was recommended that Mrs Dodd continue with a soft and bite sized diet and thin fluids. The notes recorded that she was to be monitored for aspiration and no bread/toast or mixed consistencies (e.g. cereal with milk) was recommended. The records indicate that there should be an attempt to review in nine months,[8] however no review was ever documented in the records.

Notwithstanding the speech pathologist's recommendation to cease bread/toast or mixed consistencies, three Risk Enablement (Dignity of Risk) Assessments were completed, documenting Mrs Dodd's informed choice to continue eating these foods. Such assessments are consistent with best practice principles supporting consumer choice, independence and the Aged Care Quality Standards. The assessments were

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[5]A dietician's assessment is designed to ensure that modified diets remain nutritionally balanced, while minimising the risk of swallowing difficulties.
[6]The review was therefore due in December 2021/January 2022.
[7]A speech pathology review is intended to identify the exact cause of the swallowing difficulty, to minimise life threatening choking incidents.
[8]The review was therefore due in March 2023.

dated 8 June 2022, 11 August 2022 and 9 November 2022. A review due on 27 February 2023 appears not to have been completed.

A swallowing screening tool[9] was conducted on 7 July 2024 in which Mrs Dodd scored 8, indicating a medium (4-8) risk of dysphagia. The assessment noted that there had been no history of aspiration or choking incidents in the previous three months. It was recommended that Mrs Dodd be monitored and reevaluated as required. Importantly, this screening tool did not capture the reported choking event on 21 June 2024 that required back thrusts.

In Ms Rooke's opinion,

> *"Had this choking episode been identified, the deceased's total score would have increased to nine, potentially placing her in the high-risk category and potentially altering the management strategies and recommendations."*

While noting that the screening tool did not identify which risk mitigation strategies are implemented at each risk level, Ms Rooke stated that common strategies for people at high risk include: supervision and/or assistance with meals; re-review by a speech pathologist for reassessment of food and drink consistency; and reminders and prompts by staff to maintain a safe eating posture and an appropriate speed of eating.

Further, eight Nutrition and Hydration Assessments[10] were completed between 15 December 2020 - 7 July 2024. The initial assessment stated that meals and drinks were to be prepared and placed in front of Mrs Dodd, noted the requirements of a soft cup diet and thin fluids and her preference to have meals in her room and placed on her table. The April 2021 review occurred within the six month review period and noted that she was "easily distracted, particularly focussing on wanting a cigarette" and that "staff to supervise all meals". Other specifications remained the same as the earlier assessment.

An assessment was scheduled in six months' time. The third assessment in January 2022 occurred outside the six month review period and reverted to the original recommendations made in December 2020. Thereafter, there were very few changes to the recommendations. However the timing of the reviews varied, with a number of reviews brought forward due to changes in circumstances. The exception being the

[9]The review is designed to identify indicators of swallowing impairment (dysphagia) and aspiration risk.
[10]The review is designed to provide staff with clear guidance on individual resident's meal preparation and consumption requirements by ensuring meals and liquids are prepared, served and managed safely.

last review on 7 July 2024 which was conducted 16 months after the last review, well in excess of the maximum 12 month review period.

Findings

Mrs Dodd had a combination of risk factors that significantly increased her likelihood of choking including advanced age, dementia and behavioural characteristics where she was described as stubborn, impatient (particularly when eating) and reluctant to follow advice. These factors not only elevated her choking risk but also reduced the effectiveness of risk mitigation strategies.

Importantly, it had been recommended that Mrs Dodd not eat bread or toast or foods of mixed consistency, however she repeatedly exercised her choice, through Dignity of Risk assessments to continue eating these foods. Mrs Dodd underwent numerous health care assessments which identified concerns around her eating and swallowing, however she was not always subject to timely review of these assessments. Importantly, the swallowing assessment completed on 7 July 2024 did not accurately reflect her risk status, as it omitted consideration of a reported choking event on 21 June 2024, potentially obscuring her classification as a high risk of choking and preventing an accurate assessment of her needs.

While the timeliness of the reviews warrants further consideration, it is to be noted that Mrs Dodd's dementia and associated behavioural symptoms likely limited both her capacity and willingness to consistently follow recommendations or adhere to implemented risk mitigation strategies. As such, supervision during mealtimes or repeated prompts to slow her eating may have had limited effectiveness and may have instead adversely impacted her autonomy, care experience or nutritional intake.

Comments and recommendations

This case highlights the importance of ensuring, for those living in residential aged care, that assessments and care reviews are conducted and updated in a timely manner, in accordance with established timelines and facility policies. It is important that assessments and reviews are completed using all available and relevant clinical information, including recent incidents and changes in the resident's condition, in order to inform accurate assessments of risk and appropriate care planning.

Furthermore it is essential that each resident's current resuscitation status is clearly documented, regularly reviewed and readily accessible to staff so that it can be promptly identified and acted upon in the event of an emergency.

The circumstances of Mrs Dodd's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mrs Dodd.

Dated: 21 August 2026 at Hobart, in the State of Tasmania.

Madeleine Wilson
Coroner