

# Queen Elizabeth Hospital announces investigation findings of sentinel event

The following is issued on behalf of the Hospital Authority:

The spokesperson of Queen Elizabeth Hospital (QEH) today (October 12) announced the findings of the investigation report regarding a sentinel event of a case of maternal death.

A 24-year-old pregnant woman who had been receiving regular antenatal check-ups at QEH was diagnosed with oligohydramnios and proteinuria. The woman was admitted for induction of labour during gestation of 38 weeks. She was admitted in the morning on August 10, 2018, to receive induction of labour with the use of medication. The medical staff closely monitored her condition and the foetus. Their conditions were both stable at the time. In the evening, the woman suddenly developed a short duration of seizure and the medical staff immediately examined and monitored her condition. She developed cardiac arrest a few minutes later. The medical staff immediately performed resuscitation and an emergency bedside caesarean section for her. A baby was delivered subsequently. During the process, the medical staff continued to perform resuscitation for the woman, but her condition was still critical with repeated occurrence of cardiac arrest. The woman finally succumbed on August 11.

The hospital reported the incident to the Hospital Authority (HA) Head Office via the Advance Incident Reporting System and set up a Root Cause Analysis (RCA) Panel to investigate the incident. After a thorough investigation, the Panel has completed the report with the following conclusions:

1. The woman had a history of proteinuria at 33 weeks of gestation and oligohydramnios at 35 weeks of gestation. A doctor admitted her for induction of labour during gestation of 38 weeks. The management was reasonable;
2. The woman's sudden deterioration of condition was without signs and unpredictable but was promptly recognised. The medical staff immediately performed resuscitation. During the process, the medical staff performed cardiopulmonary resuscitation, intubation and blood transfusion in accordance with the international guidelines, and closely communicated with her husband and relatives;
3. When the woman's condition suddenly deteriorated and she developed cardiac arrest, senior medical staff from various specialties, including Obstetrics and Gynaecology, Anaesthesiology and the Intensive Care Unit, arrived at the ward immediately to assist in the resuscitation, and made every endeavour to save and revive the woman and the baby. The

- resuscitation process was prompt, appropriate and thorough;
4. An emergency caesarean section was conducted within four minutes after the woman's cardiac arrest and the baby was later delivered. The caesarean section was prompt and proper in accordance with the international guidelines. The baby was discharged from hospital 18 days after birth;
  5. The woman developed post-partum haemorrhage about one hour after the cardiac arrest. According to her clinical conditions, the cause resembled an amniotic fluid embolism resulting in disseminated intravascular coagulopathy and uterine atony. The multi-disciplinary clinical teams had already provided various resuscitative treatments, blood transfusion and medications; and
  6. The probable differential diagnoses had been considered by the multi-disciplinary clinical teams upon the sudden deterioration of the woman's condition. They had endeavoured to provide all possible resuscitation and treatments.

The spokesperson said the hospital had accepted the panel's investigation report and had submitted it to the HA Head Office. The hospital has met the family to explain the investigation report and also expressed its deepest condolences once again to the family over the death of the woman, and will continue to closely communicate with the family to provide the necessary assistance.

The hospital also expressed its gratitude to the Chairman and members of the RCA Panel. Membership of the Panel is as follows:

#### Chairman

- Dr Leung Wing-cheong, Chief of Service, Department of Obstetrics and Gynaecology, Kwong Wah Hospital

#### Members

- Dr Lee Kai-wan, Chief of Service, Department of Obstetrics and Gynaecology, Caritas Medical Centre/Princess Margaret Hospital/Yan Chai Hospital
  - Dr Shum Hoi-ping, Consultant, Department of Intensive Care, Pamela Youde Nethersole Eastern Hospital
  - Ms Lai Sui-yi, Department Operations Manager, Department of Obstetrics and Gynaecology, United Christian Hospital
  - Dr Osburga Chan, Service Director, Department of Quality and Safety, Kowloon Central Cluster/Queen Elizabeth Hospital
  - Ms Katherine Pang, Manager, Patient Safety and Risk Management, Quality and Safety Division, HA Head Office
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## **Duchess of Kent Children's Hospital at Sandy Bay announces vaccination incident**

The following is issued on behalf of the Hospital Authority:

The spokesperson for the Duchess of Kent Children's Hospital at Sandy Bay (DKCH) made the following announcement today (October 12) on an incident concerning a vaccine injection:

The Seasonal Influenza Vaccination Programme commenced in DKCH on October 10 for hospital staff and volunteers. During inventory checking this morning, it was found that 19 hospital staff and two volunteers had been wrongly injected with tetanus vaccine. It is suspected that the two vaccines got mixed up during distribution yesterday (October 11). No other vaccines or patients have been affected.

