Chapter 7 Outbreak at the Alice Ho Miu Ling Nethersole Hospital

Finding of facts

7.1 At 11:30 am on 12 March 2003, two days after the SARS outbreak at the Prince of Wales Hospital (PWH), an urgent meeting was held among the Consultant of the Department of Medicine and Therapeutics in PWH, Dr CHOW Chun-chung; the Hospital Chief Executive (HCE) of the Tai Po Hospital (TPH), Dr TUNG Sau-ying; the Chief of Service (COS) of the Department of Medicine in the North District Hospital (NDH), Dr WONG Kwan-keung; and the then COS of the Department of Medicine in the Alice Ho Miu Ling Nethersole Hospital (AHNH), Dr CHAN Hok-sum. Having briefed his colleagues at the meeting on the situation in PWH, Dr CHOW requested NDH and AHNH to deploy some doctors to help out at PWH. Since the only thing known about the disease which caused the outbreak at PWH was its high infectivity, and considering that healthcare workers (HCWs) might get infected more easily when working in an unfamiliar environment, it was decided at the meeting that non-atypical pneumonia (non-AP) medical patients be transferred from the Accident and Emergency Department (AED) in PWH to NDH and AHNH instead. Dr CHAN reported this decision to HCE of AHNH, Dr Raymond CHEN Chung-i, in the same afternoon.

7.2 This was how AHNH first got involved in the battle against SARS.

<u>Admitting non-atypical pneumonia medical patients transferred from the Prince of Wales Hospital</u>

7.3 The General Manager (Nursing), Ms TSANG Sou-wah, and the Department Operations Manager of the Department of Medicine, Ms CHAN Kit-hoi, were informed of the above decision at a departmental meeting on 12 March 2003. The diversion of non-AP medical patients to AHNH started on 13 March 2003.

7.4 According to Ms CHAN, as AHNH was to receive non-AP medical patients from PWH, the Infection Control Officer (ICO) of the New Territories

East Cluster (NTEC), Dr Donald James LYON, did not provide any advice on the extra precautionary measures that needed to be taken in this connection. Neither did Dr LUI Siu-fai, the Service Director (Risk Management and Quality Assurance) of NTEC, undertake any risk assessment on the decision to transfer non-AP medical patients to AHNH and the impact of the closure of AED in PWH on AHNH. The Select Committee, however, noted from the information subsequently provided by Dr LYON that he had issued 13 NTEC guidelines from 14 March to 31 March 2003 (as set out in Appendix VII), and that such guidelines were followed by the hospitals in NTEC. According to Dr LUI, there was no need to carry out any risk assessment as the transfer involved non-AP medical patients only.

7.5 Although the decision was for AHNH to receive non-AP medical patients from PWH, infection control measures in AHNH were enhanced. HCWs were provided with additional training on infection control and the use of personal protective equipment (PPE), including surgical masks and disposable gowns. Improvements were made to the environmental facilities in AHNH which included increasing air circulation to six air changes per hour and installing air filters in the wards. The patients transferred from PWH or patients suffering from respiratory illness were admitted and observed in two designated wards, E1 and F1, in order to prevent the possibility of the infection spreading. The Wards had better infection control facilities as well as four isolation rooms with en-suite toilets.

7.6 A total of 60 patients were diverted from AED in PWH to AHNH between 13 March and 18 March 2003. Measures taken in AHNH to cope with the increased patient load included adding extra beds in wards, enhancing the overflow arrangement for patients transferred from the medical wards to the non-medical wards, enhancing the convalescent support in TPH, and stopping all elective admissions.

<u>Further increase of patients as a result of the suspension of the Accident and Emergency Department services at the Prince of Wales Hospital</u>

7.7 As the situation in PWH deteriorated, it was decided at the NTEC Meeting on Management of AP Incidence on 18 March 2003 that the AED

services at PWH be suspended, initially for three days, starting from 19 March 2003. Dr Raymond CHEN told the Select Committee that before supporting the proposed suspension of the AED services at PWH, he had assessed the capacity and preparedness of AHNH to cope with additional patients. He reiterated that the capacity of AHNH was discussed at the NTEC Meeting on Management of AP Incidence.

7.8 Dr CHAN Hok-sum was informed of the above decision on the same day.

7.9 With the suspension of the AED services at PWH on 19 March 2003, all accident and emergency cases were diverted to NDH, AHNH and other hospitals. In view of AHNH's proximity to PWH, it took up a substantial portion of these cases. Trauma patients with no immediate life threatening conditions were sent to NDH. Other cases were sent to AHNH. In order to relieve the workload of AHNH, some cases were transferred to NDH or hospitals in other clusters after assessment.

