IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 004578

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: Chang Ying XU

Delivered On:	26 March 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	15 November 2012
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr J. HANNEBERY of Counsel, instructed by Ms L. CROWE of McMahon Fearnley Lawyers, appeared on behalf of Seventh Day Adventist Aged Care Ltd.
Police Coronial Support Unit:	Leading Senior Constable T. CRISTIANO, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of CHANG YING XU

and having held an inquest in relation to this death at Melbourne on 15 November 2012:

find that the identity of the deceased was CHANG YING XU

born on 1 August 1938, aged 72

and that the death occurred on 30 November 2010

at Advent Care Whitehorse Nursing Home, 163 Centre Road, Nunawading, Victoria 3131

from:

I (a) HANGING

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES[1]

1. Chang Ying Xu was a 72 year old woman, originally from China where she was a medical practitioner.[2] Ms Xu did not practice medicine in Australia. Ms Xu was married to Mr Hu with whom she had two sons. For more than ten years, Ms Xu and her husband lived with one of their sons, Ying Hua Hu (known as Peter) and his wife, Li Yan.[3] Ms Xu spoke Mandarin. She was unable to communicate in English, other than by using gestures or the words 'yes' and 'no'.[4]

2. Ms Xu had a medical history that included severe spinal cord compression, chronic back pain, osteoarthritis, osteoporosis, right hip replacement, bilateral carpal tunnel syndrome, high cholesterol, hypertension, hypothyroidism, asthma and depression.[5] Ms Xu was prescribed a

[1] This section is a summary of facts that were uncontentious, and provide a context for those circumstances that were contentious and will be discussed in some detail below.

[2] Transcript page 63.

[3] Transcript page 58.

[4] Coronial Brief of Evidence.

[5] Exhibits A and D.

number of medications to manage these conditions. Ms Xu experienced considerable pain and diminishing mobility and so increasingly relied on her husband for assistance.[6]

3. In 2003 and 2007, Ms Xu had spinal surgeries to decompress the spinal cord in her cervical and thoracic spine respectively.[7] These surgeries did not significantly improve Ms Xu's chronic pain or her mobility.[8] About four months after her second back surgery, Ms Xu attempted suicide by taking an overdose of sleeping tablets.[9]

4. In October 2009, Ms Chan from the Chinese Community Social Services Centre made a referral for an Aged Care Assessment on Ms Xu's behalf. On 30 October 2009, Ms Sandra Wong, a Mandarin-speaking Assessment Clinician at the Central East Aged Care Assessment Team [CEACAT] assessed Ms Xu and her husband in their home.[10] Ms Xu's medical history, medications, mobility and needs (and those of her husband) were evaluated and the couple were approved for low level permanent residential and respite care.[11] A copy of the assessment was provided to the referrer, Ms Xu and her general practitioner, Dr Lili Thompson of the Box Hill Centro Clinic. At the time, Ms Xu declined referrals for council-operated assistance packages and a community aged care package [CACP] but was provided information about these programs.[12]

5. In January 2010, Ms Xu self-referred for an aged case assessment of her eligibility for a CACP. Once again, Ms Wong conducted an assessment of Ms Xu and her husband's needs in their home.[13] Ms Wong noted that Mr Hu now assisted his wife with dressing and showering and domestic care tasks. Ms Xu used an orthopaedic chair and bed stick but remained 'mostly independent', with bed and chair transfers.[14] Ms Xu walked with the assistance of a four-wheeled frame or single-point stick at home, and her husband pushed her in a wheelchair when they were outdoors. Mr Hu reported that Ms Xu was 'usually in tears a few times per

---

[6] Exhibit B and Transcript page 58-59.

[7] Exhibit C.

[8] Transcript page 24.

[9] Exhibit C.

[10] Exhibit A.

[11] Exhibit B.

[12] Exhibit A.

[13] Exhibit A.

[14] Exhibit A.

day', she was taking amitriptyline (an antidepressant)[15], and that he was experiencing some 'carer stress'.[16] As a result of Ms Wong's assessment, Ms Xu was approved for a CACP for case management and service co-ordination, along with low level permanent and residential respite care.[17] Dr Thompson received a copy of the assessment and Ms Xu was placed on the high priority CACP waiting list with a request for a Mandarin-speaking case manager and carers.[18]

6. In May 2010, Ms Xu underwent her third back surgery to decompress the spinal cord, this time in her lower thoracic spine.[19] Unfortunately, the surgery did not relieve Ms Xu's symptoms. Rather, following the surgery she developed progressive neuralgia, muscle spasm and weakness, and pressure sores.[20] Ms Xu continued to experience chronic pain and was prescribed medications to manage this and her other medical conditions.[21]

7. On 29 June 2010, Ms Xu accepted a UnitingCare Community Options CACP.[22]

8. Later in 2010, Mr Hu and his son planned to travel to China together for several weeks and so made arrangements for Ms Xu to spend the same period in residential respite care. Ms Xu was placed on a waiting list to enter AdventCare Whitehorse [AdventCare] for respite care.

9. AdventCare is a Commonwealth government-subsidised aged care facility that consists of a retirement village, a day therapy centre, a hostel and a nursing home.[23] Under the current regime, aged care facilities are accredited by the Aged Care Standards and Accreditation Agency if they demonstrate ongoing compliance with the standards stipulated in the *Aged Care Act* 1997. AdventCare is, and was in 2010, an accredited aged care facility and had a good record of compliance with applicable operating standards.[24]

10. Prospective residents of AdventCare must have a current aged care client assessment, known as an "Aged Care Client Record", formulated by an accredited assessor and approved by a

---

[15] Exhibit B.

