Ref No. GB/P/9/08

REASONS FOR ORDER

Mental Health Ordinance (Cap. 136)[1]

(Section 59O)

BETWEEN

The Director of Social Welfare	**Applicant[2]**
and	
Madam YCY	**Subject[3]**
Ms TYP	**Party added[4]**

Members of Guardianship Board constituted

Chairperson of the Board: Mr Charles CHIU Chung-yee

Member referred to in section 59J (3) (b): Dr FONG Wing-chi

Member referred to in section 59J (3) (c): Ms Sally HO Wing-fong

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[1] Sections cited in this Order shall, unless otherwise stated, be under Mental Health Ordinance (Cap. 136) Laws of Hong Kong.

[2] S2 of Mental Health Guardianship Board Rules

[3] S2 of Mental Health Guardianship Board Rules and S59N(3)(a) of Mental Health Ordinance

[4] S2 of Mental Health Guardianship Board Rules and S59N(3)(b) of Mental Health Ordinance

Date of Reasons for Order: 21st May 2008.

Party added

1. The Board directed that Ms TYP, the daughter of the subject, be added as party to these guardianship proceedings.

Background

2. The subject was a 83-year-old woman suffering from senile dementia and multiple physical illnesses. She was used to live with the daughter, Ms TYP at the rented village house. After subject's husband moved away about 10 years ago, the daughter became the only carer to look after the subject. They were living on Comprehensive Social Security Assistance (CSSA). The daughter was the CSSA holder of the family. The subject was also granted Higher Disability allowance (HDA), special diet and diaper allowances.

3. Ms TYP used to help the subject in her daily living and activities including bathing, feeding, toileting and drug compliance. She perceived that the subject liked to be cared by her and did not want to be removed to institutional care. During the subject's hospitalisation, Ms TYP seldom visited the subject.

Mental and health conditions

4. The subject was assessed as mentally unfit to make statement on 30 January 2008. According to the medical report, subject suffered from senile

dementia with progressive deterioration in self-care, memory and cognition since 2004. Subject was bedbound and on long-term Ryles tube feeding. She was aphasic and failed to express herself. Physically, the subject was suffering from diabetes mellitus and has been on insulin therapy. Her health condition was deteriorating. She was totally dependent in managing her daily activities.

Suspected elder abuse

5. On 5 February 2008, the hospital hosted a multi-disciplinary case conference which involved three doctors, medical social workers, nurses, community nurse and assistant supervisor of an elderly community centre on suspected elderly abuse on the subject. According to the minutes of case conference, it stated:

> *"Report by Community Nurses*
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> *…the subject had started to receive the Community Nurse Service (CNS) since 2004. She observed that there were three main caring problems. Firstly, the daughter insisted self-adjusting the insulin dosage for the subject even she was suggested repeatedly not to do so. Besides, the daughter did not follow the medical officers' instruction to feed the subject properly. The subject was found having dropped blood albumin level which reflected that she had deteriorated nutrition status. Lastly, the daughter had self insertion of Ryle's tube even she was warned that her action was very high risk as she was not trained for this procedure which could only be done by the health care professionals. The community nurse shared that the daughter was unco-operative with the helping professionals and*

even requested the community nurses not to visit her family.

…the daughter had prepared rehabilitated items including the ripple bed, wheelchair, etc for the elderly. Yet, she did not have sufficient skills in turning or moving the subject. Besides, the daughter refused other community nurse to provide service to the elderly as she regarded their service quality not good enough. Furthermore, the daughter had requested to insert the Ryle's tube for the subject by herself. The nurse refused her request but let her try it under the guide of the former. The daughter was repeatedly reminded not to inert the Ryle's Rube for her mother by herself without community nurse's monitoring.

<u>Discussion of case nature</u>

……Doctor considered the case as an elderly neglect case as the daughter did not provide proper care to her mother with the following evidence that she refused to follow the professionals' recommendations on the feeding issue despite repeated advice and warning causing repeated Ryle's tube block, the subject's poor DM control and deteriorating nutritional status. Besides, he considered the case as an elderly abandonment case as the daughter always went missing and could not be contacted all the time during the subject's hospitalization, so that the medical officers could not discuss the subject's medical or caring plan with her.

The meeting concluded that the case was established as an elderly neglect and abandonment case."

