MEMORANDUM

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

DATE: NOV 30 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 Third Quarter FY2000

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

Between April 1, 2000 and June 30, 2000, the Division of Inspections and Surveillance received 7493 error and accident reports from biological product manufacturers. Blood and plasma establishments submitted 7459 reports and non-blood manufacturers submitted 34 reports. There were 371 (5.0%) 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, 196 (2.6%) 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 June 30, 2000, the Division of Inspections and Surveillance received 16,960 error and accident reports from biological product manufacturers. Blood and plasma establishments submitted 16,850 reports and non-blood manufacturers submitted 110 reports. There were 1053 (6.2%) 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, 506 (3.0%) 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 – Third Quarter
3 - Pie charts - Blood and Plasma Establishments
    Total Reports, Potential Recalls – Year-To-Date
4 - Pie chart - Types of Errors/Accidents
    Licensed Blood Banks
5 - Pie chart - Types of Errors/Accidents
    Unlicensed Blood Banks
6 - Pie chart - Types of Errors/Accidents
    Plasma Centers
7 - Table - Types of Errors/Accidents
    Blood and Plasma Establishments
        Reportable, Non-Reportable, Total
8 - Pie chart - Types of Errors/Accidents
    Reportable E/A's
9 - List - Top Three Categories of Reportable Errors/Accidents
10 - Pie chart - Types of Errors/Accidents
    Non-Reportable E/A's
11 - List - Top Three Categories of Non-Reportable Errors/Accidents
12 - Table - Reporting Time
13 - Line graph - Reporting Time
    All Reporting Blood Establishments
14 - Line graph - Reporting Time
    Total Reports
15 - Line graph - Reporting Time
    Potential Recalls
16 - Table - Types of Errors/Accidents
    Non-Blood Manufacturers
17 – Tables (4 pages) Detailed Listing of Errors/Accidents for Non-Blood Manufacturers
18 - Pie chart - Types of Errors/Accidents
    Non-Blood Manufacturers

ALL REPORTING ESTABLISHMENTS

FY2000

	NUMBER OF REPORTING ESTABLISHMENTS		TOTAL REPORTS RECEIVED		POTENTIAL RECALLS	
	Third Quarter	**Year To Date**	**Third Quarter**	**Year To Date**	**Third Quarter**	**Year To Date**
BLOOD/PLASMA MANUFACTURERS						
LICENSED BLOOD BANKS	129*	155*	6524	14535	323	919
UNLICENSED BLOOD BANKS	21	44	31	86	3	9
TRANSFUSION SERVICES	7	17	19	43	0	0
PLASMA CENTERS	233	291	885	2186	41	111
SUB-TOTAL	390	507	7459	16850	367	1039
NON-BLOOD MANUFACTURERS						
BLOOD DERIVATIVE MANUFACTURER	6	12	7	19	0	0
IN-VITRO DIAGNOSTIC MANUFACTURER	6	10	11	32	1	4
VACCINE MANUFACTURER	3	6	3	9	0	0
ALLERGENICS MANUFACTURER	2	5	3	27	1	6
THERAPEUTIC MANUFACTURER	9	12	10	23	2	4
SUB-TOTAL	26	45	34	110	4	14
TOTAL	**416**	**552**	**7493**	**16960**	**371**	**1053**

*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:

THIRD 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 INFO	5320	5	0	773	6098	81.8%
STORAGE/DISTRIBUTION	447	9	4	15	475	6.4%
DONOR SCREENING	229	2	0	66	297	4.0%
LABELING	261	4	0	4	269	3.6%
MISCELLANEOUS	72	1	12	19	104	1.4%
ROUTINE TESTING	75	2	3	0	80	1.1%
COMPONENT PREPARATION	52	2	0	0	54	0.7%
COLLECTION	38	1	0	0	39	0.5%
VIRAL TESTING	13	5	0	4	22	0.3%
DONOR DEFERRAL	17	0	0	4	21	0.3%
TOTAL	6524	31	19	885	7459	100.0%

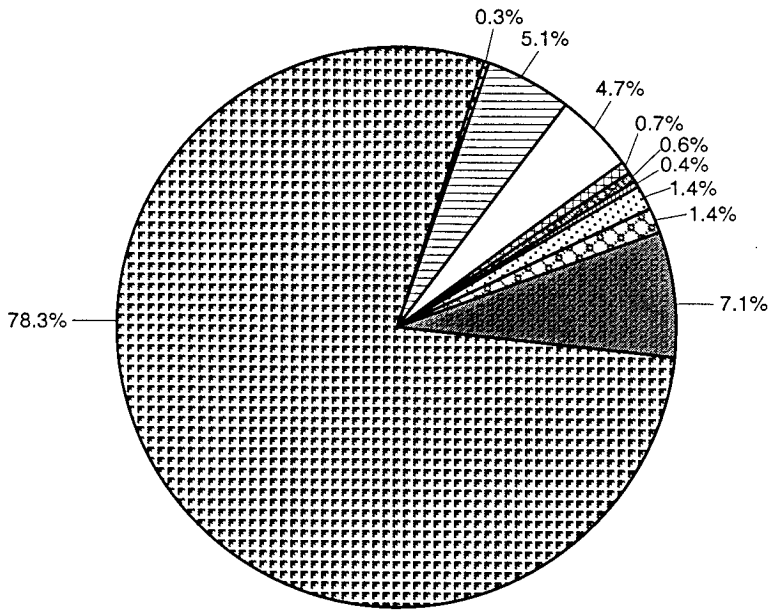
POTENTIAL RECALLS

TYPE OF ERROR/ACCIDENT	Licensed Establishments	Unlicensed Establishments	Transfusion Services	Plasma Centers	TOTAL	
DONOR SCREENING	128	1	0	17	146	39.8%
STORAGE/DISTRIBUTION	68	0	0	7	75	20.4%
LABELING	40	0	0	4	44	12.0%
COMPONENT PREPARATION	35	0	0	0	35	9.5%
COLLECTION	21	0	0	0	21	5.7%
POST DONATION INFORMATION	12	0	0	8	20	5.4%
DONOR DEFERRAL	14	0	0	4	18	4.9%
VIRAL TESTING	4	2	0	1	7	1.9%
ROUTINE TESTING	1	0	0	0	1	0.3%
MISCELLANEOUS	0	0	0	0	0	0.0%
TOTAL	323	3	0	41	367	100.0%

