FHB requests testing service provider to follow up on delay in releasing test results

â€‹Regarding media enquiries concerning members of the public not being able to receive test results within two days after attending the community testing centre at Henry G Leong Yaumatei Community Centre on March 3, the Food and Health Bureau (FHB) immediately followed up with the service provider concerned and gave a response as follows:

It is understood that the KingMed Diagnostics (Hong Kong) Limited, which ran the community testing centre at Henry G Leong Yaumatei Community Centre, encountered technical issues on March 4 while uploading test results of specimens collected from community testing centres and mobile testing stations the previous day (March 3). Due to the problem in uploading the test results to the information system in accordance with established procedures, the service provider failed to send out on March 4 the negative results of those underwent testing. Such delay was resolved by noon on March 6 (the third day after testing), and relevant test results had all been sent to the concerned persons on the same day.

About 6 000 persons were affected by the incident. All their test results were negative. The incident does not involve the accuracy or validity of the test and no personal data of persons who underwent testing were lost.

It was also mentioned in a media report that a person who underwent testing on March 4 at the community testing centre located at Henry G Leong Yaumatei Community Centre has yet to receive test result by March 6. The service provider, on our request to account for the situation, stated that specimens collected from that community testing centre on March 4 were all tested on March 6. Test results were uploaded in batches for dissemination to persons who underwent testing on the same day.

Though the incident did not affect the service provider’s progress in conducting tests or the accuracy of the results, and it did not compromise the objective of identifying confirmed cases as early as possible to cut the transmission chain, it did cause inconvenience to those who underwent testing. Staff of the concerned community testing centre also failed to reply accurately enquiries from the public. The FHB found the situation very unsatisfactory and had taken stringent follow-up actions, including instructing the service provider to conduct thorough investigation, submit incident report and make improvements. The service provider was also suspended from operating new mobile specimen collection stations when the situation was being resolved. The FHB will take further follow-up actions in accordance with the contract should there is occurrence of similar situations in future.