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5 February 2004

Miss Flora Tai
Clerk to Select Committee

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 forward a complete set of my written statement and enclosure 9 which supersede the partial statement sent to you on 3 February. As you may observe, I have made a couple of textual amendments. The annexes and other enclosures referred to in the written statement have already been sent to you under cover of my letter of 3 February.

Please note that I have re-arranged the sequence of questions 3 and 4 to facilitate the readers to gain a better understanding of the events.

Yours sincerely,

(Dr. T.K. AU)
Community Physician (NTE)
Department of Health

TKA/cc
[L264]

WRITTEN STATEMENT OF DR AU Tak-kwong

To assist me in recollecting events and presenting information to the Select Committee, I have consulted colleagues in the Department of Health (DH) and perused relevant files and records. However, I remain responsible for the accuracy of this written statement which has been prepared to the best of my knowledge.

2. In response to some of the evidence given in earlier hearings, I would wish to make some general points before answering the specific questions raised by the Select Committee.

Media Reports on 11 March 2003

3. I learnt about an abnormal pattern of sick leave among Prince of Wales Hospital (PWH) Ward 8A staff through media reports on 11 March 2003. On my own initiative, I immediately rang Dr Philip Li, Deputy Hospital Chief Executive and finally managed to speak to him at around 10:45 hours. He confirmed the media reports and informed me that there would be a special meeting at 11:00 hours at PWH. I volunteered to attend the meeting (see para 11).

Notification

4. DH was not notified on 10 March. The Hospital Authority (HA) notified DH by email [Annex 1] of the outbreak on 11 March at 10:05 hours. I note that in his evidence, Dr Donald Lyon of PWH said that he could not confirm having raised the matter with the New Territories East Regional Office (NTERO) of DH on 10 March.

The role of NTERO in the PWH Outbreak

5. During the SARS outbreak in 2003, the division of responsibility was that DH was responsible for epidemiological studies and the prevention of the spread of the disease in the community. The Hospital Infection Control Teams, comprising Consultant Microbiologists, medical doctors and nurses, would be responsible for infection control measures within hospitals. In the case of PWH, there was also professorial staff.

6. Given the then division of work, attendance of DH officers at PWH meetings was mainly for the purposes of understanding the outbreak situation in PWH and discussions on the epidemiological study, contact tracing and related matters. We did not generally participate in discussions on management/operational matters of the hospital nor were we invited to attend those meetings on management/operational matters.

7. In this connection, I note that with the benefit of hindsight, the SARS Expert Committee in para 8.11 of its report included a recommendation "*Infection control and epidemiological experts should be based in every major hospital, working as employees of DH seconded to HA. These individuals will have responsibility for hospital infection control, data collection and reporting, and regular liaison between colleagues in HA and DH.*". This recommendation represents a change in division of responsibility and requires injection of resources as far as DH is concerned.

Meetings at PWH

8. As I said in para 3 above, at my own initiative, I attended the first meeting at PWH on 11 March chaired by Prof Sung of the Department of Medicine and Therapeutics, Chinese University of Hong Kong (CUHK). Starting from 12 March, PWH management took over the chairmanship of the meetings. There were more than one meetings daily. DH normally attended one of the meetings and only in respect of matters of interest to DH as explained in para 6 above. My understanding at the time was no notes of meetings were kept.

9. I wish to clarify the following points -

(a) Upon my enquiry on receipt of the summons from the Select Committee, Dr Fung Hong provided me on 15 and 26 January 2004 with the notes of meetings held on 13-21 March 2003. I understand from Dr Fung that the notes were not distributed to attendees, but abstracts from the notes were put on the HA intranet. However, HA colleagues did not realize at the time that I did not have access to the HA intranet. As such, I did not have the opportunity to verify the accuracy of the notes.

(b) I observe that the notes were basically status update and action checklists. There was no record of any advice which I or my colleagues had tendered. Indeed, for some meetings attended by NTERO representatives, there were no notes.

(c) As regards the attendance lists, I note that the names of NTERO staff appeared as being in attendance at some meetings which we did not attend. On the other hand, the names of NTERO staff were not included for some other meetings which we attended.

(d) The names of participants were included without specifying the period of their attendances. As explained in para 6 above, DH participants sometimes attended sessions of a meeting only.

10. For a better understanding of the actions taken by me and NTERO at the initial stage of the PWH outbreak, I think it would assist the Select Committee if I set out my account of the activities on the first two days, i.e. 11 and 12 March.

11 March 2003

11. The meeting chaired by Prof Sung had already commenced when I arrived at PWH at around 11:30 hours. I recalled that Prof Sung and some other members left at about 12:30 hours. I stayed behind to discuss further technical details with the following participants -

Dr Donald Lyon, Consultant of Microbiology and Infection Control; Prof John Tam, Prof of Microbiology and Virology; Prof Paul Chan, Associate Prof of Virology; Dr Kitty Fung, Senior Medical Officer of Microbiology and Infection Control; Dr Nelson Lee and Dr Alan Wu, Medical Officers of Infectious Disease Medicine; and Ms Deborah Ho and Ms Regina Chan, Infection Control Nurses.

12. I could recall the above names because we circulated a piece of paper for the individuals to put down their telephone nos. for easy contact. The gist of the discussions that day is covered in paras 13-16 below.

13. Upon my arrival at the meeting, Prof Sung summed up for me the position in PWH. He advised that more than 10 staff had reported sick. The cluster apparently only involved staff of Ward 8A and no abnormal pattern had been observed in patients. The decision to close Ward 8A to admission, discharge and visitors had been implemented on 10 March.

14. Prof Sung further advised that from their own experience earlier on 10 March, PWH felt that if family members were denied visits, they might insist on / persuade their relative patients to discharge themselves against medical advice. Thus, the no-visiting policy was relaxed in the evening of 10 March. Visitors were restricted in numbers, given health advice and required to put on protective gears before visits. As the relaxation was made on practical grounds and there were adequate precautionary measures, I did not raise any objections.

15. I advised PWH to isolate cases, screen other wards and monitor the sick leave pattern of staff. I also undertook to conduct an epidemiological survey for the staff who had reported sick and to design a questionnaire for that purpose. The survey was essential to help understand the cluster, to work out the case definition and to estimate the incubation period. The case definition and incubation period would then form the basis for establishing a case reporting system and the period for medical surveillance of contacts.

16. As a follow up to my above advice, PWH decided to set up a special staff clinic in the evening and recall staff for screening. PWH also agreed to complete the questionnaire which I had undertaken to provide for those turning up at the special staff clinic and return them to NTERO for case / contact follow up and epidemiological analysis. A copy of the questionnaire was sent to PWH later in the day after the meeting.

17. NTERO received from PWH at about 16:37 hours by fax a list of 36 persons, comprising both staff and medical students [encl 1 under confidential cover]. NTERO successfully interviewed 26 persons (including two additional ones traced as a result of our contact tracing). Most were found to have symptoms of fever and chills. NTERO

advised all of them to seek immediate medical treatment at the PWH special staff clinic. Advice on personal hygiene was also given. The remaining ones were followed up on the following day. The survey data were analysed for clinical and epidemiological features until about 23:30 hours.

12 March 2003

18. I came in at my office at NTERO at about 8:15 hours and rang Prof Sung to inquire about the position with regard to the staff screening exercise in the previous evening. I also reviewed the preliminary epidemiological findings and make preparations for the meeting to be held at PWH that morning.

19. I arrived at PWH at around 10:00 hours. The meeting chaired by Dr Philip Li had already commenced and it lasted until about 13:00 hours. Participants included, among others, Prof Sydney Chung, Prof Joseph Sung, Dr SF Lui, Dr Donald Lyon, Prof John Tam, Prof Paul Chan, Dr Kitty Fung, Dr Nelson Lee, Dr Alan Wu, Ms Deborah Ho and Ms Regina Chan. I further recall that Dr Fung Hong joined the discussion in the middle of the meeting. This was the usual makeup of participants from PWH / CUHK although sometimes certain participants did not turn up while others joined in.

20. At the meeting, PWH advised that more than 20 staff had been admitted and isolated. The 8th floor of the main building of PWH had been made a restricted area. There was no abnormal sick leave pattern for staff in wards other than 8A. There was a long discussion on possible arrangements to suspend some of the services in the specialist out-patient clinics and to stop new admissions from the accident & emergency department to medical wards because a number of healthcare workers (HCWs) had fallen sick.

21. I presented the preliminary epidemiological findings and the epidemic curve was tabled. The probable mode of spread was discussed and droplets and fomites were incriminated. The incubation period was estimated from one to seven days. The survey findings on clinical features were shared and PWH and NTERO agreed on a working case

definition for active case finding and surveillance. I requested PWH to provide a list of cases satisfying the case definition for NTERO's follow up and contact tracing. As positive Chest X-ray (CXR) findings were observed in some cases, I advised PWH to include CXR as one of the screening tools. I also advised PWH and CUHK to freeze movement of staff and medical students who had been exposed in Ward 8A.

22. Before leaving PWH for NTERO at about 13:30 hours, Dr Kitty Fung of PWH gave me a pile of completed questionnaires for PWH staff / medical students who had visited the special staff clinic in the previous evening together with two covering lists [encls 2-3 under confidential cover].

23. At about ~~14:25~~ 14:14 hours, NTERO received from PWH a third list [encl 4 under confidential cover] with a heading of "patient listing". This third list consisted of two pages of a total of three. Upon clarification with PWH, we were advised that all the 34 names on the first page and the first five names on page 2 were staff / medical students who required follow-up action by NTERO. The remaining names on page 2 (which were patient data of Ward 8A) and page 3 (which was not provided by PWH) were not matters of concern to NTERO.

24. As can be observed from encls 2-5, the data provided to NTERO was not organized and rather unclear. I would cover this aspect in my answers to the specific questions raised by the Select Committee. [Note: encl 5 is the list for 13 March].

25. While I was attending the meeting at PWH in the morning, my colleagues in NTERO set up a Special Control Team in NTERO to assist with the handling of the PWH outbreak, including case follow-up, contact tracing, surveillance, and epidemiological analysis.

Amoy Gardens' Index Case

26. Questions on the index case of the Amoy Gardens Outbreak (YY) were raised in some previous hearings. In my response, I would first explain the data flow from PWH to NTERO, starting with the establishment on 13 March of the PWH Disease Control Centre (DCC).

27. I understand from my colleagues that the information flow was as follows. First, PWH clinicians faxed to the DCC names of patients who satisfied the case definition. DCC clerical staff would then input the details of all these patients into their database. In parallel, the PWH doctor(s) in DCC would discuss with PWH clinicians and refer urgent / serious cases to the DH Team at DCC for immediate investigation. The daily list provided to NTERO through the DH Team at DCC would thus contain names of some patients reported by clinicians as satisfying the case definition but who had not been referred to the DH Team at DCC earlier in the day for urgent action. Until 19 March, these daily lists in hard copy form were in a cumulative manner with new and old cases mixed together without any particular order or indication of new cases.

28. On receipt of the daily list, NTERO would compare it with the previous lists to identify new cases of the day. NTERO would then check for cases which had not already been investigated by the DH Team at DCC for follow up action. Such cases were normally investigated by the nursing team in NTERO by phone. If there was no phone number on the list, the nurses would seek the assistance of staff in the ward. If phone no. could not be obtained or if the case could not be reached by phone, it would be referred to the DH Team at DCC for direct face to face interview. NTERO did not ask the DH Team at DCC to follow up these cases in the first instance to allow it to focus on urgent / serious cases.

29. YY was admitted to PWH Ward 8A on 15 March when he attended for his scheduled haemodialysis and was found to have symptoms. His name first appeared in the list faxed to NTERO at about 18:00 hours on 16 March. There was no record of him having been interviewed by DH before his readmission on 22 March. Based on the normal work procedures described in paras 27-28 above, the likely scenario is described in para 30 below.

30. YY was not referred to the DH Team at DCC for immediate follow up on 16 March. As his name appeared on the list of that day, the NTERO nursing team initiated follow up action on 17 March. Given the list did not contain the phone no. of YY, the nursing team sought the assistance of PWH ward staff. With the phone no. not available by the evening of 17 March, the case was referred to the DH Team at DCC for

direct face to face interview on 18 March. By then, YY had already been tested positive for influenza A. Hence, no follow up action was taken.

31. NTERO was not notified that YY was discharged home on 19 March and that follow-up was required of DH. I note from the list of 20 March at encl 6 which was received by NTERO for follow up action, with print time marked 15:27 hours, that the name of YY was not there. NTERO did not receive the "Patient Movement" list of the same date at encl 7 which PWH claimed to have been sent to us at the time. Encl 7 was provided to us recently at my request. [Both encls 6 and 7 are forwarded under confidential cover].

32. I would highlight / emphasize three points relating to encl 7. First, NTERO did not receive the list at the material time. Second, the list stated YY was "home" on 20 March when in fact he should have been discharged home on 19 March. Third, since encl 7 contained more names than encl 6, it would have been prepared after the latter was available at 15:27 hours on 20 March. We knew as a matter of fact that YY went back to Shenzhen on 20 March, by which time no contact tracing by DH was possible.

33. I now turn to the specific questions raised by the Select Committee –

Q1. When did DH commence the contact tracing work in respect of the outbreak of SARS at PWH? When and how did you first find out the outbreak at PWH? How was information on cases for contact tracing provided by PWH to DH? Were there difficulties in the flow of information between PWH and DH? If yes, what were the difficulties and had the difficulties affected the contact tracing work? If yes, in which respect?

A1. (a) I found out the outbreak on 11 March through the media (see paras 3-4).

(b) DH commenced contact tracing work immediately on 11 March. Based on the survey undertaken that evening, DH

and PWH agreed on a case definition on the following day, 12 March (see paras 15-21). Since then, DH had investigated all cases satisfying the case definition reported by PWH through a list provided to DH daily. In the light of the developing situation, the case definition was subsequently revised on 17 March.

(c) There were difficulties in the flow of information from PWH to DH because we were dealing with an unknown disease with non-specific nature of symptoms and a lack of a quick diagnostic test. The speed and magnitude of the outbreak had been unprecedented. I hasten to add that all staff in DH and PWH had tried their best to deal with the situation, working extended hours.

(d) During 12-18 March 2003, PWH provided hard copies of the lists in a cumulative manner with new and old cases mixed together without any particular order or indication of new cases. To facilitate the Select Committee's consideration, I have provided the Committee with copies of all the lists of data in the first three days which PWH had asked DH to follow up under separate confidential cover because of concerns about protection of personal data of patients. New case lists were provided starting from 19 March.

(e) During this period (12-18 March), NTERO had to compare the current list daily with the previous ones to identify new cases of the day for case investigation and contact tracing. Moreover, different formats were used for the lists in the initial days. Sometimes, more than one lists were received in a day and some of the lists included names not intended for case reporting to DH for action. Occasionally, there were also typos in patients' names and different forms (e.g. initials/full names) were used for patients' names. As days went by, the list got longer and longer, and the sorting process became very laborious and time consuming. NTERO staff tried to make up for these by working extended hours.

(f) Appreciating that PWH colleagues were hard pressed to provide lists showing new cases only or indicate new cases on the cumulative lists, we requested PWH to provide soft copies of the lists as well. The intention was to sort the current day and previous day lists in alphabetical order to facilitate the identification of new cases. The soft copy was first made available to NTERO on 15 March. There were many worksheets and PWH colleagues had advised that NTERO would only need to use the worksheet corresponding to the hard copy they had provided and should ignore the rest.

(g) The lack of contact telephone nos. had sometimes caused difficulties in our contact tracing work. (see paras 28 and 30).

Q2. What were the contact tracing methodology and procedure adopted in the contact tracing work of the SARS outbreak at PWH? Was there any strategy for data management? What were the staff resources available for the contact tracing work of the outbreak at PWH and was DH able to cope with the work given the large number of SARS cases in PWH? Was DH able to complete the contact tracing work in a timely manner? Was there any time limit within which the contact tracing work had to commence and to be finished in respect of Severe Community-Acquired Pneumonia patient? Had there been any delays and if so, had such delays led to more infections? How were the results of contact tracing assessed and made use of?

SC 2 Paper No.: E3(c)-6

A2. (a) On contact tracing procedures, please refer to ~~SC-01-38P-EX~~: Contact Tracing – Then and Now, which was further elaborated in paras. 84-93 of ~~SC05-01L-EZ~~: DH's letter dated 18 August.

