



Investigations & Compliance

Improving root cause investigations, risk assessment, and addressing common audit findings

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Why this matters?

- Weak investigations create **repeat failures**
- Strong RCA **prevents recurrence** and supports compliance
- Investigation maturity = **quality culture** indicator

What Auditors Expect

- Timely initiation and closure
- Evidence-based conclusions and documented rationale
- Product impact assessment
- Effective CAPA
- Management oversight and trending

Top 10 Audit Findings – RCA & Investigations

| Common Finding | What Auditors Usually Observe | Regulatory Concern |
|---|---|---|
| Superficial root cause (“human error”) | Operator blamed with no system analysis | Failure to identify true cause |
| No documented investigation methodology | No 5-Why, fishbone, fault tree, timeline etc. | Investigation not scientifically justified |
| CAPA does not address root cause | Retraining only, no system/process fix | Recurrence risk remains |
| Repeat deviations with no trending | Same issue, multiple times | PQS and/or prior RCA ineffective |
| Delayed investigations/overdue closure | Events left open too long | Risk not controlled promptly and poor quality culture indicator |
| Poor impact/risk assessment | No product impact or batch risk review | Potential unsafe/nonconforming product released |
| Incomplete scope of investigation | Related batches/equipment/materials ignored | Extent of issue unknown |
| No effectiveness checks for CAPA | CAPA closed without verification | No proof problem solved |
| Weak data evidence | No review of logs, EM data, calibration, trends | Conclusions unsupported |
| QA oversight inadequate | Investigations approved without challenge | Governance weakness |

Human Error is not a Root Cause

- Need to address:
 - Why was it possible?
 - Process robustness?
 - Control adequacy?

Your SOP could be your Root Cause

- Weak SOP → weak RCA
- Strong SOP → structured thinking
- QA oversight required

Improving Root Cause Analysis (RCA)

- Define what effective RCA looks like
 - Establish clear expectations for analysis
- Use structured tools
- Risk-based depth
- Use data and expand scope

CAPA and Governance

- Link CAPA to cause
- Avoid retraining-only or “Toolbox” talks
- Implement prevention
- Verify effectiveness

DMAIC Framework

- Use DMAIC as a thinking framework, not just a checklist.
 - Define – clear problem statement
 - Measure – use data
 - Analyse – structured, system-based RCA
 - Improve – preventive / sustainable CAPA
 - Control – verify effectiveness
- SOP to define each process stage
- Form to capture outcomes



Audit Examples

Scenario: *Raw material “X” appeared degraded, there was no investigation on cause or impact of continuing use.*

- Investigate transit/storage damage, moisture, packaging, shelf life
- Quarantine, test, supplier investigation request, batch impact review

Scenario: *Recall due to fungal growth investigation did not identify root cause or impact to other batches.*

- Needs source identification
- Look-back to other lots / batches, room(s), equipment, shift, operators

Scenario: *EM trend data is not investigated.*

- EM upward trends below limits still require investigation
- Waiting for failure **is not** contamination control

Audit Examples cont'd...

Scenario: *Temperature probe review identified multiple excursions of greater than 30°C. Product must be stored below 30°C. No investigation or impact reviewed for the product.*

- Assess lots impacted, stability risk, HVAC, alarm process, maintenance, CAPAs

Scenario: *There were six (6) sterility failures of batch “Y”, with no investigation of trend or common cause.*

- Six (6) failures treated separately
- Trend review should assess room, operators, shifts, organism, utilities
- Escalate contamination control review and EM intensification

Strong vs Weak CAPA

- Weak:
 - Retraining and/or toolbox talks
- Strong:
 - Redesign process
 - Automate checks
 - Segregate labels
 - Add verification
- **Verify effectiveness** after implementation

Key Takeaways

- Stop accepting human error as a Root Cause
- Design SOPs and Forms for RCA
- Use data
- Focus on prevention
- Verify effectiveness



THANK YOU!

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