RESEARCH STANDING OPERATING PROCEDURES (SOP)
Reporting of Unanticipated Problems Involving Risk to Subjects and Others (UPIRSO),
Unanticipated Adverse Device Effects (UADE), and Adverse Events (AE)

1. PURPOSE: To outline the procedures for reporting of Unanticipated Problems Involving Risk to Subjects and Others (UPIRSO), Unanticipated Adverse Device Effects (UADE), and adverse events (AE) related to human subjects research studies at the STVHCS.

2. POLICY:
   a. The monitoring and reporting of UPIRSOs, UADEs, and AEs is a critical component of the Human Research Protection Program (HRPP) at the STVHCS.
   b. Congruent with Federal Policy (Common Rule) for the protection of human subjects in research, VA regulations require written procedures for the reporting of UPIRSOs to the IRB of record. Federal policy, and VA and FDA regulations do not contain explicit requirements for the prompt reporting of adverse events (AE) that do not meet the definition of UPIRSO to the IRB of record; however, investigators must promptly report Unanticipated Adverse Device Effect (UADE) to the IRB of record.
   c. Definitions:
      (1) Adverse event (AE): is any untoward physical or psychological occurrence in a human subject participating in research.
      (2) Related AE, Death, or Problem: is an AE, death, or problem that may reasonably be regarded as caused by, or probably caused by, the research.
      (3) Serious Accident/Injury: include those that require medical attention or treatment, other than basic first aid provided at the site where the accident/injury occurred; those that require extended medical surveillance of the affected individual(s) that may include sequential serology or other medical testing; and those that lead to a serious long-term health complication or death. Note: Must be unanticipated and related to research.
      (4) Serious Adverse Event (SAE): is an untoward occurrence in human research that results in death, a life-threatening experience, inpatient hospitalization, prolongation of hospitalization, persistent or significant disability or incapacity, congenital anomaly, or birth defect, or that requires medical, surgical, behavioral, social, or other intervention to prevent such an outcome.
      (5) Serious Noncompliance: is any failure to adhere to requirements for conducting human research that may reasonably be regarded as:
         (a) Presenting a genuine risk of substantive harm to the safety, rights, or welfare of human research subjects, research personnel, or others, including their rights to privacy and confidentiality of identifiable private information; or
(b) Substantively compromising a facility's HRPP.

(6) Serious Problem: is a problem in human research or research information security that may reasonably be regarded as:

(a) Presenting a genuine risk of substantive harm, to the safety, rights, or welfare of human research subjects, research personnel, or others, including their rights to privacy and confidentiality of identifiable private information; or

(b) Substantively compromising a facility's HRPP or research information security program.

(7) Unanticipated problem: involving risk to subjects or others includes any incident, experience or outcome that meets all of the following criteria:

(a) unexpected (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent document; and (b) the characteristics of the subject population being studied (note: the unfounded classification of a serious adverse event as "anticipated" constitutes serious non-compliance);

(b) definitely related or probably related to participation in the research; and

(c) suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

(8) Unanticipated Adverse Device Effect (UADE): Is defined by the FDA (21 CFR 812.3(s))

(a) any:
   1. serious adverse effect on health or safety; or
   2. any life-threatening problem; or
   3. death

(b) caused by, or associated with, a device, if that effect, problem, or death was: not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or

(c) any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects.

(9) Unexpected death: is a death of a research subject in which a high risk of death is not projected, as indicated by the written protocol, informed consent form, or sponsor brochure. This definition does not include deaths associated with a terminal condition unless the research intervention clearly hastened the subject's death. A subject's death that is determined to be clearly not associated with the research is not an "unexpected death" for purposes of this SOP.

3. ACTION:

a. 
   Responsibilities of the Principal Investigator/Study Team:
(1) The Principal Investigator is responsible to review all incidents, experiences, and outcomes that may represent any of the definitions above (2c) and promptly, or within 5 business days, report all to the IRB of record.

(2) The timeline for reporting serious AEs, UPIRSOs, and UADEs by the principal investigator to the IRB of record is 5 business days based on internal information (e.g. experienced by subjects enrolled by the investigator(s)) or 5 business days upon receipt of documentation from study sponsor or FDA that a serious AEs, UPIRSO, or UADE has occurred.

(3) The PI is responsible to comply with the determinations and requirements of the IRB of record related to the reports made.