Circumstances leading to application

6. The member of the multi-disciplinary case conference agreed that the subject needed intensive care on her daily living and suggested institutional care for her. The subject was found suitable to be under nursing home care and she had been waitlised for nursing home placement since October 2006. The meeting concluded that an application for Guardianship Order was needed in order to make decision for the best interests of the subject.

Recommendation of the Director of Social Welfare

7. The social enquiry report maker supported the application and she also recommended the Director of Social Welfare to be the guardian.

Hearings at the Board on 21 MAY 2008

8. Ms TYP, the elder daughter ("the daughter") of the subject confirmed that she objected to guardianship for the subject and that she was ready to proceed today despite an adjournment was suggested to her by the Board. The Board then stood the case down for the social enquiry report maker to explain the contents of the social enquiry report, two Supplementary reports and the note of the nursing officer as attached to the minutes of the Multi-disciplinary Case Conference held on 5 February 2 May 2008.

9. After recess, all parties confirmed that they were prepared to proceed immediately.

10. The Board ordered that the daughter of the subject be added as a party to these proceedings. She consented to it.

11. **The applicant-medical social worker** said in the written reason attached to the application form (Form 1), she described the daughter suddenly appeared to arrange a discharge for the subject. She recalled that she came into contact with this case since October 2007. There were a few hospital admissions of subject since that time. She was told by ward nurses that it was difficult to contact the daughter on the question of discharge throughout. During those admissions, the daughter usually suddenly appeared at the ward and sought discharge by way of non-emergent ambulance service.

12. **Dr L** said he was invited by the ward staff and medical social worker in January 2008 to involve in this case, as he was the liaison officer for elder abuse cluster and the officer-in-charge of community nursing service of his hospital. For the year 2007, there were multiple admissions of the subject to hospital. He handed up a list of subject's admission record (entitled "Episode List For PMI Enquiry") showing, amongst other years, ten admissions during that year.

13. The Board referred the doctor to the second page of community nurse's report dated 15 May 2008. Regarding the insulin prescription stated as 22 units om, doctor explained that it meant to be an injection of 22 units of Mixtard in the morning before breakfast. As for the second daily injection of 12 units pm, it meant an injection to be taken before dinner. Such a prescription of dosage indicated a moderate severity of the illness of diabetes mellitus. However, the interpretation should also take into account of the body size of the patient.

14. Doctor particularly drew the Board's attention to the 7th hospital admission in 2007 of the subject which was on 20 July 2007. For that hospitalization, the subject was found to have suffered from severe hyperosmolar coma,

which was a severe and acute complication resulted from diabetes mellitus. Before that admission, neither insulin injection nor oral medication was required for the subject.

15. Regarding the multiple admissions, there was no record that the admissions were resulted from wrong or improper insertion of the feeding tube by the daughter. However, doctor noted that in respect of the admission on 30 December 2007, the medical record showed that subject was suffering from aspiration pneumonia. The subject was discharged home on 10 January 2008. [The Board noted that the community nurse's report dated 15 May 2008 showed that the daughter inserted the feeding tube of the subject again and was found out by the visiting nurse on 16 January 2008, i.e. six days after discharge.]

16. **The maker of social enquiry report** said, in her supplementary report, she only recorded six hospitalizations of the subject during which the daughter of the subject turned down the suggestion of admitting the subject to an aged home. There should be many more hospital admissions, even in respect of the year 2007 alone.

17. The subject and her daughter were granted CSSA in around 1997. The subvented elderly community centre was only involved for a short time in 2004 in respect of provisions of home help service, but nothing concrete was offered or accepted at that time. The recent offer of a priority placement for the subject at a subvented nursing home was kept open pending today's result. Regarding the daughter's view on the placement, the social enquiry report maker said the daughter maintained home restoration for the subject.

18. **The daughter** of subject said she objected to place the subject under guardianship and objected to let the subject be admitted to the nursing home because she wanted to take care of her at home.

19. She said she was not told of the diabetes mellitus of the subject all along, despite many hospital admissions before July 2007. It was only on the July admission that the subject was found to be in a critical condition due to the illness.