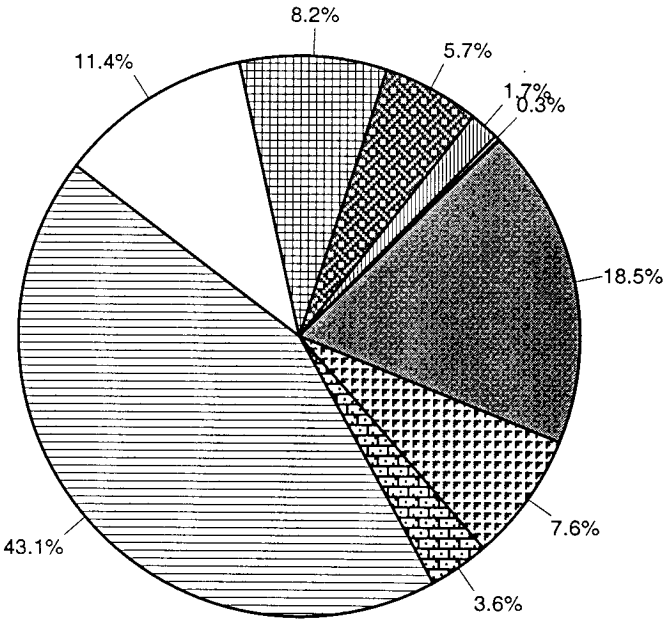
ERROR AND ACCIDENT REPORTS

ALL BLOOD AND PLASMA ESTABLISHMENTS

FY2000



TOTAL REPORTS



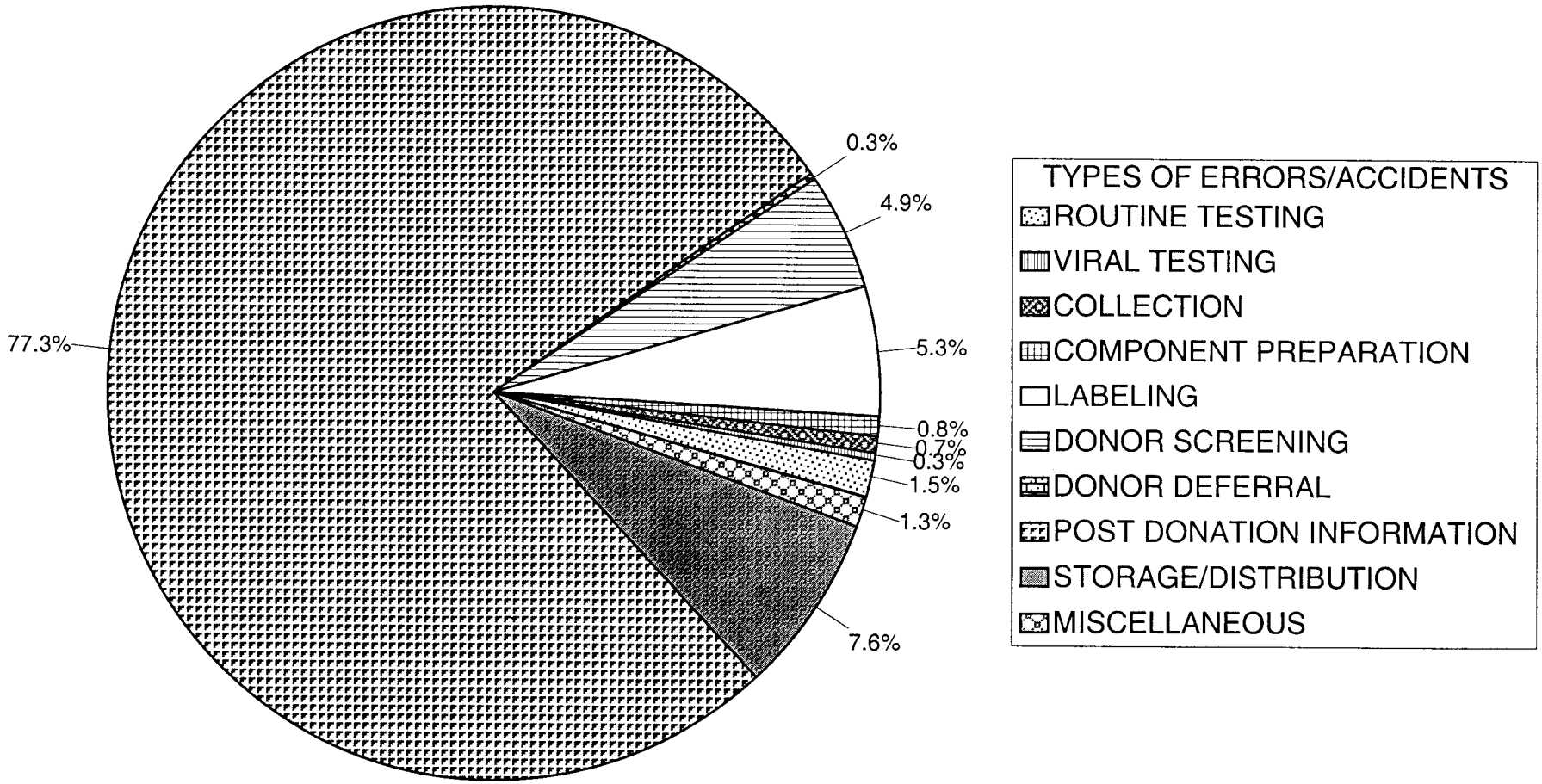
POTENTIAL RECALL

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 - 6/30/00) = 16,850
POTENTIAL RECALLS = 1039