(4) If research non-compliance also involves an unanticipated problem involving risk to subjects or others (UPIRSO) or Unanticipated Adverse Device Effect (UADE) the investigators and research staff are responsible for taking appropriate action to protect the safety and welfare of the subject(s).

b. **Procedures for handling AE, SAEs, UPIRSO, UADE (without death):**

(1) If the ACOS for R&D becomes aware of an incident that is possible serious adverse event or serious problem, either directly through the PI or through any other component of the STVHCS HRPP, that has not been previously reported to the IRB of record, the Principal Investigator will be informed of the requirement to promptly notify the IRB of record. The ACOS for R&D will also promptly report the possible non-compliance to the IRB of record.

(2) A report of any possible serious adverse event or serious problem that is both unanticipated and related to the research will be received and reviewed by the IRB of record to determine whether it is substantiated, per the definitions found in above (2.c). Within 5 business days after written notification, the IRB Chair or a qualified IRB member-reviewer must determine and document whether any actions are warranted to eliminate apparent immediate hazards to subjects.

(3) The IRB must review the incident and the determination of the IRB Chair or qualified IRB member-reviewer at its next convened meeting and must determine whether:

(a) The incident was serious and unanticipated and related to the research; or

(b) There is insufficient information to determine whether the incident was serious and unanticipated and related to the research; or

(c) The incident was not serious and not unanticipated and the incident was not related to the research.

(4) Regardless of the determination, the convened IRB of record must also determine and document whether any protocol or informed consent modifications are warranted. If modifications are warranted, the convened IRB must determine and document whether or not the investigators must notify or solicit renewed/revised consent from previously enrolled subjects; and if so, when such notification or consent must take place and how it must be documented.
(5) Within 5 days of receiving the convened meeting, the IRB of record must notify the Facility Director and the ACOS R&D in writing. This must include (if applicable):

(a) Actions were taken to eliminate apparent immediate hazards to subjects; or

(b) The IRB determined the incident was serious and unanticipated and related to the research, or there was insufficient information to make the determination; or

(c) Protocol or informed consent modification were warranted

(6) Within 5 days of receiving the determination from the IRB of record, the ACOS R&D or HRPP staff must report the findings to ORO. This report (and all subsequent reports) must be routed through the Chief of Staff and signed by the Director. Requirements for this report are specified below:

(a) The nature of the event (reference 2.c)

(b) Name of the institution conducting the research

(c) Title of the research project or grant proposal in which the problem occurred.

(d) Name of the principal investigator on the protocol.

(e) Identification numbers of the research project as assigned by the IRB of record and the STVHCS R&D Office and the identification number of any applicable federal award(s), grant, contract, or cooperative agreement.

(f) A detailed description of the problem including the findings of the organization and the reasons for the R&D Committee and/or IRB’s decision.

(g) Actions that the IRB of record has taken or plans to take to address the problem (e.g., requirement to revise the protocol, suspend subject enrollment, terminate the research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.).

(h) Additional actions that the STVHCS R&D Committee has taken or plans to take to address the problem (e.g., requirement to revise the protocol, suspend subject enrollment, terminate the research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.).

(i) Plans, including a timetable for completion of the investigation and/or corrective action if appropriate, for the IRB of record to send a follow-up or final report.

(j) Plans, including a timetable for completion of the investigation and/or corrective action if appropriate, for the STVHCS R&D Committee to send an additional follow-up or final report.

(7) Confirmed UPIRSOs or UADEs involving a VA-funded research protocol will also be reported to the VA Office of Research and Development (in addition to the report to ORO) within 10 days of the IRB’s determination that a Report of Possible UPIRSO or UADE meets criteria as an UPIRSO or UADE.
(a) Reporting of determinations of serious adverse event or serious problem to non-VA regulatory agencies such as the Office for Human Research Protections (OHRP), the Food and Drug Administration (FDA) if the protocol involves FDA regulated research, and/or any other federal agencies overseeing research that require separate reports from OHRP

1. If the UTHealthSA IRB is identified as the IRB of record, they will accomplish this requirement according to the procedures and timelines outlined in the "Reporting Policy and Procedure" (http://research.uthscsa.edu/irb/Policy/Reporting_Policy.pdf). In addition to the UTHealthSA IRB reporting to the above agencies, the STVHCS Medical Center Director will also forward the report, prepared by the UTHealthSA IRB, with a cover letter to the non-VA federal agencies according to the same timelines outlined in the "Reporting Policy and Procedure".