7.10 In order to cope with the increased workload, AHNH took further measures. These measures included increasing the medical in-patient service capacity by stopping clinical admissions, making internal overflow arrangement with the Department of Day Surgery and the Department of Orthopaedic and Traumatology, strengthening the convalescent support provided by TPH, and making arrangements to transfer medical patients directly from AED in AHNH to other hospitals. Despite such measures, the bed occupancy rate at AHNH reached 120% at one stage. According to the information subsequently provided by Dr Raymond CHEN, the occupancy rate of 120% occurred only on 15 March and 22 March 2003 in Ward E1. In fact, around that time, the average occupancy rate of the medical wards in AHNH was 105% (from 13 March to 31 March 2003) which was lower than the occupancy rate of 112.9% in the same period in 2002. The Select Committee also noted that the number of ambulance cases transported directly to AHNH increased from a daily average of 48 in February 2003 to a daily average of 115 in the last two weeks of March 2003. The number of patients attending AED in AHNH reached its peak of 626 on 27 March 2003. The workload at both

AED and in-patient wards vastly exceeded AHNH's manpower and ward capacity.

7.11 There is no evidence showing that anyone in AHNH had requested for a risk assessment on AHNH before the decision to accept additional patients was made. Dr Raymond CHEN explained to the Select Committee that this was because an overall assessment had already been made during the discussion at the NTEC Meeting on Management of AP Incidence on 18 March 2003.

7.12 In the meantime, additional training on infection control measures and the use of PPE was provided by the Infection Control Nurse (ICN). The environment was further improved by increasing fresh air supply and air change inside the medical wards. To prevent cross-infection, patients with respiratory tract infection were admitted to designated wards with upgraded infection control measures and were closely monitored. It remained the strategy of NTEC to keep AHNH a "clean" hospital admitting only non-SARS medical patients. Different levels of infection control measures were adopted according to the nature of the wards in the Hospital.

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7.13 Although AHNH was supposed to admit non-AP and non-SARS medical patients, it did not escape the fate of having an outbreak of SARS. The cause of the outbreak, which started on 21 March 2003, was attributed to what was described as "cryptic" SARS patients, i.e. patients who did not present sufficient symptoms to enable HCWs to diagnose them as suffering from either AP or SARS. The outbreak at AHNH mainly affected five wards and resulted in a total of 90 patients and 41 HCWs being infected. In the outbreak, there were seven index patients, who were admitted via AED in AHNH.

7.14 AED in AHNH was divided into fever and non-fever zones. Senior Medical Officers (SMOs) were engaged in case triage and segregation. According to the triage criteria adopted at that time, patients having a fever (higher than 38^{o}C), new chest X-ray infiltrate, respiratory tract infection, a

history of SARS contact and low lymphocyte count would be classified as a SARS or suspected SARS case. Patients suspected to have been infected with SARS were admitted to either the Princess Margaret Hospital (PMH) or PWH. Patients with conditions not matching the diagnostic criteria of SARS but requiring hospitalization were admitted to AHNH or other hospitals. Between March and April 2003, AED in AHNH transferred 123 suspected SARS patients to other hospitals. Forty-one or 33.3% of them were ultimately found to be confirmed cases of SARS.

7.15 The index patient in Ward E1 sought treatment in AED in AHNH for fever and cough on 21 March 2003. He had a history of fever and headache since 15 March 2003. His lymphocyte count was normal and chest X-ray showed left mid-zone haziness. The respiratory physician diagnosed him as a bacterial Community-Acquired Pneumonia case. Ms CHAN told the Select Committee that as the patient lived in Tai Po, he would have sought treatment in AED in AHNH irrespective of whether the AED services at PWH had been suspended.

7.16 Although the index patient in Ward E1 showed highly suspected SARS symptoms, he was not diagnosed as a SARS case because first, he had not indicated any contact with SARS patients or travel history to the Mainland when asked in AED and second, he had normal lymphocyte count. The patient was then admitted to Ward E1, which was a male medical ward.

7.17 According to Dr CHAN, the standard questions on the history of contact put to the patients in AED were set out in a form provided by the Head Office of the Hospital Authority (HAHO). Ms CHAN told the Select Committee that to be extra cautious, HCWs in AHNH were instructed to ask patients whether they had any contact with people who had been associated in any way with Ward 8A in PWH. However, the patients were not asked whether they had been contacted by the Department of Health (DH).

7.18 It was intended to put the index patient (who had cough and a fever) in Ward E1 in an isolation room which was provided with negative pressure and an ante-room with a wash basin in it. However, that could not be done as the four isolation rooms in Ward E1 were already fully occupied by suspected

SARS patients and patients with symptoms of communicable diseases who were in more serious conditions. The index patient could only be placed in a bed close to the window where there was only one patient next to him. He was asked to put on a mask upon admission, but he did not always do so properly because of discomfort, especially after continuous and prolonged wearing. Ms CHAN and her colleagues had discussed the issue of patients refusing to wear masks. They found it difficult to enforce the practice as it was not obligatory for patients to wear masks. Dr CHAN told the Select Committee that the patient was put in the open area of the Ward because he considered that the patient's infectivity would be low. All the patients and HCWs in the Ward wore masks and the air change in the Ward was sufficient to prevent airborne infection.

7.19 After being treated with antibiotics, the index patient in Ward E1 recovered from fever, but he relapsed subsequently. On 24 March 2003, he was diagnosed as an AP patient by a Medical Officer and was transferred to PMH. The patient ultimately turned out to be a "cryptic" SARS patient, a concept conceived at a later stage of the SARS epidemic. The other six index patients in AHNH all turned out to be "cryptic" SARS patients.

7.20 The index patient in Ward E6 was admitted on 23 March 2003 with abdominal pain and diarrhoea, but no fever. The index patient in Ward E3 was first admitted on 25 March 2003 with per-rectal bleeding, and the diagnosis was "Ca rectum". He was discharged on 29 March 2003 and re-admitted on 1 April 2003 with per-rectal bleeding, abdominal pain, fever and headache, but showed no change on his chest X-ray. There were two index patients in Ward F5. The first one was admitted on 30 March 2003 with right-sided weakness. The patient had a low grade fever shortly after admission but the initial chest X-ray was clear. The computerized axial tomographic scan showed left thalamic haemorrhage in the brain. The second index patient with a history of "Ca lung" was admitted on 1 April 2003 because of haemoptysis. The patient did not have a fever on admission, with his chest X-ray showing no sign of pneumonia. Regarding Ward F6, there were two possible index patients. The first one was admitted on 4 April 2003 with a fever and myalgia, but with no cough or other respiratory tract infection symptoms. The lymphocyte count was normal. The diagnosis was chest infection and sepsis.

The patient was transferred to PWH after two and a half hours as his condition was not stable initially. Dr CHAN recalled that this patient might have a history of contact with SARS patients. The second suspected index patient, who was more likely to be the index patient, was admitted on 9 April 2003 with a sudden onset of dyspnoea and fever. His chest X-ray showed only some haziness and lymphocyte count was normal. The diagnosis was bacterial pneumonia. As all these patients did not fulfil each and every criterion of the SARS definition, they were not so categorized. The seven index patients were admitted between 21 March and 9 April 2003.

7.21 The first HCW who was infected with SARS developed a fever on 25 March 2003. He had attended to the index patient in Ward E1 before. With a complaint of fever and malaise, he sought treatment in AED in AHNH and was suspected to have SARS. He was transferred to PMH for further observation and management on 28 March 2003.

7.22 After the first HCW came down with the disease on 28 March 2003, Dr CHAN immediately telephoned Dr LYON to seek his advice on the infection control measures to be taken and his views on whether it was necessary to close Ward E1. Upon receiving Dr LYON's advice, AHNH enhanced the infection control measures in Ward E1. All HCWs were required to wear N95 masks and protective gowns. After the patients in the Ward had been screened, none of them was found to have developed a fever or respiratory tract infection. It was decided not to close the Ward owing to the great demand for beds in AHNH resulting from the suspension of the AED services at PWH. Dr CHAN explained to the Select Committee that the Ward would not be closed when only one "suspected" case was found; otherwise they would not have sufficient beds to cope with the patient load.

7.23 On 31 March 2003, three nurses in Ward E1, who had contact with the index patient in Ward E1, developed a fever and chest X-ray abnormality and were transferred to PMH. Noting that a total of four HCWs had been infected, Dr Raymond CHEN reported the outbreak to the community physician of DH. At that stage, the infection control measures were further enhanced and HCWs in all medical wards were required to wear N95 masks and protective gowns. All HCWs in Ward E1 were required to undergo

medical check-up in the staff clinic. In order to check the spread of the infection, Dr CHAN proposed and Dr Raymond CHEN agreed that Ward E1 be closed on 31 March 2003. Dr Raymond CHEN informed the Select Committee that on 3 April 2003, a contract cleaning worker developed a fever and was admitted to PMH.

