CONFIDENTIAL

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Statement of Ng Tak Keung

I am the Consultant Microbiologist of Princess Margaret Hospital (PMH). The followings are my professional and academic qualifications and experience :-

(A) Qualification

(B) Working experience

(C) Membership

On 6 March 2003, the patient was admitted to PMH. I was informed on 6 March 2003 that the patient had been admitted into ICU on 6 March 2003. I note the ICU had reported this case as a severe CAP case to the HAHO. The form was copied for our reference. I was kept informed of the infection control measures taken by ICU and was satisfied with these measures.

The details of the patient's condition included the following :-

- The patient was admitted on 6 March 2003. The onset date was stated to be around 23 February 2003. In mid-January 2003, he travelled to Shanghai and then to Hong Kong. He stayed in Hong Kong for 2 days. On or about 23 February 2003, he travelled to Hanoi, Vietnam and on 6 March 2003, he was sent back to Hong Kong.
- It was not known whether there was any respiratory symptoms among the patient's family members but a number of healthcare workers in Hanoi Hospital were sick after caring for the patient.
- The patient's CXR on admission to Hanoi Hospital was clear on 26/27 February 2003 with bilateral white out from 3 March 2003 onwards.
- His lymphocyte count and total WBC were as follows :-

	26/2	28/2	2/3	3/3	5/3	6/3
Lymphocyte	0.7K	0.4K	0.4K	0.5K	0.4K	0.3K
Total WBC	6.6K	7.4K	12.4K	6.5K	8.5K	10.5K

- The patient was an American Chinese and his general condition was stated to be critical.

As the patient had a travel history to China and Hong Kong before he went to Hanoi, we were particularly interested in finding out the aetiology of the pneumonia. We had made arrangements with QMH and DH virus laboratories to receive the specimens for investigations.

Initial investigations in both QMH and DH had excluded commonly known agents such as RSV, adenovirus, parainfluenza, mycolplasma, Chlamydia, legionella, Flu A and Flu B. Flu A PCR was also negative. We have cultured pseudomonas aeruginosa from his sputum which only represented secondary infection superimposed upon his damaged lung and he had received appropriate antibiotic treatment.

The patient's case was discussed and reviewed in the weekly ICU ward round on 12 March 2003. Infection control team, ICU doctors and myself were present. We discussed the infection control measures, laboratory investigations and use of antibiotics.

The patient died on 13 March 2003. Autopsy was done on the next day on 14 March 2003. I had a thorough discussion with our consultant pathologist Dr. Ng Wai Fu on the infection control precaution we should take and on the type of specimens to take for microbiological investigation. Dr. Lim of DH and Dr. Peiris QMH were also alerted about this case. Surveillance of the staff who had contact with this case was also conducted subsequently and no staff were affected. This information was passed to the Secretariat of Central Committee of Infection Control.

I will set out my reply to the questions raised in the Legco letter to me below :-

(1) Q: When was PMH informed of the transfer of the American Chinese patient from Hanoi to PMH? By whom was the hospital first informed? Why was the patient admitted to PMH and not to another hospital? What procedures were adopted for admitting the patient?

A : CCE Dr. Chiu was informed on 5 March 2003 by HAHO that a patient on ventilator would be transferred via SOS from Hanoi hospital to PMH. PMH has an infectious disease unit equipped with isolation facilities and expertise and can handle infectious diseases in Hong Kong.

The patient was admitted directly to ICU without passing through A&E. He was put in a single isolation room with negative pressure. All attending healthcare workers adopted standard and droplet precaution wearing surgical/N95 mask, eye/face shield and gloves.

(2) Q : What details about the condition of the patient were provided to PMH and by whom were the details provided?

A : CCE was informed first hand of the condition of the patient. COS ICU notified HAHO and Infection Control Team in the morning of 6 March 2003 of admitting a severe community acquired pneumonia by fax. The patient had recent history of travel to China, Hong Kong and Hanoi and was in critical condition. On 8 March 2003, SOS provided further information by phone that 14 healthcare workers who

took care of the patient were sick and hospitalised. Please refer to further details of the patient's condition as mentioned above.

(3) Q : What was the condition of the patient when he was admitted to PMH?

A : He was in critical condition and needed ventilation support in ICU.

(4) Q : What infection control measures were taken in handling the patient? Were such measures taken because of the Hospital Authority (HA)'s advice or guidelines, advice from the hospital in Hanoi in which the patient was treated, or otherwise?

A : The infection control measures taken included :

1. Direct admission to ICU without going through A&E minimizing staff involved.
2. Isolation in single room with exhaust fan creating a negative pressure.
3. All attending HCW adopted standard and droplet precaution wearing surgical/N95 mask, gloves, gown, eye/face shield when in contact with the patient.
4. High efficiency filter were put in the expiratory arm of the ventilator.
5. Close suction system was used in ventilator circuit.
6. Exhausted gas from ventilator was purged by the scavenging system of the ventilator (Evac 180 of Servo ventilator).

The above precautions would be taken by ICU in caring for patients with suspected highly infectious diseases such as pulmonary TB and other novel infectious diseases

such as Avian Flu. It fell in line with HA guidelines for management of SCAP. 24 staff in C2 have taken Tamiflu as advised by SOS doctors.

(5) Q : Was any healthcare worker infected as a result of handling the patient?

A : None was infected.

(6) Q : Was PMH aware of AA [redacted]'s case handled by Kwong Wah Hospital? If yes, when and how was PMH informed? What details about the case were provided to PMH? Did the information affect the infection control measures taken by PMH in handling the patient?

A : I cannot remember if I was aware of AA [redacted]'s case when the patient from Hanoi was admitted to PMH. In any event, I would not have been aware of the details of AA [redacted]'s case at that time.

(7) Q: Was the patient classified as a Severe Community Acquire Pneumonia case and if so, was the head office of HA notified? If yes, when and how was HAHO notified? What details about the condition of the patient and the infection control measures by PMH were provided to HAHO?

A: The patient was classified as a severe community acquired pneumonia case and was reported to HAHO by COS ICU on 6 March 2003 by fax. The patient was reported in critical condition and to have history of travel to China, Hong Kong and Hanoi.

Date : 22 Dec 2003

Dr. NG Tak Keung

T. Keung.