20. The Board took her through the community nurse's report dated 15 May 2008. The daughter said the omission of the evening injection of insulin on 24 December 2007 was based on her general understanding from the treating doctor that she might do so on findings of blood glucose level of the subject on a particular day. The injection of only 14 units of insulin preparation on 29 December 2007 in the morning was without prior specific consent of treating doctor. The same situation applied to the modified and single injection on 14 January 2008. Being questioned by the Board, she stressed that the treating doctor had told her that she could adjust the dosage down according to the blood sugar level as shown on subject's daily blood profile. [Dr L said in medical practice, provided blood sugar monitoring was close enough e.g. with blood tests done three to four times daily, a doctor might allow the family to adjust the dosage slightly. However, in respect of the subject, the community nursing record showed that only one blood test was done by the daughter daily and sometimes once in a few days. Particularly, the subject needed two injections a day amounting to 34 units of insulin preparation as prescribed whereas the daughter only gave one injection of 14-18 units, which was a great departure from the doctor's prescription and thus was dangerous. Dr L further drew the Board's attention to the fact that on 29 December 2007, the community nurse

recorded in her notes that the daughter declined to have more frequent blood tests in a day. Earlier on 24 December 2007, the daughter requested another visiting nurse to teach her as to how to delete the data in the glucometer. These matters worried him.] The daughter said the nurses simply missed her point.

21. The daughter confirmed that she had no training in nursing. She admitted that she frequently changed the feeding tubes for the subject as she thought she knew how to do it and she wished to learn it. It could save the subject from attending the Accident & Emergency Department of a hospital. The Board could hardly understand her reasoning.

22. On request, she told the Board step by step how she inserted the feeding tube for the subject. On being challenged as how she could detect a wrong insertion, she said apart from listening to the sound, she could tell whether the tube was in the stomach by extracting the stomach juice to look for colour change on a piece of testing paper. But she could not tell the theory bringing the colour change and could not tell the next step in case if the stomach juice could not be extracted. The Board did not find the steps taken by Ms TSE in the way as described by her as correct. The Board was exceedingly worried that the daughter did not have the proper skill and knowledge to properly insert a feeding tube, which was required to be done only by a properly trained nursing professional.

23. Regarding the shortness of the tube inserted by her on 16 January 2008 (appearing in the last paragraph of the community nurse's report dated 15 May 2008), she thought the visiting nurse who found out the problem, was being too pedantic as the visiting nurse was the only single nurse who insisted on 65 cm. [Dr L said for the insertion by the daughter, the tube

was far too short at 50 cm, thus there was potential risks of aspiration and suffocation.]

24. On the latest hospital admission on 26 January 2008, the subject was found to have the feeding tube choked. During the period from 16th to 26th, she confirmed to the Board that she did not change the feeding tube by herself. [Dr L said the choking of the tube might be caused by the food, water or drugs passing through the tube. It was not usual that a blockage was due to a tube inserted longer than necessary. Blockage did not happen that way.]

25. She thought she was able to give care to the subject at home continuously. She promised she would not change the feeding tube by herself in future. However, she did not agree to stop adjusting the dosage of insulin injection as she must watch out for the blood sugar level from blood tests daily. She knew she could send the subject to Accident & Emergency Department if anything emergent happened. [Dr L said in an aged home setting, the prescription of insulin must be strictly followed except the blood test showed a very significant drop of blood sugar. Even if that happened, it would only mean that the injection was to be withheld and the patient must be brought for immediate medical attention or consultation of a specialist nurse in diabetes mellitus. In this case, it all depended on whether there was enough support and the readiness of the daughter to seek and follow independent medical advice. Also, the lowering of dosage by the daughter was almost by half of what was prescribed. As well, the daughter was not willing to open door to visiting nurses.] Despite the Board took the daughter through the two relevant records of denial of entry (respectively on 24 December 2007 and 16 January 2008), she denied to have ever refused visits of the visiting nurses on those days.

26. She would like to show to the Board some pictures stored in her mobile phone regarding wounds of skin at subject's back and near-side of upper legs. [The Board asked the social enquiry report maker to call the hospital ward immediately to clarify the skin conditions of the subject. On returning to the hearing room, the social enquiry report maker informed the Board that the ward nurse confirmed that the subject did not have any bedsores or wounds except some redness at her buttock.]

27. The Board sought clarification from the daughter on community nurse's notes attached to the Multidisciplinary Case Conference held on 5 February 2008 on skipping meals of the subject for the purpose of doing away with one daily injection of insulin. The Board cross-referenced to the incident on 14 January 2008 recorded in the community nurse's report dated 15 May 2008. According to the report, on 14 January 2008, the daughter told the visiting nurse that she fed the subject according to blood test profile and sometimes she fed the subject only one meal a day.

