Department of Health's handling of a complaint about a residential building being mistakenly put on the list of buildings with infection cases of COVID-19 Investigation Report

The complainant complained to this Office against the Department of Health ("DH") in March 2022.

The Complaint

2. The complainant resided at a village house ("Block X"). On 26 February 2022, DH put Block X on the List of Buildings Resided by Cases Tested Positive for SARS-CoV-2 Virus in the past 14 days ("the List"). To the complainant's knowledge, there were no infection or suspected cases involving households of Block X. Allegedly, on 27 and 28 February, the complainant called 1823 and DH's hotline respectively to make a complaint but his calls were not answered. On 28 February, the complainant made a complaint to DH by email. On 3 March, the complainant found that Block X had been removed from the List.

3. On 23, 29 and 31 March, DH replied by email and provided the complainant with hyperlinks to the COVID-19 Thematic Website ("Thematic Website"), referring to different topics on the website. On 12 May, DH called the complainant.

4. According to the complainant, DH mistakenly put Block X on the List had caused him unnecessary trouble and worry. He believed that the error was due to DH's failure to verify the address of infection cases. This had also made the residents wrongly monitored Block X instead of Block Y where there was a confirmed case, thus reducing the effectiveness of anti-epidemic measures ("**Allegation (1)**"). The complainant also said DH did not explain or apologise to him despite having found the error and removed the incorrect information from the List ("**Allegation (2)**").

5. Besides, the complainant was of the view that DH had all along wrongly taken his complaint as a general enquiry and provided no substantive replies to him in March ("**Allegation (3)**"). He said that during the telephone conversation with him on 12 May, DH tried to blame its error in writing Block Y as Block X on the semi-detached structure of these two village house blocks, saying it was easy to mix them up. He considered that DH was using this as an excuse for the error. He was also dissatisfied with DH for not recording the conversation with members of the public when giving verbal replies ("**Allegation (4)**").

Our Findings

6. This Office commenced a preliminary inquiry against DH on 29 March. Having scrutinised the information provided by DH and the complainant, we launched a full investigation against DH on 23 August, pursuant to The Ombudsman Ordinance and completed the investigation on 16 September.

DH's Procedures for Updating the List

7. Upon receiving a report of COVID-19 infection, the Centre for Health Protection ("CHP") of DH would conduct an epidemiological investigation and contact tracing. Normally, the Communicable Disease Branch of CHP would obtain preliminary epidemiological information of a case by way of questionnaire and then pass the information to the Contact Tracing Office ("CTO") for follow-up action.

8. Following DH's prevailing procedures, CTO would conduct contact tracing and update case particulars including residential addresses on the case platform ("the System"), so that CHP's supporting staff could assign case numbers to the addresses and release such data via the System to CHP's centre for epidemic information ("Information Centre").

9. On receiving data on residential addresses of infection cases via the System, the Information Centre would prepare an updated List for uploading to CHP's website every day. The addresses would remain on the List for 14 days and be removed from the List after the period if no cases involving the same addresses are noticed.

DH's Response

10. Upon our preliminary inquiry (see **paragraph 6**), DH conducted an investigation. It was revealed that the reported address of a confirmed case was Block Y when DH staff completed the relevant questionnaire on 15 February 2022, but CTO's staff mistakenly input Block X to the System.

11. DH explained that during February and March 2022 when the fifth wave of COVID-19 was severe, it had to handle a large number of cases every day and CHP's supporting staff were unable to handle assignment of case numbers to all new addresses in a timely manner. On 25 February, CHP's supporting staff assigned a case number to Block X, which should be Block Y. On 26 February, i.e., more than ten days after the case concerned was reported (15 February), the Information Centre received the information and added it to the List. The relevant information remained on the List until 1 March, and was then removed on 2 March.

12. It was not until we commenced our preliminary inquiry that DH became aware that Block X had been incorrectly put on the List (see **paragraph 10**). Upon discovering the error, DH corrected the records of the List between 26 February and 1 March.

