M E M O R A N D U M

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Food and Drug Administration
Center for Biologics Evaluation and Research

DATE: May 16, 2000

FROM: Sharon O'Callaghan, CSO,
Division of Inspections and Surveillance (HFM-650)
Office of Compliance and Biologics Quality

SUBJECT: Error and Accident Reports - Summary for Second Quarter FY2000

TO: Director, Division of Inspections and Surveillance (HFM-650)
Office of Compliance and Biologics Quality

Between January 1, 2000 and March 31, 2000, the Division of Inspections and Surveillance received 5194 error and accident reports from biological product manufacturers. Blood and plasma establishments submitted 5156 reports and non-blood manufacturers submitted 38 reports. There were 369 (7.1%) reports forwarded to the District Offices for follow-up and evaluation as potential recall situations. Based on the information submitted in the error and accident reports, 174 (3.3%) reports did not appear to meet the threshold for reporting, i.e., products were not made available for distribution or the safety, purity, or potency of a product was not affected.

Between October 1, 1999 and March 31, 2000, the Division of Inspections and Surveillance received 9469 error and accident reports from biological product manufacturers. Blood and plasma establishments submitted 9393 reports and non-blood manufacturers submitted 76 reports. There were 680 (7.2%) reports forwarded to the District Offices for follow-up and evaluation as potential recall situations. Based on the information submitted in the error and accident reports, 305 (3.2%) reports did not appear to meet the threshold for reporting, i.e., products were not made available for distribution or the safety, purity, or potency of a product was not affected.

Attached are tables and charts that identify the types of errors and accidents submitted by blood and plasma establishments and by non-blood manufacturers. In addition, a table and graphs representing reportable errors and accidents submitted by blood and plasma establishments are also provided that illustrate the distribution of the reporting time, i.e., time from the date the error or accident was discovered to the date that CBER received the report.

Attachments

Attachments

1 - Table - Total Error/Accident Reports
    All Reporting Establishments
2 - Tables - Types of Errors/Accidents
    Blood and Plasma Establishments
        Total Reports, Potential Recalls
3 - Pie charts - All Blood and Plasma Establishments
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    All Reporting Blood Establishments
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    Non-Blood Manufacturers
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17 - Pie chart - Types of Errors/Accidents
    Non-Blood Manufacturers

ALL REPORTING ESTABLISHMENTS

FY2000

	NUMBER OF REPORTING ESTABLISHMENTS		TOTAL REPORTS RECEIVED		POTENTIAL RECALLS	
	Second Quarter	**Year To Date**	**Second Quarter**	**Year To Date**	**Second Quarter**	**Year To Date**
BLOOD/PLASMA MANUFACTURERS						
Licensed Blood Banks	103	109*	4320	8010	313	594
Unlicensed Blood Banks	18	33	29	56	3	6
Transfusion Services	5	15	13	24	0	0
Plasma Centers	205	239	794	1303	45	70
SUB-TOTAL	331	287	5156	9393	361	670
NON-BLOOD MANUFACTURERS						
Blood Derivative Manufacturer	3	8	5	11	0	0
In-Vitro Diagnostic Manufacturer	3	5	9	16	3	3
Vaccine Manufacturer	6	7	6	11	0	0
Allergenics Manufacturer	1	6	9	25	3	5
Therapeutic Manufacturer	4	7	9	13	2	2
SUB-TOTAL	17	33	38	76	8	10
TOTAL	**348**	**320**	**5194**	**9469**	**369**	**680**

*Number of license holders; may be one establishment or multiple establishments operating under one license.

The following tables and pie charts show the type of errors and accidents reported by blood and plasma establishments:

SECOND QUARTER – FY2000

BLOOD AND PLASMA ESTABLISHMENTS

TOTAL ERRORS AND ACCIDENTS

TYPE OF ERROR/ACCIDENT	Licensed Establishments	Unlicensed Establishments	Transfusion Services	Plasma Centers	TOTAL	
POST DONATION INFORMATION	3198	1	0	714	3913	75.9%
STORAGE/DISTRIBUTION	355	10	4	25	394	7.6%
DONOR SCREENING	270	0	0	40	310	6.0%
LABELING	286	9	0	0	295	5.7%
MISCELLANEOUS	64	2	3	11	80	1.6%
ROUTINE TESTING	66	4	5	0	75	1.5%
COMPONENT PREPARATION	37	0	1	0	38	0.7%
COLLECTION	21	1	0	2	24	0.5%
VIRAL TESTING	14	1	0	0	15	0.3%
DONOR DEFERRAL	9	1	0	2	12	0.2%
TOTAL	4320	29	13	794	5156	100.0%

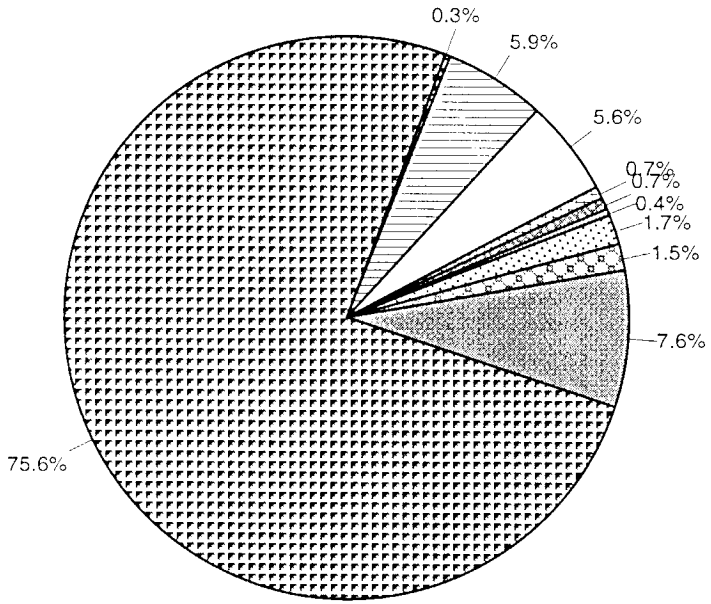
POTENTIAL RECALLS

TYPE OF ERROR/ACCIDENT	Licensed Establishments	Unlicensed Establishments	Transfusion Services	Plasma Centers	TOTAL	
DONOR SCREENING	144	0	0	22	166	46.0%
STORAGE/DISTRIBUTION	52	2	0	14	68	18.8%
LABELING	45	0	0	0	45	12.5%
COMPONENT PREPARATION	28	0	0	0	28	7.8%
POST DONATION INFORMATION	22	0	0	6	28	7.8%
COLLECTION	13	0	0	2	15	4.2%
DONOR DEFERRAL	5	1	0	1	7	1.9%
VIRAL TESTING	4	0	0	0	4	1.1%
ROUTINE TESTING	0	0	0	0	0	0.0%
MISCELLANEOUS	0	0	0	0	0	0.0%
TOTAL	313	3	0	45	361	100.0%

