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醫院管理局
HOSPITAL AUTHORITY

群策群力為病人·優質醫護齊參與
Quality Patient-Centred Care Through Teamwork

Your Ref : CS2/SC2

4 February 2004

Miss Flora Tai,
Clerk to Select Committee,
Legislative Council,
Legislative Council Building,
78 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

With reference to your letter of 14 January 2004, I enclose my written statement.

Thank you.

Yours sincerely,

Dr KO Wing Man

Encl

WRITTEN STATEMENT OF DR. KO WING MAN

Q1) ***What are your role and duties as Director (Professional Services & Public Affairs) of the Hospital Authority (HA)? What were your specific responsibilities in the handling of the outbreak of the Severe Acute Respiratory Syndrome (SARS)? Who did you report to and who reported to you in respect of those responsibilities at that time?***

A1) As Director (Professional Services & Public Affairs) of HA, my duties cover both professional services, such as pharmacy services, nursing services, emergency services, infectious diseases, and public affairs of HA.

Prior to my appointment as Deputizing Chief Executive (the CE) of HA on 24 March 2003, I was a member of the team, headed by the CE and comprising other directors and Cluster Chief Executives and others, which handled the outbreak of SARS. I took part in the Daily SARS Round Up Meetings. Dr. S.H. Liu, the convenor of the Working Group on Severe CAP (WG) and the Central Committee on Infection Control (CCIC), directly reported to me until the work of the WG and CCIC was subsumed under the Daily SARS Round Up Meetings.

After I was appointed Deputizing CE on 23 March 2003 and until 30 April 2003, I headed the HA team which handled the SARS outbreak. As from 25 March 2003, the Chairman of the HA Board also attended the Daily SARS Round Up Meetings, chaired by me, to provide his input.

Q2) ***Did HA have any unofficial communication channels with the health authorities in the Mainland prior to the outbreak of SARS in Hong Kong? If yes, what were those channels and did HA make use of those channels to find out more about outbreak in Guangdong the Task Force on Infection Control (as it was then called) was aware, in February 2003, of a very infectious disease in Guangdong that had put healthcare workers (HCWs) at risk? If not, why not? If yes, did it receive any information from the Mainland?***

A2) No, HA did not have any official or unofficial communication on outbreak of infectious diseases with the health authorities in the Mainland prior to the outbreak of SARS in Hong Kong.

Q3) Did HA have any strategy and/or contingency plan for dealing with an outbreak of infectious disease prior to the outbreak of SARS? If yes, what were the details of the strategy/contingency plan? If not, why not?

A3) CCIC, formerly called Task Force on Infection Control (TFIC), was established in 1994. CCIC reported to HA directors' meeting chaired by the CE and comprising directors (such as myself) and Cluster Chief Executives. Each cluster also had an Infection Control Officer who reported to CCIC. CCIC was in communication with the Department of Health. In addition, at the hospital level, the infection control team of each hospital also had regular communication with the Department of Health. Through this system, the strategy on infection control, which focused on surveillance, early diagnosis, treatment and hospital infection control measures, was carried out.

Q4) What was the working relationship between the Working Group on Severe Community-Acquired Pneumonia (CAP) and the Task Force on Infection Control during the SARS outbreak? How was the work of the two bodies coordinated? What was your role with respect to the Working Group and the Task Force?

A4) Since its establishment on 11 February 2003, the WG was part of the TFIC and reported to the TFIC. Both the TFIC and the WG were chaired by Dr. S.H. Liu who reported directly to me. Information was shared between the WG and the TFIC through the 6 joint meetings of the WG and the TFIC held between 17 February and 18 March 2003. With effect from 24 March 2003, the functions of the WG and TFIC were subsumed in the Daily SARS Round Up Meetings.

Q5) Was it contemplated that information would be exchanged between the Working Group and the Task Force when the Working Group was set up? If yes, how was the information exchanged? If not, why not?

A5) Yes. Please refer to the answer to question 4 above.

Q6) How were the decisions, guidelines and other information of the Task Force conveyed to individual hospitals during the SARS outbreak? How did you ensure that such information was conveyed effectively to all concerned?