[16] Exhibit A.

[17] Exhibit B.

[18] Exhibit A.

[19] Exhibit D.

[20] Exhibit D.

[21] Exhibit C.

[22] Exhibit A.

[23] Exhibit H.

[24] Exhibit H.

Department of Health delegate. Ms Wong's assessment of Ms Xu, and approval for low level residential/respite and community care, fulfilled these requirements.[25]

11. On 18 November 2010, Ms Xu attended AdventCare with her husband and daughter-in-law, and was admitted for respite care until 12 January 2011. Admission was facilitated by Division 1 Registered Nurse Janice Lim, who spoke Mandarin, and included completion of a "Clinical Assessment and Care Plan for Respite Residents", a "Resident Profile", and details of Ms Xu's preferences concerning language, diet and similar matters.[26]

12. AdventCare's admission policy also required that a doctor provide a written record of the resident's prescribed medications within 24 hours of admissions, so that these could be administered by staff.[27] Although Ms Xu's husband provided a list of her current medications, a medication chart prepared by a medical practitioner was not available until the following day – 19 November 2010 – when Dr Weng attended AdventCare to examine Ms Xu given that Ms Xu's usual doctor, Dr Thompson, was unavailable.[28]

13. Whilst at AdventCare, Ms Xu was accommodated in room 15 of Barratt Wing, a single bedroom with an en suite bathroom. It became apparent over time that Ms Xu preferred to remain in her room much of the time, forgoing meals in the communal dining room and all optional afternoon activities, with the exception of a Christmas party held five days after her admission.[29] There were few Mandarin-speaking co-residents and staff at the same time as Ms Xu, however, she was visited almost daily by her daughter-in-law and received a couple of visits from friends, Ms Ly and Ms Jiang.

14. On 30 November 2010, Ms Xu complained of dizziness on waking but reported no other symptoms. She took breakfast and lunch in her room and remained there. Ms Xu appeared well when staff checked on her at morning tea, and at midday when administering her medications.

15. At about 2.35pm, Nurse Lim checked on Ms Xu and, believing she was using the bathroom, knocked on its door. She received no response. Nurse Lim then tried to open the bathroom door but could not do so because it appeared to be blocked. Upon looking into the bathroom,

---

[25] Exhibit H.

[26] Coronial Brief of Evidence (AdventCare Admission Documents) And Exhibit H.

[27] Transcript pages 42, 45-48 and page 74.

[28] Coronial Brief of Evidence (AdventCare Resident Notes) and Transcript pages 42, 45-48.

[29] Coronial Brief of Evidence (Statement of Ken Cheong and AdventCare Resident Notes).

Nurse Lim saw Ms Xu's hand and so pushed the door open so that she could enter. Nurse Lim observed Ms Xu to be slumped on the seat of her walking frame with her face resting against the back of the bathroom door. A shoelace was looped around Ms Xu's neck and one end attached to a hook behind the door. Ms Xu was unresponsive and so Nurse Lim alerted Nurse Bayangos, the Clinical Care Co-ordinator, and severed the ligature.

16. On arrival, Nurse Bayangos was unable to find Ms Xu's pulse and noted that her extremities were cold. Emergency services were called. On arrival a short time later, ambulance paramedics confirmed that Ms Xu was deceased, and attending police commenced the coronial investigation of her death.

17. Forensic Pathologist Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine [VIFM], performed a post-mortem examination or autopsy of Ms Xu's body. Dr Baber also reviewed the circumstances of Ms Xu's death as reported by the police to the coroner, and post-mortem CT scanning of the whole body also undertaken at VIFM. Dr Baber's anatomical findings at autopsy were of a parchmentised abrasion of the neck, consistent with the ligature seized by police at the scene and provided to her for examination, no strap muscle bruising (such as might be seen in strangulation) and no significant natural disease, that is such as would cause or contribute to death, Dr Baber advised that it would be reasonable to attribute Ms Xu's death to hanging.

18. Routine toxicological analysis of post-mortem samples detected buprenorphine (a narcotic analgesic) and its metabolite norbuprenorphine, carbamazepine (used to treat neuralgia) and metoclopramide (an anti-emetic), all prescription medications at therapeutic levels.

INVESTIGATION – SOURCES OF EVIDENCE

19. This finding is based on the totality of the material the product of the coronial investigation of Ms Xu's death. That is the brief of evidence compiled by Senior Constable Quinn of Nunawading Police and Leading Senior Constable Tania Cristiano of the Police Coronial Support Unit, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them. All of this material, together with the inquest transcript, will remain on the coronial file.[30] In writing this finding, I do not purport to

[30] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

20. The purpose of a coronial investigation of a *reportable death* is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[31] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[32]

21. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[33] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[34] These are effectively the vehicles by which the prevention role may be advanced.[35]

22. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or maybe, guilty of an

---

[31] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[32] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[33] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[34] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[35] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

offence.[36] However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if the coroner believes an indictable offence may have been committed in connection with the death.[37]

FINDINGS AS TO UNCONTENTIOUS MATTERS

23. In relation to Ms Xu's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. Her identity and the date and place of death were not at issue. I find, as a matter of formality, that Chang Ying Xu, born on 1 August 1938, aged 72, late of 2 Jayson Street in Burwood East, died at Advent Care Whitehorse Nursing Home, 163 Centre Road, Nunawading, Victoria 3131, on 30 November 2010.

