

GMP Inspection Deficiencies 2013

Review of Deficiencies Observed in 2013



Medicines and Healthcare Products Regulatory Agency

Executive Summary



- The most frequently encountered defect categories raised over the previous five years have remained relatively consistent with the exception of 'Contamination, chemical/physical (or potential for)' which has significantly increased.
- Deficiencies relating to 'Quality Systems' are by far the most prevalent observed during inspections.
- Over the last five years, where inspections identified Major or Critical deficiencies;
 - the ratio of Majors raised per inspection has remained relatively constant
 - the ratio of Criticals raised per inspection had remained relatively constant until 2013 where there was an increase observed. This is due to a cluster of data integrity issues with potential impact to public health.
 - the relative number of Critical deficiencies raised per inspection in a given continent is higher in Asia than other the other continents where inspections were carried out.
- A number of areas for focus by the inspectorate have been identified based on review of the attached data, changes in the regulatory environment and due to intelligence gained from other agencies.



Overview of GMP Inspections Carried Out



- Of 630 GMP inspections carried out in 2013,
 216 resulted in Major or Critical Deficiencies.
 - Of the inspections with Major/Critical deficiencies
 - 174 were in the UK
 - 42 were overseas
 - The sites with Major/Critical deficiencies comprised of
 - 170 Facilities with MIA, MS & IMP licences, or overseas manufacturers
 - 32 Blood Sites
 - 14 API Manufacturing Facilities

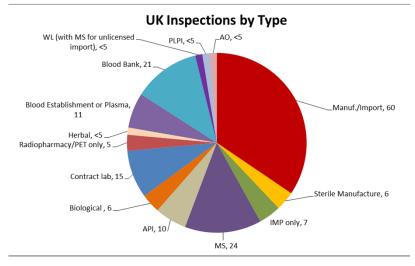


Detail of Site Types with Major/Critical Deficiencies

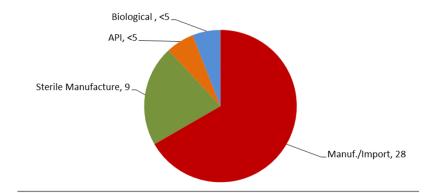


INSPECTIONS WITH MAJOR/CRITICAL FINDINGS						
	UK	Overseas				
Inspection Category	Inspections with Critical/Major Findings	Inspections with Critical/Major Findings				
Manuf./Import	60 (28%)	28 (13%)				
Sterile Manufacture	6 (3%)	9 (4%)				
IMP only	7 (3%)					
MS	24 (11%)					
API	10 (5%)	<5 (<2%)				
Biological	6 (3%)	<5 (<2%)				
Contract lab	15 (7%)					
Radiopharmacy/PET only	5 (2%)					
Herbal	<5 (<2%)					
Blood Establishment or Plasma	11 (5%)					
Blood Bank	21 (10%)					
WL (with MS for unlicensed import)	<5 (<2%)					
PLPI	<5 (<2%)					
AO	<5 (<2%)					
	174	42				
		216				

Note: Values in brackets give % relative to the 216 inspections with Critical /Major findings



Overseas Inspections by Type

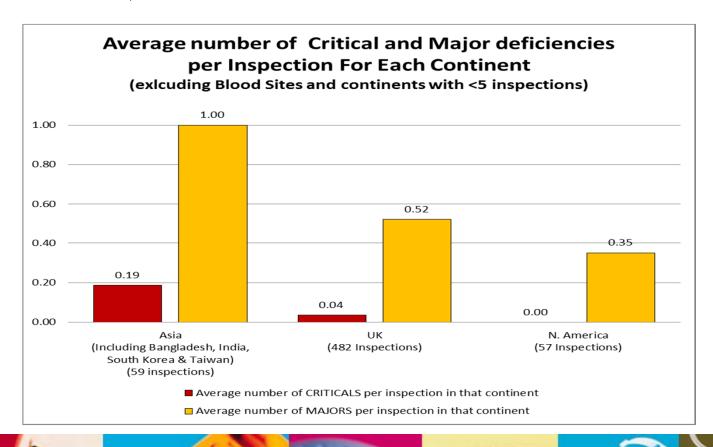




Overseas Deficiencies Review Split by Continent



 The average number of Critical and Major deficiencies raised per inspection for each continent (where ≥5 inspections were carried out), is presented below;



Total Number of Critical / Major Findings in 2013



Criticals

- 29 Critical deficiencies raised
- 3.0% of all 630 inspections raised Critical deficiencies
- A maximum of 3 Critical deficiencies were raised on a site.

