

EXECUTIVE SUMMARY
of
Analysis and Recommendations in
the Case of Mr. Thomas Ray Lippert

University of Utah Health Sciences Center
Special Review Committee
4/21/2014



The Special Review Committee (“Committee”) was convened by the University of Utah Health Sciences Center in January 2014 to review the Thomas Ray Lippert case and provide recommendations for an institutional response. The report is an ethical analysis of the case and does not represent a legal analysis of the issues. The Committee’s recommendations are based upon its review of relevant documents and information from witnesses.

The case arose because the Pamela and John Branum family learned from DNA testing that their daughter, Annie, was biologically related to Mr. Lippert and not to John Branum, as they had supposed. The Branum family had received fertility services in 1991 at an andrology laboratory on 3900 South in Salt Lake City, Utah, co-maintained by the University of Utah and a separate legal entity, Reproductive Medical Technologies, Inc. (RMTI), which had been founded by University faculty and staff.

Mr. Lippert was employed by the University at the 3900 South Lab from 1988-1993, and it is believed Mr. Lippert’s employment with RMTI may have extended to 1994. Mr. Lippert was also a frequent sperm donor between 1983-1993 at the 3900 South Lab. The presumption of the case is that Mr. Lippert either intentionally or accidentally switched his sample with that of John Branum, or that another 3900 South Lab employee intentionally or accidentally switched the sample.

Careful review of relevant documents and information from witnesses provided no understanding as to how the sample switch actually occurred. The Committee cannot rule out an inadvertent laboratory error. Nationally, andrology laboratory standards were substantially less stringent in the 1980s and 1990s than today. The switch could have occurred from an unintentional lab error, since Mr. Lippert’s donor specimens were processed and maintained at the lab. On the other hand, the Committee cannot exclude intentional tampering by Mr. Lippert or another employee because the principals of the case, Dr. Urry (who ran the 3900 South Lab), and Mr. Lippert, are deceased and unable for interview, and because the relevant documents are incomplete.

The Branum case is the only case of which the Committee is aware of a couple having unintended biological offspring of Mr. Lippert. The Committee found no evidence of any unintended biological children of Mr. Lippert beyond the case in question.

The Committee’s careful factual review and ethical analysis of the case follows. The recommendations and findings in the case are best understood within the full context of the report. Nonetheless, for brevity’s sake, the Committee produces below its primary recommendations and findings in the case.

Primary Recommendations

- 1) *The University of Utah should apologize to the Branum family for the switch in samples in 1991. Such a sample switch is unacceptable, whether caused by the unethical or irresponsible conduct of Mr. Thomas Lippert or any other employee of the University.*
- 2) *The University of Utah should continue to offer paternity testing to determine whether Mr. Lippert is the biological father of children born to parents who were clients of the University of Utah 3900 South Community Laboratory (“Community Laboratory”) during the time that Mr. Lippert was a Community Laboratory employee. This offer should continue for a reasonable period of time (such as 1 - 2 years).*
- 3) *The University should not attempt to contact patients who were clients of the Community Laboratory during the time that Mr. Lippert was an employee of the Community Laboratory. It is the Committee’s assessment that contact from the University regarding this matter is more likely to cause harm to these families than to provide benefit.*

Findings

Finding 1: *The Committee does not recommend contacting couples and their children who chose Mr. Lippert as a donor. Such contact would provide no significant benefit to the couples or the children that resulted from those services and might create unwarranted concerns as well as disruption to families of those couples, if any, who chose not to share the circumstances of the conception with their children.*

Finding 2: *The Committee recommends that Mr. Lippert’s donor number remain confidential and that it not be publicly released unless new information emerges that supports a compelling justification for release.*

Finding 3: *The Committee does not recommend contacting couples who received fertility services by the Community Lab/RMTI during Mr. Lippert’s employment in order to warn them of a possible sample switch. The justification for this recommendation is that the risk of having been victimized by Mr. Lippert might be very low, the burdens of this information are likely to outweigh the benefits to families, and the challenges of accurately identifying and informing hundreds of couples after two to three decades are enormous.*