ERROR AND ACCIDENT REPORTS
LICENSED BLOOD ESTABLISHMENTS
FY2000

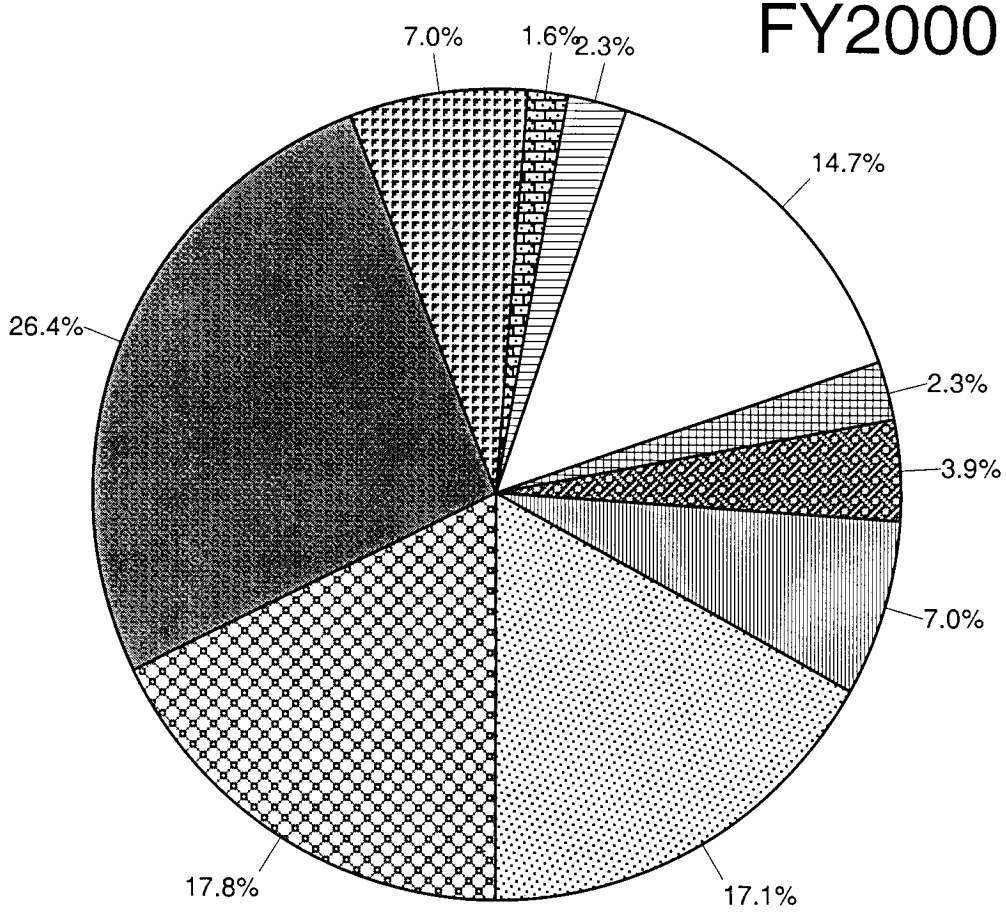


REPORTS RECEIVED (10/1/99 - 6/30/00) = 14,535

ERROR AND ACCIDENT REPORTS

UNLICENSED BLOOD ESTABLISHMENTS

FY2000



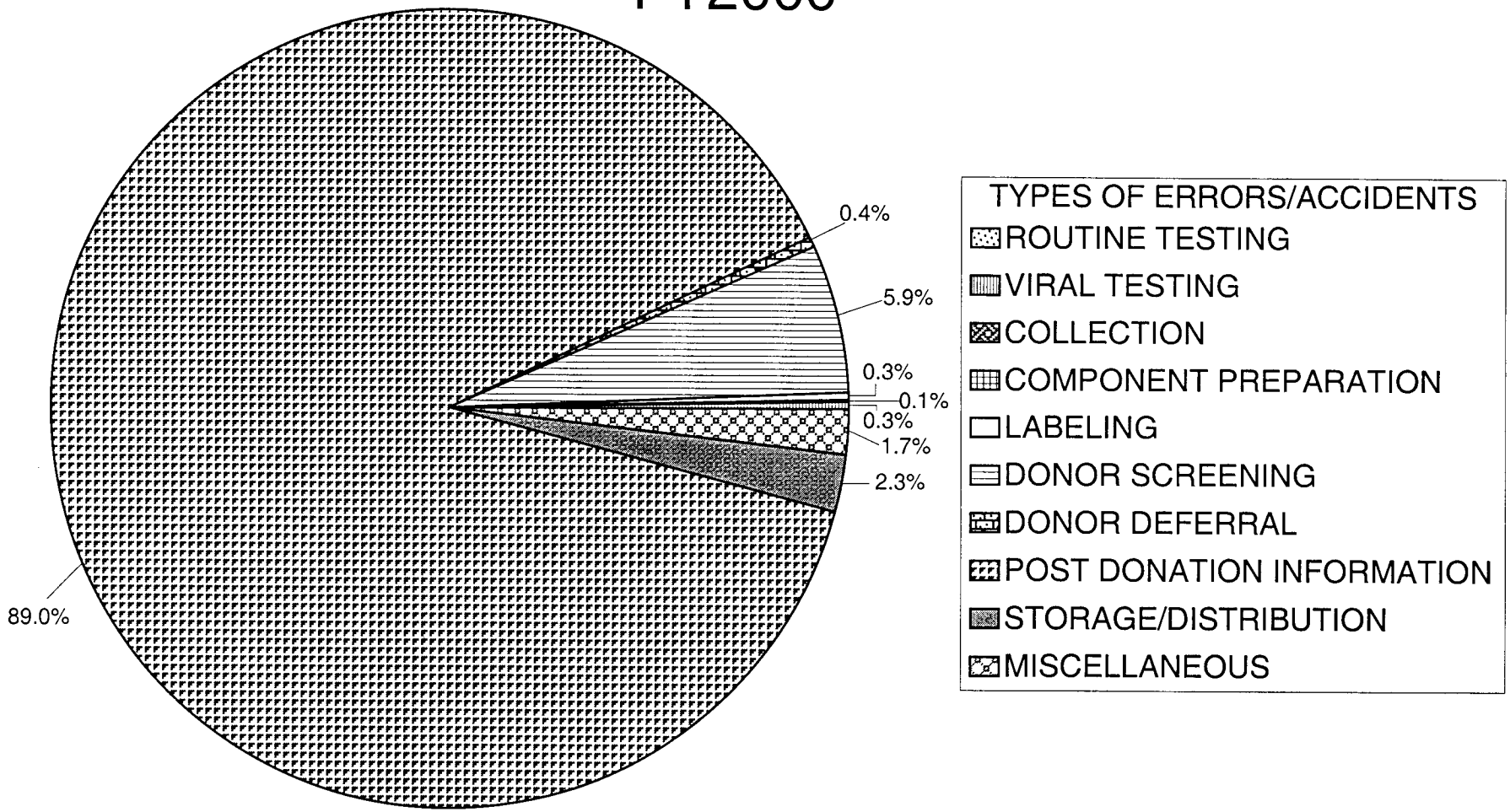
TYPES OF ERRORS/ACCIDENTS
- ROUTINE TESTING
- VIRAL TESTING
- COLLECTION
- COMPONENT PREPARATION
- LABELING
- DONOR SCREENING
- DONOR DEFERRAL
- POST DONATION INFORMATION
- STORAGE/DISTRIBUTION
- MISCELLANEOUS

REPORTS RECEIVED (10/1/99 - 6/30/00) = 129
UNLICENSED BLOOD BANKS = 86; TRANSFUSION SERVICES = 43

ERROR AND ACCIDENT REPORTS

PLASMA CENTERS

FY2000



REPORTS RECEIVED (10/1/99 - 6/30/00) = 2186

BLOOD AND PLASMA ESTABLISHMENTS

FY2000

THIRD QUARTER

TYPE OF ERROR/ACCIDENT	REPORTABLE	NON-REPORTABLE	TOTAL	%REPORTABLE
POST DONATION INFORMATION	6085	13	6098	99.8%
STORAGE/DISTRIBUTION	454	21	475	95.6%
DONOR SCREENING	272	25	297	91.6%
LABELING	243	26	269	90.3%
MISCELLANEOUS	2	102	104	1.9%
ROUTINE TESTING	80	0	80	100.0%
COMPONENT PREPARATION	53	1	54	98.1%
COLLECTION	36	3	39	92.3%
VIRAL TESTING	21	1	22	95.5%
DONOR DEFERRAL	20	1	21	95.2%
TOTAL	7266	193	7459	97.4%