The DKCH has contacted all 21 persons to explain and extend its apology. Generally speaking, a tetanus vaccine injection would not result in serious side effects. The hospital will closely monitor their condition and will arrange follow up consultations in the staff clinic if necessary.

The hospital has reported the incident to the Hospital Authority Head Office via the Advance Incident Reporting System. An investigation panel will be formed to review the case. The Hong Kong West Cluster (HKWC) will review the vaccine storage, distribution and delivery, and the injection process at all HKWC hospitals. Staff are reminded to follow the medication verification protocol. Regular inventory checking should also be performed as a safety precaution.

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## **HKSAR Government responds to media enquiries regarding 2018 Legislative Council Kowloon West Geographical Constituency By-election**

In response to media enquiries regarding the 2018 Legislative Council (LegCo) Kowloon West Geographical Constituency By-election, a spokesman for the Hong Kong Special Administrative Region (HKSAR) Government today (October 12) replies as follows:

Article 26 of the Basic Law stipulates that "Permanent residents of the Hong Kong Special Administrative Region shall have the right to vote and the right to stand for election in accordance with law". The HKSAR Government all along respects and safeguards the rights enjoyed by Hong Kong residents according to law, including the aforesaid rights to vote and to stand for election. At the same time, the HKSAR Government has a duty to implement and uphold the Basic Law and to ensure that all elections will be conducted in accordance with the Basic Law and relevant electoral laws.

The constitutional and legal status of the HKSAR is very clear. Article 1 of the Basic Law points out that the HKSAR is an inalienable part of the People's Republic of China (PRC). Article 12 of the Basic Law states that the HKSAR shall be a local administrative region of the PRC, which shall enjoy a high degree of autonomy and come directly under the Central People's Government. Further, Article 159(4) of the Basic Law stipulates that no amendment to the Basic Law shall contravene the established basic policies of the PRC regarding Hong Kong (i.e. Hong Kong should be a special administrative region of the PRC under the "one country, two systems" principle).

The LegCo is the legislature of the HKSAR under the Basic Law. Its functions and other related matters are governed by Articles 66 to 79 of the Basic Law. In other words, the Basic Law is the genesis of the establishment and function of the LegCo. Moreover, according to Article 104 of the Basic Law, members of the LegCo must swear to uphold the Basic Law and pledge allegiance to the HKSAR when assuming office.

"Self-determination" or advocating independence could be an option for Hong Kong is inconsistent with the constitutional and legal status of the HKSAR as stipulated in the Basic Law, as well as the established basic policies of the PRC regarding Hong Kong. Upholding the Basic Law is a basic legal duty of a legislator. If a person advocates or promotes self-determination or promotes independence could be an option for Hong Kong, he or she cannot possibly uphold the Basic Law or fulfil his or her duties as a legislator.

The HKSAR Government notes that the Returning Officer for the 2018 LegCo Kowloon West Geographical Constituency By-election has begun to make decisions on the nomination of candidates. The HKSAR Government supports the making of decisions on the validity of nomination by the Returning Officer in accordance with the law. The Returning Officer has the duty as well as power to make those decisions according to the relevant electoral laws.

Regarding the Returning Officer's decision that the nomination of a candidate was invalid as she did not comply with section 40(1)(b)(i) of the Legislative Council Ordinance, the HKSAR Government agrees to and supports the decision by the Returning Officer. The candidate cannot possibly comply with the requirements of the relevant electoral laws, since advocating or promoting "self-determination", or promoting independence could be an option for Hong Kong is contrary to the content of the declaration that the law requires a candidate to make to uphold the Basic Law and pledge allegiance to the HKSAR.

