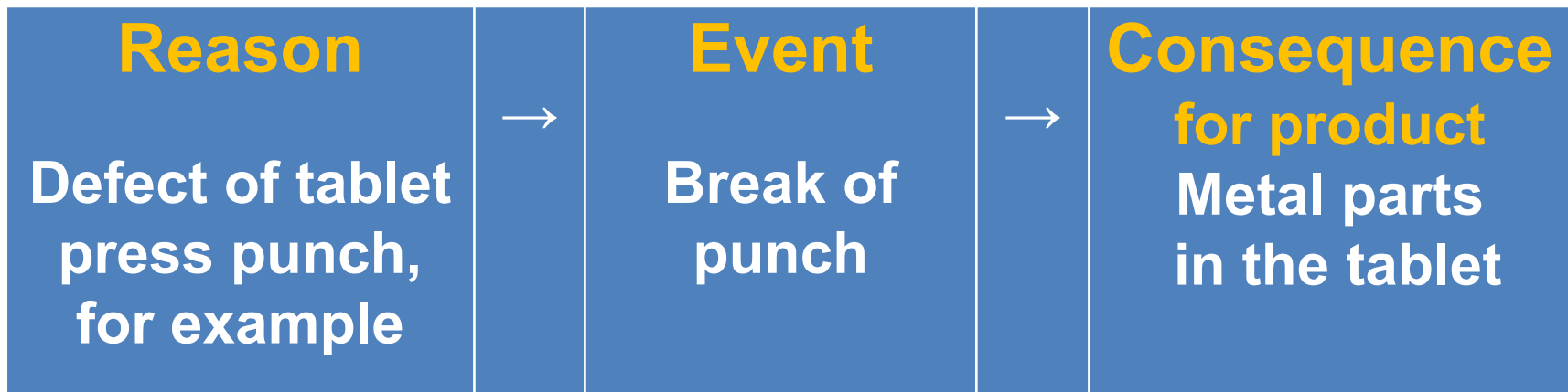


Risk Analysis: myths, confusions and real sense

Dr. Alexander Fedotov,
Director of “Invar-project”
Company, Moscow, Russia
fedotov@invar-project.ru
www.invar-project.ru

What is Risk analysis?

- **Risk** means the possibility of dangerous or unwanted event to occur;
- People analyze risk **for ages and every day** to be protected against unwanted events;
- Purpose is to understand chain:



GMP EU and ICH Q9 promise

- 2005: **ICH Q9** “Quality Risk Management”;
- 2008: **ICH Q9 became Annex 20** GMP EU;
- 2010: it became **Part III** of GMP EU

Introduction to GMP EU says:

“The aim of Part III is to **clarify regulatory expectations** and it should be viewed as a source of information on ***best current practices***”.

Is it true?

GMP EU and ICH Q9 promises

- **General methods** include Flow charts, Check sheets, Fishbone diagram & others. General methods are **trivial** and **no special guide is needed**
- **Other methods** include FMEA, FMECA, HACCP and so on abbreviations.

Let's look how they work on example of **FMEA (Failure Mode Effect Analysis)** method that is propagated widely.

FMEA method: “**Quantity estimation of risk**”

1st Step. Setting **evaluation criteria** of risks :

- **Severity/Impact** (*I*);
- **Occurrence** or probability of event (*O*);
- **Detectability** (*D*).

2nd Step: Each criteria has **numerical value**

For example, numbers from **1 to 5**,

- **1** means the **lowest risk** and
- 5** means the **highest risk**.

FMEA method

3d Step

- **Risk Priority Number (RPN)** is calculated by multiplying **evaluation criteria**:

$$RPN = I \times O \times D;$$

- **RPN** grows from **1** to **125** with risk increasing

4th Step

- **Acceptance level** of **RPN** shall be specified in advance;
- It can be any number within **RPN** range (1 -125), say, 27; 51 or 109.

FMEA method

- If ***RPN < Acceptance level***, then risk is low;
- **No** further action needs to be implemented;
- **In contrary** if ***RPN > Acceptance level***, correction actions are needed.

FMEA has three fundamental mistakes:

1st mistake:

Acceptance levels (and RPN) are assigned by human **arbitrary** or **subjectively**, by his own mind.

2nd mistake

- Values with **different sense (I; O; D)** are multiplied, that **is not allowed** by science!
- To **compare incomparable** is a huge and obvious **methodical** mistake.

3d mistake

- ***Mathematical play*** with ***RPN*** gives ***image*** of Quantity analysis only;
- This ***arbitrary*** estimation serves further as a basis for ***responsible decision***;
- This play has ***nothing common*** with science!

It is a very dangerous approach!

