Lapses and delays

Key findings of the Independent Review Committee tasked to look into the spread of the hepatitis C virus in SGH earlier this year.

Prof Leo Yee Sin, chairman of the Independent Review Committee, speaking to reporters yesterday.

WHAT CAUSED IT?

- There were gaps in SGH's infection control practices.
- 20 of the 25 patients who contracted HCV had kidney transplants, making them susceptible to infection.
- Most infections took place when the renal ward moved from Ward 64A to Ward 67, changing workflow patterns.

WHY THE DELAY IN REPORTING?

- SGH did not recognise the severity of the outbreak or respond fast enough.
- The SGH laboratory took nearly two months to conduct phylogenetic testing, to determine if the infections were related, because it was doing the test for the first time. SGH wanted to complete its investigations into the cluster before alerting MOH.
- MOH, too, did not respond in a timely way as it had no single division to deal with an unusual hospital outbreak.

WHAT NOW?

- SGH has been told to put corrective measures in place within a month and send them to MOH for review.
- A task force will seek to strengthen infection control in all hospitals.
- MOH has set up a unit to deal with unusual outbreaks in hospitals.

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