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Comments of Health, Welfare and Food Bureau (HWFB) and Department of Health (DH) on the Report of the Hospital Authority Review Panel on the SARS Outbreak

HWFB and DH welcome any recommendation that will further help the Government to enhance the capacity of preventing and combating infectious diseases. The recommendations of the Hospital Authority Review Panel on the SARS Outbreak (Review Panel) are no exception. The Government has been taking follow up action to that end.

2. However, we have reservations on some of the observations and comments of the Review Panel and the review process, noting that the remit given by the Hospital Authority (HA) Board to the Review Panel was an internal review on how HA had managed and responded to the SARS outbreak. There was limited contact between the Review Panel and HWFB and between the Review Panel and DH in the review process. HWFB was asked to provide a written explanation on the role of HWFB in relation to HA during the SARS epidemic. In order to understand how HWFB could help in the review process, the Secretary for Health, Welfare and Food (SHWF) offered to meet with Members of the Review Panel and in the event one such meeting was held. Apart from these, there was no other communication between the Review Panel and the Bureau. For DH, in response to the Review Panel's stated purpose of facilitating their assessment of HA's actions in proper context, one written submission on its role in relation to HA in handling the SARS crisis and answers to specific questions raised were made in two batches to the Review Panel. No other information was sought and no DH staff was interviewed. Neither HWFB nor DH was aware that the scope of the Review Panel's review extended to the work and response of the Government in relation to the SARS outbreak. Consequently, neither HWFB nor DH provided information or submissions relevant to some of the Review Panel's considerations. Furthermore, HWFB and DH were not asked to verify/confirm the facts and figures quoted in the Report of the Review Panel. Neither of them had been given any opportunity to make representations on the Review Panel's observations and comments prior to their publication as a matter of procedural fairness. These limitations had undermined the validity of some of its findings.

3. We also noted that some of the facts and explanations offered by the DH in the two batches of answers provided in response to the Review Panel's questions were not taken into account in the Report at all. Omission of pertinent information may give readers a false impression that the DH had not taken appropriate action and give rise to inappropriate conclusion by the Review Panel. An example is the Review Panel's account of and comments on contact tracing at Hotel M. Details are explained at Annex A.

4. In Annexes B to G, we have listed some examples of the factual discrepancies between the Report and our record. As HWFB and DH have not been asked to provide submissions on the issues and verify/confirm the facts, there was no opportunity whereby we could provide relevant information or highlight the discrepancies to the Review Panel before the publication of the Report.

5. While some inaccuracies or inadequacies of the Report are set out in the Annexes as examples, HWFB and DH should not be taken as accepting the entirety of other observations or comments made by the Review Panel in respect of which neither HWFB nor DH were consulted or given an opportunity to respond.

Health, Welfare and Food Bureau/Department of Health
March 2004

Annex A

Contact-tracing at Hotel M

The Review Panel commented in paras. 2.12 and 6.83 that DH's contact-tracing of [redacted] only extended to family members who had attended two family meals on 21.2.2003, but was not done at Hotel M where [redacted] had stayed or in relation to the coach on which he had traveled to Hong Kong. The Panel believed that this was at least partially due to a failure to assemble all of the "soft" intelligence data held by a range of people inside and outside the HA into a single picture. The Panel then mentioned a number of cases which were related to Hotel M. It also said that it seemed that the agencies involved were concentrating on a patient who died of Avian Flu.

2. In the course of its review, the Review Panel had asked DH whether any contact-tracing action by the department regarding the Hotel M cluster would have changed the course of events in the outbreak at PWH. The Director of Health offered a lot of facts in answering this question. The gist of DH's explanation is as follows –

- The fact that a number of persons related to [redacted] had fallen sick appeared to be an intra familial spread due to close contact and such spread was not an uncommon phenomenon in respiratory illnesses;

- There was no environmental factor supporting a case for initiating contact-tracing at Hotel M;

- There was no Severe Community-Acquired Pneumonia (SCAP) case among staff at the Hotel M. The one admitted to Yan Chai Hospital during 2 – 11.3.2003 had a diagnosis of bacterial pneumonia and subsequently recovered;

- The Singapore Ministry of Health first discussed with DH on 8.3.2003 the cases of three pneumonia patients who had traveled to Hong Kong and stayed at Hotel M. The illness of the three patients had improved with antibiotics treatment and laboratory

investigations were pending then. At that stage, there was insufficient evidence that their illness was related to the hotel;

- The St. Paul's Hospital (SPH) cluster index case was not a SCAP case when admitted to SPH on 2.3.2003. DH was only notified on 13.3.2003 when the index case became a SCAP case. DH only learnt of his stay at Hotel M during case interview/contact-tracing on 14.3.2003;

- Even if DH had initiated contact-tracing at Hotel M on 14.3.2003, it would not have any effect on the course of events in the outbreak at PWH. This was because –

  - The PWH index case had onset of symptoms on 24.2.2003 and was hospitalized as early as 4.3.2003;

  - The PWH index case was not a guest at Hotel M at the material time thus would not be found on the guest list. It was only on repeated questioning that he admitted that he had visited a friend in Hotel M around that period; and

- The wife of the American Chinese transferred from Hanoi was not aware of all the facts relating to her husband and did not inform DH that her husband had stayed in Hotel M. It was WHO who informed DH on 20.3.2003 that the patient transferred from Hanoi had also stayed in Hotel M around the same time.

