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THE GOVERNMENT OF THE HONG KONG
SPECIAL ADMINISTRATIVE REGION
NEW TERRITORIES (EAST) REGIONAL OFFICE
DEPARTMENT OF HEALTH
ROOM 331, 3/F,
SHA TIN GOVERNMENT OFFICES,
NO. 1 SHEUNG WO CHE ROAD,
SHATIN, N.T.

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30 April 2004

Miss Flora Tai
Clerk to Select Committee
Legislative Council
Legislative Council Building
8 Jackson Road
Central
Hong Kong

Dear Miss Tai,

Select Committee to inquire into the handling of the Severe Acute Respiratory Syndrome outbreak by the Government and the Hospital Authority

Thank you for inviting me to comment on the draft transcript of the hearing which I attended on 7 February 2004.

2. I have suggested amendments in the attached draft transcript (a total of 27 pages). I am also taking the opportunity to respond to issues which I have undertaken to follow up and to clarify a couple of other points.

Prof Sydney Chung's letter to Dr Margaret Chan dated 19 March 2003

3. At the hearing, I explained that the New Territories East Regional Office (NTERO) of Department of Health (DH) did take timely contact tracing actions for all three cases cited in Prof Chung's letter of 19 March. In response to requests from Honourable Members for further information on two of the cases, I now provide my answers in paras 4 and 9-10 below.

Appendix 10 to H24

Discovery of Index Patient of PWH Cluster and Follow up Action

4. The events leading to the discovery of the index patient of the Prince of Wales Hospital (PWH) cluster (JJ) were set out in my written statement (para A3(a)-(b) on p.12). In my oral evidence, I mentioned that a boy who was a relative of JJ was hospitalized on 13 March 2003. The case was reported to NTERO in the early morning on 14 March, and was one of the four cases found on 14 March as mentioned in para A3(a) of my written statement submitted on 5 February 2004. **As requested by the Honourable Cheng Ka-foo [p.16-17 of the draft transcript], I can advise that the boy had been isolated when a DH nurse first visited him that morning.** W94(C) CB(2)1327/03-04

W94(C)

5. In para A3(c) of my written statement, I said that a meeting was held in the same evening (14 March) and the findings of the index patient were shared and discussed. Apart from myself, participants included, among others, Dr Fung Hong, Dr Philip Li and Dr Donald Lyon of PWH; Prof Sydney Chung, Prof Joseph Sung, Prof John Tam, Prof Paul Chan and Prof Wong Tze-wai of CUHK; and Dr Thomas Tsang of DH. The meeting agreed on the need to trace all persons who had been exposed to JJ in his cubicle, covering staff, medical students, patients and visitors.

A Visitor to PWH Ward 8A who later became the Index Patient of the Flight CA112 Cluster

6. **At the hearing, the Chairman asked about the action taken by NTERO regarding a visitor to PWH Ward 8A in early March 2003 who subsequently turned out to be the index patient for the cluster involving flight CA112 from Hong Kong to Beijing on 15 March 2003 (QQ) [p.73 of the draft transcript]. My response then, as detailed on p.74 of the draft transcript, was that DH's action could be traced to the identification of the index patient in the PWH cluster (JJ) on 14 March 2003. I have recently found out that this was not entirely accurate. The correct position is described in paras 7 and 8 below.** CB(2)1327/03-04

7. First, let me refer the Select Committee to Annex 1 on the events leading to the discovery on 25 March 2003 of the cluster of cases on board CA112 from Hong Kong to Beijing on 15 March. The index patient (QQ) of the CA112 cluster was a Beijing resident who had visited his brother (UU) in PWH Ward 8A when the latter was hospitalized in early March 2003. UU was a non-SARS patient. He suffered from Salmonella enteritidis and died on 9 March. As UU had not stayed in the same cubicle as the PWH index patient JJ, no action was taken to trace UU's contacts at the time when JJ was

identified, following the decision taken on 14 March evening as explained in para 5 above.

