Dr. Hon Law Chi-kwong JP
Chairman
Select Committee

17 May 2004

Dear Dr. Law,

Thank you for your letter dated 11 May 2004.

The Select Committee's observation that "Prince of Wales Hospital decided on 10 March 2003 to close Ward 8A to admission, visit and discharge but the decision was reversed on the next day, 11 March 2003" is incorrect. The re-opening of ward 8A to admission was a decision of the Hospital Management on 13 March 2003. The opening and closure of wards was an operational, rather than clinical issue. As a clinician of the Department of Medicine of the Prince of Wales Hospital (PWH), I had to execute the decision of the Hospital Management and focused on caring of our sick colleagues and patients. So that the Select Committee may fully understand the position, let me reiterate in brief the events from 10 March to 15 March 2003.

10 March 2003

AM

- 11 Health Care Workers (HCW) reported sick with influenza-like illness.
- Clinical impression was a cluster of Influenza-like illness occurred in hospital.
- **In view of the urgency of the situation, PWH's Department of Medicine (內科部) and Hospital Management decided to close ward 8A (no visiting, admission and discharge) until further evaluation.**

PM

- Due to visitors agitation on the "No Visiting" policy, and the concern that patients might discharge themselves against medical advice, the "No Visiting" policy was reviewed by a meeting chaired by Philip Li, Deputy Hospital Chief Executive of PWH in the late afternoon and attended by J Sung (Medicine), SF Lui (Hospital Management), Albert Ng (DOM) and D Lyon (Microbiology)
- **At the meeting, it was decided that "Restricted Visiting" to ward 8A would be allowed** under the following conditions
  1. Visitors must report to ward manager or nurse-in-charge before visiting
  2. They were to be informed an outbreak of unknown infectious disease in 8A.
  3. Only 1 visitor was allowed per patient at one time.
  4. They had to wear a surgical mask if patient contact was necessary
  5. They were advised not to feed or getting too close to patients
- This policy change from "No Visiting" to "Restricted Visiting" was reported to and endorsed by Fung Hong, Hospital Chief Executive of PWH.

11 March 2003

AM

- The number of staff members fell ill with influenza-like illness increased from 11 to 14.

Hospital Outbreak Management Meeting (with DH – Dr Au's presence)

1. Confirmed no visiting changed to restricted visiting.
2. "No admission" policy continued.
3. Microbiologist recommended upgraded droplet precautions i.e. N95. Microbiologist also recommended separation of fever patients from other patients and cohorted fever patients into bays.
4. DH advised to isolate cases, screen other wards and monitor sick pattern of staff. DH to carry out epidemiological survey through questionnaire.
5. Discharge policy was discussed. In order not to expose unaffected patients from the unknown infection, 8A patients who had not had fever and were fit for returning home were to be discharged. Patients were not to be discharged to Old Age Home or other hospitals for convalescence to avoid risk of cross-infection.
6. PWH agreed with DH that PWH would inform DH all fever patients discharged from PWH. DH agreed to continue monitoring these discharged cases.
7. Patients who were fit for discharged would be follow-up by DH by home surveillance. Discharged patients were given precautionary advice and asked to watch out for symptoms of fever and to return to Accident & Emergency Department of PWH when symptomatic.

PM/Evening

- In the afternoon, PWH was informed that 1 HCW admitted to Kwong Wah Hospital and 1 to Union Hospital were diagnosed to have atypical pneumonia (AP).
- Hospital management decided to set up a clinic to recall staff back for screening and prepared the Observation Room in Accident & Emergency Department for admission of staff
- 23 out of 50 staff members screened were admitted to PWH. 8 had pneumonic changes.

12 March 2003

AM

- P Li chaired Hospital Outbreak Management Meeting which included representatives from the departments of Medicine, Microbiology, Paediatrics, Accident & Emergency Department of PWH.
- **The roles were clearly defined: Clinical teams were to be responsible for the clinical management of patients; microbiologists were to be responsible for infection control and Hospital Management was to be responsible for operational issues.**

Clinical:

- On clinical side, I separated the Department of Medicine of PWH into dirty and clean teams. The clinical team started to devise treatment protocol.

Hospital Management

- Clinicians reported on the seriousness of the situation and made various suggestions including (a) the closure of PWH, (b) suspension of hypertension clinic, (c) suspension of cardiac clinic and (d) suspension of emergency admission of medical cases.
- No consensus was reached on closure of services. Hospital Management mobilized Family Medicine doctors to help run clinics.
- Discharge and restricted visiting policy continued. "No Admission" to 8A continued.
- Hospital Management prepared mobilizing manpower from AHNH and NDH to support PWH.