SC 2 Paper No.: A 32

(b) As for database management, NTERO developed a standard questionnaire for share with PWH (para 15-16) and other Regional Offices to capture information on cases and their contacts. The data were centralized and computerized in an epidemiological investigation tool, EPI-INFO. The database was used to generate useful epidemiological findings, work out

case definition, estimate incubation period, assess mode of spread and attack rate, and project development of the outbreak in PWH.

(c) From the very beginning, staff redeployment had been made to cope with increasing workload. Manpower was doubled by the second week and tripled by the third, from the original 14. Despite the enhancement of manpower, our staff had to work extended hours. In the first two weeks, NTERO investigated 386 reported cases and traced 1 884 contacts. Details by days are presented in Annexes 2-4.

(d) Throughout the PWH outbreak, DH had adhered to its pledge of commencing investigation of reported cases and contact tracing within 24 hours from the time of reporting to us. The contacts were put under medical surveillance for 14 days from the last day of exposure to a reported case. It was changed to 10 days when the incubation period was better defined.

(e) Although we initiated contact tracing action within 24 hours of receipt of a report, it was not possible to reach the contacts within that period in all cases. Retrospective analysis indicates that in about 3% of the reported cases were their contacts not reached within 24 hours.

(f) Contact tracing helped early identification of cases and prevention of further spread of the disease. Contacts were provided with health advice and advice on precautionary measures, e.g. attend PWH accident and emergency department and wear face masks when they displayed symptoms.

Q3. Did DH conduct contact tracing work in respect of the index patient of PWH and the relatives of the patient who were also hospitalized? If yes, what was the result of the contact tracing work? If not, why not?

A3 Identification of PWH Index Patient (JJ)

(a) During the course of epidemiological investigation, the DH Team at DCC found on 14 March that four cases with fever admitted to PWH on late 13 and early 14 March were relatives of JJ. The investigation also found on 14 March that another relative of JJ had been admitted to Baptist Hospital on 13 March with fever. A DH Team Nursing Officer at DCC Ms Cheung Yim-hing immediately interviewed JJ in the morning of 14 March. He was then in an open cubicle in Ward 8A. The same Nursing Officer conducted a further interview with JJ in the evening of 14 March. By then, he was put in an isolation room. The Nursing Officer has made a statement to the above effect, attaching the relevant duty roster where her name appears in item 4. The statement has been forwarded under confidential cover at encl 9.

(b) While two were household contacts, the other three relatives only met JJ during his stay in Ward 8A. The DH Team at DCC informed PWH of the linkage, and the latter immediately reviewed exposure history of sick staff / medical students and identified a number of them had contact with JJ during the incubation period. The above discoveries by DH and other epidemiological findings by PWH supported JJ as the index.

(c) At a PWH meeting held in the same evening (14 March), the above findings were shared and discussed. Apart from myself, participants included, among others, Dr Fung Hong, Dr Philip Li and Dr Donald Lyon of PWH, Prof Sydney Chung, Prof Joseph Sung, Prof John Tam, Prof Paul Chan and Prof Wong Tze-wai of CUHK, and Dr Thomas Tsang of DH. The findings indicated the need to trace all persons who had been exposed to JJ in his cubicle, meaning those exposed staff, medical students, patients and visitors. The agreement was that PWH would follow up their staff, medical students and inpatients while DH would follow up discharged patients (by which we understood to mean patients discharged before 10 March) and hospital visitors.

Tracing of Contacts of Index Patient (JJ), excluding Relatives

(d) It was first necessary to identify all patients who had been exposed to JJ in his cubicle. This would include inpatients, some of whom might be still in the cubicle in Ward 8A where JJ had stayed before isolation while others could have moved to other cubicles or even outside Ward 8A. Another group would be patients who had been exposed to JJ in his cubicle but were discharged before 10 March.

(e) With the assistance of PWH, the data referred to in (d) above was obtained on 15 March. A total of 36 inpatients / discharged patients had been so identified. As five of them had been investigated on 12-14 March by NTERO as reported cases, there remained 31 patients (some inpatients and some discharged patients) to be followed up.

(f) The agreed arrangement as per (c) above was that PWH would deal with inpatients. Thus NTERO's follow up action referred to in (e) above covered discharged patients and visitors/contacts of the 31 patients.

(g) Altogether, NTERO identified 174 visitors/contacts of these 36 patients. All of them were contacted for epidemiological investigation, medical advice and medical surveillance. Symptomatic persons were advised to attend the PWH accident and emergency department for assessment as previously agreed with the hospital. Others were put under medical surveillance.

(h) The outcome was that a total of 20 patients and 26 visitors / contacts turned out to be SARS cases, and there was further spread to six persons from these visitors / contacts cases.

Relatives of JJ

(i) Six relatives had been exposed to JJ. DH started investigation for all of them on 14 March. Five were later confirmed as SARS cases. Contact tracing revealed that three of them had in turn infected 10 contacts.

(j) On 15 March, DH traced the social contacts exposed to JJ. None of them had symptoms during the surveillance period.

Q4 Did DH conduct contact tracing in respect of the seven patients who were discharged from Ward 8A on 12 and 13 March 2003? If not, why not? If yes, what was the result of the contact tracing work?

A4 Lists of Patients discharged from Ward 8A on 11-13 March 2003

(a) As explained in para 13, PWH informed me at a meeting on 11 March that Ward 8A had been closed to admission and discharge on 10 March. This freezing of ward movements would assist in the prevention of the spread of the disease outside the ward. I do not recall any discussion about re-opening of Ward 8A, let alone the receipt of any report from PWH about patients discharged from that ward during period 11-13 March for NTERO to follow up.

(b) In his written statement (answer to Question 13), Dr Fung Hong said that 10 patients were discharged from Ward 8A in the first three days. At my request, PWH provided on 26 January 2004 the names of these patients, 3 discharged on 11 March, 5 on 12 March and 2 on 13 March [encl 8 sent to you under separate confidential cover].

(c) I would now refer the Select Committee to encl 1-5 which were documents provided by PWH to NTERO for follow up action in the same period in March 2003. The only list with a possible indication of "discharge" (because of the appearance

of the word "Dis" under the column of "bed number") can be found in encl 4. As explained in para 23 above, this "patient listing" consisted of two pages out of a total of three. Upon clarification with PWH at the time, we were advised that all the 34 names on the first page and the first five names on page 2 were staff / medical students which required follow-up action by NTERO. The remaining names on page 2 (which were patient data of Ward 8A) and page 3 (which was not provided by PWH) were not matters of concern to NTERO.

(d) I would also draw attention to the terms "Home" or "Home + FU CXR" which appeared against some names under the column heading "destination" in encl 5 which was received by NTERO on 13 March 2003. They denoted that the persons screened in the PWH Special Staff Clinic or put under observation in the accident & emergency department were allowed to go home with or without follow up by PWH. None of them were Ward 8A patients discharged after 10 March.

(e) Among the patient data, there were <u>four</u> names with the term "Dis" under the "bed number" column. This contrasts with the <u>eight</u> names discharged on 11 and 12 March now provided by PWH [encl 8]. In fact, there was only one name common to both lists (the last name on page 2 of Encl 4).

(f) I submit that the above analysis all support my statement at (a) above that NTERO was not provided with the names of the 10 discharged patients for follow-up action at the material time.

<u>Whether Action had been taken for the 10 Discharged Patients</u>

(g) Among these 10 discharged patients, five eventually were SARS cases. Four of them were picked up through the joint effort of PWH/NTERO in the active case finding exercise on 15 March and the other through the case reporting system. Please see answer (d)-(h) to Question 3 above.

(h) NTERO traced the four discharged patients referred to in (f) above and their visitors on 15 March. None of the visitors had symptoms during the surveillance period. Three of the four patients subsequently turned out to be SARS cases and were readmitted to PWH. One of them had spread the disease to a close contact.

(i) Of the remaining six discharged patients, one turned out to be a SARS case and was picked up by the case reporting system to NTERO on 17 March evening. The case and their contacts were traced on 18 March. None of his contacts were affected.

Q5. Did the team of DH staff stationed at PWH during the SARS outbreak make any assessment of the risk of the spread of the disease from patients and HCWs in Ward 8A to other HCWs and patients in PWH? If not, why not? If yes, what was the assessment and the follow-up actions taken?

