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To : Miss Flora TAI
Clerk to Select Committee of the Legislative Council
(Your Ref : CB2/SC2)
(Fax : 2248 2011)

Response to questions raised by the select committee

According to the information of AHNH, they followed the infection control guidelines in their daily practices. They are following the universal precautions and droplet infection precautions. There is provision of an infection control guideline to each unit.

In AHNH, an infection control team is responsible for conducting regular infection control training to all staff. The team carries out audits and monitors the compliance of staff on the infection control policies and guidelines.

Q1. I was not involved in the decision to divert emergency medical patients (except Atypical pneumonia / Severe Acute Respiratory Syndrome cases) to AHNH, and therefore I do not know the details discussed at the relevant meetings. I believe the relevant issues would be considered at the meetings including the diversion arrangements and the measures to prepare AHNH for receiving these patients.

Q2. I did not know the detailed information of the outbreak. I was not involved in the operational management in AHNH and did not have any knowledge of outbreak at that time. According to the information given by AHNH, there were outbreaks in wards E1, E3, F5, E6 and F6.

Q3. The index patient of Ward E1 of AHNH was admitted on 21 March 2003. The patient was asked to wear a mask upon admission but he was not co-operative and he was encouraged to put it back. Hospital staff would advise patients with respiratory symptoms to put on surgical mask but the measure was not compulsory. The health care workers would continue to encourage and educate any un-cooperative patients to wear the masks but it was not possible to compel patients to do so.

Q4. According to the information from AHNH, the health care workers followed the infection control measures as instructed in the infection control guidelines. For example, wearing masks, personal protective equipment, gloves and washing hands after each procedure. I did not know why the health care workers(s) who attended the index patient in Ward E1 were infected.

Q5. The index patient in Ward E1 was transferred to PMH on 24 March 2003. According to the information from AHNH, the patient was strongly advised to and did eventually wear a mask during the transfer. The patient was transferred by an ambulance. The ambulance man would take the appropriate precaution to prevent infection. The ambulance man would be informed that this was a suspected case of 'SARS'.

Yours sincerely

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