GUARDIANSHIP BOARD

REASONS FOR ORDER

Mental Health Ordinance (Cap. 136)[1]

BETWEEN

Mr B **Applicant[2]**

and

Mr A **Subject[3]**

The Director of Social Welfare[4]

Members of Guardianship Board constituted

Chairperson of the Board: Mr Charles CHIU Chung-yee

Member referred to in section 59J (3) (b): Miss WONG Oi-kau

Member referred to in section 59J (3) (c): Mrs Josephine WONG CHU Yin-ping

Date of Reasons for order: the 6th day of February 2018.

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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)(c) of Mental Health Ordinance

BOARD'S ORDER

1. These Reasons for Decision are for the Board's Order made on 6 February 2018 concerning Mr A ("the subject"). The Board appointed Mr B as the guardian of the subject, for a period of one year, with powers to make decisions on the subject's behalf, as set out in the Board's Order, and subject to the conditions referred to therein.

THE HEARING ON 6 FEBRUARY 2018

2. The following persons gave evidence to the Board: -

   (a) Mr A, the subject (represented by Ms M of counsel on the instruction of Messrs TY, Solicitors);
   (b) Mr B, the applicant and proposed guardian (represented by Mr H of counsel on the instruction of Messrs KM & Co., Solicitors);
   (c) Dr L, T Hospital;
   (d) Dr V, T Hospital ;
   (e) Dr F, T Hospital ;
   (f) Dr C, private psychiatrist;
   (g) Dr W, private psychiatrist;
   (h) Ms S, a public officer, on behalf of the Director of Social Welfare.

REASONING OF THE BOARD

Background

3. The application for the appointment of a guardian for the subject, under Part IVB of the Ordinance, dated 20 March 2017, was registered as received by the Board on 21 March 2017. The applicant is Mr B, son. The evidence shows that the subject is 81 years of age, man, with vascular dementia. The subject was unable to handle finances and was incapable of consenting to treatment.

4. The Board adjourned the hearing on 20 July 2017.

The Law

5. Section 59O (3) of the Ordinance provides that, in considering whether or not to make a guardianship order, the Guardianship Board must be satisfied that the person, the subject of the application, is in fact a mentally incapacitated person in need of a guardian, having considered the merits of the application and observed the principles and criteria set out in sections 59K (2) and 59O (3) (a) to (d) of the Ordinance respectively.

Issues and Reasoning

Reasoning for receiving the subject into guardianship and choosing the proposed guardian as the legal guardian

6. The Board has the benefits of (inter alia) considering a number of psychiatric reports and being assisted by five psychiatrists and two counsel at the hearing today.

7. The subject is represented by Ms M of counsel on the instruction of Messrs TY, Solicitors.

8. The applicant, subject's son, is represented by Mr H of counsel on the instruction of Messrs KM & Co., Solicitors.

9. Dr L and Dr V, doctors of T Hospital have prepared two reports which were the medical reports supporting the present guardianship application (i.e. documents marked LH and LW in the table below).

10. Dr C has prepared two reports on the instruction of the subject's legal team. (i.e. C-1 and C-2 in the table below).

11. Dr W has prepared two reports on the instruction of the applicant's legal team (i.e. W-1 and W-2 in the table below).

12. There were also presented to the Board of other examination or assessment results, progress notes (PN-1 and PN-2 in the table below) and Medical Enquiry Form ("MEF") [collectively "other medical documentations"]. Of the standardized tools of assessments used, the main ones were Mini-Mental State Examination (MMSE) and Montreal Cognitive Assessment-Hong Kong version (MoCA). Since MoCA has better sensitivities and reliability, the Board would not comment on MMSE in this case.