Incubation Period

DH presented preliminary epidemiological curve based on admissions on 11 March 2003. The understanding was that further works would be undertaken to come up with an incubation period.

PM

- As the situation in PWH deteriorated quickly with 14 new patients admitted to 8D with fever and/or pneumonia, the Hospital Management of PWH was convinced that closure of Accident & Emergency Department was necessary
- Fung Hong chaired the hospital outbreak management meeting in the evening
- Long discussion about shortage of manpower, heavy clinic workload and concerns about cross-infection between staff and patients. Closure of services was debated again
- Members were cognizant that quarantine power was not available
- WM Ko indicated that there was insufficient rationale to close Accident & Emergency Department and all specialty clinics
- **The Meeting decided that:**

1. **Divert non-AP medical admissions to cluster hospitals.**
2. **PWH to continue to admit all AP cases.**
3. **Close some medical OPD (cardiac/liver).**
4. **Stop elective surgical admission.**
5. **Set up Disease Control Center**

13 March 2003

- Fung Hong chaired Hospital Outbreak Management Meeting
- **With the continuous influx of AP cases, the Meeting at mid-day decided**
  1. **to use 8A and 8B to admit (a) cases satisfying case definition (CXR changes, lymphopenia) or (b) linked with 8A (i.e. stayed, visited or worked in 8A before outbreak & close contacts).**
  2. to use 8D as triage ward; and :
  - Cases from 8D highly suggestive of SARS would be admitted to 8A (males) and 8B (females). 8B was vacated for SARS patients.
  - To prepare for the opening of 10C and 10D wards to provide care for patients with fever conditions other than SARS (10C and 10D opened on March 15)
- **The first patient to 8A was admitted in the late afternoon of 13 March.**

14 March 2003

- Fung Hong chaired Hospital Outbreak Management Meeting.
- There was huge pressure for beds due to the continuous influx of patients (8D admitted 21 additional patients on 13 March and all together 60 cases of suspected AP were admitted). Beds were tight all over the hospital
- **The Meeting re-affirmed that all AP cases would be admitted to PWH (8A and 8B) to leave other cluster hospitals clean. 8A and 8B had to admit AP patients with or without 8A epidemiological link as epidemiological link was difficult to establish for some patients**

15 March 2003

- Ward 10C and 10D opened to look after patients triaged from 8D unlikely to suffer from AP but required hospital treatment
- As per the arrangement on 11 March 2003, patients who were fit for discharged would be follow-up by DH as home surveillance. These patients were not kept in hospital because of serious shortage of beds. We also did not want to expose them to the risk of infection.
- YY presented to renal dialysis unit. He started to have fever on 14 March but did not inform renal nurses until temperature was taken. He was diagnosed to have atypical pneumonia. Clinicians agreed to admit the patient to 8A based on his clinical diagnosis and possible epidemiological link with China.

19 March 2003

- YY was diagnosed to have influenza A by serology. His fever resolved, CXR almost completely clear. Based on clinical ground, there was good reason to explain his fever. DH informed to monitor this patient.

Based on this factual account, my response to your specific questions are as follows:

(a) The name(s) of the persons(s) who were involved in the decision of re-opening ward 8A to admission on 11 March 2003;

Ward 8A was not re-opened for admission on 11 March 2003.

The decision to re-open Ward 8A for admission to cases (a) satisfying strict case definition (CXR changes, lymphopenia) or (b) linked with 8A (i.e. stayed, visited or worked in 8A before outbreak & close contacts), was made in the Hospital Outbreak Management Meeting held at noon time on 13 March 2003. The meeting was chaired by Dr Fung Hong and attended by Prof. Sydney Chung (CUHK), Prof. Peter Cameron (AED), myself and Prof. CS Cockram (Medicine), Prof. John Tam, Dr. Paul Chan, Dr. Donald Lyon (Microbiology), Dr. Shiu Tak Chi (Department of Health), Dr. N. Tung, Dr. CK Li, Ms. Lily Chung, Ms E. Mok (Hospital Management).