8. Separately on 19 March 2003, when NTERO followed up on a suspected SARS case notified by PWH earlier on the day, we discovered that the patient was the daughter of a former patient of Ward 8A, viz. UU. She mentioned that her uncle QQ had visited UU in PWH Ward 8A in early March. However, she did not have detailed information on QQ and suggested that NTERO approach his god-daughter (契女) for more information. With the assistance of the god-daughter and through investigation into the cluster related to flights CA112 / CA115 as described in Annex 1, NTERO eventually learned on 25 March that QQ had already returned to Beijing on 15 March on board flight CA112. The Beijing resident, QQ, was then identified as the index patient of the cluster.

The Case of a PWH Doctor referred to in Prof Sydney Chung's letter

9. In response to an enquiry of Dr Hon Lo Wing-lok, I spoke extensively on this case at the hearing. The name of the PWH Doctor (MM) first appeared on the list provided by PWH in the afternoon on 11 March 2003. He was contacted by NTERO that evening. MM said that his condition was improving and that he had taken a chest x-ray which was clear. He also reported that all his home contacts were asymtomatic. We gave him health advice and asked him to attend the PWH special staff clinic that night. He did attend the clinic and was discharged home. In accordance with the agreement with the hospital, PWH was responsible for following up on MM as staff. It was unfortunate that the next time we heard of MM on 17 March, he had already been hospitalized and found to have spread the disease to his contacts.

10. **At the hearing, I undertook to provide the Select Committee documentary evidence of our follow up action after MM was hospitalized on 17 March 2003. I now provide at Annex 2(A) the contact tracing record and at Annex 2(B) a description of the work undertaken by NTERO.**

Flow of Information from PWH to NTERO

11. I explained in some details in my written statement of 5 February 2004, and again at the hearing, that daily lists of names of patients satisfying the agreed case definition were sent by PWH to NTERO in hard copy form. Up to 19 March 2003, these daily lists were in a cumulative manner with new

W94(C)

and old cases mixed together without any particular order or indication of new cases. The name of YY (who was subsequently identified as the index patient of the Amoy Gardens cluster) was on the cumulative lists during period 16-19 March.

12. On 20 March, the format of notification was changed. Instead of a cumulative list, only new cases appeared on the list provided by PWH to NTERO as per encl. 6 of my written statement of 5 February 2004. There was no list of discharged patients. Hence, there was no indication from PWH that YY was discharged home on 19 March 2003.

W94(C)

13. PWH claimed that it started providing NTERO on 20 March the movement list as per encl. 7 of my written statement of 5 February 2004, where YY was shown to be home on 20 March. I have to reiterate again that there was no such a list provided to NTERO. Indeed, YY was discharged home on 19 March, not 20 March.

14. The flow of information from PWH to NTERO on these two days is summarized below for easy reference -

19 March 2003 - YY's name appeared on the case list, which was compiled on a cumulative basis. As such, there was no indication that YY was discharged home on 19 March.

20 March 2003 - Beginning from this day, PWH only provided DH with a list of new cases. Of course, YY's name did not appear on the list. In other words, there was no information to indicate that YY was discharged home on 19 March.

15. I would now comment again on the purpose of the soft copies of database provided by PWH. As explained in para A1(f) of my written statement of 5 February 2004, the soft copies were provided for the sole purpose of facilitating identification of new cases. The soft copy files included many worksheets. PWH colleagues had advised NTERO that we would only need to use the worksheet corresponding to the hard copy they had provided and should ignore the rest.

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16. **As requested by the Chairman [p.26 of the draft transcript], I forward a copy of the soft copy of the database received on 20 March 2003. It was a SPSS file copied from the PWH Disease Control Centre on 20 March at 15:10:46 hours. For easy reference, I have made hard copies from this soft copy at Annex 3. As Honourable Members may observe, there was no "movement list" as claimed by PWH. Para 13 above refers.**

Advices provided by DH

17. **As requested by the Chairman and the Honourable Michael Mak [p.35 and 37 of the draft transcript], I attach at Annex 4 the advices provided by DH colleagues and the response from PWH.**

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Guidelines on Contact Tracing

18. I said at the hearing that at the initial stage of the PWH outbreak, experienced health nurses were assigned to carry out contact tracing. Additional staff were later drafted in to cope with the increase in workload and I gave a briefing to colleagues on 15 March 2003. I also issued them with a guideline setting out the procedures as well as the intervals for follow up checks in medical surveillance.

