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DEPARTMENT OF HEALTH & HUMAN SERVICES
Food and Drug Administration
New England District

Food and Drug Administration
One Montvale Avenue
Stoneham, Massachusetts 02180
(617)279-1675 FAX: (617)279-1742

October 2, 1997

**WARNING LETTER**

**NWE-01-98W**

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Mr. Jeffrey Otten, President
Brigham & Women's Hospital
75 Francis Street
Boston, MA 02115

Dear Mr. Otten:

During an inspection of Brigham & Women's Hospital Blood Bank located at 75 Francis Street, Boston, Massachusetts, on August 27 through 29, 1997, and September 2 through 4 and 8, 1997, our Investigators documented violations of Section 501(a)(2)(B) of the Federal Food, Drug, and Cosmetic Act (the Act) and Title 21, Code of Federal Regulations (21 CFR), Parts 600-680 as follows:

1. Failure to report a possible transfusion related fatality to the Center for Biologics Evaluation and Research (CBER). For example, Corrective Action Report (CARe) #4910 dated 5/30/97 contains information regarding a death in which a patient with Anti-C antibodies was transfused with red blood cells incorrectly identified as "antigen c-negative", and which were subsequently identified to be "antigen c-positive". In addition to not being reported to CBER, this report does not contain adequate documentation to describe the investigation of the fatality.

2. Failure to maintain complete and accurate records from which donors may be identified so that products from such individuals will not be distributed. For example:

   a. Donor [redacted] associated with Unit [redacted] drawn on 10/22/96, who identified himself/herself during the donor history interview as a Human Immunodeficiency Virus (HIV) positive hemophiliac had not been placed on the Donor Deferral Registry (DDR) as of 8/28/97.

   b. Donor [redacted] associated with Unit [redacted] drawn on 7/24/97, identified himself/herself as an immigrant of Nigeria, an Acquired Immune Deficiency Syndrome (AIDS) endemic country, when answering the AIDS questionnaire, and you have a deferral category for answers given in the affirmative to questions indicative of AIDS, yet donor IO had not been placed on the DDR as of 8/28/97.

   c. Donor Deferral files are not reviewed to ensure that newly obtained deferral information is accurately and completely entered into the DDR.

3. Failure to adequately determine the suitability of persons to serve as the source of Whole Blood. For example:

   a. Unit [redacted] was collected at an off-site blood drive on 6/24/97 from a donor who was permanently deferred due to a previous repeat reactive HIV result, and whose name appeared on the DDR. There is no mechanism by which deferred donors can be identified prior to collection at off-site blood drives.

   b. Donors [redacted] and [redacted] who answered "Yes" to having had any "unexplained fever, night sweats, or swollen glands within the past six months" were accepted as eligible blood donors, despite the fact that these items are identified in your donor educational material as symptoms or signs suggestive of an AIDS risk, and you have a deferral category for answers indicative of "High Risk AIDS".

4. Failure to incorporate and document appropriate corrections, conclusions and follow-up in response to errors and accidents in the manufacture of blood products. For example,

   a. Corrective Action Report (CARe) #4924 dated 7/28/97 which describes the acceptance of blood from an ineligible donor does not contain adequate documentation of unit disposition.

b. Corrective Action Report (CARe) #4752 dated 10/23/96 which describes the autologous collection of blood from an HIV positive donor, does not document the disposition of the unit.

c. Corrective Action Report (CARe) #4908 dated 6/27/97 which describes a unit of blood logged into the computer system under an incorrect donor name/social security number, does not document the corrective action taken.