YEAR-TO-DATE

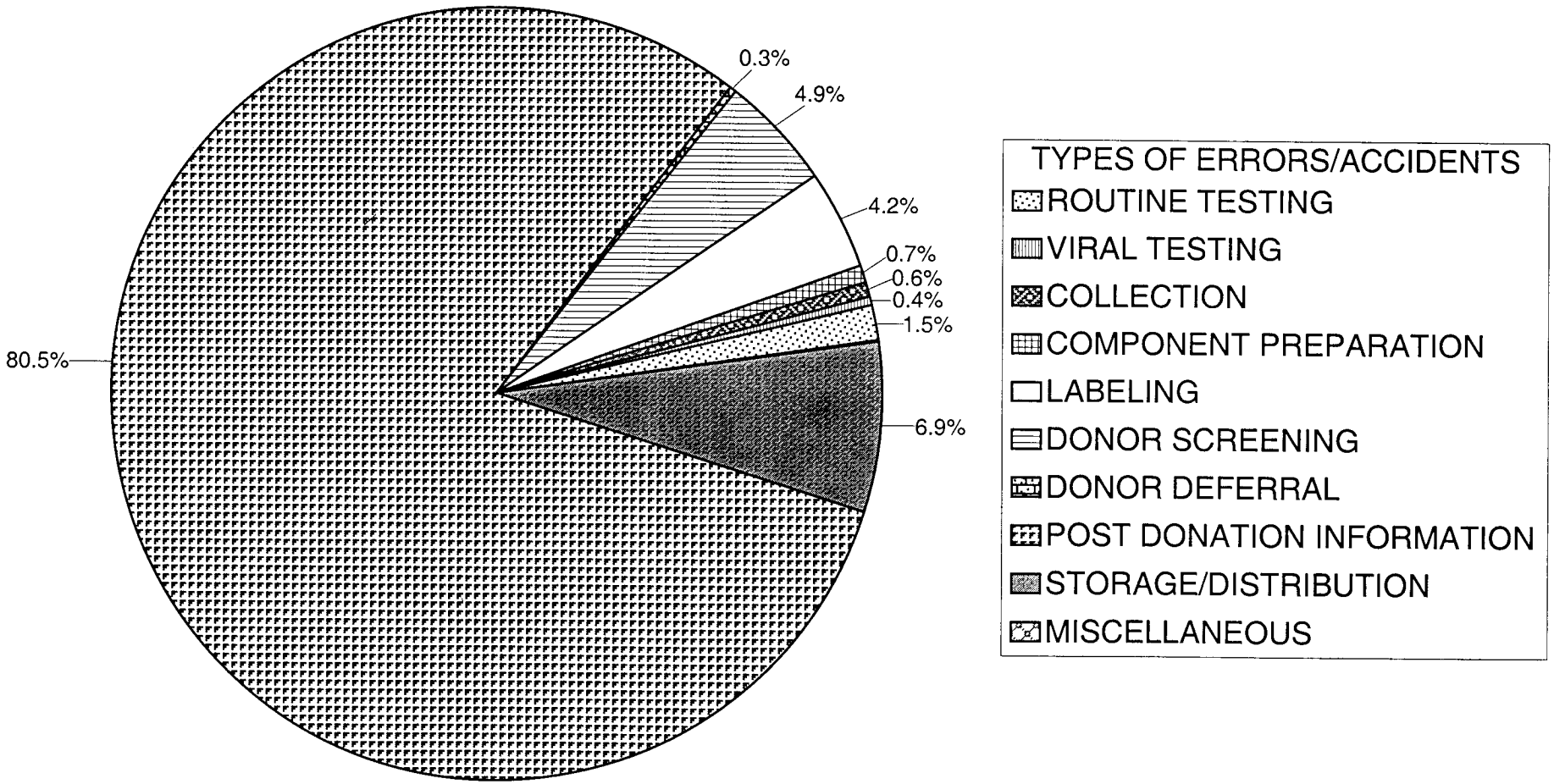
TYPE OF ERROR/ACCIDENT	REPORTABLE	NON-REPORTABLE	TOTAL	%REPORTABLE
POST DONATION INFORMATION	13162	34	13196	99.7%
STORAGE/DISTRIBUTION	1132	59	1191	95.0%
DONOR SCREENING	798	53	851	93.8%
LABELING	692	101	793	87.3%
MISCELLANEOUS	5	238	243	2.1%
ROUTINE TESTING	238	2	240	99.2%
COMPONENT PREPARATION	120	1	121	99.2%
COLLECTION	100	5	105	95.2%
VIRAL TESTING	58	1	59	98.3%
DONOR DEFERRAL	47	4	51	92.2%
TOTAL	16352	498	16850	97.0%

ERROR AND ACCIDENT REPORTS

ALL BLOOD AND PLASMA ESTABLISHMENTS

REPORTABLE ERRORS/ACCIDENTS

FY2000



TOTAL REPORTS RECEIVED (10/1/99 - 6/30/00) = 16,850
REPORTABLE ERRORS/ACCIDENTS = 16,352 (97.0%)

FY2000
Reports Received 10/1/99 – 6/30/00

REPORTABLE ERRORS/ACCIDENTS – 16,352 (97.0% of total reports)

Top Three Categories of Errors/Accidents:

Post Donation Information – 13,162 (80.5% of reportables)
**Examples:*
Information provided post donation:
- [1]Donor traveled to UK between 1980 and 1996 (nvCJD risk)
- Donor traveled to a malarial endemic area
- 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 November 11, 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 3585 reports in FY2000 related to risk factors for CJD. Of the 3585 reports received in FY2000, 3397 were related to donors who provided information of travel to the United Kingdom.*

Storage/Distribution - 1132 (6.9% 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 – 798 (4.9% of reportables)
**Examples:*
- Donor provided information that warranted deferral, but donor was not deferred:
  - travel to malarial endemic area
  - history of disease, surgery or cancer
  - received medication
- Donor record incomplete or incorrect
- Donor deferral list not checked