Majors

- 403 Major deficiencies raised
- 31.6% of all 630 inspections raised Major deficiencies
- A maximum of 7 Major deficiencies were raised on a site.



Critical/Major findings by Site Type for relevant inspections



FINDINGS BY INSPECTION CATEGORY												
	ик				Overseas (OS)							
Inspection Category	Number of Inspections with Critical/ Major Findings	% of UK Inspections with Critical/ Major Findings	Total number of 'Criticals'	Max Number of Criticals on a Single Site	Total Number of 'Majors'	Max Number of Majors on a Single Site	Number of Inspections with Critical/ Major Findings	% of OS Inspections with Critical/ Major Findings	of 'Criticals'	Max Number of Criticals on a Single Site	Total Number of ' Majors	Max Number of Majors on a Single Site
Manuf./Import	60	28%	6	3	117	6	28	13%	2	1	50	4
Sterile Manufacture	6	3%	0	0	10	2	9	4%	4	2	19	4
IMP only	7	3%	0	0	8	2						
MS only	24	11%	2	1	40	4						
API	10	5%	0	0	15	3	<5	<2%	5	3	13	7
Biological	6	3%	3	3	12	4	<5	<2%	0	0	1	1
Contract lab	15	7%	5	3	20	6						
Radiopharmacy/PET only	5	2%	0	0	9	5						
Herbal	<5	<2%	1	1	9	4						
Blood Establishment or Plasma	11	5%	0	0	20	4						
Blood Bank	21	10%	1	1	48	6						
WL (with MS for unlicensed import)	<5	<2%	0	0	3	2						
PLPI	<5	<2%	0	0	7	3						
AO	<5	<2%	0	0	2	2						
TOTALS	174		18		320		42		11	:	83	:

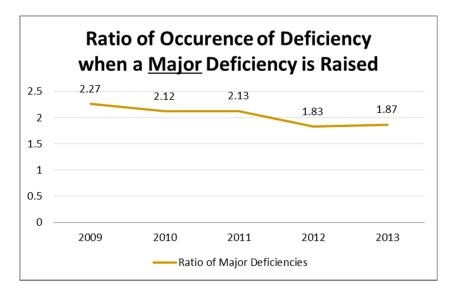
Total number of 'Critical' & 'Major' deficiencies in UK and Overseas 432

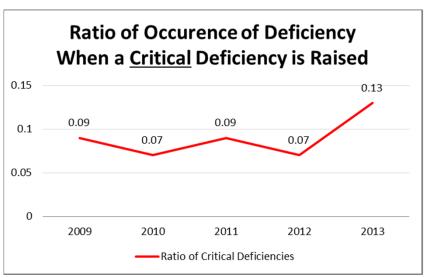


Comparison of Deficiency Ratios in the last five years



• For inspections with Critical / Major deficiencies, the relative number of Criticals and Majors per inspection over the last 5 years was tabulated.





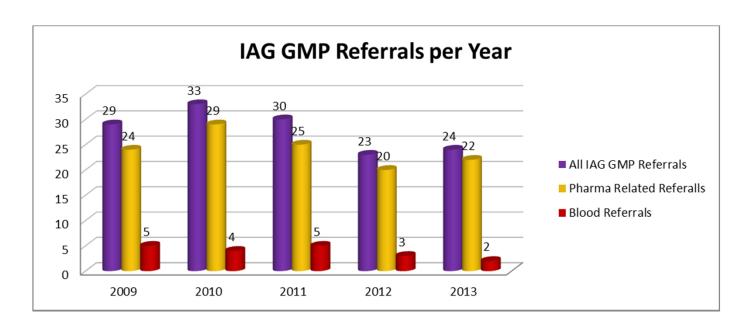
- It can be observed that for an inspection where a Critical/Major was raised;
 - the ratio of Major deficiencies per inspection has decreased since 2009
 - the ratio of Critical deficiencies per inspection increased in 2013 after being relatively consistent over the previous four years. This increase relates to data integrity findings.



GMP Referrals to IAG in the last 5 years



- A reduction in the number of overall regulatory action (IAG) referrals in 2012 and 2013 is apparent when compared to 2009 to 2011 inclusive, however, at present it is too early to conclude that a downward trend is developing.
- The implementation of MHRA's early intervention 'Compliance Management' process in April 2013 avoided the need for regulatory action referrals in 9 inspection cases.