24. Nor was there any contention around the medical cause of Ms Xu's death. Based on Dr Beber's findings at autopsy and advice, I find that Ms Xu died as a result of hanging.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

25. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Ms Xu's death was on the circumstances in which she died. Specifically, the circumstances gave rise to three issues which will be addressed sequentially below, namely:
    a. Ms Xu's suitability for 'low level' respite care;
    b. The adequacy of the clinical management by general practitioner, Dr Thompson; and
    c. The adequacy of the care provided by AdventCare during Ms Xu respite placement.

MS XU'S SUITABILITY FOR LOW LEVEL RESPITE CARE

26. Sandra Wong performed two assessments of Ms Xu's eligibility for aged care assistance[38], provided a statement concerning those assessments[39] and gave evidence at inquest.[40] Ms Wong's assessments were informed by Ms Xu's Eastern Health medical records, information provided by Ms Xu and her husband about their circumstances, observations made by Ms

---

[36] Section 69(1).

[37] Sections 69 (2) and 49(1).

[38] Exhibit B.

[39] Exhibit A.

[40] Transcript pages 3-12.

Wong, and her colleague, an occupational therapist, during the assessments and the "Aged Care Assessment and Approval Guidelines" [ACAA Guidelines].[41]

27. Ms Wong recorded Ms Xu's medical history and nominated the primary health condition giving rise to the assessment as chronic back pain secondary to severe spinal cord compression. She assessed Ms Xu as being able to independently perform several self-care tasks, transfers to and from a chair or bed, and walk short distances herself with the use of aids.[42] Ms Xu was reliant on her husband to assist with dressing, bathing and medications, and on other family members or her husband to assist with all other household tasks and with those few activities (predominantly attendance at medical appointments) that required her to leave the home.[43] Ms Wong observed that Ms Xu appeared 'mentally dependent' on her husband and required a lot of encouragement from him. [44]

28. Ms Wong asked Ms Xu specifically about her mental health because she knew about Ms Xu's hospitalisation following a drug overdose in 2007, medical records suggesting a diagnosis of depression, and the inclusion of amitriptyline (an antidepressant) on her list of current medications.[45] Although no formal mental state examination was conducted during either assessment, Ms Wong noted that Ms Xu reported no suicidal ideation, and was not delusional, aggressive or experiencing hallucinations.[46] She also recorded Mr Hu's report that his wife cried several times each day and that Ms Xu had become 'teary' during the assessments.[47]

29. Ms Wong assessed Ms Xu, in October 2009 and again in January 2010, as being suitable for 'low level care' as defined in the ACAA Guidelines.[48]

30. Although Ms Wong was aware that Ms Xu anticipated further back surgery, she was not contacted to perform another assessment of Ms Xu's needs after the third surgery occurred in

---

[41] Exhibit A.

[42] Exhibit B.

[43] Exhibit B.

[44] Exhibit B.

[45] Transcript pages 11-12.

[46] Exhibit B.

[47] Exhibit B.

[48] 'Low level care' is defined, in 2010, in part 2.4 of the ACAA Guidelines as applicable to individuals 'requiring the general accommodation and personal care service provided in residential facilities. A person receiving low level care might reasonably require daily assistance with bathing, showering/personal hygiene; organising and supervising and administering of medication; toileting and continence management; meals; transfers/mobility; dressing; fitting sensory/communication aids; assessment and referral for appropriate support; communication assistance; together with provision of special diets and emotional support'.

May 2010.[49] Ms Wong stated at inquest that a request for a fresh assessment could be made by anyone having knowledge of a change to Ms Xu's functional abilities post-operatively, such as her general practitioner, her aged care Case Worker (after one was allocated in June 2010) or Ms Xu herself.[50]

31. At inquest, AdventCare's Executive Director, Ms Ruth Welling, conceded that when assessing a prospective resident's entry to the facility for permanent or respite care, admission staff are 'heavily dependent' upon the evaluations made by aged care assessors like Ms Wong.[51] Indeed, AdventCare does not conduct any independent investigation of an applicant's needs prior to admission.[52] Thus, Ms Xu's January 2010 assessment informed AdventCare's decision to admit her, and to admit her to the 'low level care' section of the facility.[53]

DR THOMPSON'S CLINICAL MANAGEMENT

32. Since 2004, Ms Xu had been a patient of Box Hill Centro Clinic [BHCC], a general medical practice.[54] Although she had seen Dr Thompson there intermittently from 2007, it was not until 2009 that Dr Thompson became Ms Xu's regular general practitioner.[55] Medical records indicate that Ms Xu attended Dr Thompson at least twice each month, either in relation to ill-health or a renewal of prescriptions.[56] Significantly, Dr Thompson is a Mandarin-speaking clinician.

33. Dr Thompson was instrumental in arranging Ms Xu's third back surgery in May 2010. Dr Thompson testified at inquest that she believed that Ms Xu had high hopes[57] of the surgery, but that the treating surgeons had been reluctant to attempt it.[58] Dr Thompson did not consider the operation to have been a success, but acknowledged that post-operative recovery from such surgery can take up to 12 months.[59] She noted that after this surgery, Ms Xu

---

[49] Transcript page 11.

[50] Transcript page 10.

[51] Transcript page 71.

[52] Transcript page 71.

[53] Transcript pages 70-71.

[54] Exhibit D.

[55] Transcript page 14.

[56] See generally Exhibit D.

[57] Transcript page 25.

