To describe the policies and procedures involved in handling non-compliance and allegations of non-compliance.

POLICIES

1. IRB shall investigate all reports of alleged noncompliance as it pertains to applicable regulations and laws, IRB requirements and determinations, and institutional and IRB policies governing human subject research.

2. All CDU personnel whether they are involved in human subject research or not shall be responsible for reporting noncompliance involving human research participants.

3. Serious or continuing non-compliance shall be reported to but not limited to CDU institutional officials, funding agencies, