

Department of Veterans Affairs
Tuscaloosa VA Medical Center

Human Research Protection Program SOP #18

October 18, 2007

COMPLAINTS, ALLEGATIONS, OR FINDINGS OF NON-COMPLIANCE

1. POLICY

The Tuscaloosa VA Medical Center (TVAMC) Human Research Protection Program (HRPP) is committed to protecting the safety and welfare of veterans participating in VA research and ensuring the integrity of the HRPP by requiring investigators to comply with HRPP policies and procedures. It is the policy of the TVAMC to address complaints, allegations or findings of noncompliance by investigators or staff. This standard operating procedure (SOP) delineates the procedures to address complaints, allegations or findings of non-compliance. The over-arching goal of R&D HRPP is to ensure compliance with HRPP SOPs and applicable federal, state, and local laws.

2. RESPONSIBILITIES

The TVAMC Director has ultimate responsibility for ensuring that the TVAMC HRPP has a system to address complaints and allegations or findings of noncompliance with federal, state, and local regulations regarding the safe and ethical conduct of research.

Coordinator of Research and Development (C/R&D) is responsible for oversight of the procedures of handling complaints and allegations or findings of non-compliance. The C/R&D is responsible for investigating complaints or allegations of non-compliance of the R&D AO/RCO or HRPP office staff.

R&D Administrative Officer (R&D AO) serves as the TVMAC HRPP **Research Compliance Officer (RCO)** and is responsible for receiving the complaints or reports of and for coordinating the investigation of complaints and allegations or findings of non-compliance by investigators or their research team.

TVAMC Institutional Review Board (IRB) Chair or Designee is responsible for conducting the investigation of the allegations of non-compliance, described in this HRPP SOP regarding complaints, allegations or findings of non-compliance.

TVAMC IRB is responsible for determining the appropriate actions for findings of serious or continuing non-compliance.

Investigators and Anyone Involved in Research must comply with the state and federal statutes, VA and TVAMC HRPP SOPs.

3. **DEFINITIONS**

- a. **Non-compliance:** A failure to follow the relevant Federal, State, or local laws or regulations or the requirements and determination of the IRB, R&D or TVAMC HRPP, including non-compliance with VA requirements. Non-compliance may range from minor to serious, may be unintentional or willful, and may occur once or more times.
- b. **Non-Serious non-compliance:** Non-compliance that does not increase risk to participants or compromise the rights and welfare of participants. Some examples of non-compliance that may be considered non-serious are: failure to notify the IRB before an investigator is added to, or removed from, an ongoing study, and posting an IRB approved advertisement without an IRB-approval stamp.
- c. **Serious non-compliance:** Non-compliance that increases the risk to participants or compromises the rights and welfare of participants. Some examples of serious non-compliance are failure to obtain IRB approval prior to the initiation of research, entering patients into a study without informed consent, or research misconduct defined below.
- d. **Continuing Non-Compliance:** A pattern of repeated actions or omissions that indicates a lack of ability or willingness to comply with relevant Federal, State or local laws or regulations, VHA Handbook 1200.5, HRPP policies and procedures, other applicable TVAMC HRPP policies, or determinations of the IRB or R&D.
- e. **Intentional or Willful Non-Compliance:** This includes fraud or deception by an investigator or member of the research team or by IRB members, IRB staff or the TVAMC HRPP Research Compliance Officer. The intent is usually to mislead study subjects, other investigators, study sponsors, or others regarding study procedures or results. All intentional or willful non-compliance is considered serious non-compliance. This type of non-compliance may also be determined to be research misconduct.
- f. **Research Misconduct:** Fabrication, falsification or plagiarism in proposing, performing or reviewing research, or in reporting research results.
- g. **Allegation of Non-Compliance:** A report or complaint of non-compliance that represents an unproven assertion. It is an assertion made by a second party that must be supported by evidence before it is considered to be confirmed. Allegations of non-compliance may come from a variety of sources, including, but not limited to: investigators, collaborating researchers, research staff, research subjects or their families, IRB staff or IRB members, and TVAMC employees.
- h. **Finding of Non-Compliance:** A report or complaint of non-compliance that is true or an allegation of non-compliance that is determined to be true.

