Chapter 4 The M Hotel Cluster

Finding of facts

4.1 The M Hotel was associated with one of the clusters of SARS cases in Hong Kong, including *AA*, the index patient of the SARS outbreak in Hong Kong, *JJ*, the index patient of the Prince of Wales Hospital (PWH), and the index patients of the SARS outbreaks in Hanoi, Singapore and Toronto.

4.2 *AA* came to Hong Kong on 21 February 2003 and was admitted to the Kwong Wah Hospital (KWH) on 22 February 2003 after feeling unwell. The Hospital Authority notified the Department of Health (DH) of *AA*'s case on 24 February 2003. The investigation notes taken by the Kowloon Regional Office (KRO) of DH on the same day indicated that *AA* had checked into the M Hotel on 21 February 2003, before having dinner at the home of his sister, *CC*. KRO did not consider launching an investigation at the Hotel for two reasons. First, the case of *AA* was considered an imported one as *AA* had been in Hong Kong for less than 24 hours before he sought treatment at KWH. Second, the risk of respiratory tract infection was considered highest through close person-to-person contact. As such, it was considered that the appropriate measure to follow up the case was contact tracing. The Consultant Community Medicine in-charge of the Disease Prevention and Control Division of DH, Dr TSE Lai-yin, was informed of the case on 24 February 2003 and agreed to the course of action taken by KRO. The Director of Health (D of H), Dr Margaret CHAN FUNG Fu-chun, was briefed on the case on 25 February 2003.

4.3 On 8 March 2003, during a telephone conversation on another subject between Dr TSE and a doctor from the Ministry of Health (MoH) of Singapore, the latter informed the former that three tourists who were hospitalized after travelling to Hong Kong had stayed at the M Hotel around 20 February to 25 February 2003, and that two of them were friends. Dr TSE was also told that the results of the laboratory investigations were still pending and that the patients' conditions had apparently improved with antibiotic treatment. After further discussing the matter with the Singaporean doctor,

Dr TSE considered that there was insufficient evidence to suggest that their illnesses had been related to the Hotel. Dr TSE asked MoH of Singapore to keep her posted of any positive laboratory findings. Dr CHAN was briefed on the case afterwards.

4.4 On 13 March 2003, DH was notified of a Severe Community-Acquired Pneumonia (SCAP) case. The patient, *FF*, was transferred from the St Paul's Hospital (SPH) to the Queen Mary Hospital (QMH) on 8 March 2003. *FF* was later identified to be the index patient of the SARS outbreak at SPH. Investigation by the Hong Kong Regional Office of DH revealed that *FF* had stayed at the M Hotel from 18 February to 23 February 2003 before his admission to SPH on 2 March 2003. The question of launching an investigation at the Hotel was not raised then because Dr TSE thought that for a respiratory tract infection, the place of residency was not significant. Moreover, she thought that there was no indication of any environmental factors that would suggest the need for launching an investigation at the Hotel. Dr CHAN was not informed of this case until 18 March 2003.

4.5 On 18 March 2003, DH learnt from a fax sent by Health Canada that a Canadian resident, who was later identified to be the index patient of the SARS outbreak in Toronto, had stayed at the M Hotel from 18 February to 22 February 2003. Knowing that the three Singaporean tourists had also stayed at the M Hotel, Dr TSE brought the matter to the attention to Dr CHAN who decided there and then that DH should launch an investigation at the Hotel and examine exhaustively the patient records of SCAP cases and those of the PWH cases. DH's investigation at the M Hotel was launched on the same day. More cases associated with the M Hotel were identified following DH's investigation, and an announcement of the cluster at the Hotel was made on 19 March 2003.

4.6 Dr CHAN told the Select Committee that the association of *AA*'s case at KWH and of the outbreak at PWH with the M Hotel should have been identified on 14 March 2003 when the case of *FF* was reported to DH on 13 March 2003 and investigated within 24 hours.

4.7 The Deputy Director of Health, Dr LEUNG Pak-yin, who was the immediate supervisor of Dr TSE, considered that from a professional angle, initiating an investigation at the M Hotel on either 14 March or 18 March 2003 would not be unreasonable, having regard to the practice of case investigation and the contact tracing information system at that time. The linkage of the various cases to the M Hotel was only obvious when the whole cluster was looked at retrospectively.