7.24 The patients remaining in Ward E1 were examined for fever and other signs of respiratory tract infection. On 1 April 2003, a meeting was held among Dr LUI as well as senior management staff in AHNH and TPH to assess the outbreak at AHNH. It was agreed that the 14 patients remaining in Ward E1 would be cohorted in TPH for convalescence so that Ward E1 could be vacated for terminal cleansing and be re-opened for the triage of new patients. The proposal was endorsed by the Deputizing Cluster Chief Executive (CCE) (NTEC), Dr Philip LI Kam-tao. The transfer was effected on 3 April 2003 and Ward E1 was terminally cleansed.

7.25 Between 30 March and 3 April 2003, four more HCWs in Ward E3 were infected. Two HCWs who had worked in Ward E6 were infected, one on 29 March and the other on 4 April 2003. On 10 April 2003, an HCW in Ward F6 got infected. On 15 April 2003, a nurse of Ward F5 was suspected to have SARS. The four wards were closed after their respective outbreaks. A list of the discharged patients and visitors was compiled and sent to DH for contact tracing. Dr Raymond CHEN told the Select Committee that the period between 31 March and 4 April 2003 was most critical for AHNH, because the 10 days following 4 April 2003 was the incubation period of the disease, during which most of the infected HCWs contracted the disease. Dr CHAN explained that prior to 31 March 2003, i.e. before the admission of some of the seven index patients to AHNH, the level of PPE adopted by HCWs at that time was not that high. It was only after 31 March 2003 that HCWs in all medical wards were required to wear N95 masks and disposable gowns.

Opening of a SARS triage ward

7.26 In view of the continued infection of HCWs in AHNH, it was considered necessary to have a SARS triage ward for screening patients having some of the SARS symptoms on admission. Ward E1, having been

thoroughly cleansed, was re-opened on 7 April 2003 for this purpose. The precautionary measures taken in the triage ward included upgrading the infection control measures; providing more infection control training for HCWs; allowing more space between beds; installing exhaust fans and partition walls, and increasing the frequency of cleaning the ward areas. All HCWs were provided with PPE in accordance with the requirements for ultra-high risk wards. All HCWs were required to wear N95 masks, protective gowns, caps and gloves in the triage ward. They were also required to put on goggles or face shields when conducting high risk procedures that might generate droplets.

Opening of SARS wards

7.27 As the number of SARS patients continued to increase, the NTEC Meeting on Management of AP Incidence decided on 10 April 2003 that a SARS ward be opened in AHNH on 14 April 2003. Dr CHAN explained to the Select Committee the reasons for the decision were that the SARS wards in PWH were all full, and that there was a lack of nursing staff in PWH to enable additional SARS wards to be opened. Moreover, it would allow HCWs in AHNH to work in a familiar environment, thus reducing the chance of getting infected.

7.28 In the meantime, AHNH geared itself up to triage and handle SARS patients. The measures taken to enhance the preparedness for the new challenge included the upgrading of PPE; the provision of infection control training; the stratification of wards according to the risk of infection; staff re-deployment; the enhancement of the Intensive Care Unit capacity; the strengthening of supporting services; and the improvement of support to HCWs. In this connection, AHNH had received advice from experts including Dr LYON, Dr LUI, and COS of the Department of Medicine and Therapeutics in PWH, Professor Joseph SUNG Jao-yiu. Clinical protocol on management of SARS was adopted from PWH. Additional training was arranged by doctors and nursing managers from PWH. Although high standard isolation facilities could not be established in a short time, works were carried out to improve the environment including the installation of partitions between cubicles and corridors, as well as the installation of exhaust fans and

filters to improve the ventilation in all the SARS and SARS-related wards. It was also decided on 11 April 2003 to divert non-SARS medical admissions to other hospitals in order to make room for the admission of new SARS patients.

7.29 The first SARS ward (Ward F1) was opened on 14 April 2003 and the second one (Ward E1) was opened 14 days later, i.e. 28 April 2003. To be better prepared for the provision of SARS-related services, the NTEC Meeting on Management of AP Incidence agreed on 23 April 2003 that AED in AHNH be closed immediately, so that the overcrowdedness in AHNH could be eased and HCWs in AED could be released to help out in other wards. In the meantime, AHNH started to convert surgical and orthopaedic wards into medical wards for providing SARS-related services.