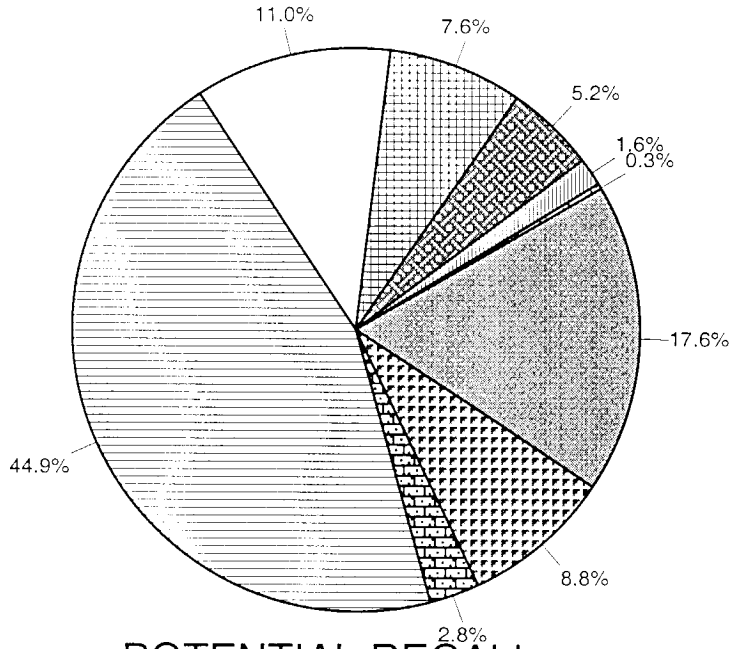
ERROR AND ACCIDENT REPORTS

ALL BLOOD AND PLASMA ESTABLISHMENTS

FY2000



TOTAL REPORTS



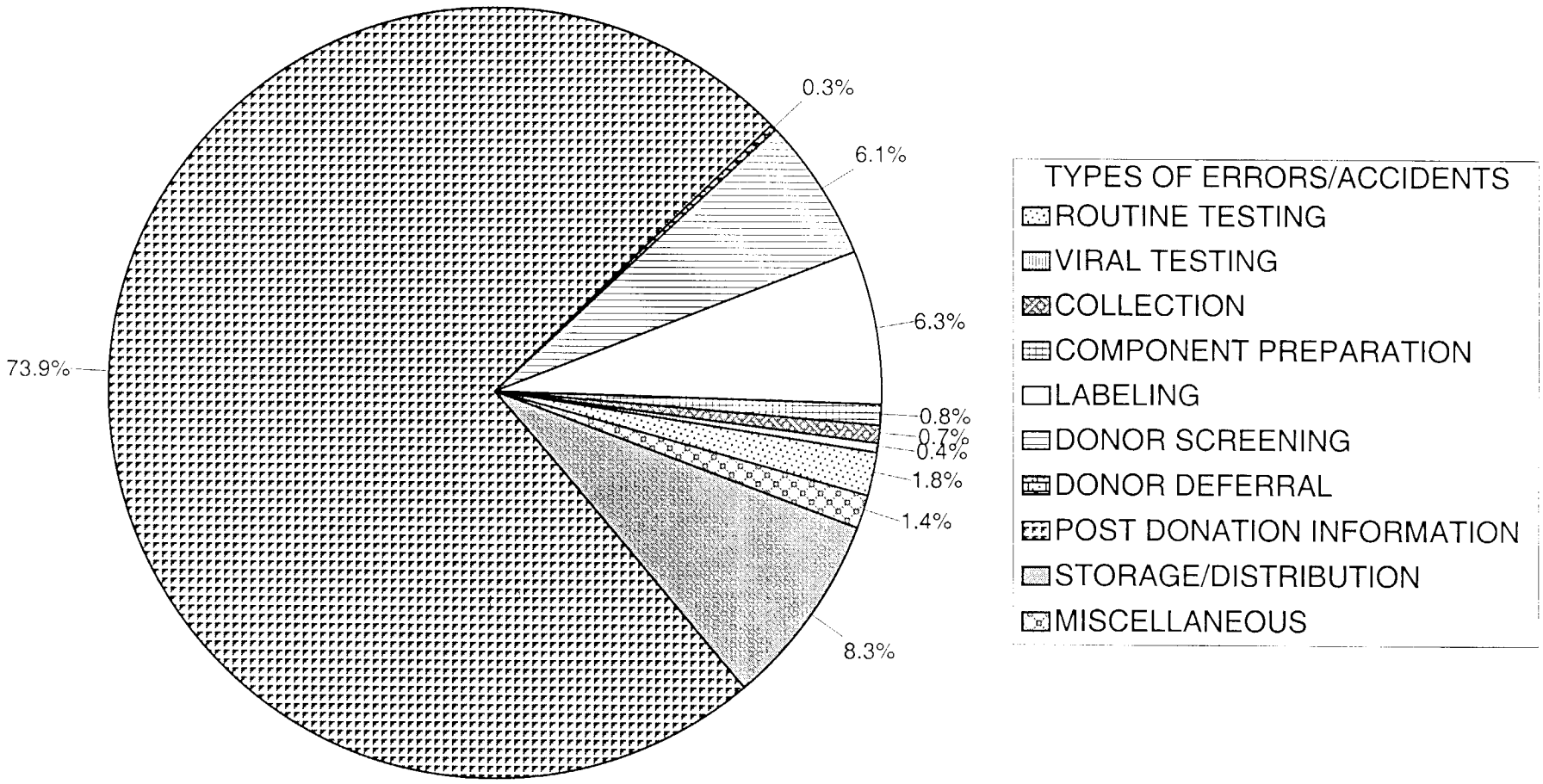
POTENTIAL RECALL

TYPES OF ERRORS/ACCIDENTS

ROUTINE TESTING	VIRAL TESTING
COLLECTION	COMPONENT PREPARATION
LABELING	DONOR SCREENING
DONOR DEFERRAL	POST DONATION INFORMATION
STORAGE/DISTRIBUTION	MISCELLANEOUS