---

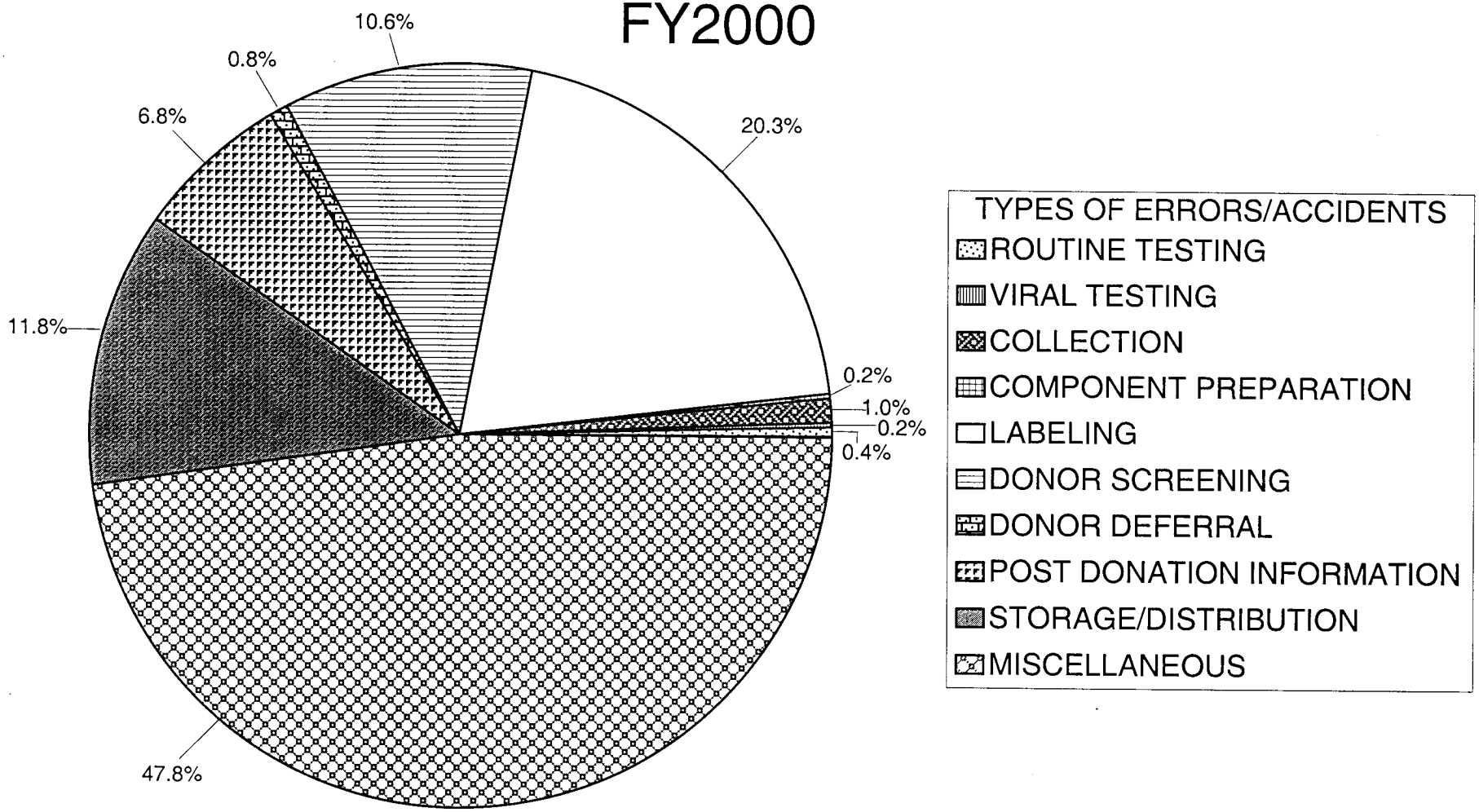
*Examples of errors and accidents represent at least 50% of reports in each category.

ERROR AND ACCIDENT REPORTS

ALL BLOOD AND PLASMA ESTABLISHMENTS

NON-REPORTABLE ERRORS/ACCIDENTS

FY2000



TOTAL REPORTS RECEIVED (10/1/99 - 6/30/0) = 16,850
REPORTABLE ERRORS/ACCIDENTS = 498 (3.0%)

FY2000
Reports Received 10/1/99 – 6/30/00

NON-REPORTABLE ERRORS/ACCIDENTS - 498 (3.0% of total reports)

Top Three Categories of Errors/Accidents:

Miscellaneous 238 (47.8% of non-reportables)
**Examples:*

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

Labeling - 101 (20.3% 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
- Directed unit, suitable for allogeneic use, labeled with incorrect name, SSN, or date of birth

Storage and Distribution - 59 (11.8% of non-reportables)
**Examples:*

- Irradiated unit requested by another facility, not provided (unit labeled appropriately)
- Sterile weld inspection not documented
- Failure to quarantine unit after receiving information concerning post donation cold or flu symptoms
- Allogeneic unit issued instead of an autologous unit
- Discrepancy between shipping form and shipment

*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.

ERROR AND ACCIDENT REPORTS

BLOOD AND PLASMA ESTABLISHMENTS
FY2000

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

THIRD QUARTER
Reports received 4/1/00 – 6/30/00

CUMULATIVE PERCENT OF REPORTS	LICENSED (Days)	UNLICENSED (Days)	PLASMA (Days)	TOTAL (Days)
10%	14	5	15	14
25%	21	13	24	21
50%	30	33	42	31
75%	40	81	72	41
90%	60	222	137	73
# REPORTS	6385	35	846	7266
RANGE	1-859	1-223	4-651	1-859

YEAR-TO-DATE
Reports received 10/1/99 – 6/30/00

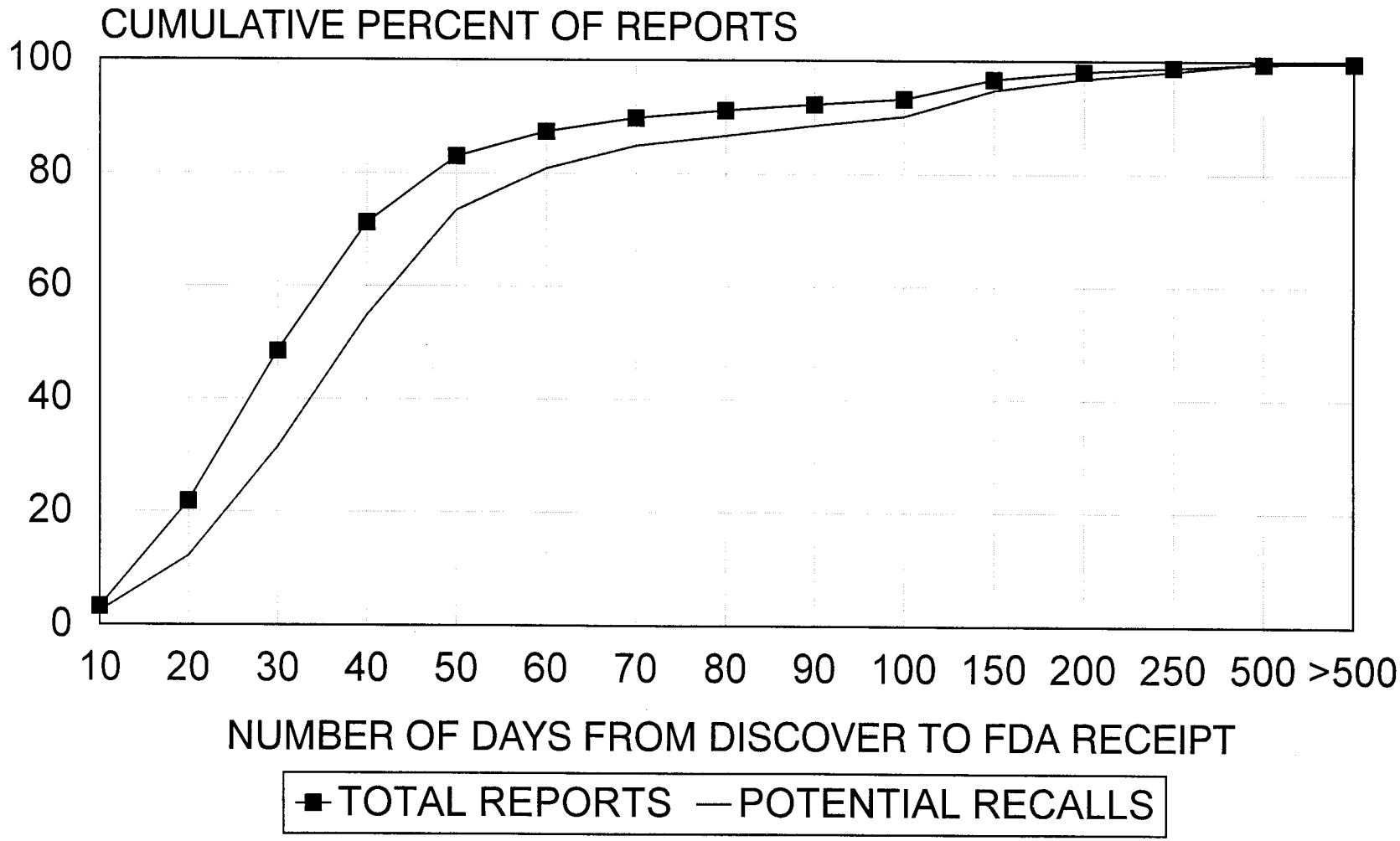
CUMULATIVE PERCENT OF REPORTS	LICENSED (Days)	UNLICENSED (Days)	PLASMA (Days)	TOTAL (Days)
10%	15	8	14	14
25%	21	14	22	21
50%	30	35	38	31
75%	41	81	63	42
90%	61	195	125	72
# REPORTS	14124	100	2128	16352
RANGE	1-1133	1-566	4-651	1-1133