13. For easy reference, major medical reports and other medical documentations are set out in the table hereunder: -

Date	**Document**	**Maker**	**Remark**
25.1.2017	Progress note/T Hospital	Dr T	(PN-1)
15.6.2017	Progress note/ T Hospital	Dr L	(PN-2)
16.3.2017	Medical report/ T Hospital	Dr L	(LH)
20.3.2017	Medical report / T Hospital	Dr V	(LW)
27.6.2017	Medical enquiry form/ T Hospital	Dr L	(MEF)
5.7.2017	Psychological report/ T Hospital	Ms W, a clinical psychologist	(CP)
12.7.2017	MMSE	Dr C	
14.7.2017	Psychiatric report	Dr C	(C-1)
20.7.2017	HK-MoCA/ T Hospital	Dr X	(MoCA-X)

22.8.2017	CT Brain report/A Hospital	Dr SY	(CT report)
9.9.2017	Report (with MMSE)	Dr W	(W-1)
9.10.2017	Supplemental report	Dr W	(W-2)
25.11.2017	2nd psychiatric report	Dr C	(C-2)
16.11.2017	HK-MoCA	Dr C	(MoCA-C)
30.1.2018	MEF	Dr F	(MEF-F)

14. The relevant law is found in Sections 59K and 59O, Mental Health Ordinance, Capacity. 136, Laws of Hong Kong.

Sections 59K, Mental Health Ordinance, viz: -

"(1) The Guardianship Board shall—

(a) consider and determine applications for the appointment of guardians of mentally incapacitated persons who have attained the age of 18 years;

(b) make guardianship orders in respect of mentally incapacitated persons and taking into account their individual needs, including the making of such orders in an emergency where those persons are in danger or are being, or likely to be, maltreated or exploited;
(c) review guardianship orders;

(d) give directions to guardians as to the nature and extent of guardianship orders made under section 59O appointing those guardians, including directions as to the exercise, extent and duration of any particular powers and duties of those guardians contained in such terms and conditions (if any) that

those guardianship orders may be subject under subsection (2) of that section;

(e) perform such other functions as are imposed on it under this Ordinance or any other enactment,

and in so doing shall observe and apply the matters or principles referred to in subsection (2).

(2) The matters or principles that the Board shall observe and apply in the performance of its functions or the exercise of its powers are as follows, namely—

(a) that the interests of the mentally incapacitated person the subject of the proceedings are promoted, including overriding the views and wishes of that person where the Board considers such action is in the interests of that person;

(b) despite paragraph (a), that the views and wishes of the mentally incapacitated person are, in so far as they may be ascertained, respected."

Section 59O, Mental Health Ordinance, viz: -

"(1) Subject to subsection (3), if, after conducting a hearing into any guardianship application made under section 59M(1) for the purpose of determining whether or not a mentally incapacitated person who has attained the age of 18 years should be received into guardianship and having regard to the representations (if any) of any person present at the hearing to whom a copy of the guardianship application has been sent under section 59N(3) and considering the social enquiry report referred to in section

59P(1) the Guardianship Board is satisfied that the mentally incapacitated person is a person in need of a guardian, it may make an order appointing a guardian in respect of that person.

(2) Any guardianship order made under subsection (1) shall be subject to such terms and conditions as the Guardianship Board thinks fit, including terms and conditions (if any) as to the exercise, extent and duration of any particular powers and duties of the guardian.

(3) In considering the merits of a guardianship application to determine whether or not to make a guardianship order under subsection (1) in respect of a mentally incapacitated person, the Guardianship Board shall observe and apply the matters or principles referred to in section 59K(2) and, in addition, shall apply the following criteria, namely that it is satisfied—

(a)(i) that a mentally incapacitated person who is mentally disordered, is suffering from mental disorder of a nature or degree which warrants his reception into guardianship; or
(ii) that a mentally incapacitated person who is mentally handicapped, has a mental handicap of a nature or degree which warrants his reception into guardianship;

(b) that the mental disorder or mental handicap, as the case may be, limits the mentally incapacitated person in making reasonable decisions in respect of all or a substantial proportion of the matters which relate to his personal circumstances;

(c) that the particular needs of the mentally incapacitated person may only be met or attended to by his being received into guardianship under this Part and that no other less restrictive or

intrusive means are available in the circumstances; and (Amended 19 of 2000 s. 3)

(d) that in the interests of the welfare of the mentally incapacitated person or for the protection of other persons that the mentally incapacitated personshould be received into guardianship under this Part."

15. The first issue to be decided by the Board is whether the subject suffers from a degree of mental incapacity which warrants his reception into guardianship.

