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CONFIDENTIAL

新界西·醫院聯網
New Territories West Cluster

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Our ref.: ( ) in HA/NTWC/CCEO/SARS/Select

15 March 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

I refer to your summon dated 1 March 2004 in which a request for a written submission was enclosed.

Please see attached reply as requested.

Please feel free to contract me at [redacted] if you have any queries.

Thank you.

Yours sincerely,

(Dr. W L CHEUNG)
Cluster Chief Executive, New Territories West Cluster
/ Hospital Chief Executive, Tuen Mun Hospital
Hospital Authority

c.c Ms Venus CHOY, CLC, HAHO
Ms Elizabeth MOK, SM(PS), HAHO

Written Submission of CCE to Select Committee, LegCo
Summon dated 1 March 2004

1. Prior to 12 April 2003, there were 28 clinical SARS cases and 8 suspected cases admitted to TMH, of which 6 cases were subsequently admitted to ICU.

   Prior to 12 April 2003, there were 2 SARS wards in operation, one for adult patients and one for paediatrics patients. At that time, the number of ward staff assigned to handle the SARS patients in these 2 SARS wards and ICU were 35, 34, and 62 respectively.

   Prior to 12 April 2003, 4 HCWs were infected. No visitor was infected. The causes of HCW infection were uncertain.

2. In the SARS round up meeting on 11 April 2003, it was decided that PMH would stop all new admissions. Other hospitals had to share out the patient load. Referrals from the 4 DMCs of Department of Health (DH) and A. & E. Department of YCH would be taken by TMH.

   The assessment was that the facilities and manpower of TMH were adequate. TMH had indeed planned and made preparation for the opening of more SARS wards, if necessary. Thus, when the referral arrangement was agreed on 11 April 2003, the planning and preparation for additional SARS wards were already in place. The time for preparations for receiving additional SARS patients was sufficient.

3. The anticipated patient load from such referrals was less than 10 per day, and the actual average referral was within the estimation.

4. Infection control was all along considered as a priority area in TMH. Various regular infection control training programs were provided to our hospital staff round the year. Droplet precautions and proper hand-washing were frequent review topics. The infection control measures in TMH were stepped up continually throughout this period in line with HA guidelines, and in accordance with new knowledge and experience gained.

5. Between 26 & 27 April 2003, 3 staff working in C8 which was a Medical & Geriatric ward reported sick and were admitted. This was immediately regarded as a likely outbreak.

Our investigation showed that two cryptic unsuspected patients in that ward were the potential sources of infection.

6. At the conclusion of the TMH C8 outbreak in early June 2003, a total of 5 staff, 10 patients and 1 patient relative were confirmed as having clinical SARS. No visitor to TMH was infected with SARS.

The first index patient was admitted through TMH A.&E. Department on 10 April 2003, three days after returning from Shanghai, for fever, chills and myalgia. The fever subsided shortly after admission and the patient remained afebrile. Since there were no chest X-ray changes and there were no lung infiltrates even on High Resolution CT, she was not diagnosed as SARS case. She responded to antibiotics and she was discharged on 14 April 2003. She presented again on 21 April 2003 and was later diagnosed as having SARS.

The second index patient was admitted to PMH on 2 April 2003 as a suspected SARS patient. She was subsequently classified as a non-SARS case and was discharged on 11 April 2003. She then presented to TMH A. & E. Department on 18 April 2003 and was admitted for fever, chills and myalgia. There was no chest X-ray change and the fever subsided shortly after admission and the patient remained afebrile for days before fever was up again.

These 2 index patients were cryptic cases. They were not from Amoy Gardens.

PPE supply was adequate and was not an issue.

7. Patients clinically diagnosed to be having SARS virus infection were cared in the SARS ward. These patients were technically categorized as "Confirmed" and "Suspected" SARS according to SARS criteria. They were physically segregated in the SARS wards.

8. Department of Health (DH) was notified of C8 outbreak on 27 April 2003. All patient admission, transfer and discharge in C8 were stopped. Outbreak investigations were commenced by TMH and DH immediately. There was a meeting on 28 April 2003 with DH to update the situation and share the findings. Contact tracing was carried out accordingly. Cohorted patients were closely monitored. Staff of that ward were counseled and instructions on home precaution were given.

9. On 27 April 2003, after notification to DH, I then informed Dr. S H LIU of HAHO. I reported to him on the situation and the immediate action plan agreed with DH. Dr. LIU also agreed with our actions. HAHO was updated on the progress regularly afterwards. Besides, HAHO also sent a team to TMH to follow up with us on the progress. They found our plan and liaison with DH adequate.

10. Secretary for Environment, Transport and Works (SETW), accompanied by 2 colleagues, visited TMH on 15 May 2003. The purpose of the visit was to see if she could help in any ways since she was the Secretary responsible for environmental protection and works.

    SETW visited one of our wards and the ICU. She was told about our infection control measures and our use of domestic air purifiers in wards. She considered the idea worked and raised an idea of placing industrial type hepa filter air purifier in wards. Subsequently, HAHO coordinated the purchase of industrial hepa filter air purifiers and local extraction hepa filter machines for all hospitals.

11. As answered in Q6.