

 <b>World Marrow Donor Association</b>	Memo to WMDA Members and Professional Societies			
	Document Type:	MEMO	WG/Committee:	SEAR
	Document	20131127-SEAR-Memo	Other (specify):	
	Version:	1	Approved by:	WBRD
	Drafting Date:	November 27 <sup>th</sup> , 2013	Approval date:	
	Status	Public		

To whom it may concern

**RE: Wrong donor cells transplanted**

Recently a Serious Product Adverse Event was reported to the WMDA S(P)EAR committee where the incorrect unrelated donor cells were infused into a patient.

Confirmatory typing (CT) requests sent from the national donor registry identified one female 10/10 HLA matched donor for the patient (example of number: A12345). A work-up request was then sent by the transplant centre directly to a donor centre. The donor ID number was incorrect on the request (a prefix was omitted: 12345), however the receiving donor centre did have a donor with a similar number (different prefix, identical thereafter: B12345). The donor centre went ahead and performed a medical clearance on this incorrect donor who was male and completely HLA mismatched (0/10). The haematopoietic progenitor cells were transplanted into the patient following reduced intensity conditioning. The error was only recognised one-month post transplant when the correct donor centre enquired whether their donor was still needed. The patient was fully engrafted with no evidence of GvHD. Further confirmatory tests showed the patient to have 100% donor chimerism (and confirmed the pre-transplant HLA types of both the patient and the donor). The patient has now been re-transplanted with the correct donor.

Root cause analyses have been carried out by the involved parties. As is common in such cases, multiple system errors were found: principally that the donor ID was not required to be complete (and when truncated is not unique) and that systems for checking multiple identifiers were not in place.

The S(P)EAR committee felt that similar errors could be made again and therefore this SAE was brought to the attention of the full WMDA membership to try and prevent this. Additionally it was felt that this should be reported to the transplant community in general as some errors originated in the transplant centre.

The WMDA urges all registries and donor centres to examine their numbering systems to ensure that numbers cannot be duplicated. All registries, donor centres and transplant centres should examine their processes to ensure that multiple donor identifiers are checked at all stages of the donation, collection and infusion process. Systems should be put in place to ensure that only full ID numbers can be accepted on all communications, as well as on the product.

The WMDA recommends that transplant centres ensure clear processes of communication with national and international registries and donor centres, particularly if not all processes are handled by the same organisation (e.g. CT request and work-up request).

In summary, multiple errors resulted in incorrect donor identity:

- The donor ID number was incorrect on the work up request submitted by the transplant centre
- The donor ID was not required to be complete at the donor centre
- Systems for checking multiple identifiers to ensure selection of the correct donor were not in place at the donor centre

Sincerely  
S(P)EAR committee, WMDA