4. PROCEDURES

a. Reporting Suspected or Confirmed Allegations of Non-compliance

Reports of suspected or confirmed allegations of non-compliance should be directed to the IRB Chair, the C/R&D or the R&D AO/RCO. Any person (staff, patient, research subject, family member, research sponsor monitor, community member, investigator, and research assistant) can initiate the complaint and may report noncompliance with HRPP or IRB policies. The person making the complaint or allegation is interviewed by the R&D AO/RCO and requested to file the complaint or allegation in written form. Particular attention is paid to patient safety and risk to research subjects. Depending on the nature or seriousness of the complaint or allegation, the IRB Chair may at any point in time suspend the named research protocol or the investigator's privilege to conduct research. The IRB or person ordering the suspension or termination will consider actions needed to protect the rights and welfare of currently enrolled participants, including informing current participants of the termination or suspension and having any adverse events or outcomes caused by the termination or suspension reported to the IRB. The Research Compliance Officer (R&D AO/RCO) has primary responsibility for receiving reports of non-compliance, e.g., allegations (anonymous or otherwise) or evidence, particularly of possible serious or continuing non-compliance. The R&D AO/RCO will keep the IRB Chair and the C/R&D informed of the investigations of reports of non-compliance.

b. Investigating Reports of Suspected or Confirmed Non-compliance: For reports of non-compliance involving the investigator or his/her research staff, the R&D AO/RCO will perform an initial evaluation to determine whether the report is acceptable or if further information must be obtained to determine whether the allegation is true. The report of a finding or allegation of non-compliance must contain the following information:

- (1.) The nature of the event;
- (2.) Individuals and parties involved;
- (3.) When and where the event occurred; and
- (4.) A corrective action plan, when applicable.

The R&D AO/RCO will submit a written report to the IRB Chair, or designee, for review within 14 days of the submitted report of complaint or allegation of non-compliance.

The IRB Chair, or designee, will consider the following options in the following order and choose which method is effective in gathering any additional information required to address the report:

- (1.) Conduct the initial review alone;
- (2.) Conduct the initial review in coordination with the R&D AO/RCO;
- (3.) Delegate some of the review to the IRB staff;
- (4.) Delegate all of the review to the IRB staff;
- (5.) Empanel a reviewing subcommittee of the IRB; or

(6.) Request that legal counsel provide advice and conduct the review, request assistance from others at TVAMC (C/R&D, a non-involved physician, the TVAMC Business and Integrity Compliance Officer), or outside consultants.

The individual(s) or subcommittee conducting the investigation process may take any of the following actions as they deem necessary to verify the veracity of any allegations and the seriousness or number of occurrences of the action:

- (1.) Reviewing any written materials;
- (2.) Interviewing knowledgeable sources; and/or
- (3.) Collecting relevant documentation.

A factual and objective written record of findings and evidence will be made by the IRB Chair, or designee, and filed in the study file in the HRPP Office. During the fact-finding process, the IRB Chair or designee will communicate with the R&D AO/RCO and the principal investigator about the progress of the investigation and review. If there are any allegations of non-compliance, the IRB Chair or designee will determine if the preponderance of evidence shows that any of the allegations of non-compliance had a basis in fact and thus, represents findings of non-compliance; and whether the incident of non-compliance was serious or continuing.

After the initial review, the IRB Chair or designee will assess whether any findings of non-compliance might be serious or continuing non-compliance. If the IRB Chair or designee determines that serious or continuing non-compliance might have occurred, the IRB Chair or designee will forward the matter to the convened IRB for review. If the IRB Chair or designee determines that immediate action is required to eliminate apparent immediate hazards to subjects, the IRB Chair or designee may take one of the following actions, pending review at the next convened IRB meeting:

- (1.) Suspend enrollment of new subjects.
- (2.) Suspend all study activities.

If the IRB Chair or designee determines that non-serious non-compliance has occurred, the IRB Chair or designee, alone or in combination with the R&D AO/CRO, will examine whether the principal investigator understands the non-compliance and has an adequate corrective action plan. The decisions and the corrective action will be documented and the principal investigator will be notified, in writing, within 10 working days of the determination. The IRB will be notified at the next scheduled IRB meeting. The report, the determination and all correspondence will be placed in the study file in the HRPP Office.