A6) During the SARS outbreak, decisions, guidelines and other information of the TFIC were conveyed to individual hospitals via e-mails, HA intranet, staff forums,

circulars and internal memoranda. Representatives from each cluster were also present at the joint meetings of the TFIC and WG held in February and March 2003, and subsequently in the Daily SARS Round Up Meetings.

Q7) ***Given that so many HCWs were infected with SARS during the outbreak, did you make any assessment on what you and/or the Task Force should have done more or should have done better in the area of infection control during the outbreak? If yes, what was your assessment? If not, why not? Did HA try to find out the reasons why so many HCWs have been infected by SARS during the SARS outbreak? If so, what were the reasons? If not, why not?***

A7) The work of TFIC was subsumed under the Daily SARS Round Up Meeting as from 24 March 2003. Before that date, I would say that, in the circumstances at that time, TFIC had done its best. With hindsight, the possible reasons of infection of HCWs included attending to patients who presented with atypical symptoms; carrying out high-risk procedures such as intubation; high patient volume and viral load; and environmental and facilities constraints.

Q8) ***Did the head office of HA (HAHO) inform other hospitals of the case of*** AA [redacted]***? If yes, when were the other hospitals informed and what details about the case were provided? If not, why not?***

A8) AA [redacted]'s case was reported as one of the SCAP cases to the CCIC and representatives from different hospitals in the CCIC were aware of this case. Moreover, the clinical features of [redacted] AA's case were shared by other SCAP cases.

Q9) ***When and why did HAHO initiate the "Daily SARS Round Up" Meeting (daily meetings) with senior staff of HAHO and Cluster Chief Executives? Did one of the purposes of the meeting include strengthening coordination? If yes, what specific measures were adopted and were they effective?***

A9) The Daily SARS Round Up Meeting was actually an expanded directors' meeting which commenced on 24 March 2003. Prior to that date, HAHO monitored the situation through the regular directors' meetings (chaired by the CE, and attended by all directors and CCEs). To strengthen coordination in dealing with SARS, the meeting was expanded to include also hospital representatives, senior executives of HA and professionals, and the meeting was renamed the Daily SARS Round Up Meeting. I would say that this was effective.

Q10) What decisions were made at the daily meetings and who were involved in implementing those decisions? Was the HA Board kept informed of the deliberations and decisions of the meetings? If yes, how were they kept informed? If not, why not? Were frontline HCWs and other staff of HA kept informed of the deliberations and decisions of the meetings? If yes, how were they kept informed? If not, why not?

A10) Strategic and major operational decisions were made at the Daily SARS Round Up Meeting. Implementation of the decisions was carried out by the relevant persons of each hospital, such as the Infection Control Officer of each hospital. The Chairman of HA started to attend the Daily SARS Round Up Meeting on 25 March 2003 after CE fell sick on 23 March 2003. Members of the Board were informed of the progress at meetings and briefing session. HA staff were informed of the decisions made at the Daily SARS Round Up Meeting via their respective CCEs or other hospital representatives who attended the Meeting, HA intranet, the "Battling SARS Update", staff forums, briefings, etc.

Q11) What was the working relationship between the daily meeting and the Health, Welfare and Food Bureau Task Force headed by the Secretary for Health, Welfare and Food? Who was responsible and what were the measures for ensuring that the decisions made by the Task Force did not duplicate or contradict those of the daily meeting? Had there been differences or disagreement between the two bodies? If yes, how were they resolved?

A11) There was close liaison between the daily meeting and the Task force of the Health, Welfare and Food Bureau (HWFB). As from 13 March 2003, the CE or myself or a representative of HA was present at inter-departmental meetings convened by HWFB or at HWFB Task Force meetings. A representative from the HWFB was present in the Daily SARS Round Up Meeting since 15 April 2003. When matters were discussed, inevitably different views were expressed. However, after discussion, consensus was reached and I do not recall any disagreement between the bodies.

Q12) Did the Chief Executive (CE) of HA continue to be involved in handling the SARS outbreak after he was hospitalized? If yes, what was the reason for his involvement? What decisions did he make while he was in hospital? Had the decision-making process been delayed because of his involvement?

A12) The CE, although hospitalised, still cared very much about the SARS outbreak and, whenever his condition permitted, was willing to provide his input on the handling of the SARS outbreak. The Daily SARS Round Up Meeting of course welcomed the CE's input. The CE did not make any decision while he was hospitalised. Decisions were made upon the consensus of the attendants at the Daily SARS Round Up Meetings. There was no delay in the decision-making process.

