



April 2, 2003

WARNING LETTER
SJN-03-08

Certified Mail
Return Receipt Requested.

Mr. Harry Kraemer
Chairman Executive Officer/President
Baxter Healthcare Corporation,
One Baxter Parkway, Deerfield,
Illinois, 60015-4633

Dear Mr. Kraemer:

During an inspection of your establishment, Baxter Healthcare Corporation of Puerto Rico, located at Rd 721, Km 0.3, Aibonito, PR 00705, on October 29, 2002, through November 22, 2002, our investigator determined that your firm manufactures sterile I.V. sets and sterile fluid path I.V. sets, (Class II devices), which are medical devices as defined by Section 201(h) of the Federal Food, Drug and Cosmetic Act (the Act).

The above-stated inspection revealed that these devices are adulterated with the meaning of Section 501(h) of the Act in that the methods used in, or the facilities or controls used for manufacturing, packing, storage, or installation are not in conformance with the Quality System regulation for medical devices as specified in Title 21, Code of Federal Regulations, Part 820 (21 CFR 820).

Quality system deficiencies were observed in the areas of nonconforming product and corrective and preventive actions. Deficiencies included, but are not limited to:

1. Failure to implement the procedure for corrective and preventive actions, as required by 21 CFR 820.100(a), and document all activities, as required by 21 CFR 820.100(b). For example, a CAPA file including an evaluation of the significance of a failure mode, based on a risk assessment was not initiated after obtaining a non-conformance product event. An event describing leaks at the junction of the male luer adapter and the lever lock cannula were reported as part of the final in-process inspection of the Interlink System 60" Micro-Volume Extension Set Lever Lock Cannula for batch [REDACTED]. Although a recurrence of a non-conformance was attributed to the use of a same defective component, a CAPA file was not initiated.

We disagree with your response dated December 6, 2002, in that "Baxter's existing system did not indicate a need to generate a high level CAPA after PRR [REDACTED] was issued." Your records show the non-conformance event to be a recurrent and significant event, requiring that a CAPA be initiated, in accordance to SOP No. [REDACTED]. In addition, this is considered a major defect that

Mr. Harry Kraemer
 April 2, 2003
 Page 2

should have required a CAPA to be initiated. Your response also fails to include any follow up action or information related to your supplier's communications of September 11, 2000, and November 2, 2002, acknowledging the leakage problem. There is no indication of any corrective actions implemented by the supplier to correct the problem and if any, an indication that these were verified.

2. Failure to have complete procedures for the implementation of corrective and preventive actions, as required by 21 CFR 820.100. For example, the investigation related to the use of a defective component (Lever Lock Cannula) to manufacture batches of Interlink System 60" Micro-Volume Extension Set Lever Lock Cannula, failed to include an evaluation of potential non-conformities in other related batches. Lots No. [REDACTED] and [REDACTED] were also manufactured with the defective lot of Lever Lock Cannula # [REDACTED] and released for distribution prior to finding the leak problem in a subsequent batch [REDACTED]. These four lots were not subject to a 100% pressure (leak) inspection and, therefore, may have been released with defective units.

Your response to FDA-483 item # 2 is inadequate in that the review of the records collected show that when other batches using the same defective lot of luer lock adapter (# [REDACTED]), as the above mentioned 4 lots, were 100% reworked or 100% in-process inspected for leakage, a significant amount of units were discarded due to a leak defect attributed to the defective adapter (e.g. 1400 of 4900 units in batch [REDACTED] (29% were discarded). Although your response indicates that an investigation was initiated to evaluate the impact of the defect on the Lever Lock Cannula on the finished product, this investigation was neither available for review during the inspection nor documented, as acknowledged in your response.

During the inspection, the FDA investigator was informed that the 100% in process inspection of the Lever Lock Cannula, assembled to the male luer adapter was reinstalled as a corrective action. Please provide in your response to this letter a list of all the lots assembled after [REDACTED] that were not subject to the 100% in-process inspection and the actions taken by your supplier to correct the defect. Also include any action(s) taken against the batches of Interlink System 60" Micro-Volume Extension Set Lever Lock Cannula that were not subject to the 100% pressure (leak) inspection, after the Lever Lock Cannula was assembled to the male luer adapter and manufactured using the Lever Lock Cannula lots [REDACTED] # [REDACTED] and # [REDACTED], or any other defective batch. Also indicate the amount of units per batch distributed without the 100% pressure (leak) inspection and the distribution (date, amount and final shipment destination) information related to batches [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. The leak defect is classified as a major defect, which by definition, "is likely to result in the partial or complete failure of a product to function in its intended manner." Your response provides no assurance that all units pertaining to these lots released are free of the leak defect.