Decisions made by the Returning Officer aim to ensure that the LegCo election is held in strict accordance with the Basic Law and other applicable laws in an open, honest and fair manner. There is no question of any political censorship, restriction of the freedom of speech or deprivation of the right to stand for elections as alleged by some members of the community.

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## [Independent Review Committee on Hong Kong's Franchised Bus Service to invite closing written submissions](#)

The following is issued on behalf of the Independent Review Committee on Hong Kong's Franchised Bus Service:

The Independent Review Committee on Hong Kong's Franchised Bus Service is now inviting closing written submissions from interested parties and members of the public on recommendations that the Committee ought to make or not make to the Chief Executive on safety-related measures, with a view to maintaining a safe and reliable franchised bus service in Hong Kong.

The Committee was set up following the fatal incident on Tai Po Road on February 10, 2018, and in light of other recent serious incidents involving franchised bus services, to conduct a comprehensive review of the operation and monitoring of franchised buses and to make recommendations to the Chief Executive.

Since the commencement of its work in March 2018, the Committee has invited and received from specified interested parties and members of the public written submissions on matters pertaining to the safety of franchised bus services. The Committee has also held, as of today, hearings over 20 days to receive oral evidence from selected interested parties including the Transport and Housing Bureau, the Transport Department, the Hong Kong Police Force, franchised bus operators, trade unions representing bus captains, District Councils, a manufacturer of black boxes installed on franchised buses, a community organisation on road safety, current and former employees of a franchised bus company, and two experts appointed by the Committee to give expert opinions in relation to the public bus regimes in London and Melbourne.

The Secretariat to the Committee has prepared a set of document bundles containing the written submissions identified for use at the hearings, which has been made available at [www.irc-bus.gov.hk/eng/bundles.html](http://www.irc-bus.gov.hk/eng/bundles.html). Transcripts of the hearings held by the Committee are also available at the website of the Committee, at [www.irc-bus.gov.hk/eng/transcripts.html](http://www.irc-bus.gov.hk/eng/transcripts.html).

The process of receiving written submissions and oral evidence is almost complete and it is anticipated that the receipt of oral evidence will conclude with the evidence of the representatives of the Transport Department on October 16, 2018. The Committee is now inviting specified interested parties and members of the public to make closing written submissions on recommendations that the Committee ought to make or not make to the Chief Executive on safety-related measures with a view to maintaining a safe and reliable franchised bus service in Hong Kong, on or before November 7, 2018.

Written submissions, which should be no more than 5 000 words (or 6 000 characters in Chinese) in length overall, may be provided in the following ways:

By post: Secretariat to the Independent Review Committee on Hong Kong's Franchised Bus Service, 21/F, Queensway Government Offices, 66 Queensway, Admiralty, Hong Kong (with the envelope specifying that the written submission is enclosed);

By fax: 3104 0254 (with the first page specifying that the written submission is enclosed); or

By email: [secretariat@irc-bus.gov.hk](mailto:secretariat@irc-bus.gov.hk) (with the email heading specifying that the written submission is enclosed).

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## [CFS finds Salmonella in rice sample with grilled pork neck](#)

The Centre for Food Safety (CFS) of the Food and Environmental Hygiene Department announced today (October 12) that a sample of rice with grilled pork neck was found to contain a pathogen, Salmonella. The CFS is following up on the case.

"Following up on a food complaint, the CFS collected the above-mentioned sample from a restaurant in Tsuen Wan for testing. The test result showed the presence of Salmonella in 25 grams of the sample, exceeding the criterion of the Microbiological Guidelines for Food which states that Salmonella should not be detected in 25 grams of food sample," a CFS spokesman said.

The spokesman said that the CFS had notified the restaurant concerned of the unsatisfactory test result and instructed it to stop selling the concerned food item immediately. The CFS has also provided health education on food safety and hygiene to the person-in-charge and staff of the restaurant, and requested it to review and improve the food production process and carry out thorough cleaning and disinfection.

"Salmonella infection may cause fever and gastrointestinal upset such as vomiting, abdominal pain and diarrhoea. The effects on infants, young children, the elderly and patients with a weak immune system could be more severe and may even lead to death," the spokesman said.

The CFS will continue to follow up on the incident and take appropriate action to safeguard food safety and public health.