Q13) Was there a procedure for appointing a Deputizing CE of HA? If yes, what was the procedure? Was the approval of the HA Board for the appointment required? Was your appointment as Deputizing CE of HA at that time made under the procedure? If not, why not? Were HA staff notified of your appointment, and if so, how? If not, why not?

A13) There was a procedure for appointing a Deputizing CE of HA. In the past, when CE was away from Hong Kong, he would appoint a Deputizing CE and I would usually be appointed. In so doing, he would consult the Chairman for approval. A memo would then be issued to inform all hospitals. As regards my appointment on this occasion, I recall that on the night of 23 March 2003, the Chairman, CE and I were in QMH. The CE was about to be hospitalised in QMH. The Chairman and CE agreed that I should deputize as the CE and I accepted the appointment. Afterwards, on 24 March 2003, the Chairman issued a letter to all the members of HA to inform them of the admission of the CE to QMH and my appointment as the Deputizing CE. A memo was also issued to inform all directors, CCEs, HCEs and unit heads in HAHO.

Q14) Was training on infection control provided for contract workers? If not, why not? If yes, were the content and duration of the training programmes the same as those provided for HA employees? If not, what were the differences and why? Who was responsible for determining the type of training to be provided for the contract workers? How would you assess the risk of SARS to those contract workers who had not undergone proper training on infection control?

A14) Prior to the SARS outbreak, only limited input from HA on infection control for contractors' employees was required. During the SARS outbreak, HA provided training to contractors' employees mainly through infection control training and briefing same as those given to HA employees. I understand that various CCEs have also been asked to provide such information to the Select Committee.

Q15) Did you know whether any contract workers were infected during the SARS outbreak while working in HA hospitals? If yes, how many were affected? How and why were they affected?

A15) I understand that the various CCEs have provided to the Select Committee statistics of employees of contractors who were infected during the SARS outbreak. I would refer the Select Committee to these statistics.

Q16) Did you take part in any discussions at meetings of Prince of Wales Hospital (PWH) staff about the closure and re-opening of Ward 8A of PWH and the closure of PWH? If so, did you offer any advice on such propositions?

A16) I did not participate in any discussions about the closure and re-opening of Ward 8A of PWH. As regards the closure of PWH, meaning the closure of the entire hospital, I understand that it had only been briefly raised at a meeting in PWH on the morning of 12 March 2003 (at which I was not present) but it was not taken further. However, I was present at a meeting at PWH in the evening of 12 March 2003 when the suspension of services of the Accident and Emergency Department of PWH (AED) was raised and discussed. Different views were expressed by those attended the meeting. I did not consider it necessary to suspend the services of the AED of PWH at that stage and, after the discussion, a consensus was reached to divert non-atypical pneumonia medical emergencies to hospitals within NTEC and to suspend medical out-patient clinic services.

Q17) When did PWH begin to divert medical emergencies to hospitals outside the New Territories East Cluster? Who were involved in the discussion and who made the decision? Was there prior consultation with the hospitals concerned? If yes, who were consulted and in which forum were they consulted? What was the result of the consultation? If not, why not?

A17) PWH began to divert medical emergency cases to outside NTEC on 17 March 2003. The decision was made at the directors' meeting on 17 March 2003 at which all CCEs were present.

Q18) Who made the decision to divert non-SARS medical admissions from Alice Ho Miu Ling Nethersole Hospital (AHNH) to other HA hospitals? Who were involved in the discussion and what were the considerations? What precautionary measures were adopted to prevent cross-infection among hospitals? How was it determined whether an admission was a non-SARS case?

A18) The decision to divert non-SARS medical admission from AHNH to other HA hospitals was made at a Daily SARS Round Up Meeting to relieve the patient load of AHNH. The infection control measures then in place would serve to prevent cross-infection among hospitals. The determination of whether an admission was a non-SARS case was a clinical decision based on the then diagnostic criteria.

