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CONFIDENTIAL

Written Statement by Dr. Lai Wai Man, UCH (14 Feb 2004)

1. Were you aware of the outbreak of atypical pneumonia in Guangdong in February 2003? When did you learn about [redacted]'s case at Kwong Wah Hospital and the outbreak of Severe Acute Respiratory Syndrome (SARS) at Prince of Wales Hospital (PWH)?
Yes, I read from newspapers and realized the incidence. I learn about [redacted]'s case at around 13 March (CE's latter) and the PWH outbreak on 11 March. AA

2. What were the measures taken to protect healthcare workers (HCWs) and patients in as well as visitors to United Christian Hospital (UCH) from contracting SARS? Was there any specific advice provided to UCH by the head office of the Hospital Authority (HAHO) and/or the Department of Health (DH) based on the experience in handling the SARS outbreak at PWH?
***Measures taken to protect HCWs** : Guidelines and information on severe CAP and SARS were disseminated through e-mail, circulars, education talks, open forum, posters and VCDs. Education talks were conducted in Cantonese and there were also Chinese version of the guidelines. Posters for proper usage of N95 respirators and sequence of gowning up / removal of PPE were issued. A total of 148 education sessions on Atypical Pneumonia / SARS were launched with over 6,000 attendances. Briefings were given by ward mangers / ward i/c of workplace in each shift to discuss the precautions and update. Ward inspection and onsite trainings were given by ICO and ICNs. A survey on the knowledge of SARS and its precautions was done. An Infection Control Enforcement Team (ICET) was established to assist in the promulgation of guidelines / information and monitoring of compliances which were carried out together with ICT, Central Nursing Division and Nursing Association. In addition a PPE e-resource center was established with their usage precautions illustrated on UCH Homepage. Work Place Shift Wardens were also appointed.*
***Measures taken to protect patients** : Patients with suspected SARS were cohorted to avoid mixing with other patients in which they were required to wear surgical masks. In non cohort areas patients with respiratory symptoms were required to wear surgical masks initially and later on all patients were required. Exhaust fans were installed in SARS wards to reduce the concentration of infectious aerosols. Portable HEPA filters were used later. Patients were also advised to avoid talking without wearing masks. They were educated about the importance of hand washing and proper disposal of waste such as tissue paper. They were also instructed to cover up the toilet seats before flushing water which were added with hypochlorite solution. Frequency of environmental decontamination was also increased.*
***Measures to protect visitors** : In cohort ward visitors were required to wear surgical mask, gowns and practiced proper hand washing and later on no visitors were allowed. In non cohort wards visitors were initially provided with surgical masks and advised to wash hands after visiting and then no visitors were allowed to the hospital.*
A HAHO guideline was issued on 19 March and a PWH guideline was attached to the HA guideline on 24 March. There was no specific advice given by DH based on the experience in handling SARS outbreak in PWH.

3. Did different wards in UCH have different levels of infection control? If yes, what were these levels and how were they determined? If not, why not? Were there problems with the supply of personal protection equipment? If yes, what were the problems and how were they resolved?
Yes. UCH was stratified into 1) Ultra – High Risk areas, 2) High Risk area and 3) Moderate Risk areas. They were determined according to the risk of acquiring SARS and the chance of encountering SARS patients in these areas.
There had been tight stock of PPE including water resistant gowns, N95 respirators, surgical masks, goggles and eye shields at different periods. They were resolved by sourcing arrangement and delivery to hospital provided by HAHO and liaison with

other clusters as a temporary support.

4. Were any wards in UCH designated as SARS wards? If not, why not? If yes, please name the wards. When were they designated as SARS wards? Did they include Ward 12A? Were SARS patients being admitted to non-SARS wards during the SARS outbreak? If yes, what was the reason? Did any HCWs and patients in as well as visitors to such wards contract SARS as a result? Were non-SARS patients being admitted to SARS wards? If yes, what was the reason? Did the patients contract SARS as a result?
Yes. 6A was designated as SARS (Cohort) ward on 15/3, 6B on 26/3, 8A on 27/3, 9A as Triage ward on 31/3, 5D and 9B as Stepdown ward on 7/4 and 17/4 respectively. 12A was not included as a SARS ward. There had patients subsequently diagnosed as SARS been admitted to non-SARS wards. Reason was that they were not suspected to be SARS on adimssion. Some HCWs, patients and visitors contracted SARS. On the other hand, there were also non-SARS patients admitted to SARS wards. This is because the initial clinical presentations were similar to that of SARS and cannot be differentiated on admission. As far as I know no such patients contract SARS.