[58] Transcript page 25. See also Exhibit D.

[59] Transcript pages 25 and 39.

experienced 'a lot more pain, [needed] a lot more painkillers, [experienced] a lot more muscle spasms [and] was more frustrated' by her condition.[60]

34. Dr Thompson confirmed that she had not performed any 'direct'[61] assessments of Ms Xu's mental state despite describing her patient as 'really upset', 'really frustrated' and 'depressed'[62] several times in clinical notes and at inquest.[63] Dr Thompson stated that she was 'not aware' of Ms Xu's 2007 suicide attempt, until she reviewed Ms Xu's history to prepare a statement for the coronial investigation into her death.[64]

35. Dr Thompson did not consider Ms Xu to be depressed in a 'clinical sense' because she did not demonstrate the typical symptoms of depression.[65] However, she conceded that she could have 'missed ... some signs' because in her experience, Chinese people are taught from childhood not to show their emotions.[66] In short, 'depression wasn't on [Dr Thompson's] agenda' when treating Ms Xu.[67]

36. Unfortunately, Ms Xu's BHCC medical records do little to clarify whether her doctors considered her to have suffered from depression. It is noteworthy that the records appear to reflect longstanding treatment of depression.[68] For instance, Ms Xu's July 2007 suicide attempt is recorded, as is a change to her 'treatment for depression' in December 2007[69] from concorz[70] to amitriptyline. Later, in August 2008, there is a notation concerning Ms Xu's unilateral cessation of amitriptyline. Moreover, Dr Thompson made a notation – "depressed" – during a consultation with Ms Xu in May 2009 and subsequently prescribed amitriptyline in June, September and December of that year.[71] I note that Ms Xu's patient notes record a

---

[60] Transcript page 25.

[61] Transcript page 26.

[62] Transcript page 26 and Exhibit D.

[63] Exhibit D.

[64] Transcript page 26.

[65] Transcript page 40.

[66] Transcript page 40.

[67] Transcript page 37.

[68] Exhibit D.

[69] This change was instituted by another doctor at BHCC.

[70] Dr Thompson provided Ms Xu with the prescription for concorz.

[71] Exhibit D. A reference to amitriptyline being a 'current' medication also appears in Dr Thompson's statement, Exhibit C.

diagnosis of depression, dated May 2009 after Dr Thompson became Ms Xu's primary doctor,[72] but that Dr Thompson's statement does not reproduce this reference.[73]

37. Dr Thompson stated at inquest that she prescribed amitriptyline to Ms Xu mainly for its analgesic properties but also because she thought it would make her happier as well'.[74] Although classified as an antidepressant, Dr Thompson noted that it was 'well known [among] doctors'[75] that amitriptyline was useful in the treatment of pain, depression and insomnia. Dr Thompson acknowledged that amitriptyline was not a first choice medication[76] for either depression or pain management, but she prescribed it to Ms Xu 'on top of everything else'[77] as her other pain medications – norspan patches[78] and tegretol[79] – appeared to provide her with inadequate pain relief.

38. Dr Thompson confirmed that she had not prescribed amitriptyline to Ms Xu since December 2009, despite the medical records and her statement identifying it as a current medication. She could not recall, or determine from patient records, the duration of the last script but noted that she often wrote prescriptions for a six month supply of medications.[80] In any event, it seems that Ms Xu continued to take amitriptyline throughout January 2010 when Dr Thompson reviewed her medications,[81] but stopped doing so unilaterally sometime between January and November 2010. This is supported by the fact that Dr Thompson wrote no further prescription, the family's reports that Ms Xu had stopped taking the drug, and the absence of amitriptyline from post-mortem toxicology results.[82]

39. Despite receiving summaries of Ms Wong's assessments, and considering Ms Xu's third spinal surgery unsuccessful, Dr Thompson stated at inquest that she never considered

---

[72] Exhibit D.

[73] Exhibit C.

[74] Transcript page 16.

[75] Transcript page 34.

[76] Transcript page 38. Dr Thompson conceded that amitriptyline has been superseded by newer and safer antidepressants.

[77] Transcript page 38.

[78] Transcript page 17 (slow-release buprenorphine prescribed by Dr Thompson to treat Ms Xu's chronic back pain).

[79] Transcript page 18 (carbamazepine an anticonvulsant prescribed to manage neurological pain).

[80] Transcript page 32.

[81] Exhibit D and Transcript page 33. See also Transcript pages 20 and 33 where Dr Thompson indicates that it is her practice to ask the patient or his/her family which medications are actually taken rather than rely on the patient's records for a list of current medications because 'sometimes [a] patient can change [the medication] themselves … they feel like they don't need to take this or that'.

[82] Exhibit G.

requesting an aged care assessment of Ms Xu given the 'fantastic' family support she received.[83] Nonetheless, she was aware as early as October 2010 that Ms Xu would be staying in respite care when her husband and son travelled overseas, and that a medication chart would be required by the respite facility.[84] Dr Thompson did not prepare a medication chart prior to Ms Xu's admission to AdventCare (despite Ms Xu attending BHCC twice in the interim)[85] and was not available to complete one immediately after her admission.[86]

40. In the course of the coronial investigation and inquest into Ms Xu's death, a number of documents containing, or purporting to be, lists of Ms Xu's "current medications" were produced. These included Ms Xu's BHCC "Complete Record"[87], Dr Thompson's statement,[88] the BHCC "Health Summary" provided to Dr Weng[89] (these three documents were inconsistent), a list written in Mandarin by Mr Hu,[90] a list written in English, of uncertain origin (from which norspan is notably absent)[91] and the medication chart prepared by Dr Weng for AdventCare and used by its staff to administer medication to Ms Xu in respite care.[92] Inconsistencies across these lists were significant and gave rise to a concern that Ms Xu was not receiving all of the medications she required whilst at AdventCare. Ultimately, and fortunately, this concern proved to be unwarranted.