A5. (a) The concern about risk of spread of the disease was shared with PWH right at the beginning at the first meeting with PWH on 11 March.

(b) By 11 March, PWH had introduced a freeze on movements of patients in Ward 8A. A restricted visiting policy with adequate precautionary measures was also implemented. To supplement these measures, I advised the hospital to isolate cases, restrict movement of Ward 8A staff, screen and monitor sick leave pattern of staff in other wards and screen sick staff. PWH responded by setting up a special staff clinic in the same evening to screen staff reporting ill.

(c) In order to better understand the nature of infection and establish a case reporting system, DH did an epidemiological investigation of the first batch of staff who had reported sick that same evening.

(d) Although PWH advised me that only staff had been infected, our epidemiological study found that medical students were also affected. I therefore advised CUHK at the 12 March meeting to screen medical students who had been exposed to cases and restrict their movement in the hospital. On the same day, CUHK stopped medical students from visiting PWH.

(e) At the same meeting on 12 March, I presented the epidemiological findings and agreed with PWH a case definition based on which a reporting system was established for timely assessment of the development and follow up actions.

(f) In my telephone conversation with Prof Sung in the morning of 12 March, I suggested that PWH consider providing quarters for the exposed staff. There was positive feedback on this suggestion as its staff had also raised the same request.

(g) Noting sporadic reported cases of staff from wards other than 8A, I decided on 13 March to station a DH Team at the PWH DCC to facilitate investigation and communication. Together with PWH colleagues at the DCC, the DH Team checked the sick leave pattern of staff and the situation in other wards. The DH Team also worked hand-in-hand with PWH colleagues on case investigation and in particular, the identification of the index patient.

Q6. At which point did DH consider that the outbreak among HCWs at PWH had peaked? In which forum was the subject discussed? What was the basis for the conclusion? Were any follow-up actions taken in relation to the conclusion? If yes, what were the follow-up actions? If not, why not?

A6. (a) Together with PWH, DH established a reporting system with agreed case definition on 12 March 2003. Based on epidemiological findings by 14 March, including the epidemic curve and the estimated incubation period of the disease, DH

had reasons to believe that the first wave of the outbreak might have peaked by that time.

(b) In the evening meeting on 14 March, DH shared the epidemiological findings with PWH. DH advised PWH that while the first wave of the outbreak might have peaked, it should be on the alert for the second wave as contacts having been exposed and incubating the disease might become sick in the following week. DH advised PWH to get prepared.

(c) As for DH, we did strengthen manpower of NTERO to cope with the workload in case investigation and contact tracing.

(d) Our epidemiological review of the PWH outbreak supports that the first wave of the outbreak peaked at onset date of 9 March.

Q7. Did you take part in any discussions at meetings of 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? Did you report these discussions to DH?

A7. (a) I was not consulted about the closure and re-opening of Ward 8A of PWH and the closure of PWH in any discussions at meetings which I attended at PWH during the SARS outbreak.

(b) I attended my first meeting at PWH on 11 March 2003. The Chairman, Prof Sung said that a decision to close Ward 8A to admission, discharge and visitors had been implemented on 10 March. However, from their own experience earlier on 10 March, PWH felt that if family members were denied visits, they might insist on/persuade their relative patients to discharge themselves against medical advice. Thus, the no-visiting policy was relaxed in the evening of 10 March. Visitors were restricted in numbers, given health advice and required to put on protective gears before visits. As the relaxation was made on practical grounds and there were adequate precautionary measures, I did not raise any objections.

(c) Apart from (b) above, I did not recall any discussions on closure and re-opening of Ward 8A and hospital closure at PWH meetings which I attended. I should mention that at the morning meeting held on 12 March at PWH, there was a long discussion on possible arrangements to suspend some of the services in the specialist out-patient clinics and to stop new admissions from the accident & emergency department to medical wards because a number of HCWs had fallen sick.

(d) During my telephone conversation with the then Director of Health in the evening of 12 March 2003, she told me that Dr Fung Hong had mentioned that there was a suggestion to close PWH and that her advice to Dr Fung was that closing a big teaching hospital was a complicated issue and that it had to be discussed at a higher level.

Q8. How often did you report the actions and measures you had taken on the control of the spread of SARS in your own region/cluster? Did you receive any advice and support from DH Headquarters in this respect?

A8. (a) During the SARS outbreak, I and my colleagues daily updated the seniors in the Disease Prevention and Control Division (DPCD) and DH Headquarters of the latest situation and actions taken.

(b) I had good access to the two consultants in DPCD who provided advice and support with regard to the methodology in case investigation and contact tracing. In particular, Dr Thomas Tsang participated in some of the meetings at PWH with me.

(c) I also received good support from DH Headquarters in reinforcing the staff complement in NTERO, including an additional Principal Medical and Health Officer (PM&HO) during 21-29 March 2003. In addition, a Community

Physician also at PM&HO level from another region was redeployed to cover my absence on sick leave during the period of 18-21 March.

Dr AU Tak-kwong
Community Physician
5 February 2004

Annex 1

LY TSE
11/03/2003 11:30

To: Gareth TK AU/DH/HKSARG@DH, Marina SUM/DH/HKSARG@DH
cc:
Subject: Outbreak of repiratory illness in a ward

Fyi.
—— Forwarded by LY TSE/DH/HKSARG on 2003/03/11 11:30 AM ——

"Shao Haei LIU Dr, HOPS&HR SEM\(PS\)1" <liush@ho.ha.org.hk>
2003/03/11 10:05 AM
Please respond to "Shao Haei LIU Dr, HOPS&HR SEM\(PS\)1"

To: <ly_tse@dh.gov.hk>
cc: "James Donald LYON Dr, PWHMIC Cons\(MIC\)" <ld127@ntec.ha.org.hk>
"Dr. FUNG Hong" <fungh@ha.org.hk>
"Philip LI" <liktph@ha.org.hk>
"Dr. W. M. KO" <kowm@ha.org.hk>
bcc:
Subject: Outbreak of repiratory illness in a ward
☐ Urgent ☐ Return Receipt

Dear Dr Tse,
Please see the update from Dr Lyon. I have also advise him to report the incident to DH's NTE Regional office send specimens to Government Virus Unit.

SH LIU

——Original Message——
From: James Donald LYON Dr, PWHMIC Cons(MIC)
Sent: Monday, March 10, 2003 7:14 PM
To: Shao Haei LIU Dr, HOPS&HR SEM(PS)1; W H SETO Dr, HKWC CD(Q&RM) / HKWC CC(MIC) / QMHMIC COS; N C TSANG, QEH CON(Path); T K NG Dr, PMH CON(Path)
Subject: RE: problems in PWH

Dear all,

To keep you up to date, the direct IF results for our fatal pneumonia from China ([redacted]) are negative for flu A, flu B & RSV. Other IF tests for adeno, paraflu & viral and bacterial culture will follow.

With regard to our medical ward situation, we have collected about 80-90 NPA samples (mostly from staff but also from patients) and clotted bloods. We have looked so far at 30 NPAs, only one had paraflu 3. All were negative for Flu A,Flu B, Adeno, RSV & Paraflu 1&2. The number of possibly affected patients has been revised down to 5, but there are 78 staff members, mostly nurses, reporting fever and URTI symptoms.