TOTAL REPORTS RECEIVED (10/1/99 - 3/31/00) = 9393
POTENTIAL RECALLS = 670

ERROR AND ACCIDENT REPORTS
LICENSED BLOOD ESTABLISHMENTS
FY2000

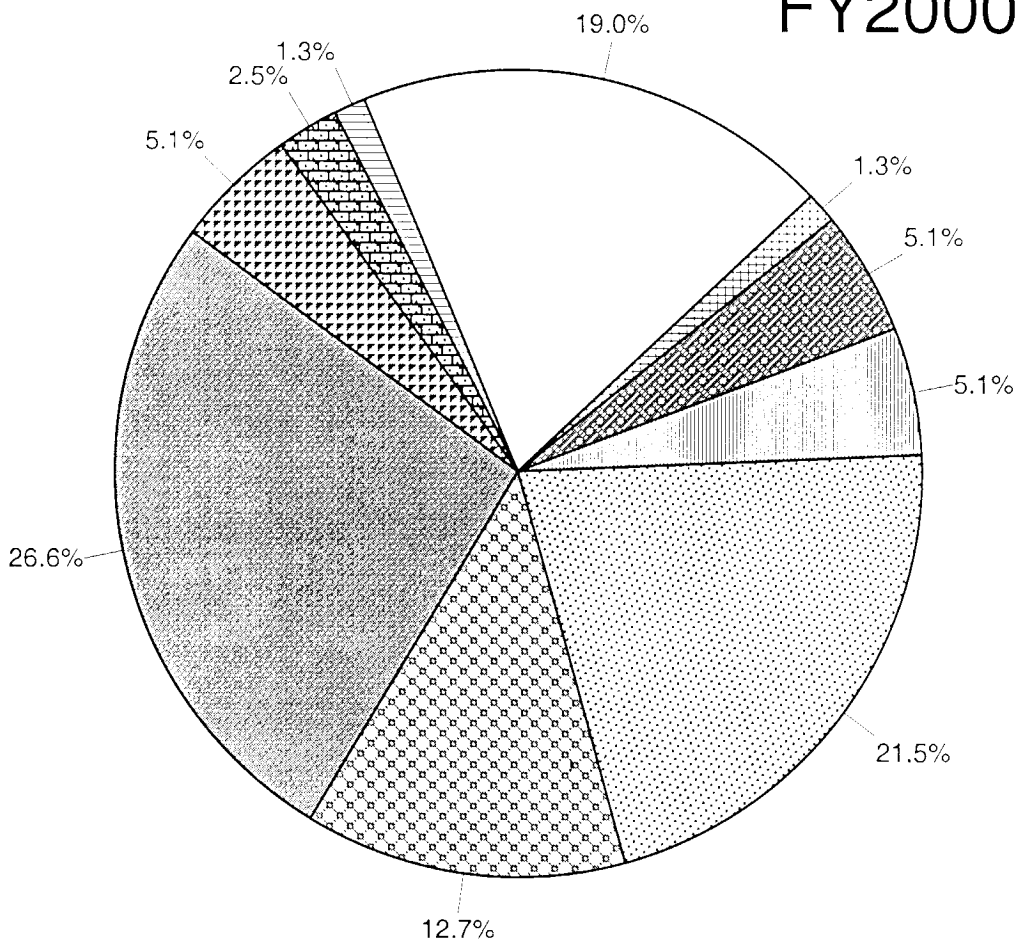


REPORTS RECEIVED (10/1/99 - 3/31/00) = 8011

ERROR AND ACCIDENT REPORTS

UNLICENSED BLOOD ESTABLISHMENTS

FY2000

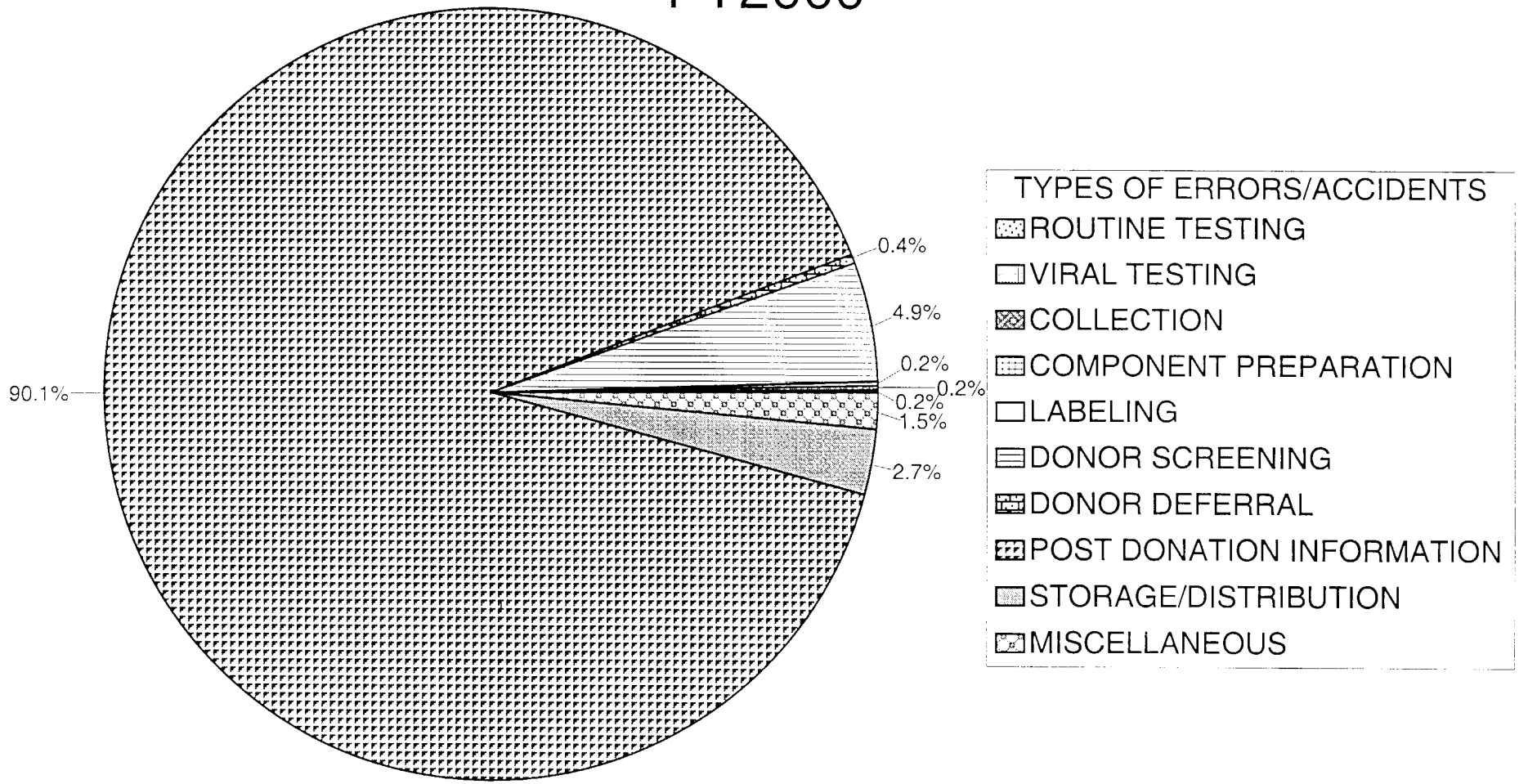


REPORTS RECEIVED (10/1/99 - 3/31/00) = 79
UNLICENSED BLOOD BANKS = 56; TRANSFUSION SERVICES = 23

ERROR AND ACCIDENT REPORTS

PLASMA CENTERS

FY2000



REPORTS RECEIVED (10/1/99 - 3/31/00) = 1303

BLOOD AND PLASMA ESTABLISHMENTS
FY2000

SECOND QUARTER

TYPE OF ERROR/ACCIDENT	REPORTABLE	NON-REPORTABLE	TOTAL	%REPORTABLE
POST DONATION INFORMATION	3901	12	3913	99.7%
STORAGE/DISTRIBUTION	375	19	394	95.2%
DONOR SCREENING	300	10	310	96.8%
LABELING	245	50	295	83.1%
ROUTINE TESTING	75	0	75	100.0%
COMPONENT PREPARATION	38	0	38	100.0%
COLLECTION	23	1	24	95.8%
VIRAL TESTING	15	0	15	100.0%
DONOR DEFERRAL	10	2	12	83.3%
MISCELLANEOUS	2	78	80	2.5%
TOTAL	4984	172	5156	96.7%

YEAR-TO-DATE

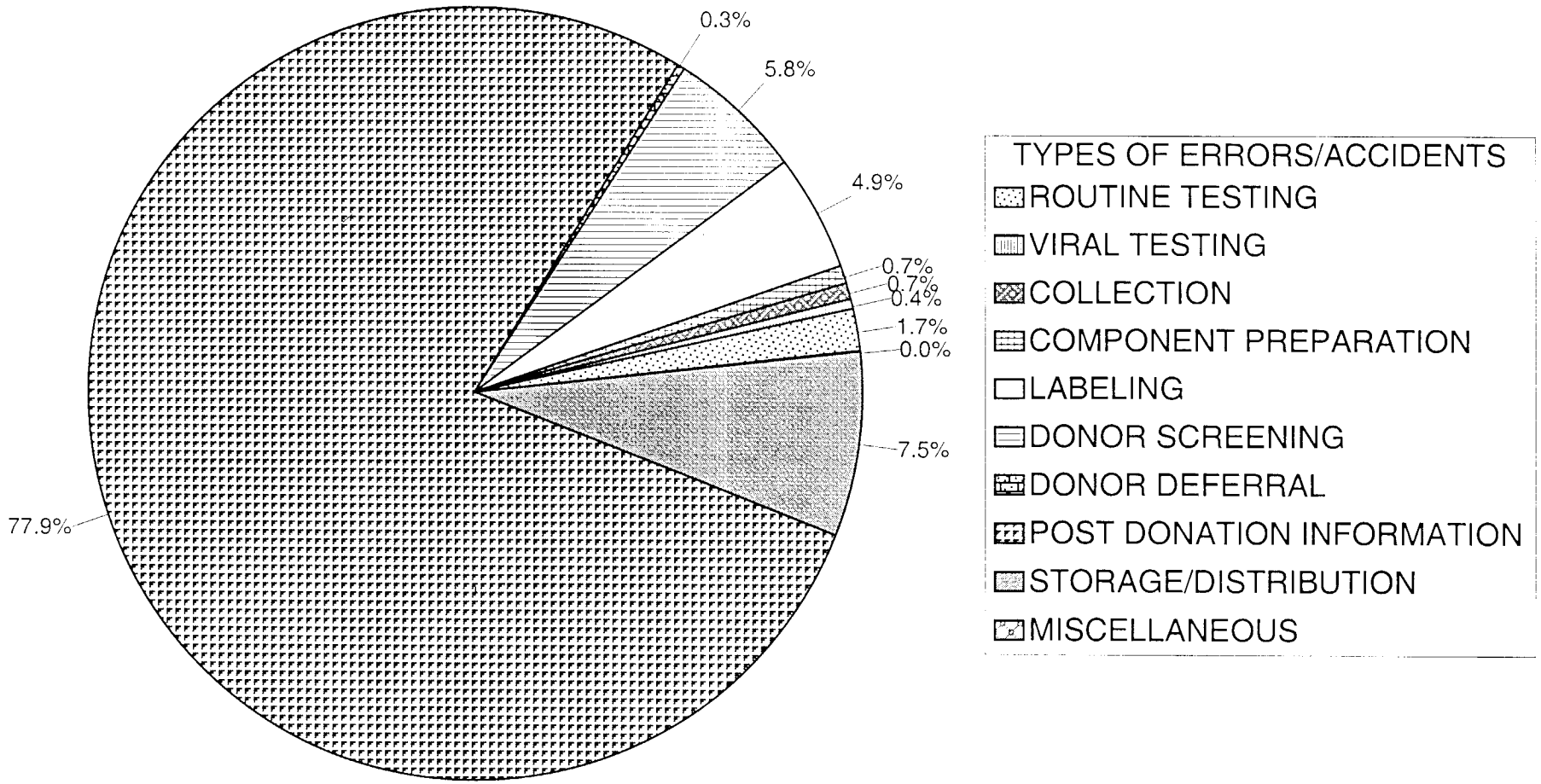
TYPE OF ERROR/ACCIDENT	REPORTABLE	NON-REPORTABLE	TOTAL	%REPORTABLE
POST DONATION INFORMATION	7080	21	7101	99.7%
STORAGE/DISTRIBUTION	685	33	718	95.4%
DONOR SCREENING	525	29	554	94.8%
LABELING	449	75	524	85.7%
ROUTINE TESTING	158	2	160	98.8%
COMPONENT PREPARATION	68	0	68	100.0%
COLLECTION	61	2	63	96.8%
VIRAL TESTING	37	0	37	100.0%
DONOR DEFERRAL	27	2	29	93.1%
MISCELLANEOUS	3	136	139	2.2%
TOTAL	9093	300	9393	96.8%