19. By 17 March, we understood that PWH had adopted a liberal admission policy in that the hospital was admitting persons screened by its Accidents and Emergency Department who showed even a slight sign of symptoms. Those who were not admitted to hospital would therefore present very low risk. On this basis, I decided that contacts of these persons should only be followed up once with health advice given, including the instruction to report to PWH should they show symptoms in the future. The guideline was accordingly revised on 17 March 2003. **I now attach copies of the two guidelines at Annexes 5(A) and (B) in response to a question from the Honourable Michael Mak [p.45 of the draft transcript].**

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20. I hope you find the above information useful.

Yours sincerely,

(Dr TK Au)
Community Physician (NTE)

Enclosures

Annex 1

Extract of DH's letter to the HA Review Panel
dated 18 August 2003 (ref. ~~SC 05-01L-EZ~~), Annex 8

A32

Flights CA112 / CA115 outbreak reported on 23 March 2003

22. DH received notification from Tuen Mun Hospital concerning a couple admitted the day before for fever since 18 March during their tour to Beijing from 15 to 19 March. The couple was on board CA112 for the outbound journey and CA115 on return. DH started case investigations the same day and quickly learned that a third case was admitted, again for fever since 18 March. Through the tour group leader, DH obtained information to contact the remaining 33 members, of whom seven subsequently had SARS. Their onset dates were from 17 to 23 March. Epidemiological investigation did not reveal a source of infection within the group.

23. Since the sick travelers were symptomatic and could be infectious on their return to Hong Kong, attempt was made to trace all other passengers on board CA115 on 19 March. Separately, while actively tracing contacts in connection with the PWH ward 8A outbreak, DH learned on 25 March that a Beijing resident had visited a terminally ill family member in PWH ward 8A (UU) in early March, subsequently to come down with illness when departing on board CA112 on 15 March. DH rapidly extended contact tracing through public announcements to appeal to passengers of the flights CA112 / CA115 to call a designated DH telephone hotline. Assistance from consulates of overseas passengers was sought. Tour agencies were invited to provide information regarding other tour groups who had taken the same flights.

24. 54 of 112 passengers on board CA112 and 124 of 164 passengers on board CA115 have been contacted. Including the index patient (i.e. the Beijing resident referred in the preceding paragraph), 23 passengers and two crew members were subsequently confirmed SARS. Among them, 13 were confirmed in Hong Kong, seven in the Mainland, four in Taiwan and one in Singapore. All had acquired the infection while traveling on board CA112 from Hong Kong to Beijing on 15 March.

Case / Contact

MM

28800 [redacted] [redacted] Cardiologist PWH [redacted] (?) (16) [redacted]

17/3 → ICU (Admission)

28400

Case No	Contact Name	S/A	Relation	Fever + C or R	Fever	Chills	Rigor	Onset	Ref No	FU DD (17/3)	FU D1 (18/3)	FU D2D (19/3)	FU D3 (20/3)	FU D4 (21/3)	FU D6	FU D8 (?/3)	FU D11 (27/3)	FU D15	FU D16	FU D	FU D
01	[redacted]	M/70	Brother	warded PWH 8D 17/3						warded 8A						ICU					
02	[redacted]	F/82	Mother	warded PWH 8B 17/3						warded 8B							ICU				
03	[redacted]	F/56	Sister	Teacher [redacted] ?	onset: 15/3–17/3 low grade fever 37.3C 17/3 有通?	mild ... malaise +		by NTH CXR 17/3 18/3 NAD SL → 25/3		S/o mild S/S. HE given		/	PWH 8D	8D							
			[redacted]: [redacted]校長 Tel [redacted] [redacted] → 19/3 Advice on environmental & personal hygiene																		
			[redacted] 小學 (上己丞)																		
			及副[illegible]了[redacted]交																		
04	[redacted]	F/22	Domestic helper	/	/	/	/	CXR 17/3 18/3 NAD					8B PWH	8B							

Surveillance 17/3 →

Annex 2(A)

Annex 2 (B)

Contact Tracing of MM (a PWH doctor) upon his hospitalization on 17 March 2003

17 March 2003

In the afternoon of 17 March 2003, the DH Team at the Disease Control Centre in Prince of Wales Hospital (PWH) was notified of the case of MM being admitted to ICU (admission time was 16:10 hours).

