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醫院管理局
HOSPITAL AUTHORITY

何兆煒醫生 行政總裁
Dr William HO, JP
Chief Executive

By fax & mail

24 February 2004

Our ref : HA 441/18/5
Yr ref : CB2/SC2

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 enclose my written statement to the questions set out in Appendix IV of your letter of 13 February, to the Select Committee as requested.

Details of my professional qualifications and experience are enclosed.

Yours sincerely,

(Dr William HO)
Chief Executive

Encl

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WRITTEN STATEMENT OF DR. HO SHIU-WEI, WILLIAM

Q1) What are your role and duties as the Chief Executive of the Hospital Authority (HA)? Do you report to the Chairman of HA or to the HA Board? In the handling of the outbreak of Severe Acute Respiratory Syndrome (SARS), what were your specific responsibilities vis-a-vis those of your Directors in the head office of HA (HAHO), the Cluster Chief Executives and Hospital Chief Executives? On what matters did they have full authority to take decisions/actions and on what matters did they require your approval before actions could be taken?

A1) As the Chief Executive (CE) of Hospital Authority (HA), I am responsible and accountable to the HA for the overall management and delivery of public hospital services. My work includes setting objectives, policies and plans of the Authority's work, monitoring implementation and hospital operations, as well as internal and external communication. I report to the HA Board and its Chairman.

The Directors and Cluster Chief Executives (CCEs) assist me whilst at the same time, they are responsible and accountable for their respective areas of work.

Until my hospitalization on 23 March 2003, I led the team of Directors, CCEs, and Hospital Chief Executives (HCEs) in the battle against SARS. Given the many complex and changing circumstances during the epidemic, the team worked cohesively exchanging views and sharing information on a very frequent basis. Decisions that had Authority-wide or cross-cluster implications were made on consensus or endorsed by me.

Q2) In the handling of the SARS outbreak, on what matters did you have full authority to take decisions/actions and on what matters did you need to report to and/or seek the approval of the HA Board and/or Chairman of HA? What was the procedure for seeking the approval of the HA Board and/or Chairman of HA? Was the calling of a board meeting required or could approval be sought by circulation of papers? During the SARS outbreak, what decisions/actions were taken by the HA Board and/or Chairman of HA in relation to the handling of the SARS outbreak?

A2) In the handling of the SARS outbreak, the HA team led by me made such decisions and took such actions as were necessary to battle SARS. We kept the Chairman informed of the development and sought his advice. As from the commencement of the SARS Daily Round Up Meetings, the Chairman was often present to provide his advice. The Board was kept

informed through the Chairman and there were also meetings at which the Board was reported to on the situation.

Q3) ***When did you learn that World Health Organization (WHO) had informed the Department of Health (DH) that an American businessman was to be transferred from Hanoi to Princess Margaret Hospital (PMH) in Hong Kong for treatment, and that seven healthcare workers (HCWs) who nursed the businessman had been infected? What was your reaction to the information that the HCWs who nursed the businessman had been infected? Did you take any follow-up action? If not, why not? If yes, what follow-up action did you take?***

A3) I learnt about the Hanoi case probably within a few days before I sent my letter to all HA staff on 13 March 2003, alerting them to this unknown disease that could potentially affect healthcare workers. Before that, our Working Group on Severe Community Acquired Pneumonia had already updated a set of Frequently Asked Questions in our information to the frontline, highlighting the potential infectivity to healthcare workers. No staff in PMH caring for this patient had been infected.

Q4) ***When and how did you first learn about the outbreak of atypical pneumonia (AP) in Guangdong? Did you approach DH to find out more about the outbreak? If not, why not? If yes, who in DH did you contact and what information did you obtain? Did HA have any unofficial communication channels with the health authorities in the Mainland prior to the SARS outbreak in Hong Kong? If yes, what were those channels and did you or anyone in HA make use of those channels to find out more about the AP outbreak in Guangdong? If not, why not? If yes, what information HA obtain?***

A4) In February 2003, the media reported that there was an outbreak of AP in Guangdong. As in other instances of public health issues outside Hong Kong, DH would gather information. In line with past practice, DH would inform HA of any useful information obtained. HA had no official or unofficial communication channels with the health authorities in the Mainland prior to the SARS outbreak in Hong Kong.