ERROR AND ACCIDENT REPORTS

ALL BLOOD AND PLASMA ESTABLISHMENTS

REPORTABLE ERRORS/ACCIDENTS

FY2000



TOTAL REPORTS RECEIVED (10/1/99 - 3/31/00) = 9393
REPORTABLE ERRORS/ACCIDENTS = 9093 (96.8%)

FY2000
Reports Received 10/1/99 – 3/31/00

REPORTABLE ERRORS/ACCIDENTS - 9093 (96.8% of total reports)

Top Three Categories of Errors/Accidents:

Post Donation Information - 7080 (77.9% of reportables)
**Examples:*
Information provided post donation:
- Donor traveled to a malarial endemic area
- [1]Donor traveled to UK between 1980 and 1996 (nvCJD risk)
- Donor received tattoo
- Donor had a history of cancer
- Donor became ill after donation,
not related to hepatitis, HIV, HTLV-I, sexually transmitted diseases or cold/flu symptoms

[1] *As a result of implementation of the guidance document published in November, 1999, there was a significant increase in the number of post donation information reports related to CJD risk factors. The guidance recommended deferral of donors who have spent six months or more cumulatively in the United Kingdom from 1980 through 1996. There were 125 reports submitted in FY-99 and 904 reports in FY2000 related to risk factors for CJD. Of the 904 reports received in FY2000, 830 were related to donors who provided information of travel to the United Kingdom.*

Storage/Distribution - 685 (7.5% of reportables)
**Examples:*
- Release of product that was broken or damaged
- Failure to quarantine unit, reason for quarantine:
  - outdated product
  - product QC unacceptable or not documented
  - product specification not met
  - collection time extended, discrepant or not documented
  - unit released prior to resolution of discrepancy
  - unsuitable medical history
- Release of product that contained clots or would not flow through a filter
- Product was shipped or stored at incorrect temperature

Donor Screening – 525 (5.8% of reportables)
**Examples:*
- Donor provided information that warranted deferral, but donor was not deferred:
  - travel to malarial endemic area
  - received medication
  - history of disease, surgery or cancer
- Donor record incomplete or incorrect
- Donor deferral list not checked

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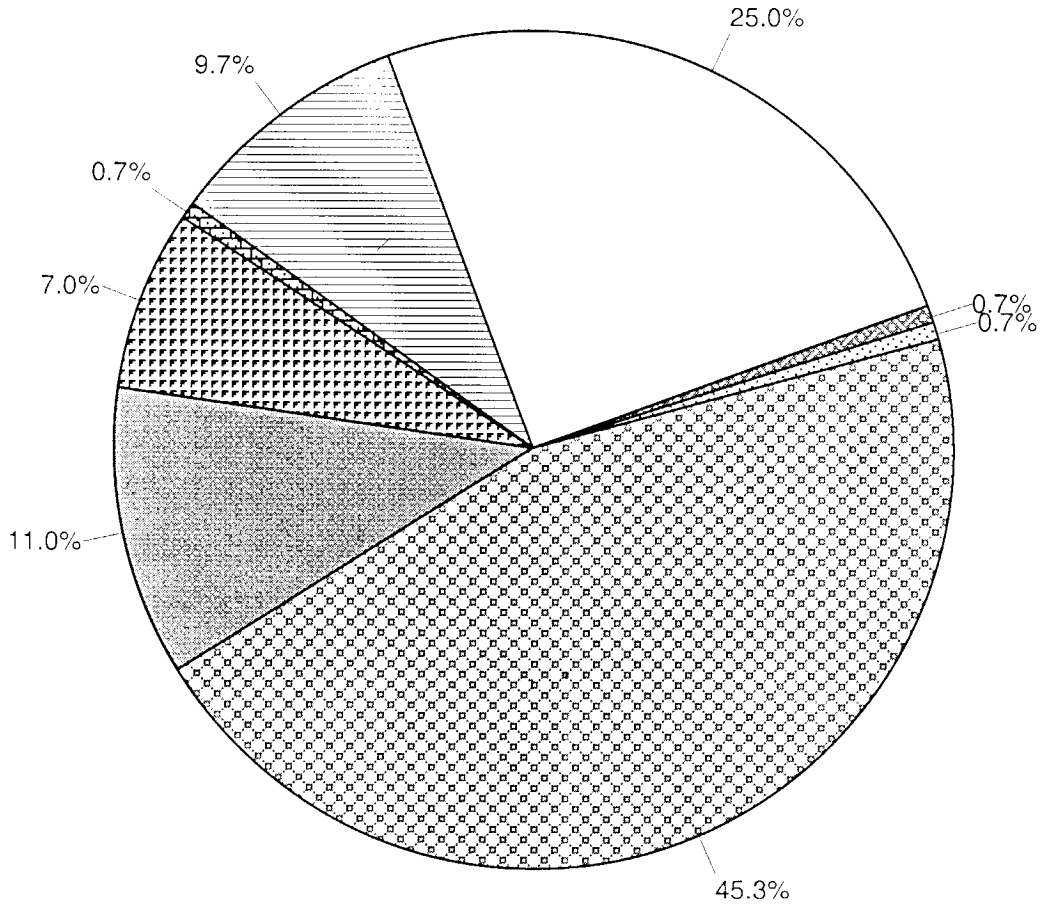
*Examples of errors and accidents represent at least 50% of reports in each category.

ERROR AND ACCIDENT REPORTS

ALL BLOOD AND PLASMA ESTABLISHMENTS

NON-REPORTABLE ERRORS/ACCIDENTS

FY2000



TOTAL REPORTS RECEIVED (10/1/99 - 3/31/0) = 9393
REPORTABLE ERRORS/ACCIDENTS = 300 (3.2%)

FY2000
Reports Received 10/1/99 – 3/31/00

NON-REPORTABLE ERRORS/ACCIDENTS - 300 (3.2% of total reports)

Top Three Categories of Errors/Accidents:

Miscellaneous 136 (45.3% of non-reportables)
**Examples:*

- Recordkeeping error/accident - record is incorrect or not reviewed, testing and labeling acceptable
- No products made available for distribution
- Records destroyed or lost, final disposition unknown; unit determined to be suitable at the time of distribution

Labeling - 75 (25.0% of non-reportables)
**Examples:*

- Unit missing label for ABO/Rh, product, or expiration date
- Unit labeled with incorrect weight, volume, collection date, or facility identifiers; unit acceptable
- Unit labeled with a shortened expiration date

Storage and Distribution - 33 (11.0% of non-reportables)
**Examples:*

- Discrepancy between shipping form and shipment
- Failure to quarantine unit after receiving information concerning post donation cold or flu symptoms
- Shipment to the wrong facility
- Allogeneic unit issued instead of an autologous unit

*Examples of errors and accidents represent at least 50% of reports in each category.

