The letter complained that (191), "[s]tudy monitors failed to identify that on multiple occasions, site personnel documented administration of study drug to different subjects at precisely the same time ... at Site #520, study monitors failed to identify that on multiple occasions, study coordinators documented administration of study drug to two different subjects at the same time ... study coordinators documented administration of study drug to two different subjects at the same time, and study monitors should have sought an explanation for these observations ... Subject #1266 at 09:00–10:00 and Subject #1267 at 09:00–10:00 on 7/2/05 ... study monitors should have noted that on multiple occasions, study site personnel documented administration of study drug to different subjects at precisely the same time, and further investigated the reason for this irregularity ... it would not be possible for the same study coordinator to begin study infusions on more than one subject at precisely the same time, even if the two subjects had been treated at the same location."

According to FDA's letter, the persons responsible for this oversight in record keeping included the study coordinator, the study monitor, and site personnel.

c. Drug Accountability Failure of CRO

The letter complaining about the record-keeping oversight, where one person administered study drug to two subjects at the same time, also complained about a drug accountability failure. The issue was the Clinical Study Protocol's requirement that (192), "receiving site storage conditions must be confirmed upon delivery of the study medication. Clinic, investigator office and/or patient refrigerator temperatures must be recorded and the plan must specify where and by whom." FDA's Warning Letter complained that, "at Site #509, study monitors failed to ensure that reconstituted study drug infusion solutions were stored appropriately. Protocol [redacted] stated that reconstituted study drug infusion solutions should ... be stored at room temperature (25°C) and used within 6 hours ... [a]lthough they were asked by [CRO] monitors, the personnel at the site never addressed how they would document the temperature storage conditions of the product in subjects' homes ... storage temperatures for these medications could not be confirmed as complying with storage conditions specified by the protocol."

The above complaint concerned deviations at Site#509. The same Warning Letter also complained about an out-of-range temperature reading, which occurred at another site (Site #520). The letter complained that (193), "at Site #520, study monitors failed to document the out-of-range temperature readings noted at this site, and failed to provide appropriate follow-up instructions to the site regarding the usage of the kits in a particular shipment." The layperson can easily understand the seriousness of this out-of-range temperature, by the Warning Letter's further complaint that,

[191]Warning Letter No. 10-HFD-45-11-04 (November 27, 2009) from Dr Leslie K. Ball, MD, Office of Compliance, CDER, U.S. Food and Drug Administration.

[192]Warning Letter No. 10-HFD-45-11-04 (November 27, 2009) from Dr Leslie K. Ball, MD, Office of Compliance, CDER, U.S. Food and Drug Administration.

[193]Warning Letter No. 10-HFD-45-11-04 (November 27, 2009) from Dr Leslie K. Ball, MD, Office of Compliance, CDER, U.S. Food and Drug Administration.