

HRC has seen

TO: Hillary Rodham Clinton
FROM: Jennifer Klein J.K.
DATE: 2/26/98
RE: Blood Supply at National Naval Medical Center

Pam said that you had asked us to follow up on the *Washington Post* article about problems with the blood supply at National Naval Medical Center at Bethesda. I spoke to both the Deputy Commander at the hospital and officials at the Food and Drug Administration responsible for investigating instances like this one. Apparently, technicians mistakenly removed a punctured, unrefrigerated bag of blood from the autoclave, where it had been left to be destroyed, and returned it to the blood bank, where it was used for a transfusion for an infant in the neonatal intensive care unit. The technicians have been terminated.

Fortunately, the baby is fine, and the instance does not seem to be representative of larger problems. While the *Post* refers to this as "the latest embarrassment at a blood bank . . . troubled by mishaps and confusion . . .," the FDA assured me that a thorough FDA review has found no other problems at Bethesda. FDA did explain that hospital officials decided themselves -- after a review indicating that their computer tracking system was out of date -- to stop collecting blood, update their system, and retrain their technicians. While the FDA has no reason to believe there are ongoing problems, they will closely monitor the hospital's blood bank.

A Naval Hospital, Two Lose Jobs After Boy Given Unusable Blood

By Avram Goldstein
Washington Post Staff Writer

Two supervisors in the blood bank at National Naval Medical Center in Bethesda have been removed from their jobs for allowing blood that should have been destroyed to be transfused into a two-pound infant in the neonatal intensive care unit.

The Jan. 28 transfusion was interrupted when a technician discovered the mistake, but the 5-week-old boy had already received 11 cubic centimeters of blood—about one-third of an ounce. Cameron Howell, the son of an Air Force staff sergeant stationed in South Korea, was put on antibiotics as a precaution, and lab tests

determined that he had not contracted any infections, officials said.

It was the latest embarrassment at a blood bank that has been so troubled by mishaps and confusion that hospital administrators suspended donations there three months ago. Inspectors from the Food and Drug Administration said that sloppy management practices and rampant book-keeping errors allowed suspect blood into the military blood supply, including units not thoroughly tested for the AIDS virus.

In this case, the blood was slated for destruction after technicians found a perforation in the plastic bag used to collect and store the blood, then left it unrefrigerated overnight in an area

See BLOOD, C10, Col. 5

closed parts of the room on the River, the

Two Blood Bank Supervisors Fired

BLOOD, From C1

designated for unusable blood. Donor blood that is exposed to air is unusable because of the risk of bacterial or viral contamination.

But because of a complex series of missteps involving several people, the Navy said, the blood wound up back in the supply pipeline.

"I was upset at first, but things worked out," said Cameron's mother, Kim Howell, who lives at Andrews Air Force Base with her three other children. "They kept me up on everything that was going on."

When Cameron was born three months prematurely on Dec. 23, he weighed 1 pound 8 ounces. Today, he weighs about 2 pounds 13 ounces, Howell said. He has battled lung problems and recently underwent intestinal surgery, but the outlook is good for the boy's release next month from the hospital, she said.

A hospital spokesman, Cmdr. Ryland Dodge, said the case did not reflect any larger, systemic problems. "However, it's a serious occurrence, and we believe we are taking the appropriate actions to prevent it in the future," he said.

Dodge said two civilian contract employees who were supervisors in the blood bank were "terminated." He was unable to release their names yesterday.

"These were people who made decisions or judgments who should have known better," he said. Because they work for a contractor, the employees have no appeal rights.

But the company they work for, Sherikon Inc., of Chantilly, a firm that provides the services of 1,000 engineering and medical personnel across the country, said that the two employees were not to blame and that they remain on the Sherikon payroll, though not at the hospital.

"Our people did not have any part in causing the blood to be used or any part of the transfusion process," said Sherikon President Edward R. Fernandez. "We instructed a technician to put the bag in the unusable container for destruction. That was the last involvement we had with that blood."

It isn't clear when blood donations will resume at the hospital, also known as Bethesda Naval Hospital, although officials said it will not happen until the 60 members of the blood bank staff are retrained. In the meantime, the hospital is getting its blood supply from other blood banks.

Separately, the hospital filed charges in December against a civilian Defense Department employee who works in the blood bank for allegedly mishandling files and mislabeling units of blood. The employee is fighting the action.

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