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Legislative Council

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LC Paper No. CB(2)1107/08-09
(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 12 January 2009 at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, JP (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Albert HO Chun-yan Hon Andrew CHENG Kar-foo Hon Albert CHAN Wai-yip Hon Audrey EU Yuet-mee, SC, JP Hon Vincent FANG Kang, SBS, JP Hon Alan LEONG Kah-kit, SC Hon Cyd HO Sau-lan Hon CHAN Hak-kan Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou
Member absent	:	Hon Fred LI Wah-ming, JP
Public Officers attending	:	Items IV to V Dr York CHOW, SBS, JP Secretary for Food and Health Mr Patrick NIP, JP Deputy Secretary for Food and Health (Health) 1 Mr Shane SOLOMON Chief Executive Hospital Authority

Dr P Y LEUNG, JP
Director (Quality & Safety)
Hospital Authority

Item IV only

Dr Loretta YAM
Cluster Chief Executive, Hong Kong East Cluster
Hospital Authority

Dr C C LAU
Chief of Service, Accident and Emergency/Deputy Hospital Chief Executive, Pamela Youde Nethersole Eastern Hospital
Hospital Authority

Item V only

Dr H C MA
Hospital Chief Executive, Caritas Medical Centre
Hospital Authority

Clerk in attendance : Miss Mary SO
Chief Council Secretary (2) 5

Staff in attendance : Ms Maisie LAM
Senior Council Secretary (2) 7

Ms Sandy HAU
Legislative Assistant (2) 5

Action

I. Confirmation of minutes
(LC Paper No. CB(2)593/08-09)

The minutes of the meeting held on 10 November 2008 were confirmed.

II. Information paper(s) issued since the last meeting
(LC Paper No. CB(2)483/08-09(01))

2. Members noted a submission dated 5 December 2008 from 準來港婦女關注組 issued since the last meeting and did not raise any queries.

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III. Items for discussion at the next meeting
(LC Paper Nos. CB(2)591/08-09(01) and (02))

3. Members agreed to discuss the following items at the next regular meeting to be held on 9 February 2009 -

(a) Progress report on promoting healthy eating among school children; and

(b) Allocation of resources among hospital clusters by the Hospital Authority.

IV. Operation of mortuaries in public hospitals
(LC Paper Nos. CB(2)607/08-09(01) and CB(2)626/08-09(01))

4. Secretary for Food and Health (SFH) and Chief Executive, Hospital Authority (CE, HA) expressed their apologies and deepest condolences to the family of the deceased baby boy whose body was found missing from the mortuary in the Pamela Youde Nethersole Eastern Hospital (PYNEH). SFH expressed disappointment about the incident, given the implementation of a series of measures to improve mortuary services across the board in public hospitals since mid 2007 as set out in paragraphs 5 to 10 of the Administration's paper (LC Paper No. CB(2)607/08-09(01)).

5. CE, HA further briefed members on the actions taken by the PYNEH after the PYNEH incident, details of which were set out in paragraphs 12 to 13 of the Administration's paper.

Investigation of the incident

6. Mr WONG Kwok-hing noted that on 2 January 2009, a Mortuary Technician (MT) conducted a bi-weekly routine checking of the number of bodily parts and discovered that the baby boy was missing. The MT and the Mortuary Attendant (MA) started a search for the body in the mortuary but to no avail. At 4:45 pm on 5 January 2009, the MT reported the baby boy missing incident to the hospital management, which subsequently reported the incident to the Hospital Authority (HA) Head Office and the Police. Mr WONG asked why the three-day delay for the mortuary staff to report the Incident to the hospital management.

7. CE, HA responded that he was also very annoyed and disappointed about the delay, as it was HA's culture to be open and accountable. The internal investigation led by Dr Loretta YAM, Chief Cluster Executive, Hong Kong East Cluster, would ask that question at the top of the list - why the mortuary staff did not report the missing baby boy to the management in the first instance and why these staff thought they could do their own investigation.