2. If the IRB of record does not notify the applicable agencies, it will fall to the ACOS R&D or HRPP staff to ensure the agencies are notified in a timely manner.

(8) The IRB of record must track the determinations required for use in the VA Facility Director Certification.

(9) All report and notifications must be presented at the next available R&D Committee scheduled or unscheduled emergent meeting.

(a) If the R&D committee determines further remedial actions are required, ACOS R&D or HRPP staff must notify the Director and ORO within 5 business days.

(b) The R&D Administrator will then update the significant research findings excel spreadsheet and provide the reports along with their respective determination letters to the ACOS for review, prior to the R&D meeting.

(10) Reports to external regulatory agencies by the STVHCS or the IRB of record will be communicated to the reciprocal office.

c. Procedures for handling local research deaths:

(1) The IRB must alert ORO by e-mail or telephone within 2 business days after receiving such notification and provide relevant information as requested. The VA facility Director and the ACOS/R&D must receive concurrent notification.

(2) VA personnel, including WOC and IPA appointees, must ensure written notification of the IRB within 5 business days of becoming aware of the death.

(3) Within 5 business days after receiving written notification of the death, the IRB Chair or a qualified IRB member-reviewer must determine and document whether any actions are warranted to eliminate apparent immediate hazards to subjects.

(4) The IRB must review the death and the determination of the IRB Chair or qualified IRB member-reviewer at its next convened meeting and must determine and document that:
(a) The death was both unanticipated and related to the research; or

(b) There is insufficient information to determine whether the death was both unanticipated and related to the research; or

(c) The death was not unanticipated and/or the death was not related to the research.

(5) Regardless of the determination under paragraph 3.c(4), the convened IRB must also determine and document whether any protocol or informed consent modifications are warranted. If modifications are warranted, the convened IRB must determine and document whether or not investigators must notify or solicit renewed/revised consent from previously enrolled subjects; and if so, when such notification or consent must take place and how it must be documented.

(6) The IRB must notify the VA facility Director and the ACOS/R&D of its determinations under paragraphs 3.c(4) and 3.c(5) within 5 business days of the determinations.

(7) The VA facility Director must report the determinations to ORO within 5 business days after receiving the IRB’s notification. (see b.6 for notification requirements)

(8) Reports to regulatory agencies by the STVHCS or the UTHSCSA IRB will be copied to the reciprocal office.

3. REFERENCES: STVHCS UTHealth IRB MOU; VHA Handbook 1200.05; VHA Handbook 1058.01

4. RESPONSIBILITY: Associate Chief of Staff for Research (151)

5. ATTACHMENTS: 1058_01_Decision_Chart_Rsch_Death_SAE_Problem_09_14_2015; Reportable Events (i.e. NC UPIRSO) Processing Procedures; Example Initial Notification ORO Non- Compliance; Example Response to ORO Non-Compliance

6. RECESSIONS: Research Service Policy Memorandum 18-48; dated July 9, 2018

7. RECERTIFICATION: October 2023
OFFICE OF RESEARCH OVERSIGHT

Reporting Local Deaths, Local Serious Adverse Events (SAEs), and Serious Problems in VA Research

September 14, 2015

A VA employee becomes aware of a LOCAL DEATH, a LOCAL SAE, or a SERIOUS PROBLEM in VA research that appears to be both UNANTICIPATED (i.e., new or greater than previously known in terms of nature, severity, or frequency, given the procedures described in protocol documents and the characteristics of the study population) and RELATED to the research (i.e., reasonably regarded as caused by, or probably caused by, the research).

- The unanticipated related incident involves a LOCAL DEATH.
  - The individual must ensure IMMEDIATE ORAL NOTIFICATION OF THE IRB and WRITTEN NOTIFICATION WITHIN 5 BUSINESS DAYS.
  - The IRB MUST ALERT ORO (by e-mail or telephone) within 2 BUSINESS DAYS AFTER RECEIVING ORAL NOTIFICATION.
  - The Facility Director and ACOS/R&D must receive notification concurrent with ORO.

- The unanticipated related incident involves a LOCAL SAE.
  - The individual must ensure WRITTEN NOTIFICATION OF THE IRB WITHIN 5 BUSINESS DAYS.

- The unanticipated related incident involves a SERIOUS PROBLEM.
  - Reporting to ORO as a DEATH, SAE, OR PROBLEM is NOT REQUIRED.
    - Report to the IRB per local SOPs.
    - Reporting to other entities may be required.