(b) The name(s) of the person(s) who made the decision to re-open Ward 8A to admission;

Please refer to my answer to (a)

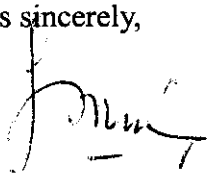
(c) The name(s) of the person(s) who formally endorsed the decision to re-open Ward 8A to admission;

Please refer to my answer to (a)

(d) The source of the above information including any documentary proof.

The Hospital Outbreak Management Meeting minutes for meeting on 13 March (draft) and 14 March (previously submitted to the Select Committee) are now attached for your reference.

Yours sincerely,



Joseph Sung

DRAFT

Notes of 1st Meeting regarding Incident at PWH Ward 8A held on 13th March 2003 at 11:00 a.m. in CR1, 2/F, Main Block, PWH

Present:

Dr. FUNG Hong - Chairman
Prof Sydney Chung
Prof Peter A Cameron
Prof Joseph Sung
Prof. C.S. Cockram
Prof TAM Siu Lun, John
Dr. SY Tung
Dr. CK LI
Dr. Paul Chan
Dr. Lyon Donald James
Dr. SHIU Tak chi
Ms. Lily Chung
Ms E Mok
Ms Winnie Cheng
Ms Fion Fung
Ms Zabrina Lee

Status update as at 11 a.m. on 13.3.03

PWH staff was admitted in PWH. Among them, 16 admitted staff was diagnosed with pneumonia symptom. Another three were admitted to other hospitals.

Ward 8A, 8B, and 8 D would be vacated to cater for admission of the case with relevant sympton.

Triaged Medical patients at A&E, PWH would be diverted to AHNH and NDH.

Elective surgical cases would be rescheduled.

Limited service at Cardiac Clinic would be provided.

Service of Medical day ward would be suspended temporary.

Press Release of the above announcement would be issued in due course.

So far, two no of staff were discharged.

Information Center at Conference 2, PWH

The following data would be updated timely at the Information Center:

- No of Admission
- Change of medical condition of the affected staff

Epidemic survey was being conducted.

Microbiologist Report

The above was updated in the meeting. More than 100 lab tests were performed—(1

flu B. 2 meta pneumovirus, and 1 enterovirus.)

Manpower Crises

Because of the medical staff in Firm 2 were sick, there were only 3 firms out of four to take up the existing workload. Staff from other firms would take up workload in Ward 8A,B, D.

There would be two groups of staff: contaminated and clean. The clean staff would take up other cases.

Because of the shortage of manpower, some service at SOPD would be suspended temporary. Other back-up medical staff would be required. Prof. Joseph Sung would send recommendation to CCE for consideration after the meeting.

Patient Follow-up Clinic

Patient discharged would require follow-up. Also, those who had fever attended A&E would require x-ray assessment the second day. A Follow-up Clinic at A & E would be established to cater for the above purpose.

Delineation role of Staff Clinic and Special Clinic at A&E

All staff would be advised of the followings:

- Those with fever and specific symptom would go to A&E
- Those with non-specific symptom would go to Staff Clinic

Understanding that there was down staff in A&E, the above would be monitored. Situation would be reviewed in the evening.

Other Backup

16 beds of isolated ward at TPH might be handed over after renovation within one or two days. It would be available for admission if situation required

Staff Forum

It would be organized at 5 p.m. today.

Frequency of the meeting

There would be meeting twice per day for updating and monitoring the situation.

Next Meeting

It was scheduled at 7 p.m. on 13.3.03 (today).

Notes of 2nd Meeting on Update of Infection Event at PWH held at 8:00 pm on 13.3.2003 (Thursday) in CR1, 2/F, Main Block, PWH

Present: Dr FUNG Hong -Chairman
Prof Sydney CHUNG
Prof Peter A Cameron
Prof Joseph SUNG
Prof C S Cockram
Prof TAM Siu Lun, John
Dr S Y TUNG
Dr CK LI
Dr Paul CHAN
Dr James Donald Lyon
Dr SHIU Tak Chi
Dr T K AU
Ms Lily CHUNG
Ms E MOK
Ms Esther LAW -Recorder

Status update as at 6:00 pm on 13.3.2003

1. A medical staff of AHNH has developed thesymptoms but he has no chest X-ray signs.
2. An ex-PWH patient has been admitted to NDH with fever and pneumonia. It was decided that the above patient should be transferred back to PWH for treatment so as to avoid the infection from spreading around.
3. A NO and an ICU nurse started to feel unwell.
4. 24 staff has been admitted to the Observation Ward, 18are in ward 8A, 5 to 6 are in ward 8B and 2 are in ICU.