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8. Mr Albert CHAN noted that PYNEH had immediately suspended the duties of the MA concerned and warned the MT on the seriousness of the delayed reporting to the hospital management. Mr CHAN expressed concern about HA only putting the blame on the frontline staff and not the management. Ms Audrey EU also expressed concern about the adverse impact of the PYNEH incident on the morale of HA staff.

9. SFH responded that as the policy secretary overseeing all healthcare services in Hong Kong, he had grave concern about the PYNEH incident. To prevent recurrence of similar incident in future, he had instructed HA to thoroughly investigate the matter. If it was revealed after investigation that the Incident was caused by human errors, appropriate disciplinary actions would be taken. SFH further said that although staff morale would inevitably be adversely affected by the PYNEH incident, it was important for HA to learn a lesson from the incident and to make necessary improvements.

10. Chief Cluster Executive, Hong Kong East Cluster, HA (CCE/HKEC, HA) responded that in accordance with HA human resources policy, the hospital management would take appropriate disciplinary actions upon findings of the independent hospital investigation team set up by PYNEH to further investigate the incident. In the meantime, the duties of the MA concerned had been temporarily suspended as he had become emotionally unstable after the incident. HA staff had been telephoning the MA concerned daily to see how he was coping. Arrangements would be made for the MA concerned to work in other areas in the Department of Pathology after his condition had stabilised. As regards the MT, he had been temporarily taken off his supervisory duties to carry out frontline work. CCE/HKEC, HA further said that she herself had met with staff of the Department of Pathology of PYNEH three times since the incident had come to light. Nevertheless, the decisions on how to deal with the incident, including disciplinary actions, would hinge on the findings of the independent hospital investigation team and their recommendations to the hospital management.

Cultivation of a caring culture in the mortuary

11. Mr WONG Kwok-hing said that the root cause of the incident was due to the lack of respect to the deceased patients by HA staff. Mr WONG asked whether HA would strengthen the training of its staff to instill in them a greater sense of respect to the deceased.

12. CE, HA agreed that HA might need to run some programmes to teach mortuary staff a greater sense of respect to the deceased. CE, HA however pointed out that there were a few good examples at HA where mortuary staff gave the greatest respect to the deceased. For instance, last year, one of the few outstanding staff awards went to the head of the mortuary at Queen Mary Hospital whose attitude was that the deceased were still patients and should thus

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be treated with care and respect.

13. Dr PAN Pey-chyou declared that he was an employee of HA. Dr PAN further said that apart from organising training programmes to instill in frontline staff a greater sense of respect to the deceased, it was equally important for staff at the management level to show their care and concern for the day-to-day operations of the mortuary to frontline staff by regularly coming down to the working areas of the mortuary to strengthen communication.

Operation of mortuaries in public hospitals

14. Mr WONG Kwok-hing asked -

(a) whether a wristband was put on the body of the missing baby boy so as to facilitate correct identification of the body through the barcode scanning system introduced in HA since April 2008; and

(b) whether garbage bags were used by HA to keep the bodies of deceased babies.

15. CE, HA replied in the positive to Mr WONG's first question. CE, HA however pointed out that the deceased body must be sighted to enable the mortuary staff to use a 2-D barcode scanner to match the information on the unique identification label on the wristband of the body with the necessary documents for the receipt and release of body. In the PYNEH incident, it appeared that the body of the deceased baby boy was not sighted on the way out. Clearly, this was one area which HA had to look into to prevent similar problem from recurring.

16. Regarding Mr WONG's second question, Director (Quality & Safety), HA (Director (Q&S), HA) said that in PYNEH, all dead bodies (whether adult or baby) were put inside adult-size plastic body bags which were silver in colour by nursing staff in the in-patient areas. Following the incident, HA decided that the colour of the body bags would be standardised across all mortuaries in public hospitals. In the long run, HA would source small body bags for dead bodies of babies. In the interim, HA would use transparent plastic bags for keeping bodies of dead babies and put these bags individually in semi-transparent plastic boxes with clear labels. Director (Q&S), HA further said that plastic bags which were black in colour were used in some HA mortuaries to store aborted foetus from pregnancies before 24 weeks, amputated body parts and body tissues, which unfortunately gave the wrong impression of them being garbage bags. After review, HA had now banned the use of black body bags to store aborted foetus, amputated body parts and body tissues across the board in HA.