28. The daughter said she only deliberately gave more water, as she felt it right to do so, to the subject in mixing the milk and extend the feeding interval to every 4 hours (counting from the time when the earlier feeding was finished). She used milk powder instead of liquid milk. She used 300 ml of water to mix with 4 scoops of milk powder. On being confronted with the nurse records again, she said she did tell the visiting nurse on 14 January 2008 that she fed the subject only one meal a day. But she said she only told a joke to her on that day. The Board could hardly accept this version of explanation.

<u>Issues and Reasoning</u>

<u>Reasoning for receiving the subject into guardianship</u>

29. Upon considering the various reports and hearing from the parties and witnesses at the hearing, the Board believed that the predominant need of the subject that remained to be satisfied is the arrangement for her long-term accommodation, daily and health care. On this, it is clear that the daughter who used to be main carer of the subject since 2004, held a diagonally opposite view from that of the medical team. The daughter insisted on home restoration of the subject to her personal care and whereas the medical team assessed that the subject must be put under institutional care on the ground that the daughter had blatant inadequacies in rendering proper care to the subject and the situation was getting worse since the later half year of 2007. The medical team further held that not only the daughter was difficult to be communicated with, her so-call care given to the subject was grossly inappropriate amounting to a degree of neglect which is a form classified as elder abuse. Against this background, the medical social worker at hospital filed the application for guardianship on the day following the meeting of multi-disciplinary case conference held on 5 February 2008.

30. The Board found as a fact, as admitted by the daughter that she did in six occasions found out by visiting community nurses in year 2006 to January 2008 that she, as a person without any nursing training, changed the feeding tube of the subject and inserted replacement tube for the latter. The daughter could not give a convincing reason of so doing and all the insertions were done against nursing advice and despite continual and persistent persuasions to her to refrain from doing it again. Particularly,

the Board noted that the subject was admitted to hospital on 30 December 2007 due to aspiration pneumonia and was subsequently discharged home on 10 January 2008. The daughter was found six days later that she changed the feeding tube for the subject at her own accord. The daughter had, in the view of the Board, little regard to the significance of the immediately preceding hospital admission of the subject due to aspiration pneumonia. Worst still, the feeding tube so inserted was far too short at 50 cm that carried the potential risks of suffocation and aspiration. As a procedure with high risk of suffocation, aspiration and causing death that required a nursing care professional to carry out, changing and inserting of feeding tube should never be carried by a lay carer such as the daughter. Her insistence to carry out this task in the past, against medical and nursing advices, is viewed by the Board as detrimental to health of the subject and a demonstration of her lack of proper insight as a carer. The Board also did not have faith in her verbal promise made at the hearing that she would not do it again.

31. Likewise, The daughter admitted that she had unilaterally adjusted down the daily dosage of insulin injection for the subject. This was found out by the visiting community nurses and was recorded clearly in three occasions in the community nurse's report dated 15 May 2008. The daughter put up an excuse that she had a blanket authorization in so doing given by the treating doctor. But, later on further probing by the Board, the daughter admitted that she did not have any actual prior consent from the treating doctor on the adjusted dosage at all. The Board could not help but believe that the daughter, according to what she said, only selectively taken in what the treating doctor had discussed with her in prior conversations. She then elaborated on what she had heard and then embarked on her own errand to make bold yet reckless decisions on substantially adjusting down the dosage

of this very crucial medication of the subject. In this matter, the Board was driven to serious worries because the Board was alarmed by the following four facts: -

(a) The subject was once admitted in critical conditions of hyperosmolar coma in July 2007 and obviously the subject was then given continual hospitalizations since that time. The Board would not like to see this happened again.

(b) Dr L raised that the dosage adjusted down by the daughter was monumental, that is, from two injections daily to one and from a total 34 units of Mixtard to 14 units. The doctor also pointed out that even if the daily blood glucose profile dropped substantially, it would only be right to withhold the injection and seek immediate medical attention. The Board would echo that it is a common sense that only medical doctor could authorize, make or change a prescription and it was never right for a lay carer to unilaterally adjust the prescribed dosage at her own volition. It is both dangerous and could be fatal, particularly to an elder of the subject's age and frailty.