FMEA Example: Two events for **airplane**

Event	Evaluation criteria			RPN
	Severity	Occurrence	Detectability	
Delay of plane arrival	1	5	5	25
Crash of plane	5	1	5	25

- Delay and Crash are **equivalent** by FMEA
- Is it better than discussions of medieval monks from **Thomas Aquinas** times: **“How many devils can be accommodated on the tip of the needle”?**

FMEA - Example for pharmaceuticals – Ac. Level=27

Process step or equipment	Possible failure/risk	Consequence of failure	Occurrence	Severity	Detection	RPN	Further action
			1–5	1–5	1–5		Yes/No
Machine preparation	Cleaning not sufficient	Cross contamination/ microbiological contamination	1	5	2	10	No
Machine preparation	Recalibration interval violated	No GMP conformity	1	4	2	8	No
Machine preparation	Punches installed not correctly	Tablets contaminated (metal) machine defect, loss of production	1	3	1	3	No
Loading	Not enough loading goods	No delivery of granules for the compression process	2	2	1	4	No
Automatic loading	Wrong granules	Patient dead	1	5	2	10	No
Machine adjustment	Wrong Adjustment	Tablet content too high, patient harm	1	5	1	5	No
IPC	Balance wrong	Wrong weight, Patient harm	1	5	3	15	No
Etc							

ICH Q9 (Part III of EU GMP) says that it helps *manufacture* and *inspector*

How it helps manufacture?

- Does it help *to construct* process flow charts, to find critical points, to draw HVAC, WFI and other schemes? – **No!**
- They all shall be *in the design!*
- To arrange *routine testing/control* and to write documents? ***But is already in GMP!***

Risk analysis helps inspector? *How?*

One of **inspectors** writes:

- Inspector has ***not enough time*** and papers on risk analysis ***prepared by manufacturer*** make his task easier to estimate the plant.

So Inspector observes:

- not **primary documents** (records, etc.),
- but **secondary ones**,
- that reflect primary sources ***only partly***;
- ***And*** prepared by ***persons to be inspected***.

A fundamental danger is hidden in this approach!

Inspections and Delayed-action Mine

It is a very important opinion:

- Inspector observes not **primary documents** (WFI schemes, records, etc.);
- but **secondary ones**, i.e. papers that reflect primary sources **only partly**;
- prepared by **persons to be inspected**.

A fundamental danger is hidden in this approach!

Inspections and **Delayed-action Mine**

It would be interesting to look:

- How *financial/tax* inspector will check the company on *interpretations* of financial documents made by people under inspection, not on the very documents;
- How *road police* will judge guilty drivers on driver's *own interpretation* of accident;
- and so on.

Inspections and **Delayed-action Mine**

- Customer buys *medicinal product* that shall comply *with primary documents* not with exercises;
- It cannot be allowed to evaluate manufacturer by *extracts from documents* or comments, especially made by *persons under control*.

This is a Delayed-action Mine!

Risk analysis – Danger of formal approach

Why are we so anxious?

- ***Time and human resources*** in real manufacturing life are always ***limited***;
- Plays with formal methods can distract attention from ***care on quality***;
- Methods can serve as ***excuse for risk***

It breaks the main condition:

No risk for medicines is permitted!

Can Risk analysis can *be positive?*

- *Yes*, if it *professional, clear and useful.*

Example of Company *Nutricia*

- In 1993 the batch of product contained *residues of disinfectants* was recalled from the market;
- This accident pressed company to implement *Risk analysis system.*

Real sense of risk analysis is to show how facility is protected against (design):

- ***Cross contamination*** (layouts; airflows; pressure differences; materials, personal flows etc.);
- ***Mixing*** of materials and products;
- ***Mixing*** of sterile and non-sterile products;
- ***Non-sterility*** in aseptic processes;
- ***Contamination*** (particles, viables...);
- Surfaces contamination;
-

Experience of *Nutricia*

Soon *problematic places* were revealed:

- personnel;
- contamination;
- raw materials defects;
- out-of-standards deviations.

It is very close to problems of pharmaceutical factories.

Conclusion

1. Method has ***no right*** to exist in two cases:
 - if it is ***wrong and misleading*** for users;
 - if it gives ***trivial result*** (result that can be got by simpler way or is obvious).

ICH Q9 methods fall under these two cases and are ***not suitable for use***.

Conclusion

2. Special danger of methods enforced is that they *allow unacceptable events*.

These methods, moving from the office to manufacture can be used by somebody to *justify wrong work*.

3. Science says that we belong to creatures named *“Homo sapience”* or *“Wise man”*.
If so, why do we accept exercises like FMEA method?

Conclusion

4. Everybody speaks about manufactures, inspectors and consultants.

- What about **customers**, who the main party?
- ***What can be their reaction on ICH Q9 and similar methods?***

5. It is necessary to arrange wide discussion on Risk analysis methods with all **pro and contra** to form public opinion