Actions Taken/To be Taken

1. The Health, Welfare & Food Bureau would set up a steering committee and a technical committee to look into the matter.
2. Dr Fung was interviewed by Radio HK 1 at 7:05 pm on the infection event
3. Dr FUNG would meet the Shatin District Council at 11:00 am tomorrow
4. DH would continue to gather information from PWH to help find out the epidemiology of the infection.
5. PWH has deployed Dr Louis CHAN, MO of O&G Department to assist DH with

the survey.

6. Ms E MOK would check if staff could claim as injury on duty with regard to their contraction of the infection on duty.

7. Dr W WONG would arrange two staff forums as soon as possible with one in NDH and the other in AHNH

8. Accomodation is available if staff want to stay in hospital after duty hours. Keys have been kept in CCU.

The next meeting would be held at 12:30 pm in the same venue.

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NEW TERRITORIES EAST CLUSTER

Hospital Authority

Notes of a meeting on Management of Atypical Pneumonia Incidence held on 14 March, 2003 at Conference Room I, 2/Fl., Main Block, PWH.

Chairman :	Dr. Fung Hong		
Members :	Dr. Philip Li	Prof. A. Ahuja	Prof. T.F. Fok
	Dr. S.Y. Tung	Prof. Augustine Cheng	Prof. Tony Chung
	Dr. William Wong	Prof. C.A. Van Hasselt	Dr. Thomas Buckley
	Dr. S.F. Lui	Prof. H.K. Ng	Dr. Louis Chan
	Dr. C.Y. Li	Prof. J. Sung	Prof. Sydney Chung
	Ms Lily Chung	Prof. Peter Cameron	Dr. Donald Lyon
	Ms E. Mok	Prof. H.K. Ng	Prof. John Tam
		Dr. M.C. Yam	Prof. C.S. Cockram
		Prof. Gavin Joynt	Dr. Au Tak Kwong /
		Prof. Paul Chan	Dr. Shiu Tak Chi
Secretary :	Ms Winnie Cheng		

Patient Status

1. There were 60 cases of suspecte AP cases in PWH. 34 of them were Health Care Workers and 8 Medical Students. 41 patients had adnormal CXR. 1 in ICU.

2. All suspected AP cases and their contacts with symptoms were cohorted in PWH.

3. The infection control team had started contact tracing of affected patients, inparticular those in 8A. If contacts were asytomatic, they would be referred to DH for health surveillance. If they had symptoms, they would be asked to attend the AED, PWH immediately.

Epidemiological Update

4. No definitive organism could be identified by rapid test.

5. More detailed culture result would be available by early next week.

6. Evidence so far pointed to droplet infection. Infection control measure on droplet infection should be strictly followed in handling patients with respiratory diseases including wearing gloves and gowns. Communal apparatus and areas should be cleaned before use and must not be contaminated with potentially infected materials.

Contingency Measures

7. Patients with no evidence of pneumonia would be moved along medical wards to allow cohort of all suspected cases of AP. All suspected AP cases were cohorted in AED Observation ward, 8D, A&B. 10AB would be vacated for admission of more AP cases. The AED Observation wards would be relocated to 5E temporarily.

8. All suspected and confirmed AP cases in NTEC would be sent to PWH. All other NTEC hospitals would be kept clean.

9. All emergency admission in Medicine would be triaged in AED. All suspected and confirmed AP cases would be admitted to PWH. Those with non-pneumonic conditions would be transferred to other acute hospital in the cluster for treatment.

10. Medicine had stopped all clinical admission in all NTEC hospitals. Medicine day ward would be closed to release manpower.

11. All elective surgical operation would be stopped for one week to conserve manpower and ICU capacity to take care of the critically ill patients. This applied to Surgery, Orthopaedics and Gynaecology.

12. Diversion of uncomplicated term delivery(more than 37 weeks gestation age) to AHNH would be effected as from 14 March. A 24-hours patient hotline would be set up in Ward 7F to answer enquiries.

13. There would be cross specialties and hospitals staff deployment to meet operational needs. Some staff would be posted to AED to help out.

14. Some medical specialist clinics including Hepatology and Hepatics clinics, Hypertension clinics and Cardiac Clinic would be suspended for the time being.

15. 40 contingency rooms would be provided on 6 & 9 floor of Block A staff quarters for staff who would like to stay in hospital.