17. Mr Albert CHAN noted that a large-size adult dead body was placed in the same compartment with the deceased baby's body in the PYNEH incident.

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Mr CHAN asked how prevalent was the sharing of two deceased bodies in the same compartment in HA mortuaries.

18. CCE/HKEC, HA responded that in general, the shared use of one compartment by more than one bodies was not allowed. Only under special circumstances, such as when the utilisation of the mortuary had exceeded 100%, would two deceased bodies be considered to be placed in the same compartment. CCE/HKEC, HA further said that the PYNEH management was not aware that a large-size adult dead body was placed in the same compartment with the deceased baby's body, until after the mortuary staff had reported the baby boy missing incident to the management.

19. Dr LEUNG Ka-lau asked why the mortuary staff at PYNEH still put the baby body and the large-size adult body in the same compartment when the occupancy rate of the mortuary was about 75%.

20. CE, HA responded that the staff concerned believed they had followed the proper procedures for storing the bodies. There were three special compartments for storing either a large-size dead bodies or baby bodies in the PYNEH mortuary. In the absence of additional special compartments, the staff concerned chose to put the baby body and the large-size adult body together in the same compartment. The reason why the staff concerned did not consider moving the baby body to another compartment was because they were concerned about the additional risks of body mix-up carried by transfer of body to another compartment. CE, HA however pointed out that these were only speculations on why the staff concerned did what they did. Inquiry into what went wrong was being conducted by the Police and the investigation team set up by PYNEH. Findings of these two inquiries should give clearer views on the cause of the PYNEH incident.

Measures to enhance mortuary services in public hospitals

21. Ms Audrey EU noted that one of the additional measures which HA had implemented after the PYNEH incident was the installation of CCTV in mortuaries. Ms EU queried whether "spying" on staff was necessary the best way forward. Ms EU considered that a better approach was to cross-check that all operating procedures for body collection and identification in mortuaries to ensure complete compliance of the procedures and to install a sound-emitting electronic device to the wristband of the deceased so as to avoid a dead body from leaving the mortuary without the knowledge of mortuary staff.

22. SFH responded that CCTV had been installed in all mortuaries under the Department of Health following the occurrence of the Fu Shan Public Mortuary Incident in March 2005 whereby a dead body was found missing and it was suspected to have been released to another family and cremated. SFH pointed out that the installation of CCTV in mortuaries could not only strengthen supervision over mortuary operation, but also provide video clips to facilitate

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investigation in the event of any mishandling of deceased bodies. SFH further said that there was no question of HA using CCTV to spy on its staff, as the CCTV surveillance system only covered areas of security concern, such as the working areas and the lobby, and not staff offices.

23. CE, HA supplemented that installing CCTV in all HA mortuaries was something which HA could introduce immediately to minimise risks in hospital mortuary operations without further investigation. Apart from this, mortuary staff had been instructed not to put small body and large body inside the same compartment, as had been done in the PYNEH incident. Moreover, deceased bodies of babies would henceforth be stored individually in semi-transparent plastic boxes. CE, HA further said that installing an electronic tag to the wristband of the deceased was certainly one area which HA would be looking at to prevent a dead body leaving the mortuary without the knowledge of mortuary staff. On the suggestion of cross-checking all operating procedures to avoid mistakes in the collection and identification of dead bodies, CE, HA said that HA would examine whether this was necessary to do so. CE, HA however pointed out that following the PYNEH incident, daily verification of deceased bodies against mortuary records had been implemented.

