RESEARCH STANDING OPERATING PROCEDURES (SOP)

Handling of Research Non-Compliance Involving Human Subjects

1. PURPOSE: To outline the procedures for handling of research non-compliance related to human subject research studies at the STVHCS.

2. POLICY:
   a. The monitoring and reporting of research non-compliance is a key component of the protection of human subjects in research and is critical to the function 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 research non-compliance to the IRB.
   c. Research non-compliance may be identified through any number of ways, including but not limited to:
      (1) A report by any individual to the IRB of record, R&D Committee, or R&D Office
      (2) Continuing review of ongoing research by the IRB of record or R&D Committee
      (3) Compliance audits conducted by the UTHealthSA or STVHCS compliance offices
      (4) A report by another committee, subcommittee of the R&D Committee, department, or official
      (5) A report from the study sponsor or sponsor’s monitoring entity
   d. Possible research non-compliance identified by any component of the STVHCS HRPP (e.g. the STVHCS compliance office, R&D office) must be reported to the UTHealthSA IRB or IRB of record within 5 business days.
   e. The STVHCS follows the procedures for evaluation and determination of research noncompliance as detailed in the VHA Handbook 1058.1 (https://www.va.gov/ORO/oropubs.asp) and the UTHealthSA Noncompliance Policy and Procedure (http://research.uthscsa.edu/irb/Policy/Noncompliance_Policy.pdf).
   f. The STVHCS will maintain procedures for the reporting of possible non-compliance to the IRB of record and reporting of any serious or continuing research non-compliance, as determined by the IRB of record, to the appropriate internal institutional officials and external oversight agencies.
   g. Definitions:
a. **Noncompliance:** is any failure to adhere to the requirements for conducting VA research covered by VHA Handbook 1058.1.

b. **Continuing Noncompliance:** is the persistent failure to adhere to the legal and policy requirements governing human research.

c. **Serious Noncompliance:** is any failure to adhere to requirements for conducting human research 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.

3. **ACTION:**

   a. **Responsibilities of the Principal Investigator/Study Team:**

      1. The Principal Investigator is responsible to report any incident of possible non-compliance of which he/she within 5 business days after becoming aware, regardless of the source, to the IRB of record.

      2. The PI is responsible to comply with the determinations and requirements of the IRB of record related to the report of possible non-compliance.

      3. If research non-compliance also involves an unanticipated problem involving risk to subjects or others (UPIRISO) 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 noncompliance:**

      1. If the ACOS for R&D becomes aware of an incident that is possible non-compliance, 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 notify the IRB of record within 5 business days. The ACOS for R&D will also ensure to report the possible non-compliance to the IRB of record within 5 business days of becoming aware, if not previously submitted by the Principal Investigator.

      2. A report of possible research non-compliance will be received and reviewed by the IRB of record to make a determination whether it is substantiated as research non-compliance, per the definitions found in above (2h).

      3. A convened IRB must review any such notifications at the earliest practicable opportunity, not to exceed 30 business days after the initial notification. The IRB Chair may take interim action as needed to eliminate apparent immediate hazards to subjects. The convened IRB must determine and document whether or not serious or noncompliance actually occurred and if remedial action is needed to ensure present and/or future compliance.
(4) The IRB of record will report determinations of serious and/or continuing non-compliance within 5 days, via encrypted email or phone, with follow-up paper copy, to the Facility Director and the ACOS for R&D, or his/her designee.

(a) Within 5 days of receiving the determination of a serious and/or continuing non-compliance 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 (4).

(b) If the serious and/or continuing non-compliance was identified by an RCO audit, the IRB of record must notify the RCO within 5 business days after its determination, regardless of the outcome.

(c) Reports of determinations of non-compliance involving a violation or compromise of information security requirements will also be reported by the STVHCS ISO to the VHA ISO within 5 business days.

1. Confirmed serious and/or continuing non-compliance involving a violation of information security requirements will also be reported by the STVHCS ISO to the VHA Information Security Officer (ISO) within 59 minutes of the STVHCS ISO receiving the notification.

(d) Reports of determinations of non-compliance involving real or suspected unauthorized use, loss, or disclosure of individually-identifiable information related to a VA research protocol will be reported by the STVHCS Privacy Officer to the VHA Privacy Officer as appropriate, within 5 business days.

1. Confirmed serious and/or continuing non-compliance involving real or suspected unauthorized use, loss, or disclosure of individually-identifiable information related to a VA research protocol will be reported by the STVHCS Privacy Officer through the Privacy Violation Tracking System to the VHA Privacy Officer within 1 hour of the STVHCS Privacy Officer receiving notification.

(e) Reporting of determinations of serious and/or continuing non-compliance 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 will be handled in the following manner:

1. If the UTHHealthSA 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 UTHHealthSA IRB reporting to the above agencies, the STVHCS Medical Center Director will also forward the report, prepared by the UTHHealthSA 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, such as VA CIRB, it will fall to the ACOS R&D or HRPP staff to ensure the agencies are notified in a timely manner. (https://www.hhs.gov/ohrp/compliance-and-reporting/guidance-on-reporting-incident/index.html)
(f) The IRB of record must track the determinations required for use in the VA Facility Director Certification.

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

1. 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.

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

(5) Notification to ORO will include any official correspondence from the IRB of record, and will include the following information when not included in any IRB of record correspondence:

(a) The nature of the event (serious and/or continuing non-compliance)

(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 decision of the R&D Committee or IRB of record decision.

(g) Actions that the IRB of record or STVHCS has taken or plans to take to address the problem.

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

(i) The name of any agencies or organization external to VA that were notified or need to be notified, of the event.

(6) The VA facility Director must ensure that ORO is notified by email or telephone as soon as possible, but no longer than 2 business days after becoming aware of:

(a) Any research-related citation or determination of regulatory non-compliance issued by a State or Federal agency.

(b) Any situation covered by VHA Handbook 1058.1 that has generated media attention or Congressional interest.
4. REFERENCES: VHA Handbook 1200.05; VHA Handbook 1058.01; 45 CFR 46; 21 CFR 50, 56; 38; OHRP Guidance on Reporting Incidents

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

7. RECISSION: Research SOP for Handling of Research Non-Compliance 18-49, dated October 31, 2018

8. RECERTIFICATION: November 2023

Jacqueline Pugh, MD
ACOS for Research and Development