(c) On probing by the Board, the daughter vouched that she would not stop adjusting the dosage of insulin in future.

(d) According to the community nurse's report dated 15 May 2008 and her notes attached to the multi-disciplinary case conference held on 5 February 2008, the daughter admitted that she sometimes gave only one

meal a day to the subject as a means to keep the blood glucose profile lower. But that deliberate act, in the view of the Board, would have had nothing good except caused unnecessary starvation to the subject and brought further deterioration to her general health. The Board did not find the daughter's explanation acceptable or convincing because she said she told the nurses of skipping meals just as a joke. This sheer pretext is never sufficient to cover her misdeed. To a certain extent, the Board felt that it was rather cruel to deprive the subject of proper nutrition on no useful purpose. The Board is indeed disturbed and driven to sympathize the subject who, being frail and powerless, was manipulated by the daughter, who obviously lacked of any necessary insight, knowledge and skill, in a way or ways dictated by her untrained hunch.

32. In light of the findings, the Board ruled that the daughter had mishandled the dosage of insulin injection for the subject. On her own admission alone, it was clear that she had done substantial downward adjustment of the daily dosage without actual prior consent from the treating doctor. She did not take the advice of the nurse who found it out nor did she show any sense of remorse as late as up till the end of the hearing today.

33. The daughter strongly refused to admit the subject upon discharge to the subvented priority placement at a nursing home. This was consistent with her pervious attitude towards long-term accommodation plan after hospital discharges. In this respect, the social enquiry report maker had recorded in her supplementary report six occasions during which the daughter insisted to discharge the subject home and refused admitting subject to a private old

age home. On this point, the Board did not find, in view of the above findings, that it is in the best interests of the subject to restore home to the care of the daughter. The Board noted that under the daughter's care, the subject had rapid successive hospital admissions in year 2007 and particularly towards the second half of the year.

34. To conclude, the Board holds that the care rendered by the daughter of the subject was far from satisfactory and the current situation of the subject warranted an intervention by way of guardianship and the public guardian should be appointed to decide on the long term welfare plan of the subject. The Board therefore accepts and adopts the views of the two medical doctors as contained in the two supporting medical reports as well as the social enquiry report and supplementary report and the views and recommendations as contained therein and accordingly decided to receive the subject into guardianship in order to protect and promote the interests of welfare of subject. The reckless misdeeds of the daughter are in fact amounting to trespass, assault or invasion to the body of the subject, carrying with it highly potential risks of bodily harms. The Board must therefore invoke its protective jurisdiction in this case.

Reasoning for choosing the legal guardian

35. The Board accepts and adopts the view of the social enquiry report maker who recommended, as contained in the report, the Director of Social Welfare to be appointed as the guardian of the subject in this case. The Board did not find the daughter of the subject a suitable candidate due to her questionable ability and lack of insight in rendering proper care to the subject. Further, the long-term care plan advanced by the daughter is not accepted by the Board as conducive to the best interests of the subject.

Thus, the Board concluded that appointing the Director of Social Welfare as the public guardian in this case is suitable and appropriate. The Board would make it clear that the Board is in entire agreement with the view of the medical team that the subject should be given residential care as soon as possible.

DECISION

36. The Guardianship Board is satisfied on the evidence and accordingly finds:-

(a) That the subject, as a result of senile dementia, is suffering from a mental disorder within the meaning of section 2 of the Ordinance which warrants the subject's reception into guardianship;

(b) The mental disorder limits the subject's capacity to make reasonable decisions in respect of a substantial proportion of the matters which relate to the subject's personal circumstances;

(c) The subject's particular needs may only be met or attended to by guardianship, and no other less restrictive or intrusive means are available as the subject lacks capacity to make decisions on accommodation, her own welfare plan and treatment plan, which has resulted the subject in her being abused physically;

In this case, the predominant needs of the subject remained to be satisfied are, namely, decision to be made on future welfare plan,

future accommodation and future treatment plan;

(d) The Board concluded that it is in the interests of the welfare of the subject that the subject should be received into guardianship.

37. The Guardianship Board applied the criteria in section 59S of the Ordinance and was satisfied that the Director of Social Welfare was the only appropriate person to be appointed as guardian of the subject.

(Mr Charles CHIU Chung-yee)
Chairperson of Guardianship Board