

SP EYE Ref SPY 712

FSN Ref: FSN2024-001 FSCA Ref: FSCA2024-001

Date: 29 July 2024

<u>Urgent Field Safety Notice (FSN) ** UPDATED**</u> <u>SP EYE Ref SPY 712</u> - Sharps Safe Intravitreal Injection Needle

MHRA Ref: 2024/007/004/601/064

For Attention of*: Distributors and Users

Updates: Section 2.2: Added in further information related to 'Hazard giving rise to the FSCA'. Section 2.3: Amended risk matrix probability/severity nomenclature and criteria. Section 2.6: Added in further details of users who reported device issues, and clarified what is meant by operational issues at the subcontractor. Section 2.7: Added in further details of the rationale for recall of lot N011169. Section 3.5: Added new text 'Devices from the affected lot N011169, which have been subject to 100% inspection and are suitable for clinical use, will be re-labelled as lot N011169R'. General: Corrected typographical errors. New appendices: Field Safety Notice Customer Reply Form and Field Safety Notice Distributor/Importer Reply Form.

Contact details of local representative (name, e-mail, telephone, address etc.)*

Andersen Caledonia, Caledonia House, Strathclyde Business Park, Bellshill ML4 3NJ United Kingdon +44 1698 844476 jlintott@andersencaledonia.com regulatory@andersencaledonia.co.uk



SP EYE Ref SPY 712

FSN Ref: FSN2024-001 FSCA Ref: FSCA2024-001

Risk addressed by FSN — Use of affected device may result in failure to control injection

1.	1. Information on Affected Devices*			
		Sharps Safe Intravitreal Injection Needle		
1	Device Type(s)*	Class IIa Medical Device		
		Single use sterile device		
2	Commercial name(s)	SP.Eye device SPY 712		
	Unique Device Identifier(s) (UDLDI)	05060544340005 (Blister pack)		
3	Unique Device Identifier(s) (UDI-DI)	15060544340002 (Box of 100)		
4	Primary clinical purpose of device(s)*	SP.Eye device is indicated for use for general adult population who require an intravitreal eye injection, predominantly those with macular degeneration		
5	Device Model/Catalogue/part number(s)*	SPY 712 (QRG30993SC198)		
6	Software version	Not Applicable		
7	Affected serial or lot number range	Lot N011169 expiration date 2026-10-28 (28th October 2026)		
8	Associated devices	Not Applicable		



SP EYE Ref SPY 712

2	Reason for Field Safety Corrective Action (FSCA)*			
1	Description of the product problem*	Excess glue on the shaft of the needle and spontaneous disassembly		
2	Hazard giving rise to the FSCA*	Risks fall into three categories: 1. Failure to control depth of injection 2. Failure to control position of injection 3. Failure to control angle of injection The non-conformities discussed herein are generally of low clinical risk, however they are understandably a potential cause for concern and loss of confidence in the device by that user. The most significant risk is to the patient - the throw of the needle being limited such that the injection depth is inappropriately limited, which, in the worst case, might cause drug to be delivered into the choroidal or scleral spaces - this could potentially lead to sight threatening complications, but more likely would induce unnecessary pain. A minor limitation of needle throw will still deliver the drug into the vitreous cavity and will not cause any adverse events. Non-conformity Risk Assessment: Glue on shaft limiting throw Severity* score 9 (hazardous severity) Spontaneous disassembly Severity score - 5 (moderate severity) *Risk matrix Severity score range: 1-10 (1 = none - no effect; 10 = catastrophic - very high severity)		



SP EYE Ref SPY 712

3	Probability of problem arising	Non-conformity Risk Assessment: Glue on shaft limiting throw - Probability* score - 8 (repeated failures, 1 in 8 probability) Spontaneous disassembly - Probability* score - 1 (failure is unlikely, <1 in 1,500,000 probability) *Risk matrix Probability score range: 1-10 (1 = remote probability - failure unlikely; 10 = very high probability - failure is almost inevitable
4	Predicted risk to patient/users	1. Probability and severity of failure to control depth. Depth may not be controlled adequately if glue on the shaft of the needle prevents full compression of the spring. Injection at any depth within the vitreous cavity is acceptable, however injection prior to penetration into this cavity would result in drug delivery to the wrong area, with the potential risk of embolisation of the choroidal vessels, pain or failure to deliver a therapeutic dose. The thickness of the sclera and choroid is approximately 220-550um, thus, providing the spring throw exceeds this distance, the risk of inadvertent injection into this space is low. The designed throw of the needle is 6.5mm. 2. Probability and severity of failure to control position. The most likely scenario in which this non-conformity might cause a failure of positional control, with respect to the limbus would be if there was no glue present and the assembly came apart from the



