CONFIDENTIAL

WRITTEN STATEMENT OF DR. C.C. LUK

1. On 12 February 2003, Dr. S H Liu sent a memo to all Cluster Chief Executives and Hospital Chief Executives in relation to Surveillance on severe Community Acquired Pneumonia (CAP).

2. Infection control measures were enforced according to the memo. Cases of severe CAP started to be reported by KWH to the Hospital Authority Head Office (HAHO). The first case was reported on 14 February 2003 and the second case was reported on 16 February 2003.

3. On 22 February 2003, [redacted] AA walked in to attend Accident and Emergency Department (AED) of KWH. He was accompanied by several relatives. [redacted] AA said he had shortness of breath (SOB). The nurse checked the level of SaO_2 by oximetry and discovered that it was about 60% which was very low. He was immediately transferred to the Resuscitation room (R room) of the AED. Before [redacted] AA 's AED attendance, KWH had not received any information about [redacted] AA.

4. [redacted] AA was first seen in the R room by a Medical Officer of AED and then the Consultant. The Chest X-ray taken in AED showed bilateral pneumonic changes. As the patient's condition was poor and there might be a need to intubate the patient if his condition worsened, [redacted] AA was admitted to ICU.

5. According to the history given by [redacted] AA, there were many patients with pneumonia in Zhongshan. He had been in contact with patients suspected to have atypical pneumonia. He had flu-like symptoms on 15 February 2003 with pleuritic chest pain. Chest X-ray examination in Zhongshan showed left lower zone haziness. He self-treated with antibiotics (levofloxacin and penicillin) and improved. He claimed that he had fully recovered from that episode of illness before coming to HK. He came to HK on 21 February 2003 to attend a wedding banquet. He had started to feel unwell since 19 February 2003.

6. The standard precaution measures in ICU when managing patients suspected to have airborne diseases (eg tuberculosis) include placing the patient in isolation room, staff wearing N95 mask, glove and gown when caring the patient. In this case, all ICU staff caring for [redacted] AA implemented these measures as if he were suffering from an airborne disease.

7. At 12:12 on 22 February 2003 (Saturday), KWH notified HAHO by fax using the Report Form for severe CAP. Further details were supplemented by fax to HAHO at 18:40 in the same afternoon. Ms But, a nurse from DH, came and investigated the case of [redacted] AA on 24 February 2003.

8. [redacted] was jointly managed by specialist physicians and microbiologists from KWH and QMH since 24 February 2003 until he died on 4 March 2003. He was later confirmed to have contracted SARS.

9. Management of patients jointly by QMH and KWH was not an uncommon practice as KWH has been closely affiliated to QMH/HKU in terms of teaching and provision of medical services.

10. Infection control measures by KWH were effective. Those team members caring [redacted] did not get infected. Around that period of time, there was one infected healthcare worker of KWH who was admitted on 28 February 2003 and discharged on 18 March 2003. She worked in the AED cubicle next to the one where [redacted] stayed and did not have direct contact with [redacted]. She wore mask at the time because she was having flu symptoms herself. She was subsequently confirmed to be a SARS case.

11. [redacted]'s brother-in-law was admitted to the Medicine and Geriatrics ward in KWH on 28 February 2003.

12. HAHO was not informed of the admission of [redacted]'s brother-in-law on 28 February 2003 as he was not a severe CAP case that time.

13. [redacted]'s sister was admitted to the Medicine and Geriatrics ward in KWH on 1 March 2003. The sister was diagnosed to have chest infection and was discharged on 6 March 2003 with antibiotics. [redacted]'s sister was never a case of SARS.

14. On 3 March 2003, KWH notified (a) HAHO of the case of [redacted]'s brother-in-law and (b) the duty microbiologist Dr. Dominic Tsang (the subject officer of severe CAP) of both cases of the brother-in-law and [redacted]'s sister. Ms But, a nurse of DH, came and investigated both cases on the same day.

15. On 3 March 2003, I attended a meeting to discuss the cases of [redacted] and his brother-in-law and sister. A new alert and admission system was decided at the meeting using the following set of criteria:- (a) severe CAP cases requiring ventilation (i.e. intubation) or CAP cases under ICU care; (b) severe CAP cases with history of travel to China, or history of exposure to persons with severe pneumonia who had been in China, or (c) severe CAP cases with exposure to poultry. These patients would be placed into isolation facilities when they were admitted from AED. The system was implemented immediately.

16. [redacted]'s brother-in-law was intubated on 4 March 2003 before an open lung biopsy operation. He was then transferred to ICU after the operation and was intubated all along. He died on 19 March 2003. It was subsequently reported that it was from the specimen of this lung biopsy that HKU subsequently discovered the novel coronavirus as the causative agent of the SARS infection on 22 March 2003.

17. HAHO was all along kept informed of the events in accordance with HAHO's guidelines.

Date : 8 December 2003

Dr. C.C. Luk