The following table and graphs show the time periods in which CBER received reports from the blood and plasma establishments. The evaluation of timeliness is limited to only reports that met the threshold for reporting.

BLOOD AND PLASMA ESTABLISHMENTS
FY2000

NUMBER OF DAYS FROM DATE E/A DISCOVERED TO FDA RECEIVED

SECOND QUARTER
Reports received 1/1/00 – 3/31/00

CUMULATIVE PERCENT OF REPORTS	LICENSED (Days)	UNLICENSED (Days)	PLASMA (Days)	TOTAL (Days)
10%	14	9	14	14
25%	20	14	23	21
50%	29	34	38	30
75%	41	67	64	43
90%	58	87	124	69
# REPORTS	4165	35	784	4984
RANGE	2-491	6-146	5-341	2-491

YEAR-TO-DATE
Reports received 10/1/99 – 3/31/00

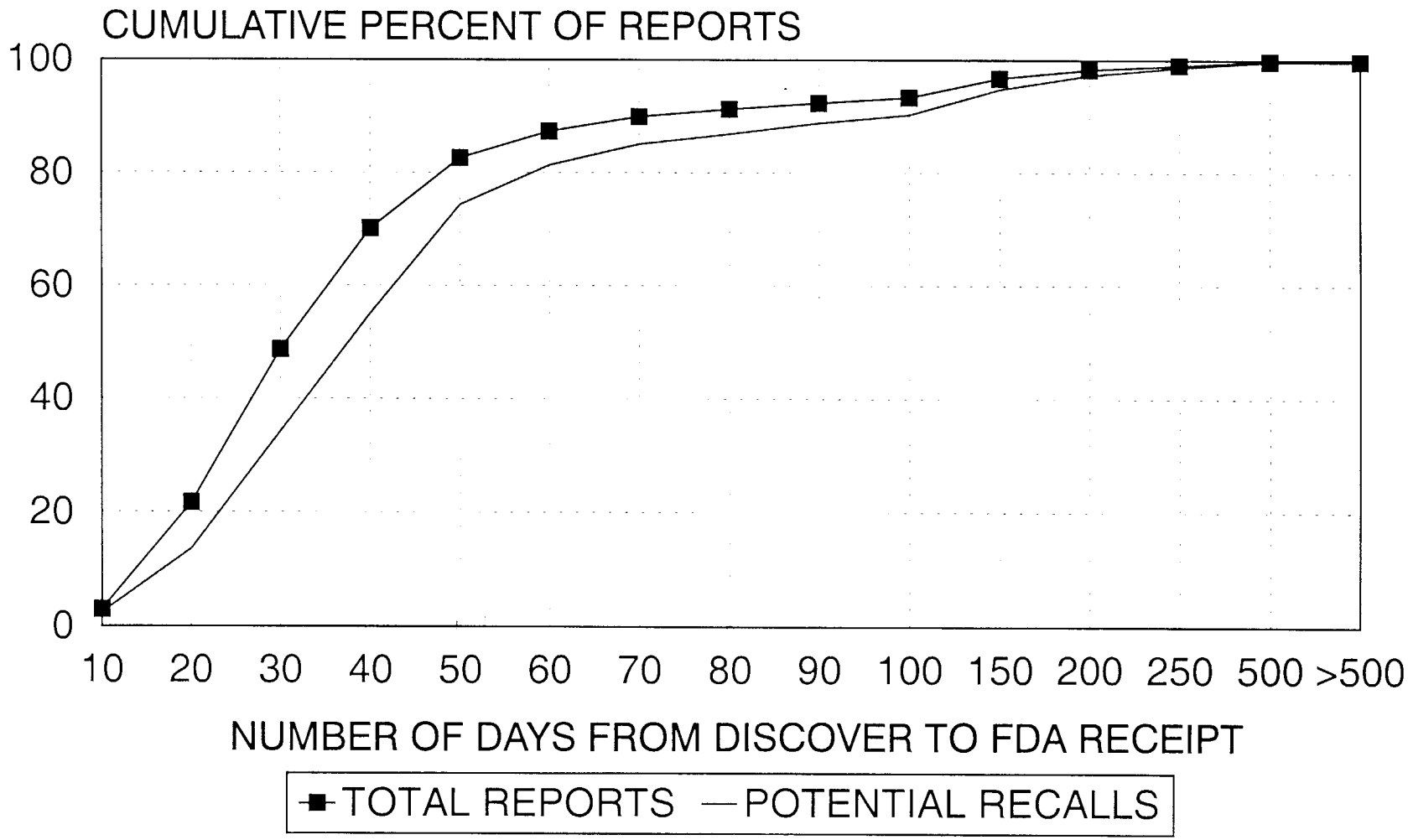
CUMULATIVE PERCENT OF REPORTS	LICENSED (Days)	UNLICENSED (Days)	PLASMA (Days)	TOTAL (Days)
10%	14	9	14	15
25%	21	18	22	21
50%	30	37	35	31
75%	42	75	60	43
90%	62	163	115	71
# REPORTS	7743	66	1284	9093
RANGE	2-1133	6-566	4-424	2-1133

