Information and Privacy
Commissioner/Ontario

Commissaire à l'information
et à la protection de la vie privée/Ontario

Personal Health Information Protection Act, 2004

REPORT

FILE NO. HI-050010-1

A Public Laboratory

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FILE NO. HI-050010-1

INVESTIGATOR: Nancy Ferguson

SUMMARY OF INFORMATION GIVING RISE TO THIS REVIEW:

A public laboratory was informed that the clinical samples and requisition forms it had shipped using a commercial courier did not arrive as expected at the lab where the testing was to be carried out. The laboratory was faced with ensuring the fulfillment of its obligations under the *Personal Health Information Protection Act* (the *Act*) including the notification of affected patients. The loss was reported to both the police and the Information and Privacy Commissioner/Ontario (the IPC). As the clinical samples in the missing box contained potentially infectious blood samples, the loss was also reported to CANUTEC. CANUTEC is the Canadian Transport Emergency Centre operated by Transport Canada to assist emergency response personnel in handling dangerous goods emergencies. Medical Officers of Health along the courier's shipping route were also notified in case they were to receive inquiries from someone in the area locating the samples.

RESULTS OF REVIEW:

Upon receiving notice that the box of clinical samples was not received by the lab that was expecting it, the courier company was immediately contacted and asked to begin a trace of the shipment. The Manager of Laboratory Safety for the lab undertook personal contact with the courier company's dangerous goods specialist to reinforce the importance of tracing the box. The courier company notified the police and CANUTEC the same day, and continued its attempts to locate the package.

The police indicated that they would not be issuing a press release regarding the loss given the nature of the materials and the type of testing involved.

The day after the loss was discovered, the lab used the copies of the requisitions it had retained to contact the physicians who had ordered the testing. These physicians were advised that the

samples had been compromised and it was suggested that they obtain a second sample for re-testing.

The search for the missing samples continued but they could not be found. A notification program was developed based on consultations with the IPC. This program included contacting each doctor who had an affected patient through an initial phone call and a follow-up letter requesting their assistance. Doctors were asked to notify their affected patient(s) about the incident at their next appointment with the patient and to provide each patient with a document describing the loss. This document set out the details of when and how the clinical samples and requisition forms had gone missing, and assured the patient that a duplicate copy of the test requisition had been forwarded to the health care provider who had submitted the request for testing. The patient was informed that the IPC was reviewing the incident and would be working with the lab to ensure compliance with the obligations under the *Act*. Contact information was provided for patients wishing to speak to someone directly who could answer further questions about the incident.

Physicians were also asked to write a note to their own files for each "affected" patient once they carried out notification so that follow-up could be undertaken by the lab to confirm that all patients had been contacted. The lab apologized to the physicians for any inconvenience caused as a result of the loss and thanked them for helping to carry out notification in a manner that would hopefully reduce anxiety for their patients. The notification of patients directly during an office visit was also designed to avoid the potential for inadvertent secondary disclosure which could occur if notification was provided by letter or by making phone calls to the patients' homes. This was considered to be especially important in this particular case, given the nature of the testing that was being carried out.

As a result of the incident, the lab requested and was provided with a report regarding the incident from the courier company. The report outlined that the courier driver recalled picking up the missing box containing the samples and requisition forms. This driver's job was to deliver the box to one of the courier company's terminals. The warehouse person at this terminal confirmed unloading the box and logging and loading it from the terminal for delivery by transport truck to another terminal. He recalled the box being marked "infectious" and that the regular procedure was followed including logging it before loading it for shipment, and segregating it from the other goods. The staff at the terminal who were to receive the box and unload it from the transport truck signed statements indicating they had no recollection of the box arriving at the depot. Other dangerous goods on the same shipment were segregated and a handwritten list of these boxes had been prepared.

The courier company reported that two physical searches of the terminals the box was scheduled to pass through were conducted including the interior and exterior premises and the garbage and cardboard containers on the property. Searches were also conducted of the vehicles the box was reported to have been carried on. The possibility that the missing box became mixed with another shipment destined for a different location that was stored in the vicinity was considered and investigated. The box was never located by the courier company.

The courier company reported that its management team reviewed its dangerous goods procedures in light of the incident. The company determined that it would revise its procedures to require the sealing of vehicles used to transport dangerous goods and documentation to indicate when these materials are leaving the terminal. These changes are designed to help detect the loss of such goods and lead to the immediate notification of all terminals when an incident occurs. These new procedures were issued to all terminal managers for review with all warehouse staff and drivers.

A process was also put into place to ensure that communication takes place each morning among the lab staff responsible for overseeing the transport of packages, to help identify any missing packages at the earliest opportunity.

In some cases involving laboratory testing of a more sensitive nature such as HIV testing, the testing is requisitioned and reported anonymously because the health care provider substitutes the patient's name with a numerical code known only to the health care provider. The decision as to whether or not to code a requisition form to protect the name of the patient is currently up to the doctor, the patient, and the clinic. Patients' names were not masked on the materials that went missing in this case.

An internal working group has been struck to study the possibility of masking the names of patients on requisition forms, test reports and other testing materials. An internal working group will also study the issue of ensuring the ability to effectively track lab requisitions, samples and reports that are sent by courier. This loss will be considered by the working groups as they examine these issues.

The lab contacted each physician and was able to confirm that all the patients were notified except one. This patient will be notified at the next scheduled appointment.

On the basis of all of the above, it was determined that further review of this matter was not warranted and the file was closed.

Original signed by: August 10, 2005

Ann Cavoukian, Ph. D.
Commissioner