ADEQUACY OF THE CARE PROVIDED TO MS XU BY ADVENTCARE

41. Li Yan, Ms Xu's daughter-in-law, was present when Ms Xu was admitted to AdventCare[93] and visited her – usually in the afternoon – on all but a few of the days that Ms Xu was in

---

[83] Transcript page 25.

[84] See Exhibit D (entries made at consultations in October and November 2010). At inquest, Dr Thompson appeared to have no recollection that a medical chart was required by AdventCare.

[85] Exhibit D.

[86] Coronial Brief of Evidence (see generally, the Resident Notes maintained by AdventCare).

[87] Exhibit D.

[88] Exhibit C.

[89] Included among those documents forming Ms Xu's 'Care Plan' provided to the court by AdventCare on 2 September 2011.

[90] Included among those documents forming Ms Xu's 'Care Plan' provided to the court by AdventCare on 2 September 2011.

[91] Coronial Brief of Evidence.

[92] Ms Xu's 'Care Plan' provided to the court by AdventCare on 2 September 2011.

[93] Transcript page 64. I note that the transcript incorrectly refers to her as Yi Lan (rather than Li Yan).

respite care.[94] Ms Yan detailed her observations of the care Ms Xu received and recounted concerns Ms Xu had raised with her about the adequacy of that care.[95] These concerns broadly related to the provision of assistance to Ms Xu and the administration of her medications.

42. Although not a concern raised by her family, given Ms Xu's physical dependence on others and the fact that she could only communicate in Mandarin, effective communication between Ms Xu and those caring for her was fundamental to the provision of appropriate care. Accordingly, in addition to those matters raised by Ms Xu's family, I investigated the adequacy of those measures in place at AdventCare to facilitate communication between its predominantly English-speaking staff and Ms Xu.

43. At inquest, Nurse Lim[96] and Ms Welling[97] gave evidence about AdventCare's organisational structure and operations. In November 2010, Ken Cheong was responsible for day-to-day operations and oversight of service-provision as the Facility Co-ordinator.[98] As he is not medically trained, clinical guidance[99] for the entire facility was provided by two Division 1 Registered Nurses per shift, the Clinical Care Co-ordinator and the Nurse-on-Duty.[100] While the Clinical Care Co-ordinator does not appear to have a front line role at AdventCare,[101] the Nurse-on-Duty is responsible for all residents and guides the Team Leaders in each wing; other nursing staff and Personal Care Assistants [PCAs].[102] Some nurses, and some appropriately credentialed PCAs, perform medication rounds.[103] Each of the 140 AdventCare residents[104] is assigned a PCA.[105] The relative numbers of qualified nursing staff and PCAs depends on the roster for each shift.[106] Unfortunately, there is no precise evidence before me

---

[94] Transcript page 58.

[95] Exhibit G and Transcript pages 57-69.

[96] Transcript pages 40-56.

[97] Transcript pages 69-84.

[98] Coronial Brief of Evidence (Statement of Ken Cheong).

[99] Transcript page 71.

[100] Transcript page 53 and 71.

[101] See generally the statements provided by AdventCare employees.

[102] Transcript page 53.

[103] Transcript

[104] Transcript page 53.

[105] Exhibit H.

[106] Transcript page 72.

about staff-to-resident ratios, only Ms Welling's evidence that AdventCare's staffing levels are adequate.[107]

44. Ms Yan testified that when she visited her mother-in-law on 22, 23 and 26 November 2010 Ms Xu complained of receiving no response when she pressed her buzzer to call for assistance.[108] Ms Yan also reported that during visits on 27 and 29 November 2010 she was present when Ms Xu called for, or anticipated receiving, assistance.

45. On the first occasion, Ms Yan went to the nurses' station to find the carer who had said she would return, 20 minutes earlier, to check Ms Xu's blood pressure a second time. Another carer told Ms Yan that the person she sought had finished her shift and left, and so the carer reviewed Ms Xu's blood pressure herself.[109] On the second occasion, Ms Yan used Ms Xu's buzzer to summon help when her mother-in-law complained of dizziness and high blood pressure. After waiting more than 30 minutes for assistance, Ms Yan left her mother-in-law's room to look for a carer. The nurses' station was unattended and the only carer Ms Yan could locate was one performing medication rounds. The request for assistance was communicated by Ms Yan and a carer attended to Ms Xu about five minutes later.[110]

46. Ms Welling stated that she had 'no specific knowledge' of instances when Ms Xu was required to wait lengthy periods for a response to a call for assistance.[111] She advised that all 'nursing staff' carry pagers that are linked to residents' call buzzers, so any call for assistance goes automatically to the pager.[112] Ms Welling testified that in addition to calls for assistance, low level care residents were ordinarily checked by staff every two-to-three hours.[113]

47. Ms Xu also complained to her daughter-in-law about the infrequency with which she was assisted to shower, saying that it was only every four or five days.[114] On admission, Ms Xu

---

[107] Coronial Brief of Evidence (Statement of Ruth Welling dated 2 May 2011). Ms Welling provided three statements (one of which appears as Exhibit H) and gave evidence at inquest (Transcript pages 69-84).

