

Deviation Report

**Record ID:** DEV\_20250808\_043849      **Generated:** August 08, 2025 04:40 AM

Report Information			
Title:	Discoloration observed on forceps during filling of batch 10000245	Priority:	Major
Status:	In Progress	Deviation Type:	Equipment
Date of Occurrence:	March 13, 2025	Department(s):	Manufacturing
Batch/Lot Number:	10000245	Quantity Impacted:	789
Planned Deviation:	No	Initiator:	Matt

## User Input - Original Deviation Description

On 13 March 2025 during the start of filling of batch 10000245 the operators noticed the forceps exhibited slight discoloration.

## AI-Generated Analysis

### Deviation Summary

On March 13, 2025, during the start of filling for batch 10000245, operators identified a slight discoloration on the forceps used in the process. This deviation impacted a quantity of 789 units. The issue was noted by the manufacturing department. The current status involves ongoing investigation to determine the root cause and assess the impact on product quality.

### Event Timeline

- March 13, 2025: Operators noticed slight discoloration on the forceps at the start of filling batch 10000245.

## Root Cause Analysis

Root cause investigation focuses on the following areas based on the deviation details:

- **Equipment:** The forceps used during the filling process require review of cleaning and maintenance records to ensure compliance with 21 CFR 211.67(b).
- **Material:** The material of the forceps needs verification for potential chemical reactions or corrosion that may cause discoloration.
- **Process:** The filling process step requires evaluation to ensure that no external factors contributed to the discoloration of the equipment.

## Impact Assessment

- **Product Quality:** The discoloration on the forceps may lead to contamination, affecting the sterility and safety of the product.
- **Batch Disposition:** The batch requires additional testing to ensure no contamination occurred due to the equipment issue.
- **Risk Level:** Classified as Major due to the potential impact on product sterility and patient safety.
- **Other Batches:** No immediate risk identified to other batches, but similar equipment should be inspected to prevent recurrence.

## CAPA Plan

### Immediate Actions (24-48 hours):

- Quarantine batch 10000245 to prevent distribution until further testing is completed.
- Stop the use of the affected forceps and replace them with verified equipment.
- Collect samples from the batch for sterility and contamination testing.

### Corrective Actions:

- Reprocess batch 10000245 if contamination is confirmed, following validated procedures.
- Recalibrate and inspect all forceps used in the filling process for compliance with maintenance protocols.
- Retrain operators on equipment inspection procedures to ensure early detection of similar issues.

### Preventive Actions:

- Implement an automated inspection system for equipment discoloration detection before use.
- Revise SOPs to include a mandatory double verification step for equipment condition before starting the filling process.
- Schedule regular audits of equipment maintenance records to ensure ongoing compliance with cleaning protocols.