Dr. Donald Lyon,
Dept. of Microbiology,
Prince of Wales Hospital,
Shatin, Hong Kong.
Tel: 852 2632 2305
Fax: 852 2645 1256

Annex 2

Special Control Team at NTERO
Staff Composition

Date	Principal Medical & Health Officer	Senior Medical & Health Officer	Medical & Health Officer	Senior Nursing Officer	Nursing Officer	Registered Nurse	Clerical staff	Total
11 Mar (Tue)	1	1	4	1	3	2	2	14
12 Mar (Wed)	1	1	4	1	3	2	2	14
13 Mar (Thu)	1	2	3	1	3	5	3	19
14 Mar (Fri)	1	2	4	1	6	4	3	21
15 Mar (Sat)	1	3	7	1	5	4	3	24
16 Mar (Sun)	1		1		3			5
17 Mar (Mon)	1	2	5	1	7	4	3	23
18 Mar (Tue)	1	3	7	1	7	6	3	28
19 Mar (Wed)	1	3	8	1	7	6	4	30
20 Mar (Thu)	1	3	8	1	7	6	4	30
21 Mar (Fri)	1	4	8	1	8	7	5	34
22 Mar (Sat)	1	4	8	1	9	8	5	36
23 Mar (Sun)	1		2		4			7
24 Mar (Mon)	1	4	8	1	9	10	5	38
25 Mar (Tue)	1	4	8	1	9	12	5	40

Annex 3

DH Team at PWH
Staff Composition

Date	Principal Medical & Health Officer	Medical & Health Officer	Nursing Officer	Registered Nurses	Total no. of Staff
13 Mar (Thu)		1	1	1	3
14 Mar (Fri)		1	1	1	3
15 Mar (Sat)		2	3	1	6
16 Mar (Sun)		1	1	0	2
17 Mar (Mon)		2	2	2	6
18 Mar (Tue)		2	2	0	4
19 Mar (Wed)		1	2	0	3
20 Mar (Thu)		1	2	0	3
21 Mar (Fri)	1	2	2	1	6
22 Mar (Sat)	1	2	1	1	5
23 Mar (Sun)		1	2	1	4
24 Mar (Mon)	1	2	1	1	5
25 Mar (Tue)	1	2	1	1	5

Annex 4

Prince of Wales Hospital Cluster

Work done by DH Team at PWH and Special Control Team at NTERO

Date	Total No. of Referred Cases & Contacts Interviewed	Referred Cases Interviewed		Contacts Follow-up	
		Total No.	*No. turned SARS*	Total No.	*No. turned SARS*
11 Mar (Tue)	87	26	*24*	61	*0*
12 Mar (Wed)	66	17	*13*	49	*1*
13 Mar (Thu)	227	77	*12*	150	*3*
14 Mar (Fri)	133	26	*9*	107	*10*
15 Mar (Sat)	161	29	*18*	132	*19*
16 Mar (Sun)	95	4	*2*	91	*3*
17 Mar (Mon)	101	26	*5*	75	*5*
18 Mar (Tue)	63	20	*8*	43	*2*
19 Mar (Wed)	129	41	*12*	88	*6*
20 Mar (Thu)	179	56	*7*	123	*4*
21 Mar (Fri)	34	9	*3*	25	*1*
22 Mar (Sat)	805	37	*7*	768*	*1*
23 Mar (Sun)	53	6	*2*	47	*0*
24 Mar (Mon)	60	2	*2*	58	*1*
25 Mar (Tue)	77	10	*10*	67	*3*
Total	2270	386	*134*	1884	*59*

*Note: The figure includes 599 contacts of a private practitioner, 82 hospital visitors, 34 contacts of an ambulance man and contacts of other cases.

Patient List of PWH Staff / Medical Students received by NTERO on 11 March 2003

Encl. 1

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Name	Status	ID	Tel
[redacted]	DR		
[redacted]	DR		
[redacted]	DR		
[redacted]	DR		
[redacted]	DR		
[redacted]	DR		
[redacted]	DR		
[redacted]	DR		
[redacted]	HO		
[redacted]	HO		
[redacted]	MS		
[redacted]	NO		
[redacted]	WM		
[redacted]	RN		
[redacted]	RN		
[redacted]	RN		
[redacted]	RN		
[redacted]	RN		
[redacted]	EN		
[redacted]	HCA		
[redacted]	TSA		
[redacted]	RN		
[redacted]	WA		
[redacted]	RN		
[redacted]	RN		
[redacted]	RN		
[redacted]	Physio II		
[redacted]	GSA		
[redacted]	MS		
[redacted]	MS		
[redacted]	MS		
[redacted]	MS		
[redacted]	MS → PWH		
[redacted]	BA patient		
[redacted]	BA patient		
[redacted]	BA patient		
[redacted]	BA out-patient		
[redacted]	RN		
[redacted]	RN		
[redacted]	WS		

36 staff

Dr [redacted]

Patient List of PWH Staff / Medical Students received by NTERO on 12 March 2003

Encl. 2

✓ 11	[redacted]	00100			RN	NAD
✓ 18	[redacted]	00200 mpy				NAD
✓ 24	[redacted]	00300			RN	NAD
75	[redacted]	00400		PHY8AB		NAD
✓ 61	[redacted]	00500	(MS)	8A	MS	NAD
✓ 68	[redacted]	00600		8A	RN	
✓ 26	[redacted]	00700 Entered			DR	NAD
41	[redacted]	00800				
✓ 50	[redacted]	00900		LFX LAB		
✓ 46	[redacted]	01000		8A (MS)	MS	NAD
✓ 31	[redacted]	01100 mpy			DR	NAD
✓ 14	[redacted]	01200			DR	NAD
33	[redacted]	01300				NAD
49	[redacted]	01400				NAD
✓ 1	[redacted]	01500			DR	NAD
✓ 15	[redacted]	01600			SS	NAD
64	[redacted]	01700				
✓ 16	[redacted]	01800			RN	NAD
78	[redacted]	01900		LKS		
52	[redacted]	02000		8C		NAD
✓ 28	[redacted]	02100				
35	[redacted]	02200				NAD
✓ 53	[redacted]	02300		8A		
62	[redacted]	02400		9A		NAD
✓ 22	[redacted]	02500	(MS)		MS	NAD
10	[redacted]	02600				
66	[redacted]	02700 ? Hmf		LKS		NAD
13	[redacted]	02800				NAD
63	[redacted]	02900				NAD
✓ 58	[redacted]	03000	(MS)	8A	MS	NAD
✓ 32	[redacted]	03100			RN	NAD
✓ 79	[redacted]	03200		8A	RN	3158 5656
43	[redacted]	03300		8B		
✓ 37	[redacted]	03400				NAD
✓ 3	[redacted]	03500			RN	NAD
9	[redacted]	03600				NAD
54	[redacted]	03700		8B		UNION
74	[redacted]	03800		PHY8AB		
72	[redacted]	03900				NAD
✓ 20	[redacted]	04000			RN	
27	[redacted]	04100				NAD
6	[redacted]	04200			DR	NAD
25	[redacted]	04300				NAD
57	[redacted]	04400				NAD
69	[redacted]	04500		EDU		
56	[redacted]	04600		LKS		NAD
47	[redacted]	04700		LKS		
42	[redacted]	04800				
✓ 45	[redacted]	04900		10C		
48	[redacted]	05000 Hmf		LFX LAB		NAD
65	[redacted]	05100		8C		NAD

Received on 12 Mar

2 progress

Union

9A (MS) Tel [redacted] F RN/9A

[redacted] F 9A/RN

[redacted] F RN 9A

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			case no.					NAD
5 147	34	[redacted]	~~05200~~	[redacted]		8A	SS	[redacted]
1?	82	[redacted]	05300	[redacted]		8A	SS	[redacted]
188 13 *	✓ 40	[redacted]	05400	[redacted]			SS	NAD
189	✓ 23	[redacted]	05500	[redacted]				
170 14 *	✓ 55	[redacted]	05600	[redacted] (?)		8A		NAD
171 15 *	✓ 81	[redacted]	05700	[redacted]		8A	SS	[redacted]
172	17	[redacted]	05800	[redacted]				NAD
173 *	19	[redacted]	05900	[redacted]			RN	NAD
174	60	[redacted]	06000	[redacted]		LKS		NAD
175 16 *	✓ 71	[redacted]	← ?H inf 06100	[redacted]		EDU		NAD
176	67	[redacted]	06200	[redacted]		PHYBAB		
177 *	21	[redacted]	06300	[redacted]				NAD
178	59	[redacted]	06400	[redacted]		LKS		NAD
179	70	[redacted]	06500	[redacted]		EDU		NAD
200	51	[redacted]	06600	[redacted]		8C		NAD
201	12	[redacted]	06700	[redacted]				
202	73	[redacted]	06800? H inf	[redacted]		PHYBAB		NAD
203 *	✓ 8	[redacted]	06900	[redacted]				NAD
204 *	✓ 83	[redacted]	07000	[redacted]		8A	RN	[redacted]
205	44	[redacted]	07100	[redacted]		9A		NAD
206	77	[redacted]	07200	[redacted]	有 tel	LKS		
207	39	[redacted]	07300	[redacted]	No Tel			NAD
208 *	✓ 5	[redacted]	07400	[redacted]			DR	NAD
209	38	[redacted]	07500	[redacted]	No tel			NAD
17 210 *	✓ 2	[redacted]	07600	[redacted]			DR	
18 211 *	✓ 80	[redacted]	07700	[redacted]	[redacted]	8A	RN	[redacted] 留言
212	30	[redacted]	07800	[redacted]	[redacted]			NAD
19 213 *	✓ 4	[redacted]	07900	[redacted]			RN	NAD
214	7	[redacted]	08000	[redacted]	No tel		DR	
215	76	[redacted]	08100	[redacted]	No tel	LKS		
216 20 *	29	[redacted]	08200	[redacted]				
217	36	[redacted]	08300	[redacted]	[redacted]		DR	NAD