Contact tracing through telephone initiated by New Territories East Regional Office (NTERO) in the same afternoon identified three persons –

- MM's mother who was already warded in PWH Ward 8B.
- MM's brother who was under observation in PWH Accident & Emergency Department
- MM's sister who had mild symptoms. She was given health advice, referred to PWH for screening and put under medical surveillance. She was a primary school teacher and she had attended school that day. As a school was involved, the nurse consulted her senior who then decided that follow up action should be taken as reported below.

18 March 2003

As a follow up of medical surveillance, NTERO managed to reach MM's sister late in the afternoon and noted that her chest x-rays taken on 17 and 18 March were normal. She was however granted sick-leave until 25 March.

The nurse sought further details from the sister about her work in the school and got her prepared that NTERO would approach the school for infection prevention and control measures and to put the school under surveillance. It was already too late on the day to contact the school.

In the same conversation, NTERO learnt that MM's brother was warded in PWH Ward 8D and that the family had a domestic servant. The latter was asymptomatic. She was given health advice through MM's sister.

19 March 2003

NTERO contacted the Headmaster of the school where MM's sister worked. No abnormalities among students and staff were detected. Advice on environmental and personal hygiene was also given.

Medical surveillance revealed no deterioration in the health conditions of MM's sister and the domestic servant.

20 March 2003

Again, as part of medical surveillance, NTERO rang MM's sister at her home. A female answered the call and said that she only paid a visit to the apartment that day and had had no contact with the family members of MM's sister in the previous days. She advised that both MM's sister and the domestic servant were hospitalized at PWH. NTERO also gave her health advice.

Dr TK Au
Community Physician (NTE)
Department of Health

April 2004

	caseno	name	id	status	rank	dept	wave	destinat	icu_ever
1	1.00	[redacted]	[redacted]	Patient			1.00	8A	.
2	2.00	[redacted]	[redacted]	HCW	RN	10EF	2.00	8B	.
3	3.00	[redacted]	[redacted]	HCW	RN	M&T	1.00	10AB	.
4	4.00	[redacted]	[redacted]	HCW	HO	M&T	1.00	10AB	.
5	5.00	[redacted]	[redacted]	HCW	RN	M&T	1.00	10AB	.
6	6.00	[redacted]	[redacted]	Patient			1.00	ICU	1
7	7.00	[redacted]	[redacted]	MS	Med 5 (G		1.00	10AB	.
8	8.00	[redacted]	[redacted]	HCW	WM	M&T 8A	1.00	10AB	.
9	9.00	[redacted]	[redacted]	HCW	Asso. Pr	M&T	1.00	8D	.
10	10.00	[redacted]	[redacted]	Patient			1.00	ICU	1
11	11.00	[redacted]	[redacted]	MS	Med 5 (G		1.00	10AB	.
12	12.00	[redacted]	[redacted]	Patient			1.00	8B	.
13	13.00	[redacted]	[redacted]	Patient			1.00	8A	.
14	14.00	[redacted]	[redacted]	Patient			1.00	8B	.
15	15.00	[redacted]	[redacted]	HCW	MO	M&T	1.00	10AB	.
16	16.00	[redacted]	[redacted]	HCW	MO	A&E	1.00	8A	.
17	17.00	[redacted]	[redacted]	MS	Med 3 (G		1.00	8A	.
18	18.00	[redacted]	[redacted]	HCW	RN	Central	1.00	8B	.
19	19.00	[redacted]	[redacted]	Patient			1.00	ICU	1
20	20.00	[redacted]	[redacted]	HCW	WA	M&T	1.00	10AB	.
21	21.00	[redacted]	[redacted]	Patient			1.00	8B	.
22	22.00	[redacted]	[redacted]	HCW	MO	A&E	1.00	8A	.
23	23.00	[redacted]	[redacted]	Patient			1.00	8A	.

(A complete set of Annex 3 is kept in **Room 015**, LegCo Building)

Annex 3

Advice provided to Prince of Wales Hospital (PWH) during 11 to 17 March 2003

The meeting on 11 March 2003

- Upon learning about an abnormal pattern of sick leave among PWH Ward 8A staff through media reports on 11 March 2003, Dr TK Au, DH's Community Physician (New Territories East), initiated contact with PWH and volunteered to join its meeting in the morning.