Most Common Findings for Sites

(Excluding Blood Sites)



All Critical/Major Defect Areas

equipment

Environmental monitoring

In-process control and monitoring of production

Handling and control of packaging components

Production planning and scheduling



1. Quality Management 262	3. Materials Management 102	7. Validation 65		
Batch release procedures	Supplier and contractor audit	Validation master plan and documentation		
Complaints and Product recall	Compliance with TSE guidelines	Analytical Validation		
Quality management	Warehousing and distribution activities – General Issues	Cleaning validation		
Quality management – change control	Warehousing and distribution activities - Transportation Temp Control and Monitoring	Equipment validation		
Quality management – product quality review	Warehousing and distribution activities - General Storage Temp Control and Monitoring	Computerised systems – validation		
Quality management – risk management	Warehousing and distribution activities - Lack of inventory control and segregation	Computerised systems – documentation and control		
Self inspection	Warehousing and distribution activities - Records – receipt and distribution	Process validation		
Investigation of anomalies	Warehousing and distribution activities - Returns Management	Process validation - rework/reprocessing		
Investigation of anomalies – CAPA	Starting material – API compliance with GMP	8. Regulatory Compliance 41		
Investigation of anomalies – OOS	Supplier and contractor technical agreements	Regulatory issues – non compliance with MIA		
Documentation - procedures/PSF/TAs	4. Premises and Equipment 86	Regulatory issues – non-compliance with MA/CTA		
2. Production 127	Design and maintenance of equipment	Regulatory issues – unauthorized activity		
Sterility Assurance - Aseptic Practices	Design and maintenance of premises	Regulatory issues – non compliance with DMF		
Sterility Assurance - Sterilisation	Environmental control	Failure to respond to previous inspection findings		
Sterility Assurance - Process Design	Calibration of measuring and test equipment	10. Personnel 38		
Sterility Assurance - Media Fill	5. Quality Control 68	Personnel issues – training		
Sterility Assurance - Sterility Investigations	Sampling procedures and facilities	Personnel issues – duties of key personnel		
Contamination, chemical/physical – potential for	Sampling procedures &facilities – retention & retain samples	Personnel issues – hygiene and clothing		
Documentation – manufacturing	Documentation – specifications and testing			
Line clearance, segregation and potential for mix-up	Starting material and packaging component testing	The total number of Critical/Major		
Housekeeping – cleanliness and tidiness	Computerised systems – data manipulation			
Contamination, microbial – potential for	Finished product testing - chemical	observed in each category is shov		
Status labelling – work in progress, facilities, equipment	Finished product testing - microbiological	above.		

Finished product testing - on-going stability

Calibration of reference materials and reagents

Intermediate and bulk product testing

monitoring

- r Deficiencies wn in the table
- It can be seen that 'Quality Management' related deficiencies are by far the most frequent.

Top Critical/Major Defect Areas MHRA



Most Frequent Defect Categories Observed

Rank	Defect Category	Percentage of Critical / Major Deficiencies with this Defect Category			
1	Investigation of anomalies	6.5%			
2	Quality management	5.5%			
3	Investigation of anomalies – CAPA	4.7%			
=4	Contamination, chemical/physical (or potential for)	3.7%			
=4	Supplier and contractor audit	3.7%			
6	Quality management – change control	3.6%			
7	Documentation - procedures/PSF/TAs	2.7%			
7	Personnel issues – training	2.7%			
=9	Design and maintenance of equipment	2.6%			
=9	Documentation – manufacturing	2.6%			
=9	Finished product testing - chemical	2.6%			

The Defect Categories presented above account for 40.9% of all Critical / Major Deficiencies raised in 2013.



Deficiency Category Trends Over Previous Five Years



- A review of the top 10 Deficiency Categories over the previous five years highlights the following;
 - 'Investigation of Anomalies' remains the most common category
 - 'Quality Management'; 'Investigation of Anomalies CAPA'; 'Supplier and Contractor Audit'; 'Quality Management – Change Control'; & 'Documentation Procedures/PSF/TAs' were consistently found in the most common deficiencies.
 - The identification of deficiencies relating to 'Contamination, chemical/physical (or potential for)' has increased significantly in 2012 and 2013

	Year and Ranking in that Year					
Deficiency Category	2009	2010	2011	2012	2013	
Investigation of anomalies	1	1	1	1	1	
Quality management	-	2	5	9	2	
Investigation of anomalies – CAPA	3	5	3	4	3	
Contamination, chemical/physical (or potential for)	-	-	-	10	4	
Supplier and contractor audit	7	8	6	2	4	
Quality management – change control	2	3	2	8	6	
Documentation - procedures/PSF/TAs	5	4	8	-	=7	
Personnel issues – training	-	-	-	-	=7	
Design and maintenance of equipment	-	-	-	7	=9	
Documentation – manufacturing	-	9	9	-	=9	
Finished product testing - chemical	-	-	-	-	=9	

 There were no significant collective issues apparent in the data i.e. where a number of deficiencies in related categories indicate a bigger issue.