In the Report, there was no mentioning of the above facts and explanation offered by DH when the remark about DH not extending contact-tracing to Hotel M was made. Advancing the timing of contact-tracing in Hotel M would not have changed the course of events in the PWH outbreak; in fact, retrospective epidemic information indicates that over 30 cases in the PWH cluster had onset of symptoms by 8 March, though the outbreak only came to light on 11 March.

3. Para 6.83 gave the impression that by early March, all cases of the Hotel M cluster had been admitted to hospital. This raises the question why contact-tracing was not done at Hotel M. DH's explanation shows that the connection with Hotel M was not known until much later for the majority of the cases in this cluster.

Annex B

Communication with the Public

Paras. 2.21, 2.22, 3.3, 4.27, 6.158

The Report remarked in para. 2.22 that "the Government could have acted sooner and with greater clarity to warn the community of the potential risks". It also mentioned in paras. 2.21, 3.3, 4.27 and 6.158 that on 24.3.2003, the day after the CE/HA's admission to hospital was widely reported, a significant change of direction was discernible and the Government recognized that the health of the public must come first when SHWF said on that day that "it must be public health that comes first".

2. These remarks do not tally with the facts. Public health has always been the first priority of the Government. The Government had been commended by the WHO on a number of occasions for our openness and transparency in the management of the SARS epidemic. Media reports about the Prince of Wales Hospital outbreak first appeared on 11 March. We started releasing hospital admission figures on the following day. On 14.3.2003, three strategic decisions were made by the Government, viz. (1) information on the outbreak should be disseminated to the public on a daily basis; (2) advice should be given to the public on precautionary measures; and (3) Hong Kong should work closely with international organizations and seek expert help if necessary. Detailed information on what was known/unknown about the causative agent, transmission mode, precautionary measures etc. was disseminated to the public. These were attempts to keep the public informed of the situation and to educate them in a timely manner. For instance, on 14 March, SHWF talked about the outbreaks in PWH, PYNEH, a private clinic and the case of the patient transferred from Hanoi. The evidence then was that the unknown disease appeared to be a subset of atypical pneumonia and have a predisposition to affect healthcare workers who cared for the patients and also to close family contacts. After the Hotel M cluster had come to light on 19 March, SHWF emphasized publicly on 20 March that "obviously it [the disease] seems to be very, very infectious.". SHWF, HWFB and DH had been honest about how little was known about the disease right from the beginning, but continued to remind the community and give health advice based on what was known at the time.

3. 24.3.2003 was not the first time SHWF or senior officials stated that public health was Government's top priority. On 22.3.2003, for example, SHWF said, "I just want to reaffirm that our primary concern is public health. So our primary concern is not Hong Kong's image, in terms of tourism or politics of it all."

4. According to para. 6.158 of the Report, the change of direction was evident in the Government's announcement of interdepartmental efforts to disseminate public health advice to the public which would involve all government bureaux and departments in disseminating information on relevant precautionary measures against the spread of SARS. The fact is that since the beginning, various departments had started taking actions to prevent the spread of the disease. For example, Education and Manpower Bureau had issued health advice to schools since 13.3.2003. These actions were, of course, constrained by how little was known about the disease before the causative agent was identified on 22.3.2003. The identification of the causative agent allowed experts and health authorities to better determine the precautionary measures that should be taken. But this does not mean that interdepartmental effort only began on 24.3.2003.

Paras. 6.83, 6.84

5. In these two paragraphs, the Report gave an account of the increase in number of Hotel M cluster cases in March 2003 and remarked that when SHWF indicated that there was no significant upsurge in cases, he was accurate but discounted the growing evidence of a new and deadly infectious disease.

6. The fact is that neither SHWF nor any member of the public health sector had overlooked the evidence that it was a new and deadly infectious disease that was affecting the patients. This is evident from the statements made. For example, on 15.3.2003, SHWF said that the disease was "a very unique atypical pneumonia which gives concern that there is a new agent". On 18.3.2003, SHWF frankly admitted that the public health sector did not understand completely the disease's behaviour.

Annex C

Chain of Command

Paras. 2.19, 6.105

In these two paragraphs, the Report remarked that there was "the absence of a clear chain of command" and "no central decision making body".