Q19) Who made the recommendation that all new cases referred by the Department of Health (DH)'s designated medical centres should be received by Princess Margaret Hospital (PMH) as a designated SARS hospital? Why was a designated SARS hospital considered necessary? Was it the Administration's intention to designate only one SARS hospital? In which forum was the recommendation discussed and made? Who were involved in the discussion and what were the considerations? Who made the decision? What were the facilities and manpower required for a SARS hospital, in particular the intensive care unit, capable of handling the anticipated workload arising from the SARS outbreak?

A19) The recommendation was made at the HWFB Task Force meeting on 26 March 2003. The suggestion was made by DH and accepted by HA. PMH, which had an infectious disease centre, was considered the most suitable among all hospitals. A designated SARS hospital would enhance the control of the SARS outbreak. Wong Tai Sin Hospital was designated to receive convalescent SARS patients from PMH subsequently.

Q20) How much time was PMH given to make preparations to serve as a designated SARS hospitals? What were the preparations made? What was the anticipated SARS patient load that would be handled by PMH when the decision was made to designated PMH as a SARS hospital? How did the actual patient load compared to the anticipated patient load? Was there a maximum number of SARS patients that PMH could handle overall? If yes, what was the number? Was there a maximum number of daily intake of SARS patients that PMH could handle? If yes, what was the number?

A20) PMH started to receive all the newly admitted SARS patients on 29 March 2003. It was anticipated that SARS patients would be admitted in phases, with a total culmulative SARS patients load anticipated at around 1,000. Wong Tai Sin Hospital would later receive convalescent patients from PMH. Subsequently, since many ICU staff of PMH had fallen sick, PMH ICU was unable to handle the SARS patient load initially anticipated. Despite the actual patient load not having

exceeded the anticipated patient load, the rate or speed of the patient load was much higher than could have been foreseen.

Q21) On 30 March 2003, HA made the decision that patients suspected to have infected SARS should be admitted to local cluster hospital and only confirmed SARS patients referred by DH should be admitted to PMH. Who in HA made the decision? In which forum was the decision made? Who were involved in the discussion and what were the considerations? How was the decision conveyed to other hospitals in the cluster? Were the hospitals consulted prior to the decision? If not, why not? If yes, what was the result of the consultation? What were the actions/measures taken in other hospitals to receive suspected SARS patients?

A21) As mentioned in the answer to Q.19 above, a decision was made at the HWFB Task Force meeting on 26 March 2003. This decision was re-affirmed at the Daily SARS Round Up Meeting on 30 March 2003, at which all CCEs were present. The CCEs would convey the decision to hospitals in their clusters and the hospitals would take such actions and measures as were necessary.

Q22) Was there a mechanism for deployment of staff from other hospitals in the same cluster to deal with a major infectious disease outbreak? If not, why not,? If yes, what were the details of the mechanism and how did it operate during the SARS outbreak?

A22) Yes. CCE, in consultation with the HCEs, had the power to deploy staff from other hospitals within the same cluster as appropriate. If deployment of staff involved different clusters, it would be coordinated at the Daily SARS Round Up Meetings.

Q23) On 7 April 2003, PMH stopped the admission of SARS patients from all hospitals, except Yan Chai Hospital (YCH) and Caritas Medical Centre. Who made the decision to stop admission? In which forum was the decision made and who were involved in the discussion? Why was the decision not made earlier? Had arrangements been made with other hospitals for admission of new SARS cases prior to the decision? If yes, what were the arrangements? If not, why not?

A23) The decision was made at a Daily SARS Round Up Meeting. The decision was made because a significant number of healthcare works had fallen ill in particular ICU clinical staff including the COS. Arrangements had been made with other hospitals to stop referring new probable SARS cases to PMH.

Q24) *On 12 April 2003, Tuen Mun Hospital (TMH) began receiving referrals from DH's designated medical centres and SARS patients from YCH. Who made the decision? In which forum was the decision made and who were involved in the discussion? Had the capability and preparedness of TMH to receive these SARS patients been assessed before the decision was made? If yes, what was the assessment? If not, why not?*

A24) TMH started to receive SARS cases from DMC and YCH on 12 April 2003. The decision was made at the Daily SARS Round Up Meeting on 11 April 2003 in view of the surge in patient load of PMH and YCH at that time. Proximity of TMH was a relevant factor in the consideration. Each HA hospital's capacity was also taken into consideration.

4 February 2004