1. Investigation of Anomalies

- There was no scope to define when or how planned deviations may be used. This allowed such deviations to be used indefinitely.
- A planned event was raised for a damaged/worn item of equipment, when a
 deviation was appropriate. There was no investigation as to the cause of the
 damage and although a critical item, no spare was available for
 replacement, production was therefore allowed to continue potentially
 compromising the product.
- Following identification of failings in the returns process resulting in an update to the procedure, there had been no consideration of the impact of the failings in the process on previously returned materials.
- A significant number of investigations were not being completed in a timely manner with a large number still open over a year after initially being raised and one example had been open for 15 months.
- The complaint for a missing label on a product bottle was not rigorously investigated to identify root cause. Instead the investigation was used to predominantly justify the current controls.



- 1. Investigation of Anomalies [contd.]
 - An appropriate level of root cause analysis was not applied during investigation of deviations. The true root cause(s) of deviations associated with numerous reconciliation issues were not adequately determined.
 - The product impact assessment and associated rationale for determining whether any issue encountered was a significant deviation or a lower level incident, was not formally documented.
 - Complaint Investigations for unfit tablets were lacking in that the complaint investigations did not document all the decisions and measures taken as a result of the complaints. There were no root cause or corrective and preventative measures identified. The implication for other batches was not documented despite being noted as a repeat issue and it was not apparent that the Qualified Person had been involved in the investigation process.





2. Quality Management

- There were no Self inspections carried out in the previous year, nor was there a programme established for the current year.
- The laboratory pharmaceutical quality system was silent with respect to stability sample management. The company stated that R&D procedures were in place to manage the latter however it was noted that a significant number of R&D procedures were overdue and that there was no oversight of the R & D function via self-inspection.
- There was no Quality Risk Management procedure.
- All significant Quality incidents were not included in the PQRs.
- The Complaints, Errors and Exceptions Procedure was weak in that:
 - The implications of complaints on other batches/analyses potentially affected and the trending of complaints was not formalised. In addition the procedure did not reflect the current complaint handling process.
 - The exceptions procedure was ambiguous as to how to perform an impact assessment or root cause analysis for the investigation levels detailed.





2. Quality Management [contd.]

- Quality risk management procedure, although based upon on GMP Part III (ICH Q9), was lacking in suitable detail as to how risk management would be applied on-site both proactively and retrospectively.
- The quality system was not being maintained in that:
 - Product Quality Reviews (PQRs) had not been completed during the required period.
 - A significant number of SOPs were past their review date, multiple change controls had been open for longer than 6 months and a number of complaints had not been closed.
 - Quality management reviews were not carried out at as per procedure.
 - API audits for two APIs had not been performed as per the formal plan. There
 was no process to justify why these suppliers could continue to be used.
 - One third of the planned self inspections had been completed in the defined period.





3. Investigation of Anomalies – CAPA

- During the review of CAPAs, the following issues were identified:
 - It was not clear how CAPA actions were linked to the root cause
 - There was no expected time given for implementation.
 - There was no mechanism as to how CAPA could be measured and shown to be effective.
- The manufacturing investigation into extraneous matter found in an API manufactured by a contract company failed to detail the final disposition of the material or the actions that needed to be performed i.e. that multiple batches of the API were to be returned to the supplier to be reprocessed.
- There was no process to ensure CAPA actions from any system including regulatory inspections were completed on time and in full.
- CAPA systems did not ensure that commitments made to the Licensing Authority following the last inspection were completed in line with the commitments provided.
- The CAPA raised regarding an API supplier that had been determined as unacceptable had not included an action to remove the manufacturer from relevant Marketing Authorisations.