16. It is apparent that the opinions of the experts, both written and oral, have been divided.

17. Dr V, Dr L and the current case medical officer Dr F of T Hospital, in which hospital the subject has stayed since 27 January 2017, are of the opinion that the subject suffers from moderate vascular dementia with impairment of executive functions and supervised daily living is needed. Both Dr V and Dr L supported the guardianship application as they have provided their respective medical reports in support of the present guardianship application.

18. Dr W, a private psychiatrist retained by the applicant, has the same opinion of the hospital doctors.

19. On the other hand, Dr C presents, in the view of the Board, a completely different opinion. Although he avers that he agrees to the medical cause as vascular in nature, he opines clearly that: -

    (a) (In his first report C-1) the subject was definitely NOT suffering from dementia and possesses full mental capacity. Dr C stated therein that he was "not able to detect any evidence of mental abnormality".

(b) (In his second report C-2), there was no evidence of subject's activities of daily living were in fact impaired and hence the diagnosis of dementia could not be made under *The lCD-10: Classification of Mental and Behavioural Disorders Clinical descriptions and diagnostic guidelines*, World Health Organization, Geneva, 1992, pages 45-46, 64-65 (ICD-10). At most, the subject was suffering from a Mild Cognitive Disorder. (Dr C then went on and stated therein that the subject had full capacity in making the specific decision of selling the factory property in Dongguan, China to his clanswoman Madam XYZ, i.e. the "factory property sale transaction" mentioned herein below). At the hearing today, Dr C asserts that he only disagrees with the degree of subject's cognitive impairment.

20. Of these conflicting psychiatric forensic evidence, the Board duly considered all written reports, all other medical documentations (including those further presented at the hearing by Dr V) and the oral evidence given by all the experts present, including all the report-makers and the current case medical officer Dr F. The Board has come to a clear conclusion that the evidence and opinion of the doctors of T Hospital should be preferred. The Board has no hesitation to rule, as a fact, that the subject suffers from Vascular Dementia of moderate severity and is mentally incapacitated to make reasonable decisions for all domains of his own affairs, including decisions on accommodation and daily care, finances and medical treatment. The Board's decision is guided by the following views, observations and rulings.

20.1. The subject was seen and examined at length at the hearing. He was clearly observed to have mental deficits as he showed poor memory (e.g. confusion of year, different versions of floor area of the factory building in Dongguan where he lived before), difficulty to find words, slurring, unrealistic thoughts and plans, extremely poor ability to do even simple subtractions, ability only to give short replies without elaborations etc. He even told that during the current one year's hospitalization, he has had four new teeth grown out of his mouth. He, without any invitation, repeated at the later

course of the hearing, his plans of new ventures (like opening a farm or an old age home or day care centre or factory on the roof top of the said factory property in Dongguan ["the said factory property"]) and was noted to be "very cheerful" from time to time. To certain extent, Dr W's like observation and remarks on the subject as contained in his reports were correct. More importantly, the subject was seen obviously lacking any mental ability to deal with more complex problems when being confronted with his entering into the agreement of the purported sale of the said factory property to his clanswoman Madam XYZ (in May 2016) in view of his earlier transfer of the said factory property to the applicant (in June 2014). [The details of the transaction were contained in paragraph 16 of the first social enquiry report dated 20 April 2017 and appendices 2, 3, 4, 5 and 6 ("the factory property sale transaction")]. At the hearing, he virtually could not give a realistic solution, e.g. he just murmured that he would just sell half of the property.

20.2. Dr V has produced five Discharge Summaries, one of P Hospital, two of N Hospital and two of T Hospital. These documentations have recorded details of the medical history of the mental and physical conditions of the subject since his first stroke (haemorrhagic CVA) on 8 October 2010 to second stroke on 21 January 2014. The second set of these discharge summaries (8 March 2012 to 9 March 2012) has clearly recorded a change in behaviour and increasing fluctuations in temper. It is also important to note that in the respective Discharge Summaries of N Hospital from 22 to 30 January 2014 and T Hospital from 31 January 2014 to 18 February 2014, the subject was complained of taking double/triple dosage of medications. Hence, due medical compliance was doubtful. The subject admitted this failure at the hearing. At any rate, he admitted he needed his wife to pack his daily medication.