- Within 5 business days after receiving written notification, the IRB Chair or a qualified IRB member-reviewer must DETERMINE and DOCUMENT whether any actions are warranted to eliminate apparent IMMEDIATE HAZARDS to subjects.

- The IRB MUST REVIEW the incident and the determination of the IRB Chair or qualified IRB member-reviewer at its next CONVENED MEETING and must DETERMINE and DOCUMENT that:
  (a) The incident was SERIOUS AND UNANTICIPATED AND RELATED to the research; or
  (b) There is INSUFFICIENT INFORMATION to determine whether the incident was serious and unanticipated and related; or
  (c) The incident was NOT SERIOUS and/or the incident was NOT UNANTICIPATED and/or the incident was NOT RELATED.

- The convened IRB MUST also DETERMINE and DOCUMENT:
  (a) Whether any PROTOCOL OR INFORMED CONSENT MODIFICATIONS are warranted, and if so,
  (b) Whether investigators must NOTIFY or SOLICIT RENEWED/REVISED CONSENT from previously enrolled subjects, and if so, WHEN and HOW consent is to be DOCUMENTED.

- For DEATHs, the IRB must notify the FACILITY DIRECTOR and ACOS/R&D OF ALL DETERMINATIONS WITHIN 5 BUSINESS DAYS.
- For SAEs or PROBLEMS, the IRB must notify the FACILITY DIRECTOR and ACOS/R&D WITHIN 5 BUSINESS DAYS after meeting if:
  (a) ACTIONS were taken to ELIMINATE HAZARDS to subjects, or
  (b) The incident was SERIOUS AND UNANTICIPATED AND RELATED TO THE RESEARCH or there was INSUFFICIENT INFORMATION to make the determination, or
  (c) PROTOCOL OR INFORMED CONSENT MODIFICATIONS were warranted.
- The FACILITY DIRECTOR MUST REPORT the incident to ORO WITHIN 5 BUSINESS DAYS after notification.

- Additional reporting may be required under local SOPs or by external agencies (such as FDA or OHRP) or sponsors. If in doubt, check with the relevant entities.
OFFICE OF RESEARCH OVERSIGHT

Reporting Local Deaths, Local Serious Adverse Events (SAEs), and Serious Problems in VA Research

September 14, 2015

NOTES

1 For complete details, see 38 CFR 16.103(b)(5)(i); 21 CFR 56.108(b)(1), 312.32(a), & 812.3(s); and VHA Handbook 1058.01 §4g, §4j, §4r, §4t, §4y, & §§6a-6.d. This chart does not cover other reportable situations (e.g., program changes, suspensions/terminations). Also see the following ORO guidance;

• Examples and a Brief Guide for Reporting Apparently Serious Research Information Security Problems That May Be Reportable to ORO under VHA Handbook 1058.01 (Revised September 14, 2015).

• Examples and a Brief Guide for Reporting Apparently Serious or Apparently Continuing Noncompliance in Human Research That May Be Reportable to ORO under VHA Handbook 1058.01 (Revised September 14, 2015).

2 Local means occurring at the reporting facility’s own research site(s). (VHA Handbook 1058.01§4g)

3 An SAE is an untoward occurrence in human research that results in death, a life-threatening experience, inpatient hospitalization, prolongation of hospitalization, persistent or significant disability or incapacity, congenital anomaly, or birth defect, or that requires medical, surgical, behavioral, social, or other intervention to prevent such an outcome. (VHA Handbook 1058.01§4r)

4 A serious problem is a problem in human research or research information security that may reasonably be regarded as: (1) Presenting a genuine risk of substantive harm, to the safety, rights, or welfare of human research subjects, research personnel, or others, including their rights to privacy and confidentiality of identifiable private information; or (2) Substantively compromising a facility’s HRPP or research information security program. (VHA Handbook 1058.01§4t)

Examples of apparently serious problems in human research that may be reportable to ORO include the following:

(1) Any situation that requires action to prevent an immediate hazard to subjects or others.
(2) Any serious research-related injury to human research subjects, research personnel, or others.
(3) Any problem described in a VA Pharmacy Benefits Management alert relevant to local human subjects.
(4) Any problem described in a Data Monitoring Committee report.
(5) Any combination of problems that collectively present a genuine risk of substantive harm to the safety, rights, or welfare of human research subjects, research personnel, or others, or substantively compromise a facility’s HRPP.