Q5) ***Did HA have any strategy and/or contingency plan for dealing with an outbreak of infectious disease in the community and/or in a HA hospital prior to the outbreak of SARS? If not, why not? If yes, what were the details of the strategy and/or plan and what were the respective roles of the HA Board, Chairman of HA, HAHO, Cluster Chief Executives, Hospital Chief Executives, Director of Health (D of H) and/or Secretary for Health, Welfare and Food (SHWF), if any, in the strategy and/or contingency plan? When was the strategy and/or contingency plan last updated and last put to use?***

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A5) HA had a strategy on infection control. The strategy focused on surveillance, early detection, treatment and infection control in hospitals. Through the Central Committee on Infection Control (CCIC) (previously known as Task Force on Infection Control set up in 1994), matters relating to infection control were reported to me as the CE, HA's directors, and Cluster Chief Executives at the regular HA Directors' Meeting. There was also an Infection Control Officer in each cluster who reported to the CCIC. CCIC and the infection control team of each hospital also had communication with DH regularly. As appropriate, the CCIC would set up special working groups to gather professional expertise to deal with specific outbreaks (like the Working Group on Severe Community Acquired Pneumonia). When the outbreak would demand cross-cluster or territory-wide response, decisions would be made in the Directors' Meeting. Relevant major decisions were reported to the HA Chairman, HA Board and the SHWF.

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Q6) When and how did you first learn about the case of [redacted] handled by Kwong Wah Hospital? What was your reaction on learning about the case? When did HA inform DH of the case? Who in DH was informed and by whom? Did you consider it necessary for HAHO to alert other HA hospitals to the case? If not, why not? If yes, how were other HA hospitals alerted and what details about the case were provided?

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A6) I first learnt about the case of [redacted] handled by Kwong Wah Hospital around early March. I understand this case was reported to the Secretariat of TFIC as one of the Severe CAP cases and DH was notified accordingly. I do not know who in DH was informed. At that time, AA [redacted]'s case was just one of the reported SCAP cases, and his clinical features were not very different from other reported SCAP cases. The representatives from various hospitals in the CCIC were aware of this case as being one of the reported SCAP cases.

Q7) When and how did you first learn that a large number of HCWs in Prince of Wales Hospital (PWH) had gone on sick leave at the same time on 11 March 2003? Did HAHO inform DH and/or Health, Welfare and Food Bureau (HWFB) of the situation? If not, why not? If yes, who in DH and/or HWFB did HAHO inform and when? By whom were DH and/or HWFB informed? What was the reaction of DH and/or HWFB to the situation in PWH?

A7) I first learnt that HCWs in PWH had gone on sick leave on 11 March 2003. PWH informed DH of this situation, but I did not know who in DH was informed, nor was I aware of DH's reaction. HWFB was not informed by HAHO, but by DH.

Q8) Did you meet with the management of PWH immediately to discuss the outbreak at PWH? If not, why not? If yes, when did you meet with the management of PWH and with whom did you meet? Did you make an assessment of whether the service arrangements of PWH were adequate to handle the outbreak? If not, why not? If yes, what was your assessment? Did you inform the HA Board, Chairman of HA, DH and HWFB of your assessment? If not, why not? If yes, what was the reaction of the HA Board, Chairman of HA, DH and/or HWFB?

A8) I met the management of PWH on 11 March 2003 and knew about the outbreak and the measures taken by PWH to deal with the situation. I had a meeting with the Secretary for Health, Welfare & Food (SHWF) on 13 March 2003 at which the situation of PWH was reported to him. I had also reported the PWH situation to the Chairman of HA with whom I visited PWH in the evening of 13 March 2003.

Q9) At the meeting of the Panel on Health Services on 14 March 2003, you told the Panel that you did not see the need to temporarily close PWH? What did you mean by "to temporarily close" PWH? What was the basis for your making such a statement? Did anyone in HA ever raise with you the need to "close" PWH? If yes, when was the matter raised and by whom? Did you know at that time who had the authority to "close" a hospital? Did you discuss the matter with the HA Board, Chairman of HA, the management of PWH, DH and/or HWFB prior to making the statement to the Panel? If not, why not? If yes, with whom did you discuss the matter and what was the response?