24. Dr PAN Pey-chyou queried whether the lack of sufficient mortuary staff was one of the main contributing factors to the PYNEH incident. Dr PAN sought information on the following -

(a) what was the management structure of the PYNEH mortuary;

(b) whether all mortuary staff met the entry qualification requirements for the job; and

(c) whether any audit had been conducted to ensure compliance with the Standard Operating Procedures for body collection and identification.

25. CE, HA responded that he did not believe that staffing level played a role in the PYNEH incident. While HA would examine whether it was necessary to introduce a cross-checking system for the release of deceased bodies, it should not require two persons to discharge a body properly and accurately. As regards the questions raised by Dr PAN in paragraph 24 above, CE, HA and CCE/HKEC, HA responded as follows -

(a) the PYNEH mortuary was one of the services operated by the Department of Pathology managed by the Cluster Chief of Service (COS) as overall in-charge. He was assisted by a number of staff to supervise and manage the day-to-day operations of the mortuary. The chain of command was as follows : four MAs reported to one MT, the MT reported to a Senior MT (SMT); the SMT reported to a Department Manager (DM); and the DM reported directly to

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COS;

(b) all mortuary staff met the entry qualifications required for the job; and

(c) a HA-wide audit conducted in the first quarter of 2008 revealed good understanding and compliance of the Procedures. Minor procedures had been made to the standard forms to further improve the Procedures, including the Standard Operating Procedures for body collection and identification.

26. Ms Cyd HO opined that if mortuary staff in PYNEH was sufficient, there was no reason why deploying a staff to cross-check each and every procedure for body collection and identification could not be implemented immediately. Ms HO further opined that conducting daily verification of deceased bodies against mortuary records could not completely prevent the PYNEH incident from recurring.

27. CE, HA responded that in addition to conducting daily verification of deceased bodies against mortuary records, mortuary staff had been instructed not to put two dead bodies in one body bag and not to put one large-size body and one small-size body in the same compartment.

Other issues

28. Mr Andrew CHENG said that medical incidents occurred over the past few months had undermined public confidence in HA and morale of HA frontline staff. Mr CHENG urged the Administration to conduct a comprehensive review of the operations of HA, instead of implementing a piecemeal approach in addressing medical incidents.

29. SFH responded that HA was committed to further enhancing service quality and patient safety in public hospitals. Notably, to improve service quality, reduce the risk to patients and prevent the recurrence of medical incidents, HA had put in place a mechanism and guidelines for medical staff to report medical incidents and take follow-up actions properly. In this connection, HA had since October 2007 implemented a Sentinel Event Policy to strengthen the reporting, management and monitoring of sentinel events in public hospitals, so as to further enhance service quality and patient safety. To benchmark public hospital services with international standards, HA was now making preparation for a pilot scheme for accreditation of public hospitals in Hong Kong. Through the project, HA aimed to (i) improve the quality of healthcare by setting goals for meeting international standards for public hospitals; (ii) improve the management of hospital services; (iii) strengthen public confidence in quality of healthcare; and (iv) strengthen public hospitals' accountability to quality.

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30. Ms Cyd HO said that HA should allocate additional resources to alleviate the workload and pressure faced by the frontline staff of HA due to shortage of manpower.

31. CE, HA responded that while there was only a 2% increase in the number of patients treated by HA in the past three years, the number of doctors, nurses and other healthcare supporting staff had increased by 6%, 0.8% and 7% respectively during the same period. Efforts would continue be made to reduce the long work hours of healthcare staff to a reasonable level. CE, HA further said that with the coming on stream of about 600 nurses each year, the existing shortage of nurses in HA would ease.

32. Mr WONG Kwok-hing asked whether the Administration would take into account past medical incidents when reviewing the appointment of Mr Shane Solomon as CE of HA.

33. SFH responded that the Administration would consider the appointment of CE of HA in the light of the decision of the HA Board.

Conclusion

34. In closing, the Administration was requested to provide the following after the meeting -

(a) information on the guidelines adopted by the mortuaries in public hospitals and the public mortuaries in relation to handling the bodies of the deceased, in particular as to whether double occupancy in the same compartment was allowed; and

(b) a written response to the suggestion of strengthening the training to staff of HA to instill in them a greater sense of respect to the deceased.

