Key findings

Hep C outbreak localised to wards 64A and 67, 25 patients affected, likely caused 7 deaths

Causes:

- Lapses in infection prevention and control
- High number of immunocompromised patients in the 2 wards
- Patients had higher exposure risk as they needed frequent intravenous procedures
- Temporary move of renal ward from 64A to 67 accentuated the lapses

Recommendations:

To SGH:

- Review infection control protocols, ensure adherence to standard infection control precautions and better supervision framework to ensure compliance

To MOH:

- Enhance national notification and surveillance system for acute hep C virus, dedicated team within MOH to carry out surveillance and outbreak investigation, and improve escalation and communications processes between stakeholders

Timeline of communication and escalation

April 27: SGH reports one Hep C infection to National Organ Transplant Unit

May 14: 4 Hep C cases found

May 30: SGH chairman of medical board, chairman of division of medicine and CEO were informed

June 5-8: SGH's preliminary epidemiological investigation instituted

June 19: SGH CEO given verbal briefing about cluster

June 21: SGH renal team tells MOH investigation is in progress

July 29: Analysis of first 20 cases completed, confirming cases are related

August 31: Initial SGH findings shared with MOH staff

Sept 1: Incident raised to MOH's director of medical studies

Sept 3: SingHealth's group CEO informed, SGH briefed MOH's director of medical studies

Sept 7: A*STAR's initial findings concurred with SGH lab findings

Sept 8: MOH's director of medical studies and SGH's chairman of medical board met to affirm plans

Sept 18: Health Minister was informed

Sept 20: SingHealth board chairman and chairman of risk oversight committee informed

Sept 25: SGH briefs Health Minister

Sept 28: MOH appoints independent review committee

Oct 6: Hep C outbreak made public

Source: Ministry of Health