In the event of findings of non-serious non-compliance with HRPP and IRB policies, the IRB may outline a specific remedial action plan for the investigator(s) that is specific to the nature of the noncompliance. This remedial plan may be developed in collaboration with the investigator(s). This remedial plan will be communicated in writing to the investigator(s) within 10 working days of the IRB Chair's or designee's determination

that a remedial plan is needed. This remedial plan may include, but is not limited to, the one or more of the following:

- Clarifications of misunderstanding or admissions/apologies by the investigator for errors sent in the form of letters or memos to the parties concerned (copies sent to IRB)
- Preparation of a written document that demonstrates the investigators' knowledge of the essentials of the protection of human subjects in research and Good Clinical Practices, to be submitted to the IRB
- Modification or restriction of investigator's research practices and procedures
- Remedial training on the protection of human subjects, ethics, good clinical practices, etc.
- Notification of complaint or noncompliance forward to the supervisor, Chief of Staff, supervisors from affiliated universities (if the investigator is a student or resident) or TVAMC Director
- Initiation of a Continuous Quality Improvement plan to monitor, track and reduce noncompliance
- Further disciplinary actions as deemed necessary
- Further audits of the investigators' research activities

NOTE: If the corrective action plan would require more than minor modifications to previously approved research, the matter will be referred to the convened IRB.

If the IRB Chair or designee determines that the allegation of non-compliance is not supported by evidence, the IRB Chair or designee will document the determination and notify the principal investigator within 10 working days of the determination. The investigator's research staff member(s) will receive a copy of the determination if the IRB Chair determines that it is appropriate. The IRB will be notified at the next scheduled IRB meeting. The report, the determination and all correspondence will be placed in the study file in the HRPP Office.

Any non-compliance that is suspected of meeting the definition of serious non-compliance or research misconduct will be immediately routed in accordance with the VA regulations.

c. Evaluating Reports of Non-Compliance Referred to the Convened IRB

The IRB Chair or designee will prepare a written report to be submitted to all of the IRB members with other relevant portions of the protocol file. The information will include names of involved parties, title of study, description of the allegation or complaint of noncompliance, information or facts gathered during the investigation, and all actions taken prior to IRB review. The IRB Chair or designee will either present the report or assign someone else to present the report at the convened IRB meeting for discussion and vote as follows:

(1.) The IRB determines that additional information is needed and requests that the IRB Chair or others obtain such information and present it at a future meeting.

(2.) The IRB determines that non-compliance did not occur or that non-compliance occurred but was neither serious nor continuing, and either takes no action or agrees with the remedial plan (see above) or recommends an additional corrective action.

(3.) The IRB determines that non-compliance occurred and that it was serious or continuing. The convened IRB will vote to take one or more of the following actions after it has determined that serious or continuing non-compliance has occurred. This list of actions includes, but is not limited to, one or more of the following:

- No action;
- Modification of the research protocol;
- Modification of the information disclosed during the consent process;
- Additional information provided to past participants;
- Notification of current participants (required when such information may relate to participants' willingness to continue to take part in the research);
- Requirement that current participants re-consent to participation
- Modification of the continuing review schedule;
- Requirement that the investigator receives additional training;
- Requirement that the investigator receives additional supervision;
- Monitoring of the research;
- Monitoring of the consent;
- Suspension of the research;
- Termination of the research;
- Referral to other organizational entities (e.g., legal counsel, performance improvement etc.); and
- Other actions deemed appropriate by the IRB.

NOTE: Terminations, suspensions and modifications to research taken in response to non-compliance will take into consideration the rights and welfare of current research participants.

If the IRB Chairperson or designee suspended some or all of the research activities, the IRB will vote to confirm or reverse that decision.

The IRB vote, determinations, and required action(s) will be recorded in the meeting minutes. All determinations and required action(s) will be communicated, in writing, to the relevant involved individual(s), including the principal investigator, within 10 working days of the convened meeting. The reports, IRB proceedings and IRB determinations will be conveyed to the R&D Committee (via copies of written reports and minutes) and will be reviewed by the R&D Committee, documented in the R&D Committee's minutes which are reviewed by the Chief of Staff and TVAMC Director.

