



雅麗氏何妙齡那打素醫院

Alice Ho Miu Ling Nethersole Hospital

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18 May 2004

Your ref.: CB2/SC2

Miss Flora Tai
Clerk to Select Committee
Legislative Council

Dear Miss Tai,

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

Your letter dated 12th May 2004 refers.

The answers to the questions raised by Select Committee are as follows :-

(a) A mechanism was in place.

NTEC senior management (including TPH) was kept informed of the SARS infection situation in AHNH since early April 2003. There was a clear understanding between AHNH and TPH that TPH would treat all patients transferred from AHNH with extra caution since AHNH was then hard hit by SARS. Both AHNH and TPH implemented vigilant screening and monitoring of cases, irrespective of which wards the patients came from. In this, TPH would screen and monitor patients transferred from AHNH as if they were involved in outbreaks.

Before 11 April 2003, any outbreak would be notified by the Department Operations Manager.

At a meeting on 11 April 2003 (Friday), due to heavy workload, it was decided that ward managers would notify TPH. Ward managers were not present in this meeting.

The outbreak in F6 was noted in the late evening of 12 April 2003 (Saturday).

The ward manager was notified of the decision of the 11 April 2003 meeting in the evening of 14 April 2003 (Monday). The ward manager thought that the need to notify was prospective, and not retroactive.

There was no outbreak in F5.

(b) See my answer to (a)

(c) See my answer to (a).

Yours sincerely,

(Dr. Raymond Chen)
Hospital Chief Executive
Alice Ho Miu Ling Nethersole Hospital