SFH agreed.

V. Handling of request from the public for urgent medical assistant by public hospitals and the Caritas Medical Centre incident

(LC Paper No. CB(2)591/08-09(03))

35. SFH stressed that healthcare workers should endeavour to save lives because it was their professional duty. HA had been asked to improve the contingency measures in dealing with emergency incidents to prevent the Caritas Medical Centre (CMC) incident from recurring. On 20 December 2008, a person tried to get help from a clerk at a hospital counter of CMC for a patient who collapsed outside the Wai Ming Block of CMC. The patient subsequently passed away on the same day after resuscitation.

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36. CE, HA expressed apologies to the deceased's family and the public for the confusion and anxiety created by the CMC incident. The incident reflected badly on all HA staff who had worked so hard to save lives and had caused the public to question their dedication to service. CE, HA then briefed members on a review conducted by HA on its principles for handling public requests for emergency medical needs within the vicinity of public hospitals/clinics, as well as the investigation report submitted by the Hospital Chief Executive of CMC on the incident, details of which were set out in the Administration's paper. CE, HA further said that a special committee, chaired by himself and comprised two members of HA Board and the Chairman of CMC Hospital Governing Committee, had been set up to review the investigation report, including apportioning responsibilities between those involved and determining the human resources actions required. The special committee would complete its work in six weeks' time.

37. Mr Andrew CHENG noted from paragraph 4.3 of the investigation report that for handling unconscious patients in non-clinical areas within CMC, the prevailing CMC's guideline required calling 999 for assistance. Mr CHENG considered such an arrangement unacceptable, not to mention that the Fire Service Department failed to achieve the performance target of answering 92.5% of the emergency calls within a target response time of 12 minutes for the period from January to June 2008 as reported by the Director of Audit in his Report No 51.

38. SFH responded that as saving lives was HA's mission, healthcare workers should give the best they could to anyone requiring urgent medical assistance regardless of whether that person was within or outside the hospital compound. The response should be based on common sense, and not bound by rigid guidelines. SFH further said that if the guideline was found inadequate, amendments should be made to better enable frontline staff to carry out their duty in a professional manner.

39. Mr Alan LEONG queried whether the reason why frontline staff rigidly followed the hospital guideline on handling urgent requests for assistance was because they were not sure whether the hospital management would support them in the event of adverse medical incidents.

40. CE, HA responded that guidelines were mainly formulated to delineate responsibilities and achieve operation standards, and could never be a substitute for professional response. It was impractical for HA, being a large organisation with many specialties and departments, to produce a guideline for every circumstance. HA, however, strongly believed that all of its staff would give the best they could offer to anyone who required urgent medical assistance. HA agreed that the response to requests for urgent medical assistance should be flexible, fitting the particular situation, rather than bound by rigid guidelines.

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41. Mr Albert CHAN said that it was unfair that patients of medical incidents had to undergo legal proceedings to obtain compensation from HA. HA should provide compensation to these patients or their family members if there was sufficient evidence that errors were made by HA side.

42. CE, HA responded that being a publicly-funded body, it was incumbent upon HA to use its funds responsibly. CE, HA further said that the CMC incident was subject to inquest by the Coroner's Court. Whilst HA had been very strong in saying that the response with regard to the CMC incident was inadequate, the Coroner's Court would ultimately decide to what extent the CMC response had contributed to the death of the deceased.

43. Mr Albert CHAN said that the investigation report of the CMC incident did not contain all the facts, as to his understanding, the investigation team had not approached the son of the deceased and the man who rushed to the ground floor lift lobby of Wai Ming Block of CMC to try to get help for the deceased.

44. CE, HA said that he was satisfied that the investigation report was a factual account of what had happened, albeit a few facts were missing. CE, HA further said that the special committee, referred to in paragraph 36 above, would also assess the appropriateness of the response to the CMC incident by the hospital management and staff, and the shortcomings in the subsequent public handling of the incident.