3. Failure to establish and maintain corrective and preventive procedures to assure that other sources of quality data are analyzed to identify existing and potential causes of nonconforming product and other quality problems, as required by 21 CFR 820:100 (a)(1). For example, defects observed during the 100% in-process pressure test inspection performed to the Interlink System 60" Micro Volume Extension Sets Lever Lock Cannula are not documented.

Mr. Harry Kraemer
April 2, 2003
Page 3

Please include in your response to this letter the number of units per lot of Interlink System 60" Micro Volume Extension Sets Lever Lock Cannula that are currently being discarded due to a leak defect found during the 100% in-process leak inspection (for lots assembled after batch [REDACTED] to the present). Also, please include a list of all your products that are subject to a 100% in-process leak test inspection and how the defects being found are currently being documented.

We acknowledge the receipt of your written response to the FDA-483. Your proposed commitments to item No. 3 will be verified during our next follow-up inspection.

4. Failure to document the evaluations and investigations of nonconforming products, as required by 21 CFR 820.90(a). For example, during 2/2002, three samples from 60" Micro-Volume Extension Set batch [REDACTED] failed the hydrophilic test [REDACTED] at [REDACTED] psig and four units of the Three Lead Extension Set batch [REDACTED], failed the hydrophobic test at [REDACTED] psig during the final testing. Investigations to specifically address the non-conforming products were not conducted. It was not until additional failures were reported on 8/15/02 that a CAPA was opened to investigate the root cause of the failures, which lead to an on-going recall.

The time that elapsed between the original and subsequent failure events and the closing of the investigation appears to be inappropriate and unjustified. However, we acknowledge your response and agree that the proposed timeframe, if properly implemented, should address this additional concern.

Deviations cited are considered to be recurrent deficiencies from your inspection of August 2000, which also revealed deficiencies in your CAPA system, including but not limited to: failure to adequately investigate the causes of non-conformities and identify the actions needed to prevent recurrence.

This letter is not intended to be an all-inclusive list of deficiencies at your facility. It is your responsibility to ensure adherence to each requirement of the Act and regulations. The specific violations noted in this letter and in the form FDA-483 issued at the conclusion of the inspection may be symptomatic of serious underlying problems in your establishment's quality system. You are responsible for investigating and determining the causes of the violations that have been corrected. You also must promptly initiate permanent corrective and preventive action on your quality system.

Also, no requests for Certificates to Foreign Governments will be approved until the violations related to the subject devices have been corrected.

Federal agencies are advised of the issuance of all Warning Letters about devices so that they may take this information into account when considering the award of contracts.

You should take prompt action to correct these deviations. Failure to promptly correct these deviations may result in regulatory action being initiated by the Food and Drug Administration without further notice. These actions include, but are not limited to, seizure, injunction and/or civil penalties.

We have received your letters dated December 6, 2002, December 12, 2002, January 13, 2002, and February 20, 2003, replying to the FDA-483 issued on November 22, 2002. The corrective actions
Baxter Healthcare Corporation

Mr. Harry Kraemer
April 2, 2003
Page 4

proposed for items 3 through 5 of the FDA-483 appear to be adequate and will be verified during the next follow-up inspection. However, please provide the additional information requested related to items 1 and 2 of this letter.

Please update this office in writing within 15 working days of receipt of this letter of the status of the actions taken to correct the noted violations, including an explanation of each step being taken to identify and make corrections to any underlying systems problems to assure that similar violations will not recur. If corrective action cannot be completed within 15 working days, state the reason for the delay and the time within which the corrections will be completed.

Your response should be sent to Carmelo Rosa, Compliance Officer at the address on the letterhead.

Sincerely yours,


for Donald J. Voeller
District Director

Cc: Edwin Betancourt, General Manager
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