5. Failure to maintain and or follow adequate written standard operating procedures. For example:

a. SOP #G3.001, "Procedure for the Selection of Designated and Volunteer Blood Donors" does not adequately describe how the interviewer should manage donors who answer "Yes" when asked, "Have you ever been deferred as a blood donor?"

b. SOP #H1.002, "Policy for Error Reporting, Classification Management of Errors" does not describe what corrective actions must be taken in terms of product disposition and management of donor status when errors are detected.

c. There is no procedure in place to describe how units "voided" out of the blood bank's computer system are handled, nor is there an adequate mechanism in place to track the disposition of units which are voided out of the blood bank's system.

d. SOP #C2.002, "Procedure for Review of Positive Serologies on Designated and Volunteer BWH Donor Units", which describes how the disposition of units with positive serologies should be handled, does not adequately describe how to complete disposition information.

e. SOP #H2.014, "Procedure for Disposition of Units from Prior Collections from Donors with Repeatedly Reactive Screening Tests" does not include lookback for HIV.

f. Our Investigator observed two phlebotomists performing phlebotomies. Neither of the phlebotomists followed SOP G7.002, "Procedure for the Collection of a Unit of Whole Blood", which requires the phlebotomist to scrub the venipuncture site for thirty seconds with an iodophor PVP scrub.

6. Donor suitability is not determined on the day of donation.

7. Failure to maintain adequate and/or detailed records concurrently with the performance of each significant step in the collection, processing, testing, storage and distribution of each unit of blood so that all steps can be clearly traced. For example:

   a. There is no document which adequately describes the interpretation of viral test results performed by [redacted]

   b. The Medical Director's release of blood units from a particular day's collection is not dated when reviewed.

   c. The original Blood Donor Registry forms completed by donors are only stored for a period of three months, not for the required period of five years.

   d. Forms associated with SOP #C2.002, "Procedure for Review of Positive Serologies on Designated and Volunteer BWH Donor Units" are inconsistently completed by laboratory staff.

8. Failure to adequately calibrate equipment. For example:

   a. Trip scales in the donor room are not calibrated using known weights.

   b. The Donormatic rocking scale in the donor room is not calibrated according to the manufacturer's instructions.

The above violations are not intended to be an all-inclusive list of deficiencies at your facility. It is your responsibility as President to assure that your establishment is in compliance with all requirements of the Federal regulations.

You should take prompt measures to correct the deviations noted in this letter. Failure to promptly correct these deviations may result in regulatory action without further notice. Such action includes seizure, and/or injunction.

Previous letters written to your facility in April, 1988, January, 1990, and December, 1991, also documented serious violations of Federal regulations. We are concerned that you, as the current President of Brigham and Women's Hospital, may not be aware of recurrent problems at your facility's Blood Bank and the seriousness with which we view them.

Please notify this office in writing, within fifteen (15) working days of receipt of this letter, of the steps you have taken to correct the noted violations and to prevent their recurrence. Specifically, in response to Item #1, please provide us with complete

copies of the deceased patient's discharge summary; autopsy report (if an autopsy was performed); pertinent notes from your Error Review Committee which would have reviewed this incident; and documentation of any retraining activities which took place as a result of this error. If corrective action cannot be completed within fifteen (15) working days, state the reason for the delay and the time within which the corrections will be completed.

We acknowledge receipt of Dr. Churchill's response to the FDA-483 issued at the conclusion of our inspection. This response was received on October 1, 1997. Please be advised that we did not have the opportunity to review Dr. Churchill's response prior to the issuance of this letter. Furthermore, receipt of Dr. Churchill's response to the FDA-483 does not preclude you from responding to the contents of this Warning Letter.

Your reply should be sent to the attention of Alyson L. Saben, Compliance Officer, U.S. Food and Drug Administration, New England District Office, One Montvale Avenue, Stoneham, MA 02180.

Sincerely,

John R. Marzilli
District Director
New England District

cc: James Winkelman, M.D.
Vice President, Clinical Laboratories
Brigham & Women's Hospital
75 Francis Street
Boston, MA 02115

W. Hallowell Churchill, M.D.
Medical Director, Blood Bank
Brigham & Women's Hospital
75 Francis Street
Boston, MA 02115