ERROR AND ACCIDENT REPORTS

REPORTING TIME

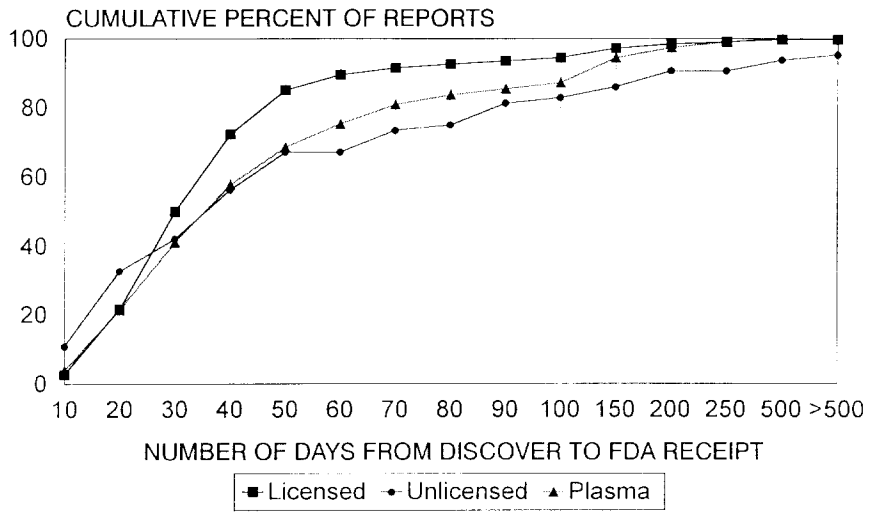
ALL REPORTING BLOOD AND PLASMA ESTABLISHMENTS

FY-2000



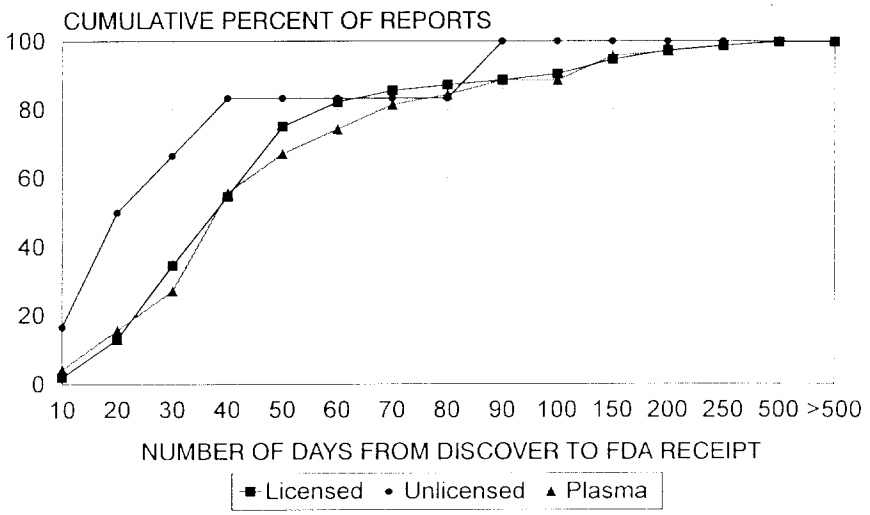
TOTAL REPORTS =9093
POTENTIAL RECALLS = 670

ERROR AND ACCIDENT REPORTS
REPORTING TIME
TOTAL REPORTS
FY-2000



TOTAL REPORTS = 9093
LICENSED BLOOD EST.= 7744; UNLICENSED BLOOD EST. = 65, PLASMA CENTERS = 1284

ERROR AND ACCIDENT REPORTS
REPORTING TIME
POTENTIAL RECALLS
FY-2000



TOTAL REPORTS = 670
LICENSED BLOOD EST.= 594, UNLICENSED BLOOD EST. = 6, PLASMA CENTERS = 70

The following tables and pie charts show the type of errors and accidents reported by non-blood manufacturers:

SECOND QUARTER – FY2000

NON-BLOOD MAUFACTURERS

	DERIVATITVE		IN-VITRO DIAGNOSTIC		ALLERGENIC		THERAPUETIC		VACCINE		TOTAL REPORTS		POTENTIAL RECALL	
TYPE OF ERROR/ACCIDENT	TOTAL	RECALL	TOTAL	RECALL	TOTAL	RECALL	TOTAL	RECALL	TOTAL	RECALL				
REAGENT PERFORMANCE	0	0	2	1	0	0	0	0	0	0	2	5.3%	1	12.5%
STERILITY COMPROMISED	2	0	2	2	4	3	1	1	1	0	10	26.3%	6	75.0%
LABELING	0	0	4	0	4	0	1	0	1	0	10	26.3%	0	0.0%
STORAGE/DISTRIBUTION	0	0	1	0	0	0	0	0	1	0	2	5.3%	0	0.0%
PROCESSING	3	0	0	0	0	0	6	0	2	0	11	28.9%	0	0.0%
MISCELLANEOUS	0	0	0	0	0	0	1	1	0	0	1	2.6%	1	12.5%
NOT REPORTABLE	0	0	0	0	1	0	0	0	1	0	2	5.3%	0	0.0%
TOTAL	5	0	9	3	9	3	9	2	6	0	38	100%	8	100%

	DERIVATITVE		IN-VITRO DIAGNOSTIC		ALLERGENIC		THERAPUETIC		VACCINE		TOTAL REPORTS		POTENTIAL RECALL	
TYPE OF ERROR/ACCIDENT	TOTAL	RECALL	TOTAL	RECALL	TOTAL	RECALL	TOTAL	RECALL	TOTAL	RECALL				
REAGENT PERFORMANCE	0	0	2	1	0	0	0	0	0	0	2	2.6%	1	10.0%
STERILITY COMPROMISED	2	0	2	2	8	3	2	1	1	0	15	19.7%	6	60.0%
LABELING	0	0	9	0	9	1	1	0	3	0	22	28.9%	1	10.0%
STORAGE/DISTRIBUTION	1	0	2	0	1	0	1	0	1	0	6	7.9%	0	0.0%
PROCESSING	4	0	0	0	4	1	7	0	5	0	20	26.3%	1	10.0%
MISCELLANEOUS	3	0	1	0	0	0	2	1	0	0	6	7.9%	1	10.0%
NOT REPORTABLE	1	0	0	0	3	0	0	0	1	0	5	6.6%	0	0.0%
TOTAL	11	0	16	3	25	5	13	2	11	0	76	100%	10	100%

NON-BLOOD MANUFACTURERS

DERIVATIVES

ERROR/ACCIDENT	#REPORTS
STERILITY COMPROMISED	*2*
Visible precipitate observed in product	2
STORAGE/DISTRIBUTION	*1*
Product released prior to CBER approval - expiration of CBE submission	1
PROCESSING	*4*
Source material unsuitable for processing due to donor previously deferred	1
Source material unsuitable for processing due to bioburden specifications not met	1
Lypholization cycle interrupted due to an earthquake that caused a power outage	1
Column effluent collected in flexible container rather than stainless steel tank (product not distributed, firm intends to submit sample for lot release)	1
MISCELLANEOUS	*3*
Glass defects	1
Water for Injection system was not sampled	1
Factor IX Complex tested positive for HAV RNA during final container PCR testing, associated products released	1
NON-REPORTABLE	*1*
Product labeled with missing/incorrect facility identifiers - product acceptable	1
TOTAL	*11*