[108] Exhibit G.

[109] Exhibit G.

[110] Exhibit G.

[111] Coronial Brief of Evidence (Statement of Ruth Welling dated 2 May 2011).

[112] Coronial Brief of Evidence (Statement of Ruth Welling dated 2 May 2011).

[113] Exhibit H. It appears that these 2-3 hourly checks correspond with meal times (breakfast, morning tea, lunch, afternoon tea, dinner). There is no specific evidence before me about the frequency with which residents are observed overnight.

[114] Exhibit G and Transcript page 65. Ms Welling's 'translation' of "every second day" and, to the extent they document activities like showering, the 'Resident Notes' included among those documents forming Ms Xu's 'Care Plan' (provided to the court by AdventCare on 2 September 2011), corroborate the infrequency of showering assistance.

indicated a preference to shower 'every second day'.[115] Ms Yan's understanding of this instruction (presumably one shared by Ms Xu) was that Ms Xu would be showered on Mondays, Wednesdays, Fridays, and so on,[116] in accordance with the ordinary meaning of every second day. However, at inquest, Ms Welling stated that Ms Xu's instruction would have resulted in her being showered one day, having no shower for two days, and then being showered on the following day.[117] Ms Welling conceded that a misunderstanding about bathing frequency may have occurred,[118] but that showering assistance would have been provided on any day, if Ms Xu had asked for it.[119] I note that Ms Xu had asked Ms Yan not to 'trouble' the staff about showering assistance, because she did not consider it to be the 'most important' issue.[120]

48. When Dr Weng completed Ms Xu's medical admission on 19 November 2010, he noted that her blood pressure was poorly managed and that she was anxious about it.[121] Dr Weng left instructions for Ms Xu's blood pressure to be monitored 'weekly'[122] and AdventCare's "Vital Observations Chart" and "Resident Notes" reflect that this was done more frequently than stipulated, often in response to Ms Xu's reports of dizziness.[123] Indeed, Ms Xu's blood pressure was recorded 11 times between 22 and 30 November 2010, and on eight occasions her systolic blood pressure exceeded 160mm/Hg.[124]

49. Following Ms Yan's intervention, by obtaining a prescriptions from Dr Thompson, on 25 November 2010 'PRN' or as required medication orders including antihypertensive medication additional to Ms Xu's regular medication, were written up by Dr Weng requiring administration of tarka if Ms Xu's blood pressure exceeded 160mm/Hg.[125] AdventCare's

---

[115] Ms Xu's 'Care Plan' (provided to the court by AdventCare on 2 September 2011).

[116] Transcript pages 80 and 82.

[117] Transcript page 80.

[118] Transcript page 80.

[119] Transcript page 80.

[120] Transcript page 65. I also note that Ms Xu's 'Resident Notes' contain an ambiguous entry, dated 21/11/10, stating that Ms Xu 'mentioned [to] staff that she doest [sic] like to have a shower or wash'.

[121] See the note created by Mark Weng on 19/11/2010 included in the 'Resident Notes' that are among those documents forming Ms Xu's 'Care Plan' (provided to the court by AdventCare on 2 September 2011),

[122] Ibid.

[123] See 'Resident Notes' that are among those documents forming Ms Xu's 'Care Plan' (provided to the court by AdventCare on 2 September 2011).

[124] See the note created by Nurse Janice Lim on 25/11/2010 in 'Resident Notes' and the "PRN Medications" chart that are among those documents forming Ms Xu's 'Care Plan' (provided to the court by AdventCare on 2 September 2011).

[125] Ibid.

PRN Medication chart demonstrates as required antihypertensive medications were administered on the afternoons of 27, 28 and 29 November 2010.[126]

50. As indicated above, Dr Weng charted Ms Xu's regular medication orders on 19 November 2010. AdventCare staff did not commence administering medications pursuant to those orders until 20 November 2010 and so, before then, Mr Hu administered his wife's medications. At inquest, Dr Thompson confirmed[127] that Dr Weng's orders properly reflected all of Ms Xu's regular medications, and Ms Welling's explanation of AdventCare's practices in relation to the charting of administered medications clarified that Ms Xu did received all of her required regular medications.[128] AdventCare's records document that Ms Xu's supply of regular medications to be administered by staff was removed from her on 22 November 2010.[129]

51. Among Ms Xu's regular medications were strong analgesics that can produce constipation as a side effect. Ms Xu complained to her daughter-in-law about constipation while at AdventCare. Indeed, Adventcare's "Bowel Chart" confirms that Ms Xu did not open her bowels between 20 and 28 November 2010. Ms Welling provided evidence that AdventCare's policy is to ask the resident if s/he wishes to take an aperient if there has been no bowel movement for four days.[130] "Resident Notes" suggest that on 24 November 2010 staff addressed this issue, and Ms Xu used a laxative that she had in her possession. The staff note refers to there being 'no PRN order' in place to alleviate Ms Xu's constipation.[131]

52. AdventCare's staff appear to have been proactive in their efforts to ensure PRN orders were made, with follow up actions noted on 21, 22 and 25 November 2010.[132] Prior to 25 November 2010, when PRN orders were finally made, Ms Xu was permitted to keep supplies

---

[126] See PRN Medications" chart that is among those documents forming Ms Xu's 'Care Plan' (provided to the court by AdventCare on 2 September 2011).

[127] Transcript page 23.

[128] Transcript pages 77-79.