2. The fact is that in the early stage of the epidemic, a number of measures were taken by the Government to delineate a clear chain of command including the establishment of three bodies, viz. the HWFB Task Force, the Chief Executive's Steering Committee and the Inter-departmental Action Co-ordinating Committee. The HWFB Task Force was chaired by SHWF. Its membership included experts in public health, respiratory medicine and microbiology from DH, HA, local universities and WHO, as well as officials from DH and executives from HA. The Task Force's role was subsumed under the Chief Executive's Steering Committee when the latter was established on 25 March. The Inter-departmental Action Co-ordinating Committee was chaired by Permanent Secretary for Health, Welfare and Food and was formed to coordinate at the operational level the implementation of SARS control-related decisions made by the Chief Executive's Steering Committee and the HWFB Task Force.

Annex D

Hospital Authority (HA) Working Group
On Severe Community-Acquired Pneumonia (SCAP)

Paras. 4.5, 4.6 and 6.94

Paras. 4.5 and 4.6 mentioned that the HA Working Group on SCAP was set up on 11 February when, on that day, a case of suspected Atypical Community-Acquired Pneumonia with history of travel to Fujian was admitted to PMH (the patient died six days later and was confirmed as having H5N1 influenza A virus).

2. Para. 6.94 mentioned that at the time when the surveillance on SCAP was set up, DH and HA appeared to connect SCAP with avian flu.

3. The fact is that the HA Working Group on SCAP was set up in response to the Guangdong AP outbreak reported in Hong Kong on 10.2.2003, not to this local case of suspected Atypical Community-Acquired Pneumonia. This suspected Atypical Community-Acquired Pneumonia case which turned out to be an avian flu case was picked up by the SCAP surveillance system on 13.2.2003.

4. Test results of the two H5N1 cases were only confirmed on 19.2.2003 and 20.2.2003. Moreover, on 27.2.2003, the HA Working Group on SCAP reviewed all reported SCAP cases in February and found that, of the 39 SCAP cases identified, only one had H5N1 Influenza virus as the causative agent (the one confirmed on 19.2.2003 was not a SCAP case), 14 others had seven other causative agents and for 24 cases, the causative agent was unknown. This shows that HA had not connected SCAP with avian flu.

Annex E

[redacted]'s case

Paras. 4.8, 5.54

Para. 4.8 mentioned that [redacted] nephew had symptoms of pneumonia after returning to Guangzhou. Para. 5.54 mentioned that the feedback received by DH on the Hotel M connection identified nine further cases linked to the hotel, including the case of [redacted]'s nephew.

2. The fact is that [redacted]'s nephew was not confirmed as a SARS case.

Paras. 6.82, 6.92

3. These two paragraphs mentioned that DH had concerns about the infectivity of the virus in [redacted]'s case thus by 3 March extended contact-tracing on [redacted].

4. The fact is that DH's contact-tracing in [redacted]'s case was the standard action taken for the few dozen SCAP cases identified under the SCAP surveillance system, and was not taken because it found the case particularly significant. The action started immediately upon receipt of notification from HA on 24 February.

Annex F

Follow-up Patients discharged from PWH Ward 8A

Paras. 6.116

According to para. 6.116, the policy of following up patients discharged from PWH Ward 8A was as follows –

> "For patients in cohort wards, the policy at the time agreed between PWH and DH was that if the attending physician's opinion the diagnosis was not SARS, the patient would be discharged with care instructions and followed up closely for any change in clinical condition. Patients who had been in close contact with SARS patients in hospital were either discharged home with notification to DH for arrangement of disease surveillance in the community or later on transferred to step-down wards."

2. According to DH's record, the agreement with PWH was that the hospital would make available to DH a daily master list of persons for case investigation/contact-tracing. DH would look into every person on the master list and take appropriate follow up action. At a meeting held in PWH on 11 March 2003, DH was informed that admission and discharge of Ward 8A had been stopped and visitors restricted. DH had never been advised about the re-opening of Ward 8A, let alone the arrangement for follow up of discharged patients. DH had explained these facts in detail in its submission to the Panel.

Paras. 2.18, 4.33, 5.48, 6.117

3. It was mentioned in these paragraphs that the Amoy Gardens index case was readmitted to PWH on 21.3.2003.

4. The correct date should be 22.3.2003.

Annex G

DH's attempts in linking cases with each other

Paras. 6.151, 6.152

It was remarked in these two paragraphs that DH had been "overly optimistic" in believing that if all cases could be linked back to one or a few cases, this would be an indication that the virus was only spread by close contact and therefore was not widespread in the community.

2. Tracing the source of infection and linking cases to the source represent the fundamental requirement of an outbreak investigation. It is important to determine the scale of the outbreak and provide treatment and medical surveillance to those in contact with SARS patients as soon as possible. Contact-tracing is also significant from an epidemiological perspective to define the pattern of local transmission, as explicitly stated by the World Health Organization.

3. The ability to link all cases back to one of a few cases is a considerable achievement in public health terms: it facilitates a better understanding of how the disease is spread and sheds light on what control measures may be considered. It was not done, however, to find evidence to support the conclusion that the disease was not widespread in the community. When senior officials spoke about most cases relating to a few clusters, they were doing so from their observations and analysis of the cases.