A9) At the meeting of the Panel on Health Services on 14 March 2003, I was asked by the Hon. Chan Kwok Keung to consider whether PWH should be closed temporarily. I answered that I did not see the need to close PWH at that stage as there had been no upsurge in the number of patients admitted to PWH in the past few days and there was no further infection amongst healthcare workers after the stepping up of infection control measures in PWH. I also informed the Panel that in order to cope with the shortfall of manpower at PWH, various measures such as referring/transferring some PWH patients to other hospitals in the New Territories East Cluster for treatment; deploying staff from other hospitals in the cluster and from a central pool of nurses managed by HA Head Office to work at PWH; and curtailing out-patient services, had been implemented.

Q10) When was the outbreak coordination centre set up in HAHO? Why was it necessary to set up the centre and what were its functions? When and why was it renamed the SARS Coordination Centre? Was there any change to its original functions? How did it operate and who was in charge of the centre? What was its working relationship with DH and HWFB?

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A10) The coordination centre began operation on 14 March 2003. It compiled data on atypical pneumonia and provided data to DH. Dr. S.H. Liu was in charge of this centre. It was called SARS Coordination Centre on 24 March 2003 when it moved to a new location.

Q11) What was the Centre's working relationship with the Hospital Clusters, the Working Group on Severe Community-Acquired Pneumonia, the Task Force on Infection Control, the "Daily SARS Round Up" Meeting and other centres/committees set up within HA for handling the SARS outbreak? Why were there so many such groups and committees within HA during the SARS outbreak? Did any of your senior staff ever raise with you that they had to attend too many meetings of these groups and committees? If yes, who raised the matter and what was your reaction?

A11) The Coordination Centre compiled data on atypical pneumonia collected from hospital clusters and provided data to DH. The other committees, such as Working Group on Severe Community Acquired Pneumonia, the CCIC, the Daily SARS Round Up Meeting, were set up to deal with a new infectious disease of the magnitude of SARS. To do so, division of labour was required and different bodies were needed to carry out different functions and specific responsibilities. None of my senior staff had ever raised with me that they had to attend too many meetings of various groups or committees.

Q12) On 16 March 2003, it was decided that all medical emergencies of PWH should be diverted to hospitals outside the New Territories East Cluster. In which forum was the decision made and who made the decision? Who were involved in the discussion and what were the considerations? Had the consequences of such a course of action, such as the staff implications on other hospitals and the adequacy of their facilities to cope with the additional workload, been assessed prior to making the decision? If not, why not? If yes, what was the assessment? Was there prior consultation with the hospitals concerned? If not, why not? If yes, what was the outcome of the consultation? Did HAHO provide any support to these hospitals to cope with the additional workload?

A12) The decision to divert all medical emergency cases of PWH to hospitals outside the New Territories East Cluster was reached at a meeting between the PWH management and myself in the evening of 16 March 2003. This decision was conveyed to other CCEs in the morning of 17 March 2003 and well accepted. With the cluster management in place, such patient diversion mechanism provided for the sharing of workload among hospitals to respond to sudden surge of demand in any part of the organization. The patient diversion mechanism was in place even before SARS.

Q13) Was there a mechanism or contingency plan whereby staff of other hospitals within or outside the Cluster would be deployed to a particular hospital which experienced a sudden shortage of staff? If not, why not? If yes, what were the details of such a mechanism or contingency plan? Was it put to use during the SARS outbreak? If not, why not? If yes, when was it put to use? Were the other hospitals cooperative in this regard?

A13) HA had a mechanism in relation to staff deployment. CCEs had the power to deploy staff from hospitals within the same cluster. Cross-cluster deployment was coordinated by HA Head Office. During the SARS outbreak, all HA hospitals were cooperative in this regard.