[129] See the note created by Nurse Janice Lim on 22/11/2010 in 'Resident Notes' that are among those documents forming Ms Xu's 'Care Plan' (provided to the court by AdventCare on 2 September 2011).

[130] Coronial Brief of Evidence (Statement of Ruth Welling dated 2 May 2011).

[131] Note created by Janice Lim on 24/11/2010 included in the 'Resident Notes' that are among those documents forming Ms Xu's 'Care Plan' (provided to the court by AdventCare on 2 September 2011).

[132] See the 'Resident Notes' that are among those documents forming Ms Xu's 'Care Plan' (provided to the court by AdventCare on 2 September 2011).

of lactulose (a laxative), temaze (a sedative), senokot (a vegetable laxative) and metoclopramide (an anti-emetic) so that she could self-medicate.[133]

53. At inquest, Ms Welling stated that AdventCare's policy in relation to residents whose first language is not English is to locate a member of staff who can assist with communication, particularly if the communication difficulty relates to a 'complex' or medical issue.[134] She stated that 'there's always someone there who will be able to communicate' with the resident.[135]

54. Indeed, among AdventCare's staff in November 2010 were two Division 1 Registered Nurses – Nurse Janice Lim (RN Lim) who worked weekday morning shifts and Nurse Yu who worked morning shifts on weekends, a PCA, Ms Hong, who worked 'a few' afternoon shifts and Mr Cheong, each described by Ms Welling as 'Mandarin speakers'.[136] She also noted that 'quite a number'[137] of Mandarin speakers were 'on roster'[138] and that Dr Weng, who completed Ms Xu's medical admission to AdventCare, spoke Mandarin.

55. Although he was not required to give evidence at the inquest, Mr Cheong prepared a statement in which he explained that his usual practice was to 'perform rounds' – visiting all residents – between 10am and 11am each weekday.[139] Mr Cheong estimated that he visited Ms Xu in this manner on 10 occasions, and as he possessed functional, but not fluent Mandarin, he was able to 'have casual chats' with her during which he would ask if she needed anything or whether she had eaten her breakfast.[140] Mr Cheong did not recall Ms Xu ever raising any 'specific concerns' about her care during these chats, and he never had concerns about her mental state: 'she always seemed fine'.[141]

56. RN Lim did give evidence at the inquest and confirmed that she was usually the Nurse-on-Duty on weekday mornings during Ms Xu's period of respite at AdventCare. She clarified that because she is Malaysian-Chinese and Ms Xu was from China, there were some linguistic

---

[133] See the 'Resident Notes' that are among those documents forming Ms Xu's 'Care Plan' (provided to the court by AdventCare on 2 September 2011). It seems that Ms Yan's concern that Ms Xu was provided medications with which to self-medicate may have arisen from a misunderstanding of AventCare's drug administration policy.

[134] Transcript page 74.

[135] Transcript page 74.

[136] Exhibit H, Transcript page 73 and Coronial Brief of Evidence (Statement of Ruth Welling dated 12 August 2011).

[137] Transcript page 73.

[138] Transcript page 73.

[139] Coronial Brief of Evidence (Statement of Ken Cheong).

[140] Coronial Brief of Evidence (Statement of Ken Cheong).

[141] Coronial Brief of Evidence (Statement of Ken Cheong).

differences even though they could 'basically understand' each other by communicating in Mandarin.[142] Notwithstanding the demands of her leadership role within the facility, RN Lim stated that she saw Ms Xu every shift because she was 'the one who can speak Mandarin'.[143]

57. RN Lim stated that no formal mental state assessments of Ms Xu were conducted but that she could 'tell' whether a resident is 'upset' or 'unwell' when attending on her/him.[144] From RN Lim's perspective, Ms Xu's main complaints were dizziness and high blood pressure. Ms Xu was 'worried' about her blood pressure, and so RN Lim would check her blood pressure, report the result to her, and provide reassurance.[145]

58. I note, in passing, the comments made in a statement by Personal Care Attendant Ms Satorre, who did not speak Mandarin. Ms Satorre acknowledged that a 'language barrier' existed between her and Ms Xu and that when communicating, they relied on gestures.[146] Ms Satorre characterised Ms Xu as a 'timid lady' who 'did not like to be alone [but] wanted to have her family around her'. However, Ms Satorre stated that she did not observe Ms Xu to show 'significant signs' of depression.[147]

59. Ms Yan stated that she 'did not notice a significant change'[148] to Ms Xu's mood after she entered respite care. Ms Yan reported that her mother-in-law continued to complain of pain, was concerned about her high blood pressure, and expressed dissatisfaction at the care she received at AdventCare.[149] According to Ms Yan, she was present when Ms Xu told their mutual friend, Ms Jiang, that she 'would rather die than live in this nursing home'.[150]

60. Ms Yan gave evidence that she and other family members believed Ms Xu suffered from depression after her suicide attempt in 2007 and that Ms Xu had stopped taking

---

[142] Transcript page 43.

[143] Transcript page 54.

[144] Transcript page 55.

[145] Transcript pages 55-56.

[146] Coronial Brief of Evidence (Statement of Maria Satorre).

[147] Coronial Brief of Evidence (Statement of Maria Satorre).

[148] Transcript page 67.

