(This letter has been edited to protect confidentiality and privacy.)

DH/CR/PUB/31
HA CON 101/83/1

28 August 2003

HA Review Panel on SARS Outbreak
Hospital Authority
Room 410S, 4/F Hospital Authority Building
147B Argyle Street
Kowloon

Dear

HA Review Panel on SARS Outbreak

Thank you for your letter of 20 August.

Contact Tracing at Hotel M

2. In the following paragraphs, I shall focus our response to address an apparent concern of the HA Review Panel as to whether any contact tracing action by the Department of Health (DH) regarding the Hotel M cluster would have changed the course of events in the outbreak at Prince of Wales Hospital (PWH). I submit not.

3. First, we learnt at a meeting of the SARS Expert Committee that the Kwong Wah Hospital had taken a very high level of infection control measures since the admission of AA into the intensive care unit (ICU) at 11:55 on 22 February. The patient was placed in an isolation room. All staff caring him wore N95 masks, cotton gown and implemented droplet precaution and universal precaution measures since his admission. DH was notified of the case two days later (Monday, 24 February) and was not aware of the infectivity of AA when a DH nurse went to see him that day. By then, he had already been intubated in an isolation room in the ICU and could not be interviewed. The spread of the disease among members of the family due to close contact was not an uncommon phenomenon.

4. Second, the fact that a number of persons related to AA had fallen sick appeared to be an intra familial spread due to close contact (paragraph 30 of my last letter refers). There was no environmental factor supporting a case for initiating contact tracing at Hotel M. This notwithstanding, Dr Margaret Chan, my predecessor, was concerned and had many discussions with one of the attending physicians and the Consultant of the Government Virus Unit to explore further actions required for identifying the causative agent.

5. Third, as explained in the note in paragraph 18 of my last letter, as at 8 March, the illnesses of the three tourists from Singapore improved with antibiotics treatment and laboratory investigations were pending. There was then insufficient evidence that their illnesses were related to Hotel M. We therefore asked the Singapore Ministry of Health to keep us posted of any positive laboratory findings and monitored the development there.

6. Fourth, JJ was initially suspected as the index case for the PWH cluster on 13 March and it was confirmed on 14 March. He had onset of symptoms on 24 February and was hospitalized on 4 March (paragraphs 21 and 66-69 of my letter of 18 August refer). Thus, even had DH initiated case investigation in Hong Kong on 8 March, it would not have any effect on the course of events in the outbreak at PWH. Neither would we be able to identify JJ earlier as he was not a guest in Hotel M at the material time. It was only on repeated questioning that he admitted that he had visited a friend in Hotel M around that period.

7. Fifth, I can advise that the wife of the American Chinese did not tell us that her husband had stayed in Hotel M. She did not have full details of her husband's travel history.

8. Sixth, the St Paul's Hospital (SPH) cluster index case was not a severe community acquired pneumonia (SCAP) case when admitted to SPH on 2 March. DH was notified on 13 March when the index case became a SCAP case. DH learnt of his stay in Hotel M from the index case himself during case interview / contact tracing on 14 March.

9. Finally, there was no clinical SARS case among staff at Hotel M. The one admitted to Yan Chai Hospital during 2-11 March had a diagnosis of bacterial pneumonia and he subsequently recovered.

Amoy Gardens Index Patient – YY

10. You have asked about the policy at the material time regarding follow up of patients discharged from PWH Ward 8A. The agreement with PWH was that the hospital would make available to DH a daily master list of persons for case investigation / contact tracing. DH would look into every person on the master list (whether discharged or not) and take appropriate follow up action, although DH's understanding was that PWH Ward 8A was closed to admission and discharge (paragraph 38 of my last letter refers). The follow up action taken by DH is illustrated by the Amoy Gardens index patient case described below.

11. YY first appeared in the master list referred by PWH to DH in the evening of 16 March. After sorting out newly reported cases from old cases, DH staff embarked on case investigation on 17 March. The normal practice was that DH started with the more serious cases. We also discussed with PWH colleagues the latest clinical conditions of persons referred to us in the master list. It was likely that by the time we were to interview YY, he had already been tested positive for influenza A. Hence no follow up action was required. As pointed out in my last letter, it was PWH which took action to drop YY from the master list subsequently. This was only a logical decision following the influenza A diagnosis and was a clear indication that PWH also did not consider it necessary for DH to follow up on YY. There was no indication from PWH that YY was discharged home on 19 March. We learnt this on 23 March when DH conducted a case interview with YY upon notification by PWH.

Flight CA112 and Flight CA 115

12. As mentioned in Annex 6 of my last letter, DH initiated active case investigation on the same day upon receipt of notification on 23 March. Passenger lists obtained from the airline contained very limited information for tracing the passengers. We therefore sought the assistance of the Immigration Department and the tour agencies with a view to obtaining contact information of as many passengers as possible. A public announcement was also issued to appeal to the passengers to contact the DH hotline.

13. Based on information on travel documents and nationalities reported, non-local passengers were identified from the lists and the relevant health authorities/consulates were duly informed to take appropriate action for follow up. The aforesaid group was not counted

towards passengers contacted by DH. Moreover, despite meticulous checking and verification, information on some passengers was still incomplete, obsolete or unavailable, hence making contact impossible. Nonetheless, DH had taken a proactive and resourceful approach and had exercised professionalism and due diligence in tracing the passengers for surveillance.

The Union Hospital - BB

14. You have also asked about the SARS case of BB. Our investigation indicated that one travel collateral of BB also contracted SARS. Later on, DH was notified that a nurse EE who had cared for BB got the disease. All three eventually recovered. There was also another nurse who was admitted to PWH on 1 March for gastrointestinal tract symptoms and that was not a SARS case. More details about our case investigation / contact tracing action are provided in the following paragraphs.

15. On 22 February, DH was notified of BB's admission into PWH ICU as a SCAP case. DH initiated case investigation and contact tracing on the same day.

16. BB was an American Chinese living in the US for more than 10 years. She came back to Hong Kong on 30 January 2003 and travelled to Henan, Guangzhou to visit a relative from 31 January to 17 February. BB developed fever and cough on 16 February while in Guangzhou. Her symptoms persisted after consulting doctor in the Mainland and she was admitted to the Union Hospital on the day of return from Guangzhou on 17 February. Chest X-ray findings were compatible with pneumonia. She was transferred to PWH on 22 February and recovered eventually. Serological tests later confirmed her as a SARS case.

17. Four relatives from Hong Kong joined BB in the visit to Guangzhou. Contact tracing revealed that one of them developed SARS. A relative who had fever and cough on 21 February was admitted to the Prince Margaret Hospital (PMH) from 22 to 24 February and re-admitted on 26 February. She recovered eventually and was later confirmed to be suffering from SARS.

18. On 28 February, DH was notified of the admission of EE to PMH as a SCAP case. DH immediately initiated case investigation and contact tracing action.

19. Case investigation revealed that EE was a nurse in the Union Hospital who had cared for BB daily during 17-22 February. She developed malaise on 22 February followed by myalgia, cough, fever and chills two days later. She was admitted into PMH on 27 February and subsequently recovered. Serological tests later confirmed her as a SARS case. None of her eight close contacts developed symptoms. DH also contacted the Union Hospital on 28 February for medical surveillance of staff and patients exposed to BB and EE, and noted that none of the contacts developed symptoms.

20. I hope you find the above information useful.

Yours sincerely,

SIGNED

(Dr P Y Lam)
Director of Health