20.3. At the hearing, Dr V further led evidence from the medical records that it was on 2 May 2014 that Dr YHW of N Hospital has made the first

diagnosis of dementia of the subject. A clear record of change of personalities of the subject was also noted, e.g. previously a quiet and solitude person but becoming very keen to comment on matters. Further, it was also noted to have decline in cognitive function, mobility and daily activities, particularly self-neglect of hygiene e.g. refusal to bath or change clothing for ten days. There was also a default of psychiatric follow-up on 27 July 2016.

20.4. The medical opinion of the hospital doctors are well grounded on long period of clinical and treatment history of the subject at different hospitals and based on the current long period of in-patient observations. There have been regular multi-disciplinary ward meetings or rounds which were comprised of various disciplines including allied health professionals, like occupational therapists and clinical psychologists.

20.5. In this regard, the Board takes note that Dr F, the current case medical officer since 1 January 2018, also came to the same conclusion that the subject suffered from Vascular Dementia of moderate severity. Her evidence given at the hearing corroborated well the MEF (by Dr L). Dr F gave various examples of subject's poor memory and disorientations. In the MEF, Dr L stated that the subject required supervision for instrumental activities of daily living (including medication taking) in view of his impaired short term memory. The subject required supervision for daily living due to executive function impairment. Dr L also explained, at the hearing, that executive function included ability to do planning of matters involving various steps. Subject's impairment in executive function was assessed as between moderate to severe impairment levels after a long period of repeated MBRT and BADS assessments. Both Dr F and Dr L came to the same view that subject's planning on business venture of opening an old age home etc on the 4th floor of the said factory property has showed the subject's impairments of executive functioning and his

limitation of ability in planning and making decision (see also paragraph 13 of the social enquiry report which well captured Dr L's explanation).

20.6. The CP report has suggested the subject's score of Dementia Rating Scale was 106 out of 144, which was below cut-off. The assessment result suggested the subject's impairment in cognitive functioning.

20.7. The hospital has produced two MoCA scores of the subject, respectively taken 26 January 2017 (not seen by the Board) and 20 July 2017 (MoCA-X). Dr L was able to confirm at the hearing that the scores of the sub-set of delay recalls in both MoCAs were 0.

20.8. These two MoCAs yielded the same total score, despite 6 months apart, of 11/30, well below the cut-off for dementia screening of 18-19 (see MEF-F). (The single cut-off score is 21 or 22.)

20.9. Dr C produced the MoCA-C score of the subject (taken subsequently on 16 November 2017). Both the MoCA-C score and the MoCA-X produced the same scores of 0 in the sub-set of delay recalls as well as the same scores of 1 in the sub-set of serial subtractions.

20.10. The score analysis in 21.7, 21.8 and 21.9 above lends support to the medical opinion of the hospital doctors on subject's poor memory and impairment of executive functioning. As a matter of common sense, the Board has serious doubts on subject's capacity to manage the portfolio of his finances (say, at the very least of the cash of, on his own averment, RMB3.5 million and the other properties under his company's name) including running a farm, an old age home or a day care centre in future. He could not even draw a clock properly and correctly.

20.11. In the judgment of the Board, the accuracy, reliability and value of the MoCA-C (produced by Dr C) is highly doubtful. In the elaborated manner

as described by the doctor at the hearing and depicted in C-2 (pages 8 and 9), the Board holds serious doubts on the due compliance of the time requirement to complete the assessment, which is ten minutes. The sudden production of a draft drawing by the subject of a clock at the back of the MoCA score sheet by Dr C at the hearing (not copied to the Board on filing) has driven the Board into suspicions that the subject was heavily coached and drilled while taking on the test.

20.12. Regarding the CT report, despite Dr C's explanation, the Board nevertheless noted the following key findings:-

(i) Periventricular white matter hypodensity suggestive of small vessel disease.

(ii) Bilateral capsuloganglionic region hypodense lesions likely lacunar infarcts.