ERROR AND ACCIDENT REPORTS

REPORTING TIME

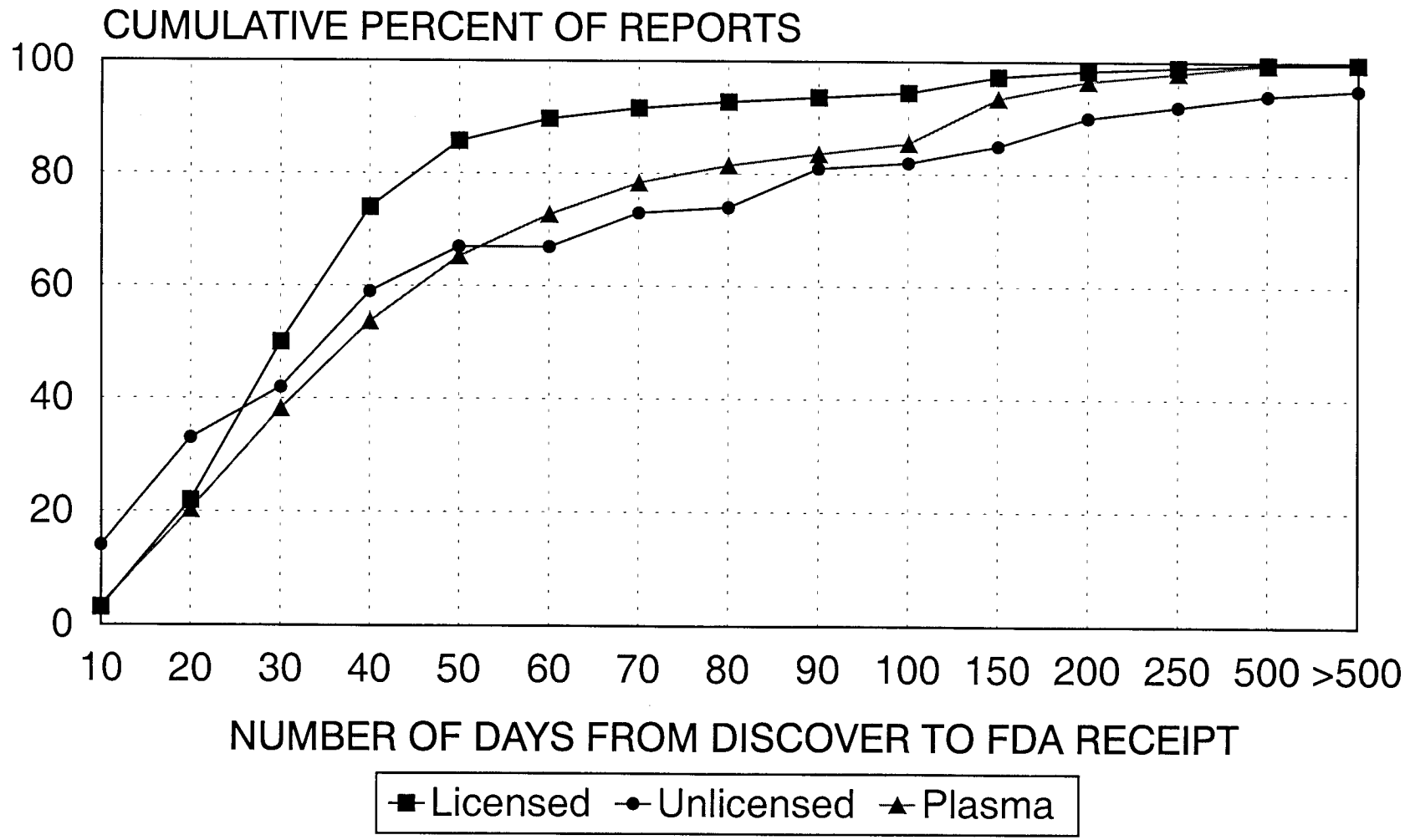
ALL REPORTING BLOOD AND PLASMA ESTABLISHMENTS

FY-2000



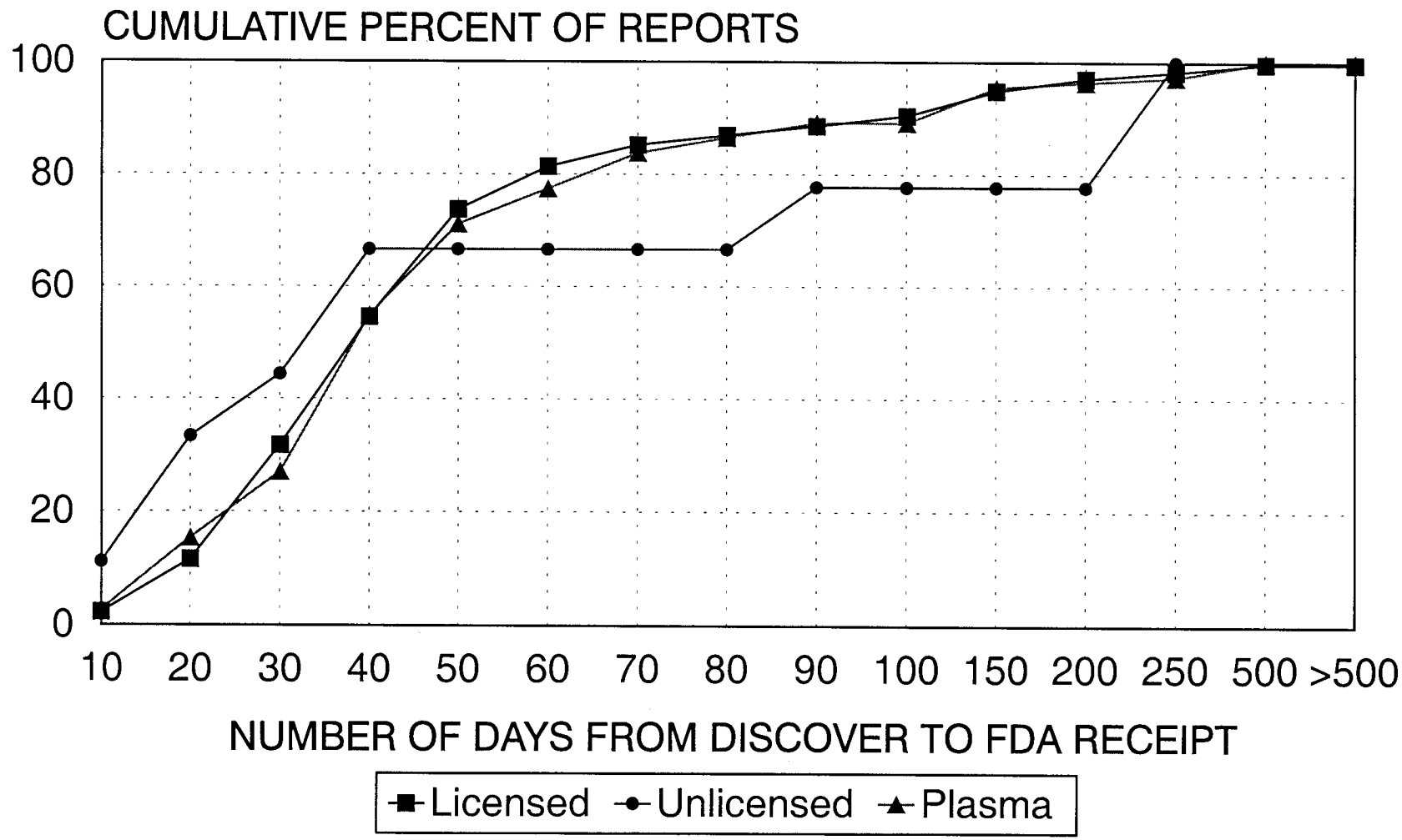
TOTAL REPORTS = 16,352
POTENTIAL RECALLS = 1039

ERROR AND ACCIDENT REPORTS
REPORTING TIME
TOTAL REPORTS
FY-2000



TOTAL REPORTS = 16,352
LICENSED BLOOD EST.= 14,124; UNLICENSED BLOOD EST. = 100; PLASMA CENTERS = 2128

ERROR AND ACCIDENT REPORTS
REPORTING TIME
POTENTIAL RECALLS
FY-2000



TOTAL REPORTS = 1039
LICENSED BLOOD EST.= 919; UNLICENSED BLOOD EST. = 9; PLASMA CENTERS = 111

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

NON-BLOOD MANUFACTURERS
FY2000

THIRD QUARTER

	DERIVATIVE		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	1	1	0	0	0	0	0	0	1	2.9%	1	25.0%
STERILITY COMPROMISED	0	0	2	0	2	0	1	0	0	0	5	14.7%	0	0.0%
LABELING	1	0	3	0	1	1	2	0	0	0	7	20.6%	1	25.0%
STORAGE/DISTRIBUTION	1	0	0	0	0	0	2	0	0	0	3	8.8%	0	0.0%
PROCESSING	3	0	1	0	0	0	2	1	1	0	7	20.6%	1	25.0%
MISCELLANEOUS	2	0	1	0	0	0	3	1	2	0	8	23.5%	1	25.0%
NOT REPORTABLE	0	0	3	0	0	0	0	0	0	0	3	8.8%	0	0.0%
TOTAL	7	0	11	1	3	1	10	2	3	0	34	100%	4	100%

YEAR-TO-DATE

	DERIVATIVE		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	3	2	0	0	0	0	0	0	3	2.7%	2	14.3%
STERILITY COMPROMISED	2	0	5	2	9	3	3	1	1	0	20	18.2%	6	42.9%
LABELING	2	0	14	0	10	2	3	0	0	0	29	26.4%	2	14.3%
STORAGE/DISTRIBUTION	2	0	2	0	1	0	3	0	1	0	9	8.2%	0	0.0%
PROCESSING	7	0	3	0	4	1	9	1	4	0	27	24.5%	2	14.3%
MISCELLANEOUS	5	0	2	0	0	0	5	2	2	0	14	12.7%	2	14.3%
NOT REPORTABLE	1	0	3	0	3	0	0	0	1	0	8	7.3%	0	0.0%
TOTAL	19	0	32	4	27	6	23	4	9	0	110	100%	14	100%

NON-BLOOD MANUFACTURERS

DERIVATIVES

ERROR/ACCIDENT	#REPORTS
STERILITY COMPROMISED	***2***
Precipitate found in product	2
LABELING	***2***
Product label incorrect	1
One syringe was missing its label	1
STORAGE/DISTRIBUTION	***2***
Product released prior to CBER approval – expiration of CBE submission	1