4.8 Dr TSE explained to the Select Committee that although she had read the investigation reports on the cases of *AA* and *FF*, she did not "register" ("註冊") the M Hotel in her mind because for a respiratory tract infection, the place of residency was not significant. As regards the Singapore cases, the M Hotel was very clear in her mind because she personally talked to the doctor concerned on the Singapore side. Dr TSE informed the Select Committee on 28 May 2004 that the investigation report she received on *FF* on 14 March 2003 specified that *FF* "live in a hotel (某酒店) at Mong Kok". She was not aware that "某酒店" and the M Hotel referred to the same premises. She reiterated that as the place of residency of a patient was not a significant factor for a respiratory tract infection at that time, she had not enquired about the English name of the hotel.

4.9 The Select Committee noted that in a staff newsletter issued in November 2003, DH informed its staff that even if it had launched an investigation at the M Hotel on 8 March 2003, it would not have changed the course of the outbreak at PWH. Retrospective epidemic information indicates that although the outbreak at PWH only came to light on 11 March 2003, over 30 cases in the PWH cluster had onset of symptoms by 8 March 2003. Neither could DH have identified *JJ* as the index patient of the PWH outbreak earlier, since *JJ* was only a visitor to and not a guest of the Hotel. *JJ* was first suspected to be the index patient on 13 March 2003 and was only confirmed as such on the following day.

4.10 According to Dr TSE, the newsletter served to inform the staff of DH of certain facts about the cluster at the M Hotel. It did not mean to say that it was not necessary to launch the investigation at the M Hotel because it would not have changed the course of the outbreak at PWH. Dr TSE

expressed the view that in dealing with infectious diseases, there would of course be benefits in conducting investigations as early as possible. Looking to the present and even with the experience of handling the SARS outbreak, a gradual approach would still be adopted. Contact tracing of close contacts would be the measure to be taken in the first instance in following up cases of influenza, SARS, tuberculosis and any unknown respiratory infection, unless there was information to suggest otherwise.

Analysis

4.11 The Select Committee has considered whether the investigation at the M Hotel should have been launched earlier than 18 March 2003. The Select Committee has looked at two dates. The first is 8 March 2003 when Dr TSE Lai-yin was informed by MoH of Singapore that three Singaporean tourists who were hospitalized in Singapore after travelling to Hong Kong had stayed at the M Hotel. The second is 14 March 2003 when DH learnt that *FF* had stayed at the M Hotel, during the investigation into the case.

4.12 The Select Committee is of the view that the investigation at the M Hotel could, at the earliest, have been launched on 8 March 2003, given that there were already three separate cases involving four persons, i.e. *AA* and the three Singaporean tourists, linked to the Hotel by that time. The Select Committee considers that these three Singaporean tourists should have been regarded as two separate cases because only two of them were friends.

4.13 As regards 14 March 2003, the Select Committee considers that there was no reason not to launch an investigation, as, by then, the M Hotel was already known to be linked to four separate cases involving five persons. The Select Committee notes that Dr Margaret CHAN also expressed the view that the date of 14 March 2003 furnished an opportunity for launching an investigation at the M Hotel.

4.14 The Select Committee accepts that even if the investigation at the M Hotel were launched on 8 March 2003, the outbreak at PWH could not have been prevented. However, the Select Committee considers that had the

investigation at the M Hotel been launched on 8 March 2003, the experience and findings of the investigation might have helped in the handling of the outbreaks at SPH and elsewhere in the world, such as Toronto and Singapore.

4.15 As detailed in paragraph 4.8 above, Dr TSE explained to the Select Committee that although she had read the investigation reports on the cases of *AA* and *FF*, she did not "register" ("註冊") the M Hotel in her mind because she did not consider the place of residency to be significant for a respiratory tract infection. Noting that ultimately Dr TSE informed Dr CHAN when she realized that the Toronto index patient had also stayed at the M Hotel, the Select Committee finds Dr TSE's explanation of her not "registering" the M Hotel in her mind not convincing.

Performance and accountability

4.16 As Dr TSE Lai-yin failed to connect the relevant cases to the M Hotel either on 8 March or 14 March 2003, the Select Committee finds her performance as the senior public health official in charge of contact tracing at that time not satisfactory.