- The meeting chaired by Prof Sung of Department of Medicine and Therapeutics, Chinese University of Hong Kong (CUHK) had already commenced when Dr Au arrived at PWH at around 11:30 hours. Prof Sung summed up the position in PWH and advised that more than 10 staff had reported sick and the cluster apparently only involved staff of Ward 8A. No abnormal pattern had been observed among patients. The decision to close Ward 8A to admission, discharge and visitors had been implemented on 10 March.

- Prof Sung further advised that the no-visiting policy was relaxed in the evening of 10 March, restricting visitors in numbers with health advice given and requiring them to put on protective gears before visits. Dr Au did not raise any objection as the relaxation was made on practical grounds and there were adequate precautionary measures.

- At the meeting, Dr Au advised PWH to isolate cases, restrict movement of Ward 8A staff, screen and monitor sick leave pattern of staff in other wards and screen sick staff. He also undertook to conduct an epidemiological survey for those staff who had reported sick and to design a questionnaire for the purpose. The survey was essential to help understand the cluster, to work out the case definition and to estimate the incubation period. The case definition and incubation period would then form the basis for establishing a case reporting system and the period for medical surveillance of contacts.

- In response, PWH decided to set up a special staff clinic in the evening and recall staff for screening. PWH also agreed to complete the questionnaire which Dr Au had undertaken to provide for those turning up at the special staff clinic, and return them to DH's New Territories East Regional Office (NTERO) afterwards for case/contact follow up and epidemiological analysis. NTERO subsequently sent a copy of the questionnaire to PWH later that day.

The meeting on 12 March 2003

- Dr Au arrived at PWH at around 10:00 hours. The meeting chaired by Dr Philip Li had commenced and lasted until about 13:00 hours.

- At the meeting, PWH advised that more than 20 staff had been admitted and isolated. The 8th floor of the main building of PWH had been made a restricted area. There was no abnormal sick leave pattern for staff in wards other than 8A. There was a long discussion on possible arrangements to suspend some of the services in the specialist out-patient clinics and to stop new admissions from the accident & emergency (A&E) department to medical wards because a number of healthcare workers had fallen sick.

- Dr Au presented the preliminary epidemiological findings and the epidemic curve was tabled. The probable mode of spread was discussed and droplets and fomites were incriminated. The incubation period was estimated from one to seven days. The survey findings on clinical features were shared and PWH and NTERO agreed on a working case definition for active case finding and surveillance. Dr Au requested PWH to provide a list of cases satisfying the case definition for NTERO's follow up and contact tracing. As positive Chest X-ray (CXR) findings were observed in some cases, Dr Au advised PWH to include CXR as one of the screening tools. Since the epidemiological study conducted by NTERO on 11 March evening found that medical students were also affected, Dr Au also advised CUHK to screen medical students who had been exposed to cases and restrict their movement in the hospital. On the same day, CUHK stopped medical students from visiting PWH.

Two meetings on 13 March 2003

- Dr TC Shiu of NTERO, attended a meeting at PWH chaired by Dr Fung Hong at 11:00 hours in the morning. The meeting discussed the latest progress of the outbreak, including figures on the number of affected staff, the number of specimens collected and laboratory results. The arrangements on control measures were also discussed. The meeting agreed on a proposal to step up infection control by separating staff into "clean team" and "dirty team". Contrary to the notes prepared by PWH, Dr Shiu did not recall any discussion at the meeting about follow up of discharged patients or the setting up of a Follow-up Clinic at the A&E department.

- In the evening, Dr Au attended a meeting at 20:00 hours at PWH. Contrary to the notes prepared by PWH, Dr Shiu was not present at that meeting. During the meeting, the updated epidemiological findings and epidemic curve were discussed and information on sporadic reported cases of staff from wards other than 8A was shared. Dr Au also advised the meeting that DH had stationed a team at the PWH Disease Control Centre to facilitate investigation and communication. Dr Au left the meeting at about 21:00 hours.