An appeal of the IRB's determinations may be made by the investigator within 30 days of the written notice. Appeals of suspension or termination of authorization to conduct

research must be submitted to the IRB. The IRB will vote to sustain or lift suspension or termination by majority vote. Their findings will be submitted to the R&D Committee for review and approval or disapproval. The Director conducts a 3rd level review and issues approval or disapproval of the appeal decision. However, neither the R&D Committee, Director, external body, nor official can override IRB disapprovals.

d. Evaluating Reports of Non-Compliance Involving the IRB Chair, IRB Members, IRB Staff or the Research Compliance Officer

The C/R&D is primarily responsible for investigating and reviewing reports of findings or allegations of non-compliance involving the IRB Chair, IRB members, IRB staff or the R&D AO/RCO. If a fact-finding review of an allegation is necessary to assess the preponderance of the evidence, its manner and time-line will be appropriate to the situation, and could include:

- (1.) The C/R&D acting alone;
- (2.) Delegating some or all of the review to the IRB staff;
- (3.) Empanelling a review committee;
- (4.) Requesting that legal counsel provide advice and conduct the review; or
- (5.) Requesting assistance from others.

The C/R&D will determine if the allegation is true and whether it might be serious or continuing non-compliance. If the C/R&D determines that it might be serious or continuing non-compliance, the C/R&D will refer the matter to the convened IRB for review.

Possible actions include, but are not limited to, the following:

- (1.) Evaluation of the individual's ability to serve on or support the IRB.
- (2.) Any administrative disciplinary action will be taken in accordance with Administrative Policies at TVAMC.

E. Reporting Serious or Continuing Non-Compliance

If the IRB determines that serious or continuing non-compliance has occurred, it will be reported in accordance with VA regulations and "What to Report to ORO" ACTION: Memorandum dated 9/8/05. The individual that made the allegation or report of non-compliance will receive a written acknowledgement that the report or the allegation was received. The R&D AO/RCO will maintain a file of all documentation pertaining to allegations and confirmed reports of non-compliance.

Serious non-compliance, continuing non-compliance, or suspensions are required to be reported by the TVAMC HRPP to the VA ORO Regional Office in accordance with VAH Handbook 1058.2 and VA ORO memo dated September 8, 2005.

Serious non-compliance, continuing non-compliance, or suspensions will also be reported within 5 working days of the IRB's determination to the TVAMC Chief of Staff;

TVAMC Director; TVAMC Privacy Officer, when the report involves unauthorized use, loss, or disclosure of individually identifiable patient information; and/or the Information Security Officer when the report involves violations of information security requirement, and within 30 days to OHRP; other federal agencies when the research is overseen by those agencies; FDA, when the research is FDA-regulated; VA Office of Research and Development, for VA-funded research.

F. Reporting that is required if a Study is Suspended or Terminated.

If a study is suspended or terminated, the report or notice of termination/suspension is also reported within a timely manner to the following:

- IRB
- The R&D Committee, which gets submitted through the minutes to the TVAMC Director through the Chief of Staff.
- OHRP, if the study is subject to DHHS regulations or subject to a DHHS federal-wide assurance
- The FDA, if the study is subject to FDA regulations
- The VA Regional ORO, if it meets the definition required
- The VA Office of Research and Development, if the research is VA-funded
- Any “Common Rule” Federal Agency that is supporting the research
- The Sponsor, if the study is sponsored
- The Privacy Officer, if the report involves unauthorized use, loss, or disclosure of individually identifiable patient information
- The information Security Officer, if the report involves violations of information security requirements
- Others as deemed appropriate by the TVAMC Director
- Current study participants, when the study is terminated or suspended or when such information might relate to participants’ willingness to continue to take part in the research

5. **REFERENCES**

VHA Handbook 1058.2, 21 CFR 56.108(b)(2), 21 CFR 56.108(b)(3) and 56.113

6. **ATTACHMENTS**

None.

7. **RESCISSIONS**

HRPP SOP #18 May 7, 2007.

8. **REVIEW DATE**

January 1, 2012

Signature on File in R&D Office
Lori L. Davis, MD
Coordinator of Research and Development