5 Unanticipated/unexpected refer to an event/problem in human research that is new or greater than previously known in terms of nature, severity, or frequency, given the procedures described in protocol documents and the characteristics of the study population. (VHA Handbook §4y)

6 A related adverse event (AE, VHA Handbook §4a), death, or problem is one that may reasonably be regarded as caused by, or probably caused by, the research. ([VHA Handbook §4])
### Processing Procedures for Reportable Events

<table>
<thead>
<tr>
<th>Initial Expedited/Designated Member Review</th>
<th>Confirmation of possible noncompliance, possible UPIRSO, or possible UADE referred to Full Board for review (include in note section if Compliance Office/Privacy Officer notification is required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determination of Not Noncompliance; or</td>
<td>• Notify Veterinarian (if applicable) Email Meeting Organizer who will send out pre-notification email</td>
</tr>
<tr>
<td>Determination of Not Serious and Not Continuing Noncompliance; or</td>
<td>Complete Expedited Review/DMR Form</td>
</tr>
<tr>
<td>Determination of Not Meeting Criteria of UPIRSO or UADE</td>
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<tr>
<td>Complete Expedited Review/DMR Form for Action by Investigator Relations Team</td>
<td></td>
</tr>
</tbody>
</table>

#### Pre-notification / Referral to Full Board – by Meeting Organizer
- Regulatory Specialist
- Engaged Institutions (as applicable)
- AVPRA - Joseph Schmelz
- Compliance Office / Privacy Officer (if indicated on the expedited review form)
- Committee Chair/Vice Chair
- Director and Associate Director (IRB/IACP)
- Attending Vet (IACP only)
- CC PI if notification is not originating from PI
- If event involves death and VA is a study site, must be reported within 2 days to ACOS – Jacqueline Pugh (Jacqueline.Pugh@va.gov); ORO (ATGOROSRO@va.gov), and Julianne Flynn (julianne.flynn@va.gov)

#### Full Board Determination/Notification
- Regulatory Specialist will finalize minutes and include internal / external reporting requirements
- Meeting organizer will send out letters as follows (letters should be consistent with minutes and include brief summary of event, determination and reporting):
  - IRB: Send letter to PI with a copy to internal / external entities (Based on Reporting Requirements below)
  - IACP: Send letter to PI and internal entities; Send separate letter (with redacted information) to external entities (verify with Associate Director)

#### Time Restraints for Committee Determinations (i.e. IRB, IACUC)
- The IRB or IACUC determination must occur within 45 days of the IRB or IACUC receiving the report of possible noncompliance.
- The IRB or IACUC must close the issue within 120 days of the IRB or IACUC decision (when remedial actions required).
- The IRB or IACUC must close the issue within 180 days after the IRB’s or IACUC’s determination, involving programmatic non-compliance unless remediation requires substantial renovation, fiscal expenditure, hiring, or legal negotiations)

Updated 7-15-16 – Addition of Not UPIRSO/Not Noncompliance
### Reporting Requirements for Internal / External Entities - (In addition to PI / Coordinator)