Product released prior to validation of the lyophilization cycle for the 0.5g fill size	1
PROCESSING	***7***
Source material unsuitable for processing due to donor previously deferred	2
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
Product specification not met	2
Column effluent collected in flexible container rather than stainless steel tank (product not distributed, firm intends to submit sample for lot release)	1
MISCELLANEOUS	***5***
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
Black particles found in WFI system	1
Evidence of surface change on stoppers of Normal Horse Serum packaged in the kit	1
NON-REPORTABLE	***1***
Product labeled with missing/incorrect facility identifiers – product acceptable	1
TOTAL	***19***

NON-BLOOD MANUFACTURERS

IN-VITRO DIAGNOSTICS

ERROR/ACCIDENT	#REPORTS
REAGENT PERFORMANCE	***3***
A2 cells gave positive reaction when tested with Anti-A1 Lectin	1
B cells gave weak positive reactions	1
Product gave false positive results	1
STERILITY COMPROMISED	***5***
Microbial contamination	2
Stoppers contaminated with endotoxin	1
Antimicrobial preservative effectiveness test may not have been performed	1
Annual revalidation of aseptic area exhibited an unacceptable number of contaminated units	1
LABELING	***14***
Package insert incorrect	7
Product label incorrect	1
Lot number missing/incorrect and expiration date also missing	5
Information on the relationship between EU/ml and IU/ml may be misinterpreted	1
STORAGE/DISTRIBUTION	***2***
Product released prior to completion of required testing	2
PROCESSING	***3***
Filling	1
Product specifications not met	1
Inappropriate temperature during manufacturing or processing	1
MISCELLANEOUS	***2***
Wrong vial replaced in the 11-cell panel, due to hemolysis.	1
Unacceptable results for linearity an assay protocol	1
NON-REPORTABLE	***3***
Product not made available for distribution	3
TOTAL	***32***