- 4. Contamination, chemical/physical (or potential for)
 - There was no documented process for assessing suitability of new molecules to be introduced to site to ensure that they were not manufactured in a facility that was non compatible with the toxicity profile of the molecule and that cleaning procedures were appropriate for the risks posed.
 - A roller compactor in the engineering workshop was covered in white powder. The unit had been there for ~6 months and the powder identity was unknown.
 - Unidentified white powder was noted on the floor of the production corridor and on a hand pallet truck in the area.
 - Cleaning validation did not include an assessment or criteria for individual swab results. Consequently, individual swabs could fail acceptance criteria with average results still being within limits. The approach limited the capability to identify hard to clean locations and evaluate the overall effectiveness of cleaning processes.





- 4. Contamination, chemical/physical (or potential for) [contd.]
 - Maximum allowable dirty equipment hold times had not been established to support the effectiveness of cleaning processes subject to cleaning validation.
 - There had been no attempts to operate on a campaign basis and no specific containment measures had been used. In addition, the cleaning systems applied were not considered to be acceptable for products of this nature [potent] handled in shared facilities.
 - There was no justification or risk analysis performed for the manufacturing of multiple batches [of different products] within the same granulation suite.





5. Supplier and contractor audit

- The audit report for a supplier was not available when the site was added to the approved supplier list. As such there was no contemporaneous evidence upon which to base the approved manufacturer decision.
- The address of a supplier site on the approved supplier file for an API differed from the address as listed on the most recent audit report.
- Audit Reports for an API were high level and it was not apparent what had actually been audited, this contravened the site procedural requirements.
- The maintenance and control of the approved supplier list was not robust as evidenced by an API supplier being listed as an approved supplier on the approved supplier list despite an audit four months previously specifying that the supplier was no longer to be approved. In addition, API had been received on site since the audit date.
- Audit frequency was specified as required by Risk Assessment however there was no maximum time frequency specified in a number of instances.





5. Supplier and contractor audit [contd.]

- In a Quality Assurance Agreement it was observed that the contact name for the contract giver was a person located at a site which has been closed for some time. The agreement failed to adequately describe the transportation conditions for APIs i.e. that an API should be transported at 3-8°C.
- The approved supplier listing contained a number of errors, e.g. missing suppliers, and some suppliers were on the list that should not have been.
- Supplier audit SOP was silent with respect to API suppliers and was ambiguous with respect to services.
- An audit report for a supplier was held concluding that the site was not suitable for supply of an API due to GMP issues. However, the action taken was not sufficient as the active substance stock held that had been manufactured on the aforementioned site was not all quarantined and rejected.



Areas for Attention



- Based on review of the observed deficiencies, upcoming changes to GMP legislation and information received from other authorities; the following areas have been targeted as priority areas;
 - Data Integrity (DI)
 - DI issues, both as a result of bad practise and to a significantly lesser extent intentional fraud, have been observed across all geographical locations and sectors of the industry with some very high profile cases being observed recently. There will therefore be a focus on this area during inspections in the near future. In addition;
 - the MHRA has communicated an expectation that companies will carry out a routine effectiveness review of their governance systems to ensure data integrity and traceability are maintained (see MHRA communication issued on the 16th Dec 2013)

http://www.mhra.gov.uk/Howweregulate/Medicines/Inspectionandstandards/ GoodManufacturingPractice/News/CON355490



Areas for Attention (cont.)



- Falsified Medicines Directive (FMD)
 - When the FMD legislation (European Directive 2011/62/EU) came into force in the UK on 20 August 2013, a number of requirements were introduced, including;
 - manufacturers, importers and distributors of APIs are required to register with the MHRA. MIA holders are required to confirm the registered status of their API suppliers.
 - API imported from a third country is required to be accompanied by a third country authority written confirmation of EU GMP equivalence, or a waiver described in Art 46(b) of the Directive.
 - Brokers of finished medicinal products in the UK have to register with the MHRA
 - Compliance with the requirements of the FMD legislation along with the knowledge and maintenance of the supply chain will be a focus during inspections.
- 'Investigation of anomalies' remains the most cited inspection deficiency over the last five years
 - This will therefore remain an area of focus during inspections
- Potential for Contamination
 - This area will be a focus during inspections for the following reasons;
 - Deficiencies categorised as 'Contamination, chemical/physical (or potential for)' have significantly increased in occurrence in the last two years (fourth most frequently sited category in 2013).
 - There has been a general trend towards higher potency active substances, therefore increasing the
 potential for a contamination event to have a greater impact.
 - Changes in EU GMP Chapters 3 and 5 regarding 'dedicated facilities'





Thank you



Medicines and Healthcare Products Regulatory Agency