Q14) When and how did you first find out that the HCWs in the Accident and Emergency Department (AED) of PWH were infected? What was your reaction on learning about the information and did you take any follow-up action? If not, why not? If yes, what action did you take? Did you know whether the infection control measures in the AED had been stepped up following the outbreak in Ward 8A of PWH? When did PWH decide to close its AED on 19 March 2003? In which forum was the decision made and who made the decision? What were the considerations? Was your and/or HAHO's approval required for the closure of the AED of a hospital? Why was the decision taken at that point in time?

A14) I first learnt that HCWs in the AED of PWH were infected on around 13 or 14 March 2003. Follow-up actions were taken by PWH. Infection control measures in PWH had been stepped up following the outbreak in Ward 8A of PWH. Temporary suspension of the services of AED of PWH was decided at the Cluster SARS Meeting at PWH on 18 March 2003 in my presence. Considerations behind the decision included manpower, work load and staff sentiments.

Q15) Did the Dean and/or other staff of the Faculty of Medicine of the Chinese University of Hong Kong directly raise with you their concern about the spread of the disease to the community? If yes, when, by whom and in which forum was the concern raised? What was your reaction and did you take any follow-up action?

A15) Concern about the spread of the disease to the community was raised with me at a meeting at PWH on the night of 20 March 2003. Professor Sydney Chung and Professor Joseph Sung, amongst others, were present at the meeting. The concern was raised because two private medical practitioners had been admitted to PWH earlier the same day. Right after the meeting, I called Dr. P.Y. Leung of DH and requested him to heighten contact tracing of patients related to PWH, and preferably if he could come to PWH the next day. I also requested to meet with SHWF on 21 March 2003.

Q16) On 21 March 2003, the Chairman of HA and senior executives of HA approached SHWF to discuss the need to inform the wider community of the seriousness of the situation. Were you present at the meeting with SHWF? If not, why not? If yes, why did you and the Chairman of HA consider it necessary to discuss the matter with SHWF? Did D of H attend the meeting? If not, did you know the reason for her absence? What other government officials were also present at the meeting? Did any Board member(s) also attend the meeting with SHWF? What were the details of the discussion? Was any follow-up action taken after the meeting? If not, why not? If yes, what was the follow-up action? What role did the HA Board play in the matter? Was the HA Board informed of the meeting with SHWF? If not, why was the HA Board not informed? If yes, how was the HA Board informed?

A16) I met SHWF together with Dr. Ko Wing Man and Dr. Fung Hong on 21 March 2003. We conveyed to SHWF the concern expressed by CUHK of a possible spread of the disease in the community, a concern that we shared. SHWF took it seriously and informed us that the necessary action would be taken, including heightening contact tracing by DH.

Q17) How would you assess the Government's reaction to the SARS outbreak during your meeting with SHWF? Was there a sense of great urgency and priority on Government's part to control the outbreak? Did SHWF see the need to inform the community of the seriousness of the situation?

A17) See answer to Q16 above.

Q18) Why was it necessary to designate a SARS hospital? Why was PMH chosen and who made the decision? What was meant by a designated SARS hospital? Did it mean that it would accept all new SARS cases referred by the designated medical centres of DH, or did it mean that it would accept all SARS cases referred by DH plus all new SARS cases admitted through the AEDs of other hospitals? What was the difference in terms of cases between the former and latter scenario? In which forum was the decision made and who were involved in the discussion? Who made the decision and what were the considerations? What were the facilities and manpower required for a SARS hospital, and in what ways did PMH meet the requirements?

A18) I was hospitalised in Queen Mary Hospital at the time when PMH was designated as the SARS hospital. I understand Dr. Ko Wing Man, the then Deputizing CE, has answered similar questions raised by the Select Committee, and would like to refer the Select Committee to his answers.

Q19) How much time was PMH given to make the necessary preparations to serve as a SARS hospital? What were the preparations made? Did HAHO assist in the preparations? If not, why not? If yes, what assistance did HAHO provide? Did you consider the time given adequate? If not, did you consider PMH ready to serve as a SARS hospital on 29 March 2003? If not, did you raise the matter with the HA Board, Chairman of HA and/or the Government? If not, why not? If yes, what was the reaction of the HA Board, Chairman of HA and/or the Government? Did anyone in PMH ever raise with you that the hospital was not ready to serve as a designated SARS hospital on 29 March 2003? If yes, who raised it with you and what was your reaction?