<table>
<thead>
<tr>
<th>For determination of non-compliance</th>
<th>For determination of serious or continuing non-compliance, suspensions or terminations <strong>(ALSO include)</strong>: Within 15 days</th>
<th>For determination of UPIRSO or UADE <strong>ALSO include</strong>: Within 15 days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UTHSCSA</strong></td>
<td><strong>Inside UTHSCSA</strong></td>
<td><strong>Inside UTHSCSA</strong></td>
</tr>
<tr>
<td>- Engaged Institutions <a href="mailto:research@uthscsa.com">research@uthscsa.com</a>; <a href="mailto:morschleic@baptisthealthsystem.com">morschleic@baptisthealthsystem.com</a>; <a href="mailto:Research_CSRHS@christushealth.org">Research_CSRHS@christushealth.org</a>; CHOFS <a href="mailto:Ra@research.christushealth.org">Ra@research.christushealth.org</a>; <a href="mailto:STXResearchService@va.gov">STXResearchService@va.gov</a>; <a href="mailto:debbie.fielder@uthct.edu">debbie.fielder@uthct.edu</a> (Tyler); <a href="mailto:irb@uthsc.edu">irb@uthsc.edu</a>; Van <a href="mailto:Johnson@va.gov">Johnson@va.gov</a>; <a href="mailto:Amrita.Kamat@va.gov">Amrita.Kamat@va.gov</a> (VA for IACP); <a href="mailto:iacuc@texasmed.org">iacuc@texasmed.org</a> (TBRI)</td>
<td>- RPP Director [only copy on letter, do not place in minutes]</td>
<td>- RPP Director [only copy on letter, do not place in minutes] (if reportable to FDA and/or OHRP, OLAW, AAALAC, or USDA)</td>
</tr>
<tr>
<td>- AVPRA <a href="mailto:Schmelz@uthscsa.edu">Schmelz@uthscsa.edu</a></td>
<td>- Department Chair</td>
<td>- Department Chair (internal UPIRSO only)</td>
</tr>
<tr>
<td>- If containing a privacy issue and noted by RS Compliance Office <a href="mailto:MadisonBrown@uthscsa.edu">MadisonBrown@uthscsa.edu</a>; Kathy James – <a href="mailto:jameskd@uthscsa.edu">jameskd@uthscsa.edu</a>; Ellie Mendiola <a href="mailto:MendiolaEM@uthscsa.edu">MendiolaEM@uthscsa.edu</a></td>
<td>- For IACP only, IC must initial final determination letter</td>
<td>- For IACP only, IO must initial final determination letter first before sending out to PI and others [convert to signable form as is done for minutes]</td>
</tr>
<tr>
<td>- Person raising allegation: Send a separate informal notification (if the feedback is deemed appropriate)</td>
<td>- OSP, if funded <a href="mailto:reapprovers@uthscsa.edu">reapprovers@uthscsa.edu</a></td>
<td>- OSP, if funded <a href="mailto:reapprovers@uthscsa.edu">reapprovers@uthscsa.edu</a> (internal events only)</td>
</tr>
<tr>
<td>- Research Monitor, if appointed in accordance with his/her duties</td>
<td>- Compliance Officer/Privacy Officer Gail Madison-Brown - <a href="mailto:MadisonBrown@uthscsa.edu">MadisonBrown@uthscsa.edu</a> and Kathy James – <a href="mailto:jameskd@uthscsa.edu">jameskd@uthscsa.edu</a> [if breach of confidentiality]</td>
<td>- Compliance Officer/Privacy Officer <a href="mailto:MadisonBrown@uthscsa.edu">MadisonBrown@uthscsa.edu</a>; Kathy James – <a href="mailto:jameskd@uthscsa.edu">jameskd@uthscsa.edu</a>; <a href="mailto:MendiolaEM@uthscsa.edu">MendiolaEM@uthscsa.edu</a> [if breach of confidentiality]</td>
</tr>
<tr>
<td>- IRB: OHRP, if federally funded See contacts below</td>
<td>- Reserch Monitor, if appointed in accordance with his/her duties</td>
<td>- AVPRA, <a href="mailto:Schmelz@uthscsa.edu">Schmelz@uthscsa.edu</a></td>
</tr>
<tr>
<td>- FDA, if regulated: See contacts below</td>
<td>- - Based on Internal Adverse Events (AE); OR</td>
<td>- - Based on Non-AE, where: 1) a local incident, experience or outcome; or 2) where external incident, experience or outcome was identified by local PI</td>
</tr>
<tr>
<td>- DoD, if funded by DoD – check with Chris Green from OSP</td>
<td>• OHRP, if federally funded <a href="mailto:olawdoc@mail.nih.gov">olawdoc@mail.nih.gov</a>; <a href="mailto:Brent.Morse@nih.hhs.gov">Brent.Morse@nih.hhs.gov</a></td>
<td>• DO, if funded by Department of Defense (will need to check with Chris Green for appropriate contact) (internal events only)</td>
</tr>
<tr>
<td>- FOR VA research, 5 business days (to Director)</td>
<td>- OLAW, if federally funded <a href="mailto:olawdoc@mail.nih.gov">olawdoc@mail.nih.gov</a>; <a href="mailto:Brent.Morse@nih.hhs.gov">Brent.Morse@nih.hhs.gov</a></td>
<td>- Engaged Institutions</td>
</tr>
<tr>
<td>- IACP: redact letter before sending outside the institution (remove PI name from letter and subject line of email AND rename document to delete PI naming convention)</td>
<td>- USDA, if regulated <a href="mailto:acwesq@aphis.usda.gov">acwesq@aphis.usda.gov</a>; <a href="mailto:Robert.M.Gibbens@aphis.usda.gov">Robert.M.Gibbens@aphis.usda.gov</a></td>
<td>• If UHS is study site only, UHS</td>
</tr>
<tr>
<td>- IRB: OHRP See contacts below</td>
<td>- AAALAC <a href="mailto:accred@aaalac.org">accred@aaalac.org</a>; <a href="mailto:kbayne@aaalac.org">kbayne@aaalac.org</a></td>
<td>• For VA research, 5 business days (to Director)</td>
</tr>
<tr>
<td>• If federally funded, AND</td>
<td>• DoD, if funded by DoD <a href="mailto:usammy.district.medicom-usammc-other.acuro@mail.mil">usammy.district.medicom-usammc-other.acuro@mail.mil</a></td>
<td>• [If UPIRSO involves Death report in 2 days to VA to Dr. J. Pugh]</td>
</tr>
<tr>
<td>• Based on Internal Adverse Events (AE); OR</td>
<td></td>
<td>• Research Monitor, if appointed in accordance with his/her duties</td>
</tr>
<tr>
<td>• Based on Non-AE, where: 1) a local incident, experience or outcome; or 2) where external incident, experience or outcome was identified by local PI</td>
<td></td>
<td><strong>IACP</strong>: redact letter before sending outside the institution (remove PI name from letter and subject line of email AND rename document to delete PI naming convention)</td>
</tr>
</tbody>
</table>