NON-BLOOD MANUFACTURERS

ALLERGENICS

ERROR/ACCIDENT	#REPORTS
STERILITY COMPROMISED	***9***
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	6
LABELING	***10***
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	4
Labeling did not list all ingredients	1
STORAGE/DISTRIBUTION	***1***
Product released prior to completion f required testing – sterility test cultures may not have been incubated appropriately	1
PROCESSING	***4***
Computer calculation error for preparation of extract	1
Error in correcting calculation error resulted in improper concentration	1
PNU value incorrectly entered into the computer	1
Formula change	1
NON-REPORTABLE	***3***
Product labeled with missing/incorrect weight or volume; product acceptable	1
Illegible expiration date	1
Expiration date shortened	1
TOTAL	***27***

NON-BLOOD MANUFACTURERS

THERAPEUTICS

ERROR/ACCIDENT	#REPORTS
STERILITY COMPROMISED	***3***
Reovirus contamination of EPO concentrated diafiltered medium.	1
Aspergillus flavus found in one roller bottle	1
Bacterial contamination	1
LABELING	***3***
Expiration date extended or missing	1
Lot number incomplete	1
Concentration or volume missing or incorrect	1
STORAGE/DISTRIBUTION	***3***
Product released prior to completion of required testing - finished goods identification testing	1
Product stored at incorrect temperature	2
PROCESSING	***9***
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
Leaking ampule from punctures caused by the automatic feeder to the pouching equipment on the packaging line	1
Out of calibration situation involving the monitoring of solution levels in the processing tanks	1
MISCELLANEOUS	***5***
Stability testing failed	2
Lack of vacuum in vials	1
Final product vial broke as being opened for cell implantation procedure	1
During stability study evaluation, the product demonstrated a new significant band on gel electrophoresis	1
TOTAL	***23***

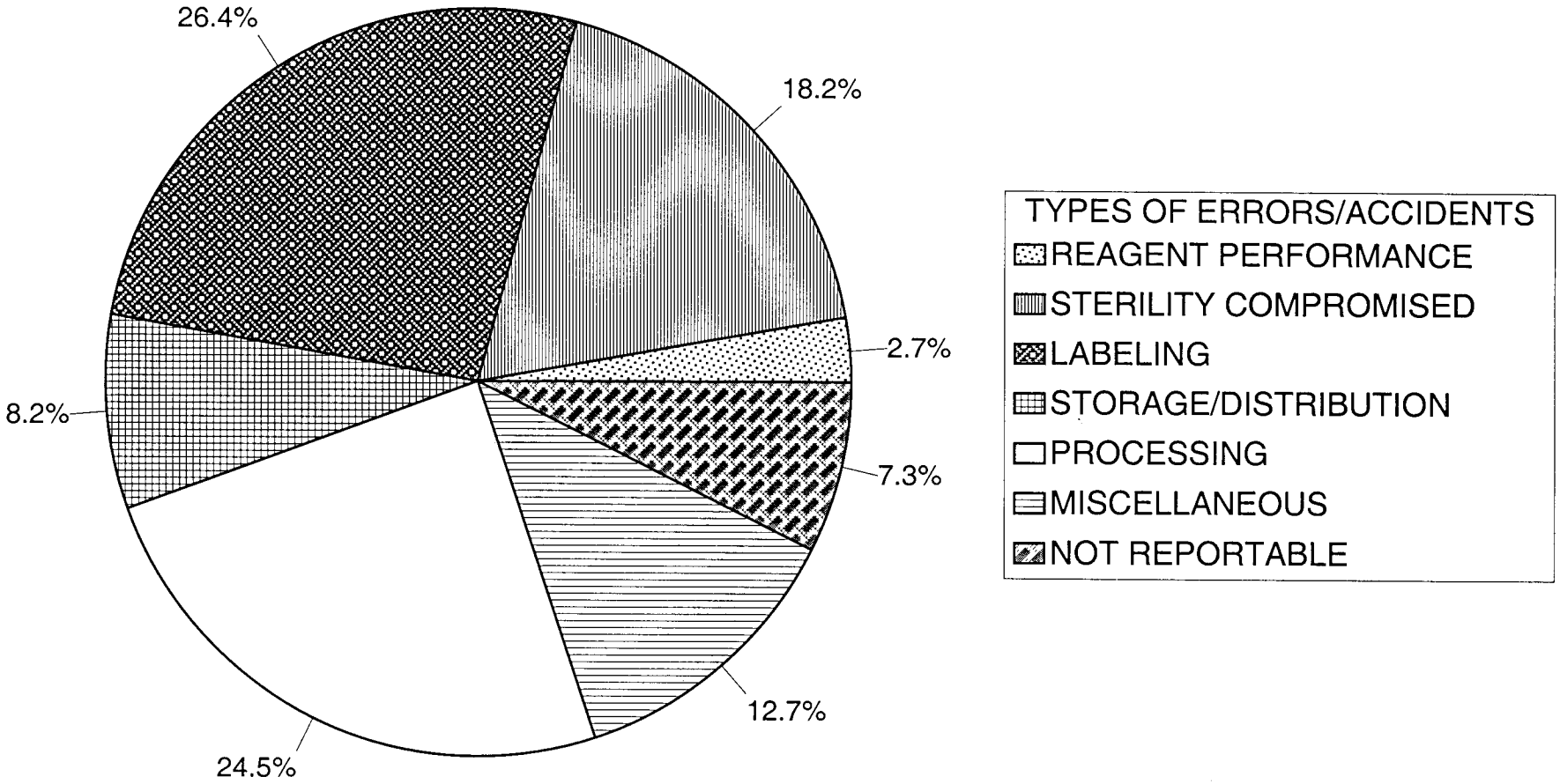
VACCINES

ERROR/ACCIDENT	#REPORTS
STERILITY COMPROMISED	***1***
Bulk intermediate failed sterility test at 12-months (yeast)	1
STORAGE/DISTRIBUTION	***1***
Product shipped or stored at incorrect temperature	1
PROCESSING	***4***
Product specification not met	4
MISCELLANEOUS	***2***
Stability testing failed	1
Decrease in potency	1
NON-REPORTABLE	***1***
Product not made available for distribution	1
TOTAL	***9***

ERROR AND ACCIDENT REPORTS

NON-BLOOD MANUFACTURERS

FY2000



TOTAL REPORTS RECEIVED (10/1/99 - 6/30/00) = 110
REPORTABLE ERRORS/ACCIDENTS = 102; NON-REPORTABLE ERRORS/ACCIDENTS = 8