DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

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Food and Drug Administration
Center for Devices and
Radiological Health
2098 Gaither Road
Rockville, MD 20850

Via Federal Express

AUG 2 2001

WARNING LETTER

James T. Robertson, M.D.
Professor of Neurosurgery
The University of Tennessee Health Sciences Center
College of Medicine
Department of Neurosurgery
847 Monroe Avenue, Suite 427
Memphis, Tennessee 38163

Dear Dr. Robertson:

This Warning Letter informs you of objectionable conditions found during Food and Drug Administration (FDA) inspections conducted at your clinical site and requests from you a prompt written reply informing us of your corrective actions. You participated as a clinical investigator in a study entitled, [redacted] sponsored by [redacted], to investigate the device [redacted]). Data from the study conducted at your site was submitted to the FDA in support of the premarket approval application, [redacted]

During the periods of February 5 through February 22, 2001, and April 2 through April 11, 2001, you were visited by David R. Heiar, an investigator from the FDA's New Orleans District Office. The purpose of Mr. Heiar's visits was to conduct inspections to determine whether your activities and procedures and those of Joseph H. Miller, M.D., and Jerry Engelberg, M.D., as clinical investigators for the [redacted] study complied with applicable regulations. The [redacted] product is a device as that term is defined under Section 201(h) of the Federal Food, Drug, and Cosmetic Act (the Act).

The inspections were conducted under a program designed to ensure that data and information contained in applications for Investigational Device Exemptions (IDE), Premarket Approval (PMA), and Premarket Notification (510(k)) submissions are scientifically valid and accurate. Another objective of the program is to ensure that human subjects are protected from undue hazard or risk during the course of scientific investigations.

We have completed our review of the inspection reports submitted by the New Orleans District Office. The reports reveal significant violations of the requirements under Title 21, Code of Federal Regulations (21 CFR), Part 50 - Protection of Human Subjects; 21 CFR, Part 56 - Institutional Review Boards; and 21 CFR, Part 812 - Investigational Device Exemptions. These violations are listed on the Forms FDA 483, "Inspectional Observations," which were presented to and discussed with you on February 22, 2001, at the conclusion of the inspections of Drs. Engelberg and Miller; and discussed with Dr. Engelberg on April 11, 2001, at the conclusion of the second inspection of Dr. Engelberg. The violations noted on the Forms FDA 483 and our subsequent review of the inspection reports are not intended to be an all-inclusive list of deficiencies found at your site.

You asserted to Mr. Heiar that you transferred Principal Investigator responsibilities to Drs. Engelberg and Miller. However, we have determined that you were the Principal Investigator of record for the [redacted] study conducted at the Veterans Administration Medical Center (VAMC), VAMC Research Center, Memphis, Tennessee.

On December 27, 1995, the [redacted] from the Department of Veterans Affairs sent to you a memorandum stating that you are listed as the responsible VA Investigator for the [redacted] study. As such, you were responsible for submitting and should have submitted to the Research Office all necessary reports and study related correspondence.

On January 24, 1996, [redacted] for you sent to the Department of Veterans Affairs a letter stating that you were no longer the Principal Investigator for the [redacted] study due to a conflict of interest. However, on January 30, 1996 and February 6, 1996, at the VAMC you operated on [redacted] study subjects [redacted] and [redacted], respectively.

In a letter dated February 25, 1997, you wrote to the Department of Veterans Affairs Research Services that you would no longer be the Principal Investigator for the [redacted] study due to your retirement from the VA. You "relinquished" your right to Maurice Smith, M.D., who was according to the Investigator's Agreement participating as a "Sub-Investigator" for the [redacted] study. On June 17, 1997, Dr. Smith wrote to the Department of Veterans Affairs Research Services stating that you would continue to be the Co-Principal Investigator at that site.

- **Failure to adhere to the general and specific responsibilities of investigators** ***(21 CFR 812.100 and 110(c)).***

  You failed to adhere to the general and specific responsibilities of an investigator in that you allowed an investigational device to be used on study subjects without your supervision. Therefore, you did not maintain control of the investigational device.

For example, on February 14, 1996, you sent to [redacted], Research Services, VAMC [redacted], a letter stating that you would remain as the Principal Investigator at the VAMC for the [redacted] study. During the months of April, May, and June, 1996, Bernie G. McHugh, Jr., M.D., operated on eight patients at the VAMC who were participating in the [redacted] study as follows:

Patient [redacted], surgery date [redacted]; Patient [redacted], surgery date [redacted];
Patient [redacted], surgery date [redacted]; Patient [redacted], surgery date [redacted];
Patient [redacted], surgery date [redacted]; Patient [redacted], surgery date [redacted];
Patient [redacted], surgery date [redacted]; Patient [redacted], surgery date [redacted].

At the time of the operations, Dr. McHugh was not an authorized "Sub-Investigator" for the [redacted] study.

- **Failure to maintain accurate, complete, and current records relating to the investigator's participation in an investigation *(21 CFR 812.140).***

  While you were on record as the Principal Investigator, you were responsible for submitting to the institutional review board all necessary reports and study related correspondence. You failed to report to the VAMC the required information regarding your participation in the [redacted] study. For example, our investigator found no record of a progress report submitted to the VAMC Department of Veterans Affairs institutional review board until April 25, 1997. On this date, [redacted], a [redacted] from The Lee Group, Inc. sent to the Department of Veterans Affairs a letter providing information needed by the institutional review board. [redacted] states in her letter that enrollment in the [redacted] study had ended nationwide effective March 31, 1997.

We acknowledge your letter dated May 30, 2001, addressed to Mr. Michael R. Duran, Supervisory Investigator, FDA. Your letter in response to the items listed on the three Forms FDA 483, two issued on February 22, 2001, and one issued on April 11, 2001, does not adequately address the violations.

As a clinical investigator, it is your responsibility to ensure that investigations that you participate in are conducted in accordance with applicable FDA regulations. To assist you, we have enclosed a copy of the *FDA Information Sheets,* guidance for clinical investigators.

Please advise this office, in writing, **within fifteen working days of receipt of this letter**, of the additional steps that you have taken to correct these violations and other violations known to you, and to prevent the recurrence of similar violations in current or future studies. Failure to respond may result in regulatory action, including disqualification, without further notice.

You should direct your response to the Food and Drug Administration, Center for Devices and Radiological Health, Office of Compliance, Division of Bioresearch Monitoring, Program Enforcement Branch II (HFZ-312), 2098 Gaither Road, Rockville, Maryland 20850, Attention: Kathleen E. Swisher, J.D., R.N., Consumer Safety Officer. A copy of this letter has been sent to our New Orleans District Office, 6600 Plaza Drive, Suite 400, New Orleans, Louisiana 70122. We request that a copy of your response be sent to that office as well.

Sincerely yours,

for Larry Spears
Acting Director
Office of Compliance
Center for Devices and
Radiological Health

Enclosure

cc:

Jon H. Robertson, M.D., Department Head (purged copy)
University of Tennessee, Memphis
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[redacted] (purged copy)

Clair E. Cox, M.D., Chairperson (purged copy)
University of Tennessee - Memphis Institutional Review Board
62 S. Dunlap Street, Suite 320
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Chairperson (purged copy)
Baptist Memorial Hospital
Patient Participation Committee
899 Madison Avenue
Memphis, Tennessee 38146

Chairperson (purged copy)
Veterans Administration Medical Center
Human Studies Sub-Committee
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