**Updated 7-15-16 – Addition of Not UPIRSO/Not Noncompliance**
For determination of Not UPIRSO or Not Noncompliance

- PI
- Engaged Institutions

- AVPRA- Joseph Schmelz
- RRP Director and Associate Director (IRB) [only copy on letter, do not place in minutes]

IACP: Send letter to PI and internal entities; Send separate letter (with redacted information) to external entities (verify with Associate Director)

Updated 7-15-16 – Addition of Not UPIRSO/Not Noncompliance
Reports to be sent to:

**OHHRP**
Office for Human Research Protections
1101 Wootton Parkway, Suite 200
Rockville, MD 20852
Toll-Free Telephone within the U.S. (866) 447-4777
Telephone: (240) 453-6900
Fax: (240) 453-6909
e-mail: IRPT.OS@hhs.gov

**For FDA Drug Products** (May have to mail these items due to issues with this group accessing our secure emails)
Ms. Dana Walters
Dana.Walters@fda.hhs.gov
Division of Scientific Investigations (HFD-45)
Office of Compliance
Center for Drug Evaluation and Research
White Oak Campus
10903 New Hampshire Ave.
BLDG 51, Rm. 5341
Silver Spring, MD 20993
Phone: (301) 796-3150
Fax: (301) 847-8748

**For Biologic Products** (May have to mail these items due to issues with this group accessing our secure emails)
Ms. Patricia Holobaugh
Patricia.Holobaugh@fda.hhs.gov
Bioresearch Monitoring Branch (HFM-664)
Division of Inspections and Surveillance
Office of Compliance and Biologics Quality
Center for Biologics Evaluation and Research/FDA
1401 Rockville Pike, Room 400S
Rockville, MD 20852-1448
Phone: 301-827-6347
Fax: 301-827-6748

**For Medical Devices** (May have to mail these items due to issues with this group accessing our secure emails)
Ms. Sheila Brown
Sheila.Brown@fda.hhs.gov
Center for Devices and Radiological Health
Food and Drug Administration
9200 Corporate Boulevard – HFZ 403
Rockville, MD 20850
Phone: (240) 276-4034
Fax: (240) 276-4009

Updated 7-15-16 – Addition of Not UPIRSO/Not Noncompliance
Dear ORO HRP:
South Texas Veterans Health Care System is reporting a non-compliance that has been reviewed by the VA CIRB. This non-compliance was serious but not ongoing. However, VA CIRB has asked that the PI submit an amendment whose submission and approval will be tracked by STVHCS.

Thanks

Jacqueline A. Pugh, MD
ACOS for Research
STVHCS
7400 Merton Minter Blvd.
San Antonio, TX 78229
Office: 210-617-5300 ext 15969
Cell: 210-602-1350

Dear Mr. Walton,

As the Medical Center Director for the South Texas VA Health Care System, you are being notified of a serious noncompliance finding made by the VA Central IRB after the review of the SAE report P18-86, submitted by your site for the VA Central IRB approved project 17-13 “Assessing the Health Effects from Blast Injuries and Embedded Metal Fragments”. The notification letter with the details of the discussion and determination sent to the local site investigator is attached for your reference. You and other local site officials are copied in this e-mail for further reporting.