SP EYE Ref SPY 712

		needle itself. This would either occur prior to the device being
		addressed to the eye - when the correct position of injection had not yet been established, or after securing the device on the
		globe. In the former scenario it would not be possible to use the
		device effectively and so its role in establishing the correct
		position with respect to the limbus would be lost - the injector would then be carrying out an unguided injection with high risk of
		inadvertent injury to the patient. In the latter scenario, the correct
		position would already have been established, regardless of the
		subsequent disassembly of the device - and the risk of incorrect
		placement would be negligible. Incorrectly placing the needle too anteriorly may cause lens strike (needle hitting the crystalline, or
		pseudophakic lens) which would be likely to require surgery to
		correct and may affect long term vision. Furthermore, placing the
		needle too posteriorly may cause retinal detachment or injury
		which may lead to further surgery and (in rare cases) permanent loss of vision.
		3. Probability and severity of failure to control angle. The most
		likely scenario in which this non-conformity might cause a failure
		of angle control would be if there was no glue present and the
		assembly came apart from the needle itself. This would either
		occur prior to the device being addressed to the eye - when the correct angle of injection had not yet been established, or after
		securing the device on the globe. In the former scenario it would
		not be possible to use the device effectively and so its role in
		establishing the correct angle would be lost - the injector would
		then be carrying out an unguided injection with high risk of inadvertent injury to the patient. In the latter scenario, the correct
		angle would already have been established, regardless of the
		subsequent disassembly of the device - and the risk of incorrect
		placement would be negligible. Were the angle of injection to be
		too flat, this could cause lens strike (needle hitting the crystalline,
		or pseudophakic lens) which would be likely to require surgery to correct and may affect long term vision. Furthermore, were the
		angle to be too acute, there is a remote risk of damaging the
		retina which may lead to further surgery and (in rare cases)
		permanent loss of vision.
_	Further information to help	Niet Applicable
5	characterise the problem	Not Applicable



SP EYE Ref SPY 712

6	Background on Issue	Manufacturer was made aware of the issue by two users (distributors) of the device on 11 June 2024. An investigation was initiated and has established that the root cause of the issue was operational failures (i.e. lack of manufacturing controls, including In Process/QC checks) at the contract manufacturer (Manufacturer's sub-contractor). Risk information can be found above.
7	Other information relevant to FSCA	As stated above, the non-conformities discussed herein are generally of low clinical risk, however they are understandably a potential cause for concern and loss of confidence in the device by the user. These non-conformities can easily be detected visually (by the naked eye) on the device, thus a Field Safety Notice and recall was initiated solely for Lot N011169 expiration date 2026-10-28 (28th October 2026), since this batch is with customers in the field and requires 100% visual inspection. Other SP:EYE batches in the field have either had no reported issues or have been subject to 100% inspection prior to dispatch to the user and are therefore not included within this Field Safety Notice.

	3. Type of Action to mitigate the risk*			
	Action To Be Taken by the Us	r*		
	☐ Identify Device	ne Device Return	Device ☐ Destroy De	evice
	☐ On-site device modification/ir	pection		
	☐ Follow patient management i	commendations		
1	☐ Take note of amendment/rein	orcement of Instructions	For Use (IFU)	
	☑ Other ☐ None			
	Further details of actions identifie	reply form and return	o complete the distributo to Andersen Caledonia ส า	
2	By when should the action be completed?	One month after rece	eiving FSN	



SP EYE Ref SPY 712

	Particular considerations for:	Not applicable
3.	Is follow-up of patients or review of patients' previous results recommended?	Not Applicable
4.	Is customer Reply Required? * (If yes, form attached specifying deadline for return)	Yes
	Action Being Taken by the Mar	nufacturer
	☐ Product Removal	n-site device modification/inspection
	☐ Software upgrade ☐ IF	U or labelling change
		one
5	Further details of actions identified	100% inspection for all batches to be implemented by manufacturer for non-conforming batch, and current batches in stock. Supplier Non-Conformance raised with contract manufacturer and corrective actions are underway including 100% inspection for all future batch manufacturing. Devices from the non-conforming lot N011169, which have been subject to 100% inspection and are suitable for clinical use, will be re-labelled as lot N011169R.
6	By when should the action be completed?	One month from date that recalled product was returned to manufacturer. Immediate action by contract manufacturer for future batch manufacturing.
7	Is the FSN required to be communicated to the patient /lay user?	No
8	If yes, has manufacturer provided additional information suitable for the patient/lay user in a patient/lay or non-professional user information letter/sheet?	Not Applicable