20.13. In both C-2 and Ms M's final submission, much emphasis has been placed on the social enquiry report maker's various remarks (whether personal or collected) of subject's calm emotion and clear or coherent speech etc. The Board takes the view that such remarks are benign in nature if one have seen hundreds and thousands of social enquiry reports. This carries little weight towards a determination of the subject's mental capacity. In this respect, as rightly remarked by Dr V, the subject was in a familiar ward environment and had his drug administration well monitored.

20.14. In summary, Dr C stated in C-2, according to page 46 of ICD-10, a diagnosis of dementia can be made only when the deficit or decline of cognitive performance "is sufficient to impair personal activities of daily living" (page 9, C-2). However, Dr V raised at the hearing that according to *Diagnostic and Statistical Manual of Mental Disorders 5th edition,* American Psychiatric Association (DSM-5), June 2013, pages 602 and 605, only one (or more) of the cognitive domains, e.g. executive function, suffers

a significant decline from the previous level, the same will meet the diagnostic criteria. Dr V quoted: -

"Major and Mild Neurocognitive Disorders

(page 602)
Major Neurocognitive Disorder

Diagnostic Criteria

A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and

2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

(page 605)
Mild Neurocognitive Disorder

Diagnostic Criteria

A. Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:

1. *Concern of the individual, a knowledgeable informant, or the clinician that there has been a mild decline in cognitive function; and*

2. *A modest impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment."*

Dr V also referred the Board to the following passage from ICD-10.

(page 8, in other version is page 13)
"Notes on selected categories in the classification of mental and behavioural disorders in ICD-10

Dementia (F01 - F03) and its relationships with impairment, disability and handicap

Although a decline in cognitive abilities is essential for the diagnosis of dementia, no consequent interference with the performance of social roles, either within the family or with regard to employment, is used as a diagnostic guideline or criterion."

Upon considering all the passages cited by Dr V, the Board unreservedly agrees with him.

20.15. For a good diagnosis or assessment in psychiatry, it is common knowledge that an assessor should have three types of clinical data: (1) clinical history (including psychiatric history), (2) behavioural observations plus (3) collateral information (from knowledgeable informant). The hospital team has possessed fully all these three important clinical data. Yet, both Dr C and Dr W obviously did not possess all information of the first two data

(see 20.2 and 20.3, supra) and completely lacked the third data as they have never interviewed the applicant or subject's wife, the essential informants.

20.16. The Board cannot attach any weight to Dr C's two reports C-1 and C-2 particularly because those two reports were plainly one-sided. At the hearing, time and again, Dr C declined to find or describe seriously any noticeable or noteworthy aspects of cognitive deficits of the subject, if at all. In his reports, Dr C has not been able to fairly deal with apparent negative behaviour or thinking or planning of the subject and explained them. In C-2, Dr C did not comment on the low MoCA scores in respect of sub-sets of delay recalls and calculation (see above) vis-à-vis consequent impairment on subject's daily living or financial management. Also in C-2, Dr C has obviously skipped the most important trigger of the factory property sale transaction, namely, the property was already transferred to the applicant two years ago. In the view of the Board, this queer act(s) taken by the subject, prima facie, directly impinged upon the extent of his comprehension in relation to, inter alia, the extent of his ownership of the said factory property, not to mention his executive functioning. Dr C was evasive at the hearing as to whether he did tap the subject on this matter. There was no way to know what actually has taken place at the interview between him and the subject in the preparation of C-2. Further, there are far too many examples in pages 6, 7 and 8 of C-2 that showed nothing but defensive and one-sided remarks. Hence, the Board cannot find Dr C's reports as fairly presented. Obviously, C-1 was completely based on a chronology of information provided by the subject (of this, Dr C should have known as substantially wrong after receiving whole set of file background documents, including the first social enquiry report and the two medical reports in support of application, from the Board via his instructing solicitors after the first adjournment). It is clear that the wrong information provided by the subject was accepted by Dr C, at that time, on their face value and taken as true and correct and the conclusion was thereby drawn, holding that the subject was in full mental capacity. Indeed, most life

events in the said chronology provided by the subject in C-1 were essentially wrong and hence it was, on a contrary, a clear demonstration of substantial memory decline. Not only the Board will not accept the report C-1, the Board will go further that all the reports and evidence of Dr C have to be critically scrutinized. It is worth to note that despite Dr C has subsequently admitted C-1 was based on inadequate information (see page 9 of C-2), he made no efforts of elaboration or explanation on the bearing of the inability of the subject to describe his major life events correctly when he saw him the first time. Dr C's peripheral and broad-brush approach in report making as shown in C-1 has significantly slanted the reliability and integrity of his second report C-2 or even his oral evidence.