5. What were the guidelines provided to HCWs for wearing different types of masks, such as surgical and N95 masks? How did you ensure that HCWs were aware of these guidelines? How were the guidelines disseminated to all concerned? Were there requests made by HCWs to wear higher protection masks (such as N95 masks) during the SARS outbreak? If yes, were these requests rejected? If yes, why were the requests rejected? Did any HCWs contract SARS as a result?
There were guidelines, posters and VCDs. Guidelines were disseminated through email and circulars. They were also emphasized during education talks and compulsory training sessions. In ward level briefings were conducted by ward manager or nursing in-charge during each shift. Ward inspections and on site trainings were done. Infection Control Enforcement Team and Warden system were in place. Compliances monitoring were also conducted. There were requests from HCWs to wear higher protection masks and they were not rejected.

6. How many HCWs and patients in as well as visitors to UCH were infected during the SARS outbreak at UCH? How and why were they infected? How many HCWs in Ward 12A were infected during the SARS outbreak at UCH? When was the first of such cases reported? How and why was this HCW infected? When were you informed and did you take any follow-up action? If yes, what was the action? If not, why not?
28 HCWs, 1 contractor staff, 9 patients and 2 visitors were infected in UCH. Possible causes included contact with unsuspected SARS patients; presence of high viral load; extensive nursing care for dependent patients and performing high risk procedures. 14 staff in 12A were infected. The first case was reported on 31 March. He was possibly infected due to contact with unsuspected cases in 12A. I was informed on 31 March. Follow up action was taken by reviewing the epidemiology history and contact history. HCE was informed and discussion was made.

7. The Kowloon Regional Office of DH was notified on 26 March 2003 by UCH that it had admitted 15 suspected SARS cases from Amoy Gardens. Who in UCH made the notification to DH and what details about the cases were provided? Why did UCH wait until 26 March 2003 to notify DH when UCH began admitting suspected SARS patients from Amoy Gardens on 24 March 2003? Who made the decision to notify DH on 26 March 2003 and not earlier? Were hospitals required to report such cases to DH on a daily basis? If yes, why did UCH not comply with such a requirement?
Dr. C Y Tse (CCE/HCE) made the notification to DH. Information about patient address, demographic data, contact history, traveling history, occupation and clinical conditions were provided. UCH notified DH on 26 March because although the first case was admitted on 24 March, the outbreak was not evident until almost midnight of 25 March when 2 families were admitted. Dr. Tse made the decision to notify DH on 26 March. Hospitals were not required to report such cases to DH.

8. Did UCH notify HAHO when UCH began admitting suspected SARS patients from Amoy Gardens on 24 March 2003? If not, why not? If yes, when did UCH notify HAHO? Who in UCH made the notification to HAHO and what details about the cases were provided? Did HAHO provide any advice to UCH on how the situation should be handled? If yes, what was the advice? If not, why not?

Yes, UCH notified HAHO for the first Amoy Garden case, but this was not done on 24 March because there was no CXR changes and thus did not fulfill the criteria for reporting on 24 March. He was reported on 26 March when the HRCT showed positive changes. Ward in charge chest physician made the notification. Dr. C Y Tse reported to HAHO as well. Information provided were the demographic data, address, contact history, traveling history, occupation, clinical conditions and CXR changes. After the notification of the Amoy Garden outbreak on 26 March, it was subsequently decided that PMH would receive all AED diagnosed SARS patients from UCH starting from 29 March.

9. Did you, as Infection Control Officer, inform the Infection Control Officers of other HA hospitals when UCH began admitting suspected SARS patients from Amoy Gardens on 24 March 2003? If yes, why did you inform other Infection Control Officers? Were you required to?

I did not inform other Infection Control Officers when UCH admitted Amoy Garden patients on 24 March. I was not required to.

Dr. Lai Wai Man