Please contact us if you have any questions.
Sincerely,

Hector

Hector I. Ramirez, CIP
VA Central IRB Manager
Research & Development (10P9P)
810 Vermont Avenue, NW
Washington, DC 24020
Office: 202-443-5656
Fax: 202-495-6155
e-mail: Hector.ramirez@va.gov
http://www.research.va.gov/programs/pride/cirb
Memorandum

From: Director (671/00), STVHCS; 7400 Merton Minter Blvd.; San Antonio, TX. 78229-4404

Subj: ORO Case #671-0044-H (SAE Report P18-86 VA Central IRB)
VA Central IRB Approved Project 17-13: "Assessing the Health Effects from Blast Injuries and Embedded Metal"

To: VHA Office of Research Oversight, 810 Vermont Avenue NW (10R), Washington DC 20420

Summary
The issue arose due to a disconnect between the Research Coordinator, who obtains Informed Consent and the hospital's MAS scheduling staff who are not focused on requirements related to Human Subjects Research. To address this issue, scheduling of Pulmonary Function Tests (PFT) for this Project have been transferred entirely to an individual within the Research Unit. The individual designated, has a thorough understanding of HIPAA compliance, regulations governing Human Subjects Research and the role of Informed Consent. Informed Consent will be obtained prior to any research related test or procedure.

Background
This Study falls under Department of Defense Award W81XWH-16-2-0058. It is a multi-site study under the oversight of the University of Maryland, Baltimore.

Procedure Leading to Issue
Study Participants are scheduled to meet with the Study Coordinator to complete the Research Informed Consent process. The Study Coordinator submits a request to the VA Medical Administrative Services (MAS) to schedule a Pulmonary Function Test (PFT).

Incident
A Study Participant failed to keep an appointment with the Study Coordinator to complete the Informed Consent. MAS scheduled the Participant for a PFT. The Study Participant rescheduled the appointment to complete the Consent process but this appointment was after the PFT was complete.

Initial Resolution
Consistent with the "LSI action plan prevent future recurrence" per the VA CIRB, the study team added language to the request to schedule a PFT, indicating the test is for research purposes and tests can only be performed if Informed Consent has been obtained. MAS staff were instructed not to contact study participants without Study Coordinators knowledge. Study Participants were also instructed not to undergo any study tests until after the Consent Process was complete. Following the implementation of these procedures, a similar incident occurred: a Pulmonary MAS clerk scheduled another Study Participant for a PFT prior to the scheduled Consent process. The incident has been reported, however, a case number is not yet available. This matter was handled internally and the clerk which failed to follow the internal directive is no longer authorized to schedule PFTs.
Current Plan for Resolution
The team considered procedures to more effectively prevent recurrence. It was determined that the schedulers for clinical PFTs are not positioned to ensure Informed Consent has been obtained prior to scheduling procedures. Responsibility for scheduling research PFTs has been transferred to a scheduling clerk in the Bartter Research Unit. This individual thoroughly understands HIPPA compliance and the requirement to obtain Informed Consent prior to performing research related procedures. A separate PFT consult request has been created in CPRS for research. The request is directed to the scheduler in the BRU; MAS schedulers for clinical PFTs will no longer have access to these requests.

The scheduling clerk in the BRU, and the Study Coordinator, who is to serve as the backup scheduler, must both obtain access privileges to VISTA and complete mandatory training. Until this is accomplished, a “Pulmonary Function Tab” on the Consult Drop Down list in CPRS was created to allow the BRU scheduler to create PFT appointments.

CIRB Stipulations
The Primary Site Investigator responded to the VA CIRB stipulation on August 31, 2018. The Local Site R&D office notified OHRP on September 28, 2018.

Any questions may be directed to Jacqueline.Pugh@va.gov / 210-617-5300x15969 or Jennifer.Moore8@va.gov / 210-617-5300x14837

Sincerely,

Robert M. Walton
Director, South Texas Veterans HCS

Attachments:
17-13 Memo_Mod 3_08.31.2018
671- San Antonio - Serious Noncompliance - ORO Case#671-0045-H - VA CIRB #17-13