45. Dr PAN Pey-chyou noted from the preamble of the investigation report that CMC had contacted the deceased's family member to verify some information, which was at variance with what Mr Albert CHAN had mentioned in paragraph 43 above.

46. Hospital Chief Executive, CMC responded that attempts had been made to verify some information with the deceased's family member on the day of the incident and afterwards, but to no avail because the deceased's family member did not wish to be disturbed in such time of grief. Attempt had also been made to verify some information with the man who rushed to the ground floor lift lobby of Wai Ming Block of CMC to try to get help for the deceased, but the man declined.

47. Mr WONG Kwok-hing said that apart from apportioning responsibilities among staff involved in medical incidents, HA should also commend those staff who had rendered all reasonable assistance to the persons in need at any time.

48. Dr PAN Pey-chyou expressed concern that HA staff were facing a dilemma in that if the guidelines were followed, their actions might fell short of public expectation as demonstrated in the CMC incident.

49. CE, HA responded that there was no cause for concern about staff being unfairly treated if they simply failed to follow the guidelines. In the event of

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adverse medical incident, a thorough root cause of the incident to identify would be conducted. If the investigation revealed that the staff involved should be held accountable (partial or total) for the incident, the case would be dealt with in accordance with the prevailing HA human resources policy and established disciplinary mechanism. CE, HA stressed that HA took a "Just Culture" approach in considering disciplinary action, having regard to the relevant factors such as the system issues, circumstances of the case, the past performance record of the staff concerned, and mitigating factors, etc.

50. Dr LEUNG Ka-lau asked -

(a) whether, and if so, what measures had been put in place to prevent the recurrence of events similar to the CMC incident, pending outcome of the special committee in six weeks' time; and

(b) whether CMC management had consulted/notified HA Head Office prior to issuing press releases and holding a press conference on 21 December 2008 with regard to the CMC incident.

51. Responding to Dr LEUNG's first question, CE, HA said that following the CMC incident, each public hospital was required to have a designated telephone number and a designated response team to provide prompt response for urgent medical assistance. These new arrangements were being set up by all public hospitals. Director (Q&S), HA supplemented that all public hospitals and clinics (HA institutions) were also required to come up with its own guideline on handling emergency request for medical assistance, based on a set of guiding principles for handling persons requiring emergency medical assistance in the vicinity of HA institutions, referred to in Annex IV of the Administration's paper, in four weeks' time.

52. Regarding Dr LEUNG's second question, Director (Q&S), HA replied in the positive. Director (Q&S), HA further said that action would be taken to improve HA staff communication skills with the media on the handling of adverse medical incidents.

53. Ms Audrey EU asked whether automated external defibrillators would be procured for all other HA institutions, apart from CMC. Ms EU further asked whether staff in the Accident & Emergency Department (A&ED) would also be expected to render assistance to persons requiring emergency medical assistance in the vicinity of HA institutions.

54. CE, HA replied in the positive to Ms EU's first question. As regards Ms EU's second question, CE, HA said that although the guiding principles for handling persons requiring emergency medical assistance in the vicinity of HA institutions were silent on the role of A&ED staff, it did not mean these staff were exempted from rendering assistance if circumstances so warranted.

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55. In closing, the Administration was requested to provide information on the existing and the new guidelines for handling requests from persons for emergency medical assistance within or in the vicinity of HA hospitals and clinics. SFH agreed.

56. Dr PAN Pey-chyou took the opportunity to express appreciation to the CMC doctor who happened to pass by the scene and immediately rendered assistance to the deceased.

VI. Report on First Stage Public Consultation on Healthcare Reform

(Report on First Stage Public Consultation on Healthcare Reform)

57. Owing to insufficient time, the Chairman suggested and members agreed to defer the discussion of the above item to the next regular meeting to be held on 9 February 2009.

58. There being no other business, the meeting ended at 10:35 am.

Council Business Division 2
Legislative Council Secretariat
17 March 2009