15 09300 (private) ✓ * [redacted] [redacted] 4A DR [redacted] 有電話

[redacted] 4A DR [redacted]

17 ✓ 09400 [redacted]

220 09500 [redacted] ? 4A DR 有电話

221 09600 ✓ [redacted] [redacted] Tel [redacted]

[redacted] [redacted] mo (P4). [redacted]

222 09700 * [redacted] m' [redacted] 留言 left

223 09800 * [redacted] F [redacted] Ar

~~09900~~ * [redacted] F [redacted]

~~09900~~

N.B * admitted to observation ward

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Patient List of PWH Staff / Medical Students received by NTERO on 12 March 2003

Encl. 3

Case tel. list as at 1:00 pm 12 Mar
double
2 pages

Name	Status	ID	tel	destination S/S
[redacted]	DR	[redacted]	[redacted]	Home
[redacted]	DR	[redacted]	[redacted]	Home
[redacted]	DR	[redacted]	[redacted]	O Ward
[redacted]	DR	[redacted]	[redacted]	O Ward
[redacted]	DR	[redacted]	[redacted]	O Ward
[redacted]	DR	[redacted]	[redacted]	O Ward
[redacted]	DR	[redacted]	[redacted]	Home
[redacted]	DR	[redacted]	[redacted]	O Ward
[redacted]	DR	[redacted]	[redacted]	
[redacted]	MO(CT)	[redacted]		10EF
[redacted]			[redacted]	Home
[redacted]				On duty
[redacted]	HO	[redacted]	[redacted]	Home
[redacted]	HO	[redacted]	[redacted]	O Ward
[redacted]	HO	[redacted]	[redacted]	On duty
[redacted]	HO	[redacted]	[redacted]	O Ward
[redacted]	MS	[redacted]	[redacted]	O Ward
[redacted]	MS	[redacted]	[redacted]	O Ward
[redacted]	MS	[redacted]	[redacted]	O Ward
[redacted]	MS	[redacted]	[redacted]	O Ward
[redacted]	MS	[redacted]	[redacted]	O Ward
[redacted]	MS	[redacted]	[redacted]	8A Ward
[redacted]	WM	[redacted]	[redacted]	
[redacted]	NO	[redacted]	[redacted]	
[redacted]	RN	[redacted]	[redacted]	O Ward
[redacted]	RN	[redacted]	[redacted]	O Ward
[redacted]	RN		[redacted]	
[redacted]	RN	[redacted]	[redacted]	O Ward
[redacted]	RN	[redacted]	[redacted]	Home
[redacted]	RN	[redacted]	[redacted]	Union
[redacted]	RN	[redacted]	[redacted]	O Ward
[redacted]	RN	[redacted]	[redacted]	O Ward
[redacted]	RN	[redacted]	[redacted]	On leave
[redacted]	RN	[redacted]	[redacted]	Home
[redacted]	RN	[redacted]	[redacted]	O Ward
[redacted]	EN	[redacted]	[redacted]	O Ward
[redacted]	GSA	[redacted]	[redacted]	O Ward
[redacted]	TSA		[redacted]	KWH
[redacted]	HCA	[redacted]	[redacted]	Home
[redacted]	WS	[redacted]	[redacted]	O Ward
[redacted]	WA	[redacted]	[redacted]	O Ward

[redacted]	Ally	[redacted]	O Ward
[redacted]	Ally	[redacted]	Home
[redacted]	Ally	[redacted]	On duty
[redacted]	9A RN	[redacted]	Home
[redacted]	9A RN	[redacted]	Home
[redacted]	9A RN	[redacted]	Home
[redacted]	9A HCA	[redacted]	
[redacted]	9B RN	[redacted]	Home
[redacted]	9B RN	[redacted]	Home
[redacted]	9B RN	[redacted]	Home
[redacted]	9B RN	[redacted]	Home
[redacted]	9B RN	[redacted]	
[redacted]	9B RN	[redacted]	
[redacted]	9B RN	[redacted]	
[redacted]	Physio II	[redacted]	Home
[redacted]		[redacted]	
[redacted]		[redacted]	
[redacted]	8A patient	[redacted]	8A
[redacted]	8A patient	[redacted]	8A
[redacted]	8A patient	[redacted]	8A
[redacted]	8A out-pati	[redacted]	
[redacted]	10C in-pati	[redacted]	10C Ward
[redacted]	Patient	[redacted]	

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Encl. 4

醫院管理局
HOSPITAL AUTHORITY

PRINCE OF WALES HOSPITAL
威爾斯親王醫院

Department of Medicine

Tel No.: (852)26323131/3133 Fax No.: (852)26375396/26373862

To : Dr. TK Au

From : Dr. Alan Wu

Date :

Fax No. : 26030523

Total pages including this page : 3

Re : Patient Listing

12-MAR-2003 14:14 PWH P.01

Humalog®/*Humulin*®

[redacted]

Linda

Lilly

Patient List received by NTERO on 12 March 2003

System Date/Time: 12-03-2003 13:09

Source Code | MRN | Confidential

Ward	Bed	Name	Chi Name	Episode	Specialty	Class	Admission datetime	HKID	Sex	Age
8A		[redacted]	[redacted]	HN03020638Q	MED	3	11-03-2003 20:17	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020648N	MED	3	11-03-2003 20:30	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020667M	MED	3	11-03-2003 20:33	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020646R	MED	3	11-03-2003 20:28	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020639O	MED	3	11-03-2003 20:18	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020701N	MED	3	12-03-2003 00:00	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020652W	MED	3	11-03-2003 20:31	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020644V	MED	3	11-03-2003 20:27	[redacted]	M	
8A		[redacted]	[redacted]	HN03020645T	MED	3	11-03-2003 20:28	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020656Q	MED	3	11-03-2003 20:33	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020672Q	MED	3	11-03-2003 20:57	[redacted]	M	
8A		[redacted]	[redacted]	HN03020702W	MED	3	12-03-2003 00:02	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020684U	MED	3	11-03-2003 21:44	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020658O	MED	3	11-03-2003 20:33	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020643M	MED	3	11-03-2003 20:23	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020650P	MED	3	11-03-2003 20:31	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020666W	MED	3	11-03-2003 20:36	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020699S	MED	3	11-03-2003 23:58	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020651N	MED	3	11-03-2003 20:31	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020678P	MED	3	11-03-2003 21:20	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020640S	MED	3	11-03-2003 20:21	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020670U	MED	3	11-03-2003 20:52	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020662T	MED	3	11-03-2003 20:36	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020649W	MED	3	11-03-2003 20:30	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020665N	MED	3	11-03-2003 20:37	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020663R	MED	3	11-03-2003 20:36	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020654S	MED	3	11-03-2003 20:32	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020653U	MED	3	11-03-2003 20:32	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020664P	MED	3	11-03-2003 20:37	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020661V	MED	3	11-03-2003 20:35	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020658V	MED	3	11-03-2003 20:33	[redacted]	F	[redacted]
8A		[redacted]	[redacted]	HN03020636U	MED	3	11-03-2003 20:16	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020642O	MED	3	11-03-2003 20:23	[redacted]	M	[redacted]
8A		[redacted]	[redacted]	HN03020665T	MED	3	11-03-2003 20:34	[redacted]	F	[redacted]