7.30 During the SARS epidemic, AHNH admitted a total of 105 SARS patients to its SARS wards. The last SARS case handled by AHNH was admitted on 4 June 2003. On 15 July 2003, all the SARS wards in AHNH were closed.

Contact tracing

7.31 Between February and mid-March 2003, AHNH reported to HAHO all the Severe Community-Acquired Pneumonia (SCAP) cases as well as those cases where patients were put on ventilators in accordance with the instruction in the memorandum on surveillance on SCAP issued by HAHO on 12 February 2003. From 19 March 2003, the reports included suspected cases of SCAP. These reports were sent to the NTEC Disease Control Centre and HAHO.

7.32 Apart from reporting new SARS cases to HAHO, Dr Raymond CHEN also alerted the community physician of DH to the outbreak in Ward E1 on 31 March 2003.

7.33 For the purpose of contact tracing, when a ward was closed after an outbreak, a list of the patients discharged from and the visitors to the ward was compiled and sent to DH.

7.34 Starting from 3 April 2003, AHNH's SARS Data Controller and the SARS ICO worked closely with their counterparts in other hospitals in the NTEC. A Contact Tracing Group was formed to deal with in-patients.

7.35 The Select Committee was told that despite such cooperation, AHNH did not receive from DH any results of contact tracing in respect of the index patient in Ward E1, the very first index patient. Upon further enquiry, the Select Committee subsequently learnt that DH in fact could not ascertain the source of infection of the first index patient but failed to so inform AHNH.

Infection control

7.36 Before accepting non-AP/non-SARS medical patients transferred from PWH, AHNH had adopted infection control measures in accordance with the guidelines issued by HAHO in February 2003. Ms CHAN Kit-hoi told the Select Committee that between the end of February and early March 2003, HCWs in Ward E1 were required to wear surgical masks and wash hands every time after contact with patients. When carrying out high risk procedures, HCWs were required to put on higher-level PPE, including protective gowns, gloves and face shields.

7.37 According to additional information provided by Dr LYON to the Select Committee, he issued 13 NTEC guidelines between 14 March and 31 March 2003 which were tailor-made for hospitals in NTEC. The guidelines were followed by hospitals in NTEC (including AHNH).

7.38 During the SARS epidemic, Ms TSANG updated HCWs in AHNH on the guidelines on infection control issued by HAHO and organized seminars on SCAP and the use of PPE for them. The training on infection control measures was provided by departmental infection control coordinators appointed by their respective departments. The implementation of infection control measures was monitored by departmental audit teams. Ms TSANG, however, said that although she had tried her best to update HCWs in AHNH on the HAHO guidelines, which were revised quite frequently, the messages posted on notice boards in the wards sometimes could not reach her colleagues because of ward movements. To address the problem, HCWs were later

required to read and sign against the messages and to pass on the messages to HCWs working in the next shift. HCWs who learnt about the messages conveyed verbally by their colleagues working in the preceding shift were still required to read and sign against the messages. Ms TSANG added that the provision of PPE was adequate, although sometimes AHNH had to press HAHO for more supply.

7.39 After the outbreak in Ward 8A in PWH, all HCWs in the medical wards in AHNH were required to wear surgical masks in ward areas, while N95 masks and gowns were made available to them when nursing patients and handling body fluids and secretion.

7.40 Starting from mid-March 2003, daily influenza surveillance among HCWs in AHNH was carried out. They were advised to look out for respiratory tract infection and fever, and attend the staff clinic or AED where necessary. Medical staff was reminded to look out for development of fever among patients and to take chest X-ray and blood tests, and consult the respiratory physician where necessary.

7.41 The infection control measures adopted in AHNH were enhanced at various stages in the SARS epidemic as described in the previous paragraphs. After the outbreak in Ward E1, the infection control measures were enhanced and HCWs in all medical wards were required to wear N95 masks and protective gowns.

7.42 Before the opening of the first SARS ward on 14 April 2003, AHNH was not expected to admit SARS patients; hence, the level of infection control measures in medical wards did not meet the requirements for SARS wards. As pointed out by Ms TSANG, different levels of infection control measures were adopted according to the nature of the wards in AHNH. Ms CHAN told the Select Committee that droplet precautions were adopted in the wake of the outbreak in Ward E1. Following the outbreak in Ward E1, the infection control measures therein were upgraded to the requirements for ultra-high risk wards.