SP EYE Ref SPY 712

4.	General Information*		
1	FSN Type*	Update	
2	For updated FSN, reference number and date of previous FSN	FSN2024-001 17 July 2024	
3	For Updated FSN, key new information as follows:	**Updates: Section 2.2: Added in further information related to 'Hazard giving rise to the FSCA'. Section 2.3: Amended risk matrix probability/severity nomenclature and criteria. Section 2.6: Added in further details of users who reported device issues, and clarified what is meant by operational issues at the subcontractor. Section 2.7: Added in further details of the rationale for recall of lot N011169. Section 3.5: Added new text 'Devices from the affected lot N011169, which have been subject to 100% inspection and are suitable for clinical use, will be re-labelled as lot N011169R'. General: Corrected typographical errors. New appendices: Field Safety Notice Customer Reply Form and Field Safety Notice Distributor/Importer Reply Form**.	
4	Further advice or information already expected in follow-up FSN? *	31 Aug 2024	
5	If follow-up FSN expected, what is the further advice expected to relate to:	Clinical Risk Assessment Report, Recall Plan Status Update, Root Cause Analysis Investigation report and Corrective Actions Plan	
6	Anticipated timescale for follow-up FSN	31 Aug 2024	
7	Manufacturer information (For conta FSN)	ct details of local representative refer to page 1 of this	
	Company Name	Andersen Caledonia	
	Address	Caledonian House, Strathclyde Business Park, Bellshill, ML4 3NJ United Kingdom	
	Website address	www.andersencaledonia.com	
8	The Competent (Regulatory) Authority of your country has been informed about this communication to customers. *	Yes	
9	List of attachments/appendices:	Appendix 1 - Field Safety Notice Customer Reply Form Appendix 2 - Field Safety Notice Distributor/Importer Reply Form	
10	Name & Job Title	Jonathan Lintott Managing Director	
	Signature	- Comment	



SP EYE Ref SPY 712

FSN Ref: FSN2024-001 FSCA Ref: FSCA2024-001

Transmission of this Field Safety Notice

This notice needs to be passed on all those who need to be aware within your organisation or to any organisation where the potentially affected devices have been transferred. (As appropriate)

Please transfer this notice to other organisations on which this action has an impact. (As appropriate)

Please maintain awareness on this notice and resulting action for an appropriate period to ensure effectiveness of the corrective action.

Please report all device-related incidents to the manufacturer, distributor or local representative, and the national Competent Authority if appropriate, as this provides important feedback..*

Note: Fields indicated by * are considered necessary for all FSNs. Others are optional.



SP EYE Ref SPY 712

FSN Ref: FSN2024-001 FSCA Ref: FSCA2024-001

Appendix 1 - Field Safety Notice Customer Reply Form



SP EYE Ref SPY 712

FSN Ref: FSN2024-001 FSCA Ref: FSCA2024-001



Field Safety Notice Customer Reply Form 3556

REV: A DCO#: 24327

	1. Fi	eld Safety Notice (FSN) inf	ormation		
		Reference number*		FSN2024-001	
FSN Date*			16 July 2024		
	Produ	ct/ Device name*			travitreal Injection Needle
	Produ	ict Code(s)		SPY 712 (QRG30993S	C198)
	Batch	/Serial Number (s)		Lot N011169 Expiration 2026)	n date 2026-10-28 (28th October
		ustomer Details			
		ınt Number			
		ncare Organisation Name*			
	Organ	nisation Address*			
	Depar	rtment/Unit			
	Shipp	ing address if different to abo	ove		
		ct Name*			
		or Function			
		hone number*			
Email*					
	3. Ct	ustomer action undertaken			nia Ltd
		I confirm receipt of the	Comments (if	none, enter N/A):	
		Field Safety Notice and			
		that I have read and			
		understood its content.			
		I have performed all	Comments (if	none, enter N/A):	
		actions requested by the			
		FSN.			
		The information and	Comments (if	none, enter N/A):	
		required actions have			
		been brought to the			
		attention of all relevant			
		users and executed.			
		I have returned affected	Qty:	Lot/Serial Number:	Date Returned
	_	devices - enter number of			(DD/MM/YYYY):
		devices returned and date			
		complete.			
			Qty:	Lot/Serial Number:	Date Returned
					(DD/MM/YYYY):
	. .		1	I	

Comments:



SP EYE Ref SPY 712

FSN Ref: FSN2024-001 FSCA Ref: FSCA2024-001

4	ANDERSEN
	CALEDONIA

Field Safety Notice Customer Reply Form 3556

REV: A DCO#: 24327

	I have destroyed affected devices – enter number	Qty:	Lot/Serial Number:	Date Destroyed (DD/MM/YYYY):
	destroyed and date complete.			
		Qty	Lot/Serial Number:	Date Destroyed
		City	Logoeriai Number.	(DD/MM/YYYY):
			1	(DD/MM/1111).
		Comments:	l .	
		Comments.		
	No affected devices are	Comments (if none, enter N/A):		
	available for return/			
	destruction			
	Other Action (Define):	Comments (if none, enter N/A):		
_				
	I do not have any affected	Comments (i	f none, enter N/A):	
ш	devices.			
	I have a query please	Comments (if none, enter N/A):		
	contact me			
	(e.g. need for replacement			
	product).			
Print	Name*			
Signa	iture*			
Date*			·	

4. Return acknowledgement to sender	
Email	regulatory@andersencaledonia.co.uk
Customer Helpline	+44 (0)1698 844476
Postal Address	Caledonian House, Strathclyde Business Park, Bellshill, ML4 3NJ, United Kingdom
Web Portal	www.andersencaledonia.com
Deadline for returning the customer reply	09 August 2024
form*	

Mandatory fields are marked with *

It is important that your organisation takes the actions detailed in the FSN and confirms that you have received the FSN.

Your organisation's reply is the evidence we need to monitor the progress of the corrective actions.

Procedure Reference 1018

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Page 2 of 2



SP EYE Ref SPY 712

FSN Ref: FSN2024-001 FSCA Ref: FSCA2024-001

Appendix 2 - Field Safety Notice Distributor/Importer Reply Form



SP EYE Ref SPY 712

FSN Ref: FSN2024-001 FSCA Ref: FSCA2024-001



Field Safety Notice Distributor/Importer Reply Form

3557

REV: A DCO#: 24328

1. Fie	eld Safety Notice (FSN) information	1				
FSN Reference number*			FSN2024-001			
FSN Date*			16 July 2024			
Product/ Device name*		SP.	SP.Eye Sharps Safe Intravitreal Injection Needle			
Product Code(s)		SPY 712 (QRG30993SC198)				
Batch/Serial Number (s)			Lot N011169 Expiration date 2026-10-28 (28th October 2026)			
2 Di	stributor/Importor Dotails					
Comp.	stributor/Importer Details any Name*	$\overline{}$				
	nt Number	-				
Addres		-				
Addres	ss					
	ng address if different to above					
Contact Name*						
	r Function					
Teleph	none number*					
Email*						
3. Dis	stributors/Importers (Tick all that a	pply)				
	*I confirm the receipt, the reading and understanding of the Field Safety Notice.	Comm	Comments (if none, enter N/A):			
	I have checked my stock and quarantined inventory	Qty:	Lot/Serial Number:	Date Quarantined (DD/MM/YYYY):		
		Qty:	Lot/Serial Number:	Date Quarantined (DD/MM/YYYY):		
		Comments:				
	I have identified customers that received or may have received this device	Comm	Comments (if none, enter N/A):			
	I have attached a customer list	Comm	Comments (if none, enter N/A):			
	I have informed the identified customers of this FSN		Date of communication:			
	I have received confirmation of	Comments (if none enter N/A):				

Procedure Reference 1018

reply from all identified customers

I have returned affected devices -

enter number of devices returned

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Lot/Serial Number:

Page 1 of 2

Date Returned

(DD/MM/YYYY):

Qty:



SP EYE Ref SPY 712

FSN Ref: FSN2024-001 FSCA Ref: FSCA2024-001



Field Safety Notice Distributor/Importer Reply Form

3557

REV: A DCO#: 24328

	and date complete.					
		Qty:	Lot/Serial Number:	Date Returned		
				(DD/MM/YYYY):		
		Comments:				
	I have destroyed affected devices	Qty:	Lot/Serial Number:	Date Destroyed		
	 enter number destroyed and 			(DD/MM/YYYY):		
	date complete.					
		Qty:	Lot/Serial Number:	Date Destroyed		
				(DD/MM/YYYY):		
		Comments:	•	•		
	Neither I nor any of my customers	Comments (if none, enter N/A):				
	have any affected devices in					
	inventory					
Print Name*						
Signature*						
Date *						

4. Return acknowledgement to Sender			
Email	regulatory@andersencaledonia.co.uk		
Distributor/Importer Helpline	+44 (0)1698 844476		
Postal Address	Caledonian House, Strathclyde Business Park,		
	Bellshill, ML4 3NJ, United Kingdom		
Web Portal	www.andersencaledonia.com		
Deadline for returning the Distributor/Importer	09 August 2024		
reply form*			

Mandatory fields are marked with *

It is important that your organisation takes the actions detailed in the FSN and confirms that you have received the FSN.

Your organisation's reply is the evidence we need to monitor the progress of the corrective actions.