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Ward	Bed	Name	Chi Name	Episode	Specialty	Class	Admission date/time	HKID	Sex	Age	Source Dept	MRN	Confidential
8A		[redacted]	[redacted]	HN03020802S	MED	3	12-03-2003 08:45	[redacted]	M	[redacted]	[redacted]		
8A		[redacted]	[redacted]	HN03020673O	MED	3	11-03-2003 20:58	[redacted]	M	[redacted]	[redacted]		
8A		[redacted]	[redacted]	HN03020677R	MED	3	11-03-2003 21:20	[redacted]	F	[redacted]	[redacted]		
8A		[redacted]	[redacted]	HN03020647P	MED	3	11-03-2003 20:29	[redacted]	F	[redacted]	[redacted]		
8A		[redacted]	[redacted]	HN03020700P	MED	3	12-03-2003 00:00	[redacted]	M	[redacted]	[redacted]		
8A	01	[redacted]	[redacted]	HN03019838N	MED	3	09-03-2003 09:50	[redacted]	M	[redacted]			
8A	01X	[redacted]	[redacted]	HN03019668S	MED	3	09-03-2003 11:52	[redacted]	M	[redacted]			
8A	02	[redacted]	[redacted]	HN03019835T	MED	3	09-03-2003 09:15	[redacted]	M	[redacted]			
8A	03	[redacted]	[redacted]	HN03018469M	MED	3	04-03-2003 13:29	[redacted]	M	[redacted]			
8A	04	[redacted]	[redacted]	HN03019875S	MED	3	09-03-2003 13:58	[redacted]	M	[redacted]			
8A	08	[redacted]	[redacted]	HN03015102Q	MED	3	21-02-2003 08:52	[redacted]	M	[redacted]			
8A	09X	[redacted]	[redacted]	HN03018749R	MED	3	05-03-2003 11:06	[redacted]	M	[redacted]			
8A	11	[redacted]	[redacted]	HN03018823V	MED	3	04-03-2003 16:25	[redacted]	M	[redacted]			
8A	12	[redacted]	[redacted]	HN03019895M	MED	3	09-03-2003 16:49	[redacted]	M	[redacted]			
8A	13	[redacted]	[redacted]	HN03019568Q	MED	3	07-03-2003 23:57	[redacted]	M	[redacted]			
8A	14	[redacted]	[redacted]	HN03019526M	MED	3	07-03-2003 19:10	[redacted]	M	[redacted]			
8A	15	[redacted]	[redacted]	HN03019850M	MED	3	09-03-2003 10:44	[redacted]	M	[redacted]			
8A	17	[redacted]	[redacted]	HN03018782O	MED	3	05-03-2003 11:41	[redacted]	M	[redacted]			
8A	17X	[redacted]	[redacted]	HN03013978O	MED	3	15-02-2003 01:23	[redacted]	M	[redacted]			
8A	18	[redacted]	[redacted]	HN03018427R	MED	3	04-03-2003 11:23	[redacted]	M	[redacted]			
8A	20	[redacted]	[redacted]	HN03016975S	MED	3	27-02-2003 11:56	[redacted]	M	[redacted]			
8A	22	[redacted]	[redacted]	HN03018821N	MED	3	05-03-2003 14:27	[redacted]	M	[redacted]			
8A	26	[redacted]	[redacted]	HN03019910U	MED	3	09-03-2003 19:12	[redacted]	M	[redacted]			
8A	27	[redacted]	[redacted]	HN03019520W	MED	3	07-03-2003 16:16	[redacted]	M	[redacted]			
8A	28	[redacted]	[redacted]	HN03019837P	MED	3	08-03-2003 09:47	[redacted]	M	[redacted]			
8A	29	[redacted]	[redacted]	HN03013326R	MED	3	16-02-2003 09:53	[redacted]	M	[redacted]			
8A	30	[redacted]	[redacted]	HN03014699S	MED	3	20-02-2003 13:09	[redacted]	M	[redacted]			
8A	31	[redacted]	[redacted]	HN03019865N	MED	3	09-03-2003 11:43	[redacted]	M	[redacted]			
8A	32	[redacted]	[redacted]	HN03018196M	MED	3	03-03-2003 18:29	[redacted]	M	[redacted]			
8A	33	[redacted]	[redacted]	HN03019861M	MED	3	09-03-2003 14:32	[redacted]	M	[redacted]			
8A	Dis.	[redacted]	[redacted]	HN03017843T	MED	3	02-03-2003 20:21	[redacted]	M	[redacted]			
8A	Dis.	[redacted]	[redacted]	HN03019265M	MED	3	07-03-2003 01:23	[redacted]	M	[redacted]			
8A	Dis.	[redacted]	[redacted]	HN03019494T	MED	3	07-03-2003 16:24	[redacted]	M	[redacted]			
8A	Dis.	[redacted]	[redacted]	HN03018879Q	MED	3	04-03-2003 23:08	[redacted]	M	[redacted]			

Encl. 5

July 2003

Patient List received by NETRO on 13 March 2003

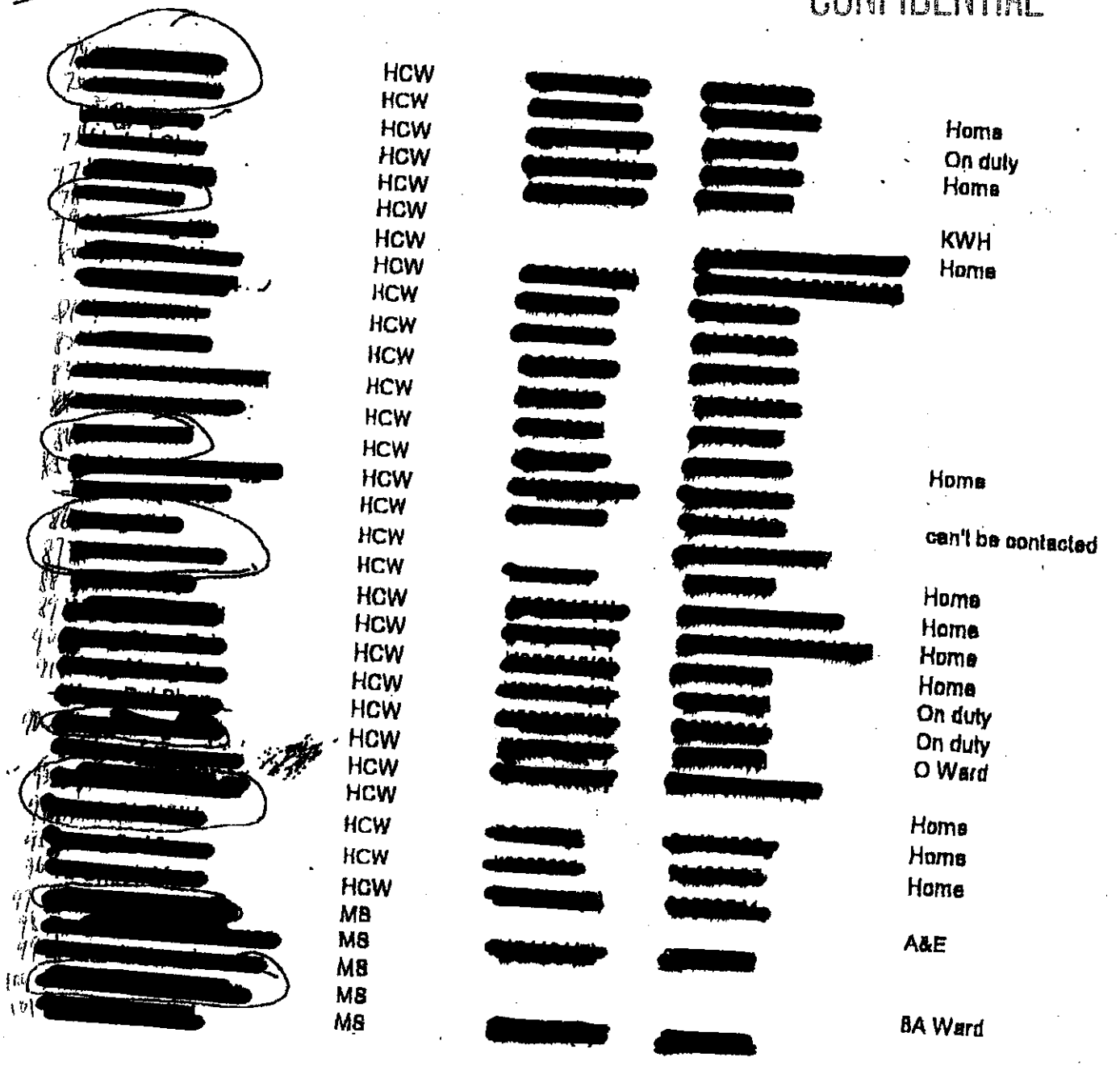
13 March 7pm

Name	Status	ID	tel	destination	S/S	MICROB
[redacted]	HCW	[redacted]	[redacted]			
	HCW					
	HCW					
	HCW					
	HCW			On duty		
	HCW			Home		
	HCW					
	HCW			Home		
	HCW			Home		RSV
	HCW			Home		
	HCW			Home		
	HCW					
	HCW					
	HCW					
	HCW					
	HCW					
	HCW					
	HCW					
	HCW			A&E		
	HCW			O Ward		
	HCW			Home		
	HCW			can't be contacted		
	HCW			Union		
	HCW			Home		
	HCW					
	HCW					
	HCW			Home		
	HCW					
	HCW			Home		
	HCW					
	HCW					
	HCW					
	HCW			On duty		
	HCW			Home		