7.43 One of the possible causes of the outbreak at AHNH was overcrowdedness in wards. Dr Raymond CHEN told the Select Committee that in making the decisions to transfer non-AP/non-SARS medical patients from PWH to AHNH on 12 March 2003 and to close AED in PWH on 18 March 2003, the capacity and the adequacy of infection control measures of AHNH were assessed. He believed that AHNH would be able to cope with the additional non-AP/non-SARS medical patients as they had anticipated that the number of patients would not be large. Regarding the closure of AED in PWH, he considered that the decision had been made hastily, and that there would be an impact on AHNH. However, given the situation at that time, he agreed to the arrangement.

7.44 Dr CHAN told the Select Committee that when it was decided to transfer the non-AP/non-SARS medical patients from PWH to AHNH, he did not expect the risk of an outbreak to be high because the patients that AHNH was going to receive should be free from SARS infection. As a result, AHNH had not considered the need to consult Dr LYON on any extra precautions that had to be taken. However, when the first nurse in Ward E1 was infected on 28 March 2003, Dr CHAN started to have concerns about the adequacy of the infection control measures and sought expert advice immediately. Dr LUI went to AHNH to discuss the transfer of the 14 remaining patients in Ward E1 to TPH. When a SARS ward was planned to be opened in AHNH in mid-April 2003, Dr CHOW and Dr LYON shared with Dr CHAN their experience in the handling of the SARS outbreak at PWH. Professor SUNG, who was the Cluster Co-ordinator (Medicine), together with some doctors from PWH, also provided assistance. As regards the supply of PPE, while Ms TSANG indicated that the supply was tight, Ms CHAN recalled that she did not receive any complaints from her colleagues about inadequate supply of PPE.

Staff movement in the Alice Ho Miu Ling Nethersole Hospital

7.45 Dr CHAN was told by Dr Raymond CHEN in the evening of 24 April 2003 that CCE of NTEC, Dr FUNG Hong, had asked him to step down as COS of the Department of Medicine in AHNH. Dr CHAN recalled that Dr FUNG explained to him on 26 April 2003 that it was necessary to control the outbreak in Tai Po as soon as possible, as there were many accusing

fingers pointing at the Government and HA. After being told that a "wartime leader" was needed, Dr CHAN resigned as COS with effect from 28 April 2003. Although Dr Raymond CHEN did not agree with Dr FUNG that Dr CHAN lacked "wartime leadership", he did not raise any objection to the decision.

7.46 Dr CHAN told the Select Committee that on reflection, he would not consider that AHNH was able to cope with such a large number of SARS patients in terms of capacity, manpower and facilities. When AHNH had to accept non-AP/non-SARS medical patients from 13 March 2003, Dr CHAN thought that although AHNH might not be completely prepared, HCWs there felt duty-bound to do their utmost to provide healthcare for the patients. The view that the facilities in AHNH were not sufficient to treat patients with infectious diseases was echoed by his colleagues in AHNH.

Analysis

7.47 The Select Committee is of the view that AHNH was not adequately prepared to cope with the increase in patient load resulting both from the diversion of non-AP/non-SARS medical patients from PWH starting from 13 March 2003 and from the suspension of the AED services at PWH from 19 March 2003. Dr Raymond CHEN reiterated that the capacity of AHNH to handle additional patients had been assessed both by himself and by his colleagues at the NTEC Meeting on Management of AP Incidence. Despite the measures taken by AHNH to cope with the additional patient load as detailed in paragraphs 7.6 and 7.10 above, the bed occupancy rate at AHNH reached 120% at one stage. The Select Committee notes that some HCWs in AHNH appearing before the Select Committee and Dr Raymond CHEN considered that overcrowdedness in the wards was one of the contributing factors of the outbreak.

Performance and Accountability

7.48 The Select Committee is of the view that Dr FUNG Hong, being CCE of NTEC, had the duty and responsibility of guiding all hospitals in his cluster to handle the outbreak which had occurred in these hospitals. He, however, at that point in time, was faced with unprecedented work pressure arising from the outbreak at PWH. In his capacity as CCE of NTEC, he should also have taken effective measures to ensure that AHNH would be capable of managing the extra patient load overflowing from PWH. The Select Committee notes that although arrangements were made to decant patients to other hospitals outside NTEC, these arrangements were not sufficiently effective to enable AHNH to manage the extra patient load.