CONFIDENTIAL

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10th December 2003

C/O Mrs Flora Tai
Secretariat
Legislative Council
Hong Kong SAR Government

By fax and post to 2248-2011

Dear Mrs Tai

AA

Re: [redacted] at Kwong Wah Hospital in February 2003

Many thanks for asking me to make a written submission on the captioned event. My clinical involvement in the management of this case was brief and indirect, as he was under the direct care of the Intensive Care Unit team which was in direct communication with the Clinical Coordinator Dr Andrew WC Yip of Kwong Wah Hospital. The following events took place and are outlined to the best of my knowledge and still vivid recollection:

24th February 2003

Approximately 10:45 a.m.
I was paged by Dr PL Ho, while doing a ward round on ward B2 of Queen Mary Hospital, requesting my participation to accompany him to go to Kwong Wah Hospital and assess the captioned case. I immediately went to the Endoscopy Suite of Queen Mary Hospital to collect what I considered to be important personal protective equipment for Dr PL Ho and myself.

Approximately 11:00 a.m.
I met Dr PL Ho at his office to show him the personal protection equipment before departure.

Approximately 11:30 a.m.
We arrived at Kwong Wah Hospital Intensive Care Unit and met Dr Andrew Yip and his Intensive Care team members including Dr Wat (Chief of Service). Chest x-ray, laboratory results and clinical notes were reviewed with Dr Wat and his team. Patient was not examined. Dr PL Ho and I provided advice on the medical management, necessity of extreme caution to be taken, and need of further investigations. Dr PL Ho and I waited at Intensive Care Unit for further specimens to be collected to take back to Queen Mary Hospital until about 2:00 pm.

2:30 pm - 3:00 p.m.
I returned to the office to gather my thoughts, and emailed Dr PL Ho outlining my views on further management, investigations required to find out the exact cause of the community acquired pneumonia, need of teamwork, and the need of extreme caution to be exercised.

3:39 p.m.
I communicated with Dr PL Ho and understood from his email that urgent processing was underway for the cause (aetiology) of this potentially highly "infectious-and-lethal" case of community-acquired pneumonia.

25th February 2003

8:14 a.m.
I emailed Dr PL Ho on my interpretation of the microbiological results. I also reiterated the need to urgently investigate the captioned case.

10:46 a.m.
I received an email from Dr PL Ho informing me that Professor KY Yuen had taken over this case, and hence my disengagement from further involvement.

I hope the above help depict my involvement in the care of this patient.

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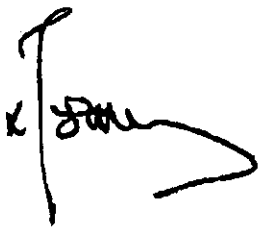
Many thanks and with kind regards.



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