13 March 7p

4 pages

(33)



[redacted]	HCW	[redacted]
	HCW	
	HCW	
	HCW	Home
	HCW	On duty
	HCW	Home
	HCW	
	HCW	KWH
	HCW	Home
	HCW	
	HCW	
	HCW	
	HCW	
	HCW	
	HCW	
	HCW	Home
	HCW	
	HCW	can't be contacted
	HCW	
	HCW	Home
	HCW	Home
	HCW	Home
	HCW	Home
	HCW	On duty
	HCW	On duty
	HCW	O Ward
	HCW	
	HCW	Home
	HCW	Home
	HCW	Home
	MS	
	MS	A&E
	MS	
	MS	
	MS	BA Ward

TOTAL P.05

CONFIDENTIAL

[redacted]	unknown	[redacted]	ENTERVIRUS
	unknown		
	unknown		
	unknown		
	HCW		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	unknown		
	HCW		
	HCW		
	HCW		
	HCW		
	HCW		
	HCW		

not admitted

HOME FROM A&E
HOME FROM A&E
HOME FROM A&E
HOME FROM A&E
HOME FROM A&E
HOME FROM A&E
HOME FROM A&E
HOME FROM A&E
HOME FROM A&E

(32)

[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	MS	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	MS	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E W/ FU CXR
[redacted]	unknown		HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	unknown	[redacted]	HOME FROM A&E
[redacted]	HCW	[redacted]	HOME FROM A&E
[redacted]	MS		HOME FROM A&E
[redacted]	MS		HOME FROM A&E
[redacted]	MS		HOME FROM A&E
[redacted]	HCW		HOME FROM A&E W/ FU CXR
[redacted]	unknown	[redacted]	HOME FROM A&E W/ FU CXR
[redacted]	HCW	[redacted]	HOME FROM A&E
			HOME FROM A&E W/ FU CXR
			HOME FROM A&E

Encl. 6

CONFIDENTIAL

20_3_03

→ Dr C Y Lo

new case of today 20/3

	careno	name	id	status	rank	dept	wave	destinat	icu_ever	in_patie	expo_8a
116	123.00	[redacted]	[redacted]	3.00			2.00	6C	.	1.00	2
117	124.00	[redacted]	[redacted]	1.00	RN	A&E	.	10AB	.	1.00	.
118	125.00	[redacted]	[redacted]	1.00	Asso. Pr	MRT	1.00	10AB	.	1.00	2
119	126.00	[redacted]	[redacted]	1.00	RN	O Room	.	8D	.	1.00	2
120	127.00	[redacted]	[redacted]	3.00			.	8D	.	1.00	2
121	128.00	[redacted]	[redacted]	3.00			.	8A	.	1.00	2
122	129.00	[redacted]	[redacted]	1.00	RN	8A	.	10AB	.	1.00	2

CONFIDENTIAL

Encl. 7

Patient Movement

Name	ID	Status	Rank	Dept		Movement	New Case	
[redacted]	[redacted]	HCW	RN	O Room		8D 20/3	20/3	
[redacted]	[redacted]	Patient				8D 20/3	20/3	
[redacted]	[redacted]	HCW	RN	A&E		10A 20/3	20/3	
[redacted]	[redacted]	HCW	RN	8A		10A 20/3	20/3	
[redacted]	[redacted]	HCW	Asso. Pro	M&T		10B 20/3	20/3	
[redacted]	[redacted]	Patient				6C 20/3	20/3	
[redacted]	[redacted]	Patient			T/F in	11B to 8A 20/3	20/3	
[redacted]	[redacted]	Patient			Transfer	ICU to 8B 20/3		
[redacted]	[redacted]	MO			Transfer	10B to ICU 20/3		
[redacted]	[redacted]	Patient			Transfer	8B to ICU 20/3		
[redacted]	[redacted]	Patient			Home	6D Home on 20/3		
[redacted]	[redacted]	Patient			Home	Home 20/3		
[redacted]	[redacted]	Patient			T/F out	8A to 10D 20/3		
[redacted]	[redacted]	Patient			Home	Home 20/3		
[redacted]	[redacted]	Patient			Transfer	8D to 8B 20/3		

YY

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Encl. 8

"Louis Chan"
<chanysl@ha.org.hk>
26/01/2004 10:33
Please respond to "Louis Chan"

To: <t_k_au@dh.gov.hk>
cc: <fungh@ha.org.hk>
Subject: Discharges from 8A 11-13 March 2003
☐ Urgent ☐ Return Receipt

Dear Dr Au,
Please find below the details of the 10 patients dischareg from 8A from 11 to 13 March 2003.
Happy new year!
Louis

<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

HKID	HN No.	SARS	Status	Patient Name	Discharge Date
[redacted]	HN03018579Q	Yes	Patient	[redacted]	11/3
[redacted]	HN03019878M	No	Patient	[redacted]	11/3
[redacted]	HN03019874U	No	Patient	[redacted]	11/3
[redacted]	HN03019837P	No	Patient	[redacted]	12/3
[redacted]	HN03019838N	No	Patient	[redacted]	12/3
[redacted]	HN03019850M	Yes	Patient	[redacted]	12/3
[redacted]	HN03019525M	Yes	Patient	[redacted]	12/3
[redacted]	HN03019568Q	Yes	Patient	[redacted]	12/3
[redacted]	HN03018469M	No	Patient	[redacted]	13/3
[redacted]	HN03019835T	No	Patient	[redacted]	13/3

Encl. 9(i)

To : C.P. N.T.E.
Attn. Dr. T.K.Au
Date: 5 Feb. 2004

I received a phone call from Dr. Au on 30 January 2004 2:35pm . He asked me to recall my memory on 14 March 2003 concerning on an investigation on a patient JJ, the index case of PWH.

I confirmed that 14 March 2003 morning was my first day duty to PWH. I could vividly remember that when I arrived PWH 8A ward to obtain history from JJ that morning, he was staying in Bed 11 of an open cubicle with some other patients. I then obtained all the necessary information from him at his bedside. I interviewed JJ again in the same evening and by then he was already isolated in an isolation room.

Attached please find my duty roster on 14 March 2003 and "W" means duty in PWH.

Ag.NO CHEUNG Yim-hing

Nursing Staff PH NTE

As at 9/3/2003

	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M
1				E 2pm			TKO				E 5pm							X	
2	W	W	W	–															
3			W	–	SL	–	–	SL			E								
4		W	W	–															
5				–	W		TKO		PYE-A FK		–								VL
6				X														X	
7	–	–	E	E 2pm	W														
8	–			E 2pm			W		W	W	W								
9	–	–	–	–	W	W		W	W	VL	W		W	W	TP	W	X	W	
10	–	–	W	W 2pm	W		W	W			X	W	SYP OEH		TP	OEH			
11	–	–	–	–	–	–	–	–		X	E								
12	–			X	W		TKO		W	VL	X		W		SL	V			
13										W	X	W	max	W		W	X	W	
14	–				VL				VL	VL	X								VL
15	–									SL	X	VL	SL	SL	SL	VL	VL	VL	
16	–									V	X								
17	–									V			–	CO	VL	VL			
18				V	V	V	V	V	V	V	V								
19																			
20	–	–	–	–	–	–	–	–											
21													TKO	W					
22																			

Encl. 9(ii)