[149] Transcript page 67. Ms Xu appears to have kept a diary of concerns while at AdventCare. She showed the notebook to Ms Yan early on and Ms Yan found the book among Ms Xu's possessions after her death. Ms Yan brought the notebook to the inquest, having translated Ms Xu's Mandarin characters into English. In addition to specific medical concerns – pain, limb weakness, facial numbness, high blood pressure, insomnia and constipation – there are the following comments, "Nurse can't understand my health ...Asked for [hypertension] medicine, not given any ... Nurse was too busy to help me in the morning and night ... Can't express feeling".

[150] Transcript page 66. See also Coronial Brief of Evidence (Statement of Wan Fang Jiang).

antidepressants early in 2010.[151] She stated that given the extent and duration of her mother-in-law's dependence on her husband and family, she believed that Ms Xu felt she was a 'burden' on them.[152] Ms Xu's son, Peter, also expressed this view.[153]

61. I note Ms Welling's evidence that AdventCare's pre-admission process for a prospective resident known to be depressed or suicidal is 'a lot more involved and detailed' than that used to admit Ms Xu.[154] Moreoever, she stated that although not mandated for non-permanent residential care, since Ms Xu's death, AdventCare now administers a psycho-geriatric depression scale tool to all new residents to assist it to evaluate his or her mental state on admission and identify risk factors so as to respond appropriately to them.[155]

62. Ms Welling provided evidence that 'the hooks that were present on some doors have been removed' to improve the environmental safety at AdventCare.[156]

CONCLUSIONS

63. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[157] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

64. Having applied the applicable standard to the available evidence, I find that:

    a. Ms Xu experienced considerable pain and diminishing mobility due to severe spinal cord compression. As a result of her condition, she was increasingly reliant upon her family, particularly her husband, to assist her with the tasks of daily life.

---

[151] Transcript pages 59-60.

[152] Exhibit G and Transcript 88-89.

[153] Transcript pages 88-89.

[154] Transcript page 70.

[155] Transcript pages 81-82.

[156] Exhibit H.

[157] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

b. Ms Wong's assessments of Ms Xu's needs in October 2009 and January 2010 were thorough.

c. In light of their therapeutic relationship, Dr Thompson was best placed – and, among those individuals with whom Ms Xu interacted in the months and weeks prior to her death, perhaps the best qualified – to assess Ms Xu's mental state. However, Dr Thompson's unfamiliarity with her patient's history of self-harm and its management at BHCC; her awareness of the longstanding, debilitating effects of Ms Xu's chronic physical conditions and their effect on her mood; and her professed cultural awareness of Ms Xu's likely reluctance to disclose emotional distress, amounted to sub-optimal clinical management, absent direct assessment and more proactive management of Ms Xu's mental health.

d. The evidence does not, however, support a finding that Dr Thompson's clinical management caused or contributed to Ms Xu's death.

e. Although Ms Xu presented with a number of signs and symptoms of depression, the available evidence does not enable me to determine whether Ms Xu was clinically depressed at the time of her death.

f. Given the information available to Ms Wong, and as a consequence to AdventCare, there is no basis for a finding that Ms Xu was not a suitable candidate for low level residential respite care.

g. AdventCare staff proactively resolved issues associated with Ms Xu's medical admission to respite care by facilitating Dr Weng's completion of Regular Medication Orders.

h. Similarly, although the establishment of Ms Xu's PRN Medication Orders was delayed, AdventCare staff were diligent in ensuring that orders were made, and that Ms Xu's 'as required' medications were available to her in the interim.

i. All of the medications usually prescribed to Ms Xu were included on, and administered by AdventCare staff in accordance with, Dr Weng's medication orders.

j. AdventCare took reasonable steps to ensure that the linguistic barrier posed by Ms Xu's ability to speak only Mandarin did not undermine their provision of appropriate care. However, even a shared language does not guarantee effective communication,

as the misunderstanding about the frequency with which Ms Xu would receive showers, for instance, bears out.

k. Although there is evidence before me that Ms Xu was dissatisfied with the care she received at AdventCare, there is insufficient evidence to support a finding that Ms Xu's dissatisfaction was brought to the attention of AdventCare, in terms, or that the care provided by AdventCare was unreasonable or inadequate.

l. Ms Xu experienced a number of physical, psychological and emotional stressors that were likely to have been exacerbated by her respite placement, away from her home and the support of family members on whom she was accustomed to rely.

m. Although I am unable to determine which one, or which combination of stressors ultimately motivated Ms Xu, given the lethality of the means she chose, I find that Ms Xu intentionally took her own life by hanging.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. AdventCare's introduction and use of the "Psycho-Geriatric Depression Scale" to assess the mental state of all new residential respite admissions to its facility is a commendable improvement with the potential for enhancing their care of residents.

2. This case highlights the challenges of providing aged care to people from Culturally and Linguistically Diverse backgrounds, and the fundamental human need for communication and social engagement. Communication is a complex process, one that is not limited to the use of language. By way of example, PCA Satorre's impressions of Ms Xu were gleaned in the absence of a shared language, but appear to be insightful. That said, during Ms Xu's respite placement she had little opportunity for meaningful conversation and social engagement, apart from her limited conversations with Mandarin-speaking staff or when she was visited by family or friends.

I direct that a copy of this finding be provided to:

Ms Xu's family

Chief Executive Officer, Adventcare Whitehorse

Seventh Day Adventist Aged Care Ltd. c/o McMahon Fearnley Lawyers,

Dr Thompson, Box Hill Centro Clinic

Ms Wong, Central East Aged Care Assessment Team/Peter James Centre

Dr Weng, Forest Hill Medical Centre

Signature:

PARESA ANTONIADIS SPANOS
Coroner
Date: 26 March 2015