IN-VITRO DIAGNOSTICS

ERROR/ACCIDENT	#REPORTS
REAGENT PERFORMANCE	*2*
A2 cells gave positive reaction when tested with Anti-A1 Lectin	1
B cells gave weak positive reactions	1
STERILITY COMPROMISED	*2*
Microbial contamination	2
LABELING	*9*
Package insert incorrect	3
Product label incorrect	1
Lot number missing/incorrect and expiration date also missing	5
STORAGE/DISTRIBUTION	*2*
Product released prior to completion of required testing	2
MISCELLANEOUS	*1*
Wrong vial replaced in the 11-cell panel, due to hemolysis	1
TOTAL	*16*

NON-BLOOD MANUFACTURERS

ALLERGENICS

ERROR/ACCIDENT	#REPORTS
STERILITY COMPROMISED	***8***
Stoppers contaminated with endotoxin	1
Loose seal resulted in a leaking vial	1
A piece of rubber from the stopper found in vial	1
Contents leaking out	1
Product found to contain precipitate	4
LABELING	***9***
Potency not on vial label	2
Product label incorrect	1
Lot number missing/incorrect	1
Concentration missing or incorrect	1
Expiration date extended or missing	3
Labeling did not list all ingredients	1
STORAGE/DISTRIBUTION	***1***
Sterility test cultures may not have been incubated for 14 days at 30-35 degrees C before products released	1
MISCELLANEOUS	***4***
Computer calculation error for preparation of extract	1
Error in correcting calculation error resulted in concentration of 835 PNU/ml instead of 1000 PNU/ml	1
Formula change	1
PNU value incorrectly entered into the computer	1
NON-REPORTABLE	***3***
Product labeled with missing/incorrect weight or volume; product acceptable	1
Illegible expiration date	1
Expiration date shortened	1
TOTAL	***25***

THERAPEUTICS

ERROR/ACCIDENT	#REPORTS
STERILITY COMPROMISED	***2***
Reovirus contamination of EPO concentrated diafiltered medium	1
Bacterial contamination	1
LABELING	***1***
Lot number incomplete	1
STORAGE/DISTRIBUTION	***1***
Product stored at incorrect temperature	1
PROCESSING	***7***
Product specification not met	4
BLA ELISA data was identical to that of a previously released lot	1
Purified water mixed into WFI distillate stream	1
Sanitization of the bulking gowning room and gowning room was not performed	1
MISCELLANEOUS	***2***
Stability testing failed	2
TOTAL	***13***

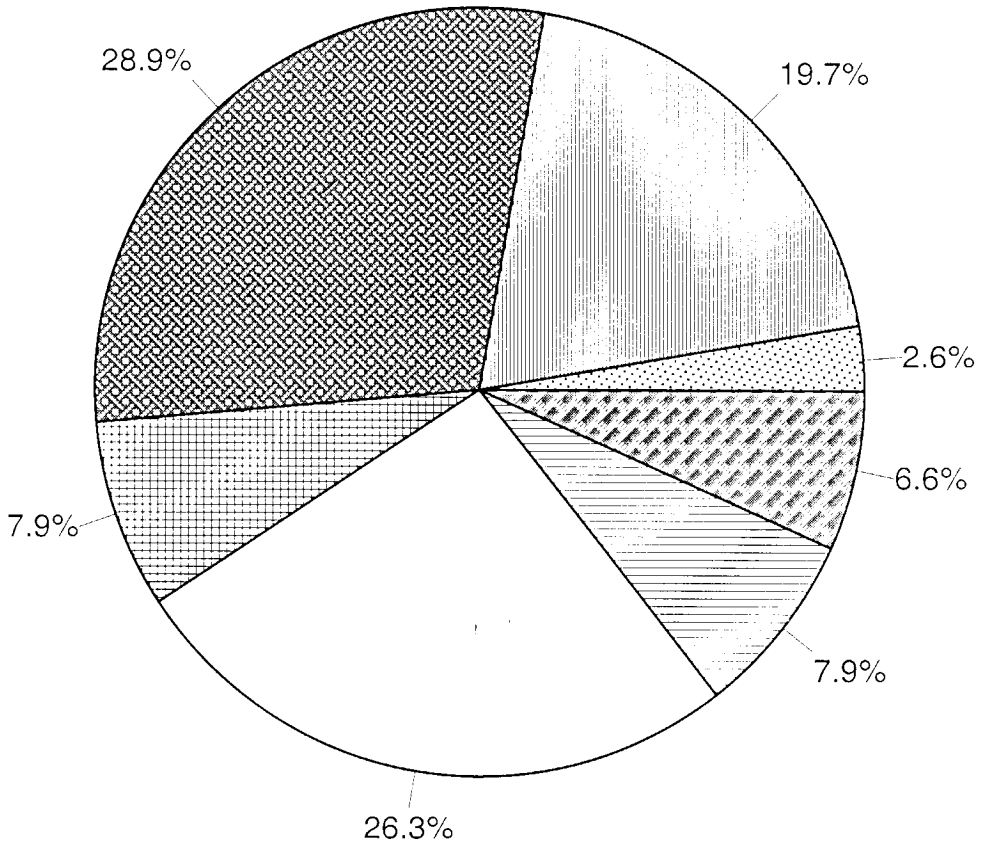
VACCINES

ERROR/ACCIDENT	#REPORTS
STERILITY COMPROMISED	***1***
Bulk intermediate failed sterility test at 12-months (yeast)	1
LABELING	***3***
Package insert incorrect	2
COA contains information on the relationship between EU/ml and IU/ml that may be misinterpreted	1
STORAGE/DISTRIBUTION	***1***
Product shipped or stored at incorrect temperature	1
PROCESSING	***5***
Product specification not met	4
Inappropriate temperature during manufacturing or processing	1
NON-REPORTABLE	***1***
Product not made available for distribution	1
TOTAL	***11***

ERROR AND ACCIDENT REPORTS

NON-BLOOD MANUFACTURERS

FY2000



TOTAL REPORTS RECEIVED (10/1/99 - 3/31/00) = 76
REPORTABLE ERRORS/ACCIDENTS = 71; NON-REPORTABLE ERRORS/ACCIDENTS = 5