A19) I repeat my answer to Q18 above.

Q20) Was there an anticipated SARS patient load that PMH would handle overall, and on a daily intake basis when the decision was made to designate PMH as a SARS hospital? If not, why not? If yes, what were the respective numbers? How did the actual SARS patient load compare with the anticipated SARS patient load?

A20) I repeat my answer to Q18 above.

Q21) Did HAHO ever consider the option of PMH not commencing to serve as a SARS hospital on 29 March 2003? If not, why not? If yes, why was it still decided that PMH should commence to serve as a SARS hospital on that date? Was it the intention to have only one designated SARS hospital? If yes, why was one designated SARS hospital considered adequate? If not, what other hospitals were considered suitable to serve as a SARS hospital and why were they not designated? During the SARS outbreak, did HA ever estimate the total number of SARS cases that its hospitals would need and be capable to handle? If not, why not? If yes, did HA correspondingly draw up a plan as to how many SARS patients would need to be handled by individual Clusters and hospitals? If not, why not? If yes, what were the details of the plan?

A21) I repeat my answer to Q18 above.

Q22) You were admitted to hospital on 23 March 2003? Did you continue to be involved in the handling of the SARS outbreak while you were hospitalized? If yes, what was the reason for your involvement? What decisions did you make while you were in hospital? Had the decision-making process been delayed because of your involvement?

A22) After my admission to Queen Mary Hospital on 23 March 2003, as and when my health permitted, I was updated on the situation, and I also participated in discussions and provided my input. Decisions were made under the leadership of the then Deputizing CE. My involvement did not delay the decision-making process.

Q23) Was there a procedure for appointing a Deputizing Chief Executive of HA? If yes, what was the procedure? Was the approval of the HA Board for the appointment required? Was the appointment of Dr. KO Wing-man as the Deputizing Chief Executive of HA while you were on sick leave made under the procedure? If not, why not? Did you know whether, and if yes, how HA staff were informed of Dr. KO's appointment?

A23) There was a practice regarding the appointment of a Deputizing CE of HA. Whenever I was out of Hong Kong or unable to carry out my duties as CE, I would appoint a Deputizing CE and seek the approval of the Chairman of HA. The hospitals would be notified of the appointment accordingly. Dr. Ko Wing Man was appointed as the Deputizing CE of HA on the night of 23 March 2003 in the presence of myself and the Chairman. A letter was issued by the Chairman on 24 March 2003 to all members of HA to inform them of my admission to QMH as well as the appointment of Dr. Ko as the Deputizing CE. A memo was also issued to inform all the directors, CCEs, HCEs, and unit heads of HAHO.

Q24) What training on infection control was provided to contract workers during the SARS outbreak? Were the content and duration of the training programmes the same as those provided for HA employees? If not, what were the differences? Who in HA was responsible for determining the type of infection control training to be provided to contract workers? Did the HA management assess the risk of SARS to those workers who had not undergone proper infection control training? If not, why not? If yes, what was the assessment?

A24) During the outbreak of SARS, HA provided infection control training and briefings to these contractors' employees which were the same as those provided to HA's employees.

Q25) Did you or HAHO make an assessment of why so many HCWs in HA hospitals were infected during the SAS outbreak? If not, why not? If yes, what was the assessment? Did you or HAHO review what could have been done to prevent HCWs and non-SARS patients in as well as visitors to HA hospitals from contracting SARS during the outbreak? If not, why not? If yes, what more could have been done?

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A25) Even up to now, not everything about the virus and its transmission modes are known. However, with the benefit of hindsight, a multitude of factors could have contributed to infection of HCWs. These included high patient volume, viral load, cryptic presentation of some of the SARS patients, high-risk procedures such as intubation, or environmental and facilities factors. It is difficult to now say what could have been done to prevent HCWs and others in HA hospitals from contracting SARS then. We had already done what we could have done under the circumstances, given the limitation in knowledge about the disease and its transmission, and the fact that we still needed to treat the huge number of other patients who needed our care, despite resource constraints.

Hospital Authority
24 February 2004