21. The second issue of this case is whether there is any outstanding particular need of the subject that must be satisfied by a grant of Guardianship Order. The answer is plainly yes. The subject obviously cannot lead an independent community living and needs supervision on daily care under a constant carer for drug administration and attending regular follow-ups. As the subject still harbours the unrealistic wish to return to Dongguan for an independent living, it is obvious that a guardian should be appointed to decide on his long-term care plan. As the subject suffers from mental incapacity to decide on his accommodation and daily care, the Board has no hesitation to receive him into guardianship. Further and indeed, with the subject obvious lack of financial capacity, the Board is therefore also concerned of the dubious factory property sale transaction. Indeed, out of the worry of financial abuse, the applicant has made this application (see paragraph 16 of the first social enquiry report). The Board shares the same worries as the documentations shown in the abovementioned appendices to the first social enquiry report bear the hallmarks, prima facie, of a financial abuse.

22. The third issue to be decided by the Board is whom should be appointed as the legal guardian of the subject. The Board has carefully considered Section 59 S, viz:-

"(1) A person (other than the Director of Social Welfare) shall not be appointed by the Guardianship Board as a guardian of a mentally incapacitated person received into guardianship under this Part unless the Board is satisfied that-

(a) the proposed guardian has attained the age of 18 years;

(b) the proposed guardian is willing and able to act as a guardian;

(c) the proposed guardian is capable of taking care of the mentally incapacitated person;

(d) the personality of the proposed guardian is generally compatible with the mentally incapacitated person;

(e) there is no undue conflict of interest, especially of a financial nature, between the proposed guardian and the mentally incapacitated person;

(f) the interests of the mentally incapacitated person will be promoted by the proposed guardian, including overriding the views and wishes of that person where the proposed guardian (once appointed) considers such action is in the interests of that person;

(g) despite paragraph (f), the views and wishes of the mentally incapacitated person are, in so far as they may be ascertained, respected;

(h) the proposed guardian has consented in writing to the appointment as a guardian.

(2) Where it appears to the Guardianship Board that there is no appropriate person available to be appointed the guardian of a mentally incapacitated person the subject of a guardianship application, the Guardianship Board shall make a guardianship order appointing the Director of Social Welfare as the guardian of the mentally incapacitated person.

(3) In the performance of any functions or the exercise of any powers under this Ordinance the guardian shall ensure-

(a) that the interests of the mentally incapacitated person the subject of the guardianship order are promoted, including overriding the views and wishes of that person where the guardian considers that such action is in the interests of that person;

(b) despite paragraph (a), that the views and wishes of the mentally incapacitated person are, in so far as they may be ascertained, respected,

and shall comply with directions (if any) given by the Guardianship Board in respect of that guardian and any regulation made under section 72(1)(g) or (h).”

23. At the hearing, the Board observes that the subject and the applicant interacted spontaneously. It was also noted that the applicant has arranged the subject to live with his wife in Hong Kong since his second stroke in 2014, after a short stay in an old age home first, till mid-June 2016. Further, Dr V has informed the Board at the hearing that the applicant was present almost at every psychiatric follow-ups. The Board comes to a view that the applicant, being the only son of the subject and the major carer all along, should be appointed as the guardian of the subject.

24. The Board so orders.

DECISION

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

(a) That the subject, as a result of vascular 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, his own welfare plan and treatment plan;

In this case, the predominant needs of the subject remained to be satisfied are, namely, decision to be made on discharge from hospital, future welfare plan, future accommodation and future treatment plan;

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

26. The Guardianship Board applies the criteria in section 59S of the Ordinance and is satisfied that Mr B is the only appropriate person to be appointed as guardian of the subject.

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