13. DH apologised to the complainant for the error committed by its staff in putting Block X instead of Block Y on the List. DH indicated that CHP had deployed more manpower on handling cases and reminded its staff to be careful when inputting data to the System. Besides, it had changed the practice of manually assigning case numbers to addresses (see **paragraph 8**) to automatic assignment in the System to reduce delay in information updates caused by manual operations.

14. As regards the complainant's allegation relating to DH's replies in March (see

paragraph 5), DH explained that it had been dealing with thousands of cases and enquiries every day amid the fifth wave of COVID-19. Hence, DH could not answer all the phone calls and it took time to reply to email messages. On 28 February, the complainant emailed DH, pointing out the incorrect information on the List. As CHP's staff wanted to respond promptly and considered that most epidemic-related information had already been uploaded to the Thematic Website, they provided hyperlinks to the website in their replies to the complainant in March 2022 (see **paragraph 3**). DH considered such replies inappropriate.

15. DH also examined the telephone conversation between its staff and the complainant on 12 May (see **paragraph 5**). DH staff called the complainant to explain the human error in putting Block X instead of Block Y on the List. During the conversation, the staff concerned did mention the "semi-detached structure" of the blocks but had no intention to make it an excuse for the error committed. DH believed that the complainant's discontent with its staff was due to miscommunication.

Our Comments

Allegation (1)

16. DH had explained that Block X was put on the List due to human error when inputting the address of the confirmed case concerned. The incorrect information was subsequently included in the List and uploaded more than ten days after the case was reported. It was not until we commenced our preliminary inquiry that DH became aware of the error (see **paragraphs 10-12**).

17. This Office considered that the error and delay in question were serious. This affected the tracking and monitoring of cases as well as the daily life of people concerned. We notice that while this case took place in February 2022, the Government announced on as early as 4 January 2020 the Preparedness and Response Plan for Novel Infectious Disease of Public Health Significance and activated the Serious Response Level. Under the Plan, when the Serious Response Level was activated, DH would conduct epidemiological investigation and contact tracing on staff or patients meeting the surveillance case definition with hospitals as well as putting close contacts of confirmed cases of the novel infection under medical surveillance and/or quarantine and other contacts under medical surveillance. In other words, in February 2022 when this case happened, DH had been conducting epidemiological investigations and tracing of confirmed cases/contacts for more than two years. Besides, as the epidemic situation in Hong Kong and the world remained volatile, the public expected that relevant departments would continue to review and improve their procedures in these two years. Nevertheless, according to the information provided by DH in this case, the procedures for updating the List were complicated involving staff from different sections (see **paragraphs 8 and 9**). Moreover, without any mechanism for verification, an omission or delay in one of the steps would easily lead to errors, and DH or the public might not be able to notice that the information was incorrect. In as late as February 2022, there was still delay in updating of the List for more than 10 days due to the fact that the procedures for assigning case numbers had to be completed manually. The system for processing information was only enhanced recently enabling automatic

assigning of case numbers (see **paragraph 13**). The public might find that DH had failed to live up to their expectation. This Office considered that DH should continue to review the procedures for data entry to improve efficiency.

18. We understand that manual data entry may not be able to achieve unerring accuracy at all times. Considering DH's workload and manpower, it would be difficult for the Department to have all the information verified. Nevertheless, strict accuracy of data entry is of paramount importance for contact tracing of cases and cutting the transmission chains. We consider that DH should arrange for random checks on the relevant information and promptly handle public enquiries and complaints about suspected errors in information to enhance accuracy.

19. As such, The Ombudsman considers **Allegation (1) substantiated**.

Allegation (2)

20. We accept DH's explanation for removing Block X from the List on 2 March (see **paragraph 11**). We do not see any evidence of DH having been long aware of the error committed but failing to inform the complainant of it, and we notice that DH had apologised to the complainant for the error (see **paragraph 13**).

21. The Ombudsman, therefore, considers **Allegation (2) unsubstantiated**.

Allegation (3)

22. The complainant suspected that the information was incorrect and had repeatedly called and emailed DH. He expected that DH would promptly clarify the matters and rectify the information. Instead of taking his email messages seriously, DH, however, replied to them with a lot of hyperlinks to the Thematic Website and its replies were in no way relevant to the List[1]. We understand that DH handles considerable amount of enquiries about epidemic situation, it would be an effective approach to provide hyperlinks to the Thematic Website when answering enquiries related to topics available on the website. Nevertheless, the hyperlinks in DH's replies failed to address the major concerns expressed in the complainant's email of 28 February. DH's failure to promptly and properly handle enquiries fell short of public expectation and even caused more complaints and follow-up work. In this case, DH missed the opportunity to rectify an error promptly. We recommend that DH make

[1] Taking DH's reply on 23 March as an example, there were 12 hyperlinks, including:
- Latest local situation and information of COVID-19
- Means for virus testing and Points to Note for Persons who Tested Positive
- Rapid Antigen Test
- Declaration System for individuals tested positive for COVID-19 using Rapid Antigen Test
- Online Submission of Information to Centre for Health Protection for COVID-19 Patients
- Arrangements for persons pending admission to hospitals or isolation facilities
- "StayHomeSafe" Scheme
- COVID-19 Electronic Testing Record System
- Compulsory Testing for Certain Persons – Compulsory Testing Notices
- Designated Quarantine Hotel Scheme
- Latest local situation of COVID-19
- Occupancy of quarantine centres

timely review of the arrangements for following up and replying to public enquiries.

23. The Ombudsman, therefore, considers **Allegation (3) substantiated**.

Allegation (4)

24. In the absence of corroborative evidence, we could not know what DH staff and the complainant had actually said during their telephone conversation on 12 May (including the reason for DH's staff to mention the semi-detached structure of the house blocks). Nevertheless, we consider that DH staff should focus on explaining the Department's findings when replying to the complaint. Regardless of what had been said during that telephone conversation, DH admitted in its reply of 19 May to the complainant about the error. In its subsequent reply of 24 June, DH explained the incident again and clarify the purpose of calling the complainant on 12 May. We consider DH had responded to the complainant's concern regarding this allegation.

25. DH's failure to record the telephone conversation is not maladministration. We also notice that the complainant gave his views on recording of the telephone conversation to the Civil Service Bureau by email on 25 July.

26. The Ombudsman, therefore, considers **Allegation (4) unsubstantiated**.

Conclusion

27. In view of the above, **the complainant's complaint against DH was partially substantiated**.

Recommendations

28. The Ombudsman recommends that DH:

(1) review the procedures for data entry of confirmed cases to improve efficiency (see **paragraph 17**);

(2) consider including random checks in the procedures to enhance information accuracy (see **paragraph 18**); and

(3) make timely review of the arrangements for handling complaints, and strengthen staff training to remind them to examine complaints carefully and reply to the complaints accordingly (see **paragraph 22**).

29. We will follow up with DH on our recommendations in **paragraph 28** above.

Concluding Remarks

30. Fighting against an epidemic is tough work. As the epidemic persists with

rapid changes, we understand that DH faces much pressure in deploying manpower and resources. Nevertheless, DH is among the frontline departments responsible for anti-epidemic work, and its core duties include tracing cases and cutting transmission chains. Hence, DH is obliged to ensure the accuracy of information for tracing cases and for releasing to the public. On the other hand, the public also need to deal with the epidemic and face all kinds of difficulty and pressure thereof. In order to fight against the virus, we believe that while it requires the continuous support, understanding and cooperation from the community, it is also important for DH to ensure the accuracy of case information, to conduct proper contact tracing and cut the transmission chains, to release accurate and clear information to the public, and to deploy manpower promptly and flexibly when the epidemic situation becomes severe. In our view, DH should make a comprehensive review on the relevant administrative procedures and arrangements to enhance the effectiveness of its anti-epidemic work.

Office of The Ombudsman
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