DH apologises for vaccination error in Maternal and Child Health Centre

The Department of Health (DH) said today (February 20) that it is investigating and following up on an incident in which pneumococcal vaccine was mistakenly administered to two children who were originally scheduled to receive hepatitis B vaccine at the Tin Shui Wai Maternal and Child Health Centre (MCHC). The DH has explained and apologised to the parents of the affected children. So far, there has been no adverse reaction in the affected children, and pediatricians have assessed that the incident would not pose a health risk to the children concerned.

In accordance with the regular monitoring mechanism, the Tin Shui Wai MCHC reviewed the vaccination records after the end of the service session on February 17 and found that the number of vaccines administered during the session between 4pm and 5.30pm on that day did not correspond to the number of vaccines that should have been administered. Thus, the incident was discovered.

Seven children should have received the hepatitis B vaccine during the said period. Upon review of the number of vaccines administered, it was found that there were two doses of hepatitis B vaccine left unused and two extra doses of 15-valent Pneumococcal Conjugate Vaccine (PCV15) were used. After double-checking with the vaccine stock, it was found that two children had been incorrectly immunised with PCV15 during that period.

A preliminary investigation revealed that the children vaccinated during that period were between 1 month and 7 months old. Under the Hong Kong Childhood Immunisation Programme (HKCIP), children receive the first dose of hepatitis B vaccine within 24 hours of birth, followed by the second and third doses at 1 month and 6 months of age respectively; for PCV15, the first two doses should be administered at 2 months and 4 months of age, and a booster dose should be given at 12 months of age.

The DH's healthcare staff have contacted the parents of the seven children to apologise and explain the follow-up actions that the DH would take. Arrangements have also been made for paediatricians to conduct detailed examinations of the children as soon as possible, to provide them with an additional dose of hepatitis B vaccine at an appropriate time, and to complete three doses of PCV15 vaccinations in accordance with the HKCIP.

The healthcare staff of the DH have consulted pediatricians and made reference to relevant information. After careful assessment, it was believed that the incident would not pose a health risk to the children concerned.

The investigation is ongoing. A preliminary investigation indicated that the incident was caused by human error. The DH has instructed all MCHCs to strengthen the training of frontline staff to ensure that they strictly

follow the internal guidelines on checking vaccine and patient information before administering vaccines, and verifying the information with the person accompanying the child for vaccination to prevent the recurrence of similar incidents.

The DH would like to reiterate its sincere apology to those affected. The nursing staff involved in the incident have been suspended from vaccination duties. If it is confirmed that any staff involved has committed misconduct, the case will be dealt with in accordance with the established procedures. Subject to the outcome of further investigation, the DH will not rule out the possibility of referring the case to the Nursing Council of Hong Kong for appropriate follow-up action.