Two meetings on 14 March 2003

- Dr Thomas Tsang (Consultant, Disease Prevention and Control Division) and Dr Au met with Dr Fung Hong, Dr Philip Li and Dr Louis Chan of PWH at 09:30 hours. The outbreak situation was discussed. The meeting then discussed the criteria for reporting cases and Dr Tsang suggested PWH to consider if positive CXR should be included as one of the criteria in the case definition. The PWH notes had no record on this meeting.

- In the evening, Dr Tsang and I attended another meeting at PWH. Other participants included Dr Fung Hong, Dr Philip Li and Dr Donald Lyon of PWH; and Prof Sydney Chung, Prof Joseph Sung, Prof John Tam, Prof Paul Chan and Prof Wong Tze-wai of CUHK. DH shared the epidemiological findings with PWH. Dr Au advised PWH that while the first wave of the outbreak might have peaked, the

hospital should be on the alert for the second wave as contacts having been exposed and incubating the disease might become sick in the following week. Dr Au advised PWH to get prepared.

- The evening meeting also shared the findings on the PWH index patient (JJ). The meeting considered that there was a need to trace all persons who had been exposed to JJ in his cubicle, meaning those exposed staff, medical students, patients and visitors. The agreement was that PWH would follow up their staff, medical students and inpatients while DH would follow up patients discharged before the outbreak, i.e. prior to 10 March and hospital visitors up to 14 March before JJ was isolated on that day.

The meeting on 15 March 2003

- Dr Shiu attended the meeting at PWH. Contrary to the notes prepared by PWH, Dr Au was not present at the meeting.

16 March 2003

- Contrary to the notes prepared by PWH, no DH representative was invited to or attended any meeting at PWH on the day.

The meeting on 17 March 2003

- Dr Tsang together with WHO experts and Dr Shiu called on Dr Fung Hong and others at PWH. They discussed the epidemiological findings and clinical presentations of the disease.

Dr TK Au
CP(NTE), DH
April 2004

High Risk Group patients (cases on the white board)
Close Contacts (including Home contacts and work place close contacts)
Follow up schedule - on Days 0, 2, 4, 6, 11, 16.
Follow-up action:

- Identify key contact person of each group of contacts (e.g. home contacts, colleagues).
- Contact the key contact person of each group.
- Ask the health condition of the group.
- Ask how close, how frequent are they contacting the patient – including visits in the hospital.
- Give them health advice on prevention.
- Give them our office contact telephone no.
- Document our follow up action of each group after each follow up (whether successful or unsuccessful, date, time and who we had spoken to, anything special).
- Report to responsible MO when we detect any abnormal findings (e.g. symptomatic contacts).

Symptomatic contacts:

- Check whether they met criteria for hospital admission.
- If admitted – trace their close contacts.
- If they are attending child care centres or kindergartens – Surveillance of ccc/kg on Days 0, 1, 2, 3, 8, 15.
  Note the following:
  Any child with fever (>38.5°C) for 3 days} - visit the ccc/kg.
  Another child of the same class with fever} - visit the ccc/kg.
  Pneumonia case } - visit the ccc/kg.
  Abnormal sick leave pattern } - visit the ccc/kg.
- Leave our office contact telephone no.

Low Risk Group patients (all other cases)
Close Contacts –
Follow up schedule – on Days 0, 5, 10, 15.
Follow up action: refer to previous group.

Instruction from CP NTE on 15.3.2003

Close contacts (including home contacts and work place close contacts)

Close contact follow-up actions:

- Identify key contact person of each group of contacts (e.g. home, contacts, colleagues)
- Contact the key contact person of each group.
- Ask the health condition of the group.
- Ask how close, how frequent are they contacting the patient – including visits in the hospital.
- Give them health advice on prevention.
- Give them our office contact telephone number.
- Document our follow-up action of each group after each follow-up (whether successful or unsuccessful, date, time and who we had spoken to, anything special).
- Report to responsible MO when we detect any abnormal findings (e.g. symptomatic contacts).

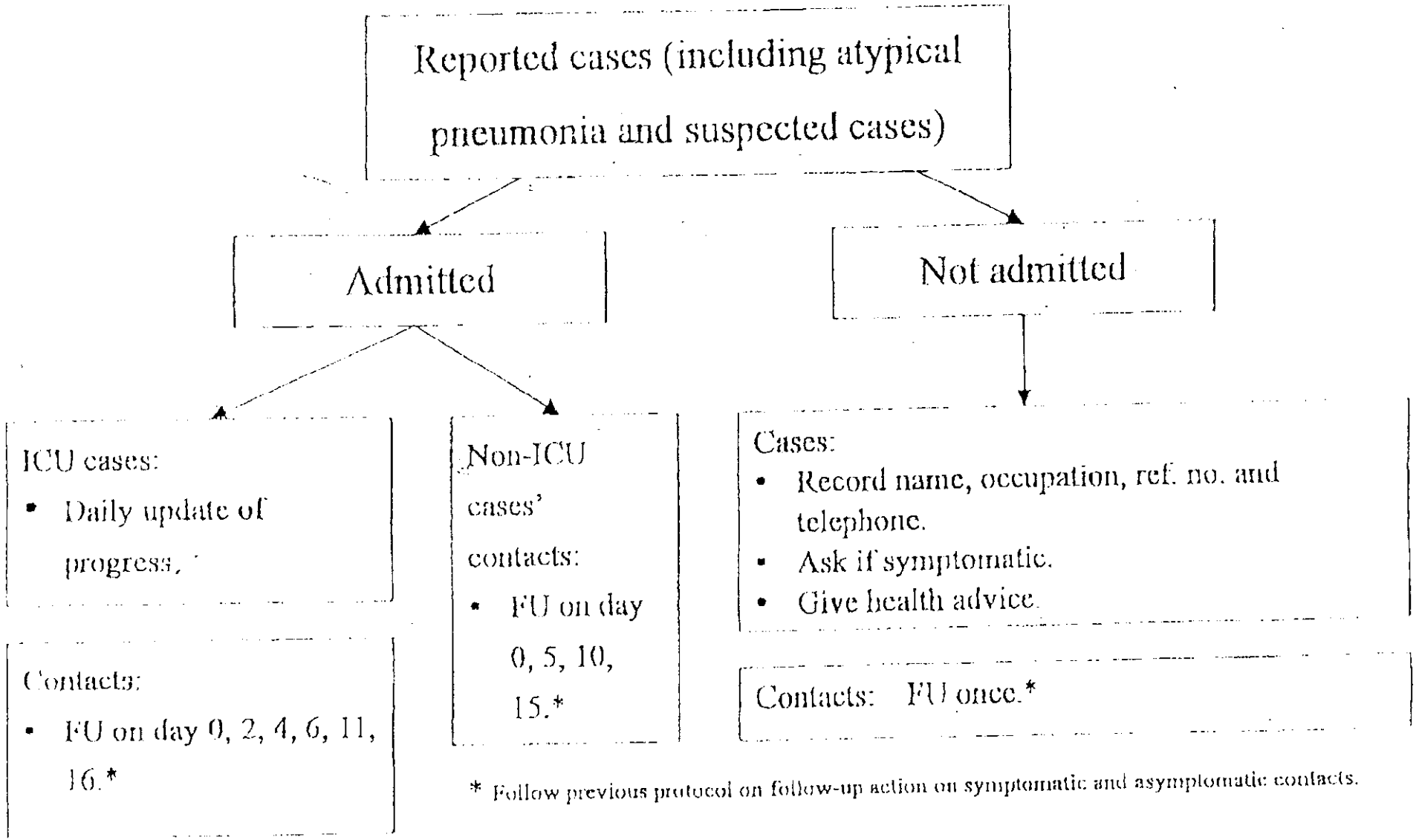
Symptomatic contacts:

- Advise them to seek medical treatment (if PWH related, advise them to attend PWH A&E).
- If they are attending child care centres or kindergartens – surveillance of ccc/kg on days 0, 1, 2, 3, 8, 15.

Note the following:

Any child with fever (>38.5°C) for 3 days } - visit the ccc/kg.
Another child of the same class with fever } - visit the ccc/kg.
Pneumonia case } - visit the ccc/kg.
Abnormal sick leave pattern } - visit the ccc/kg.

Guideline for follow-up of cases/contacts (as at 17/3/2003)



* Follow previous protocol on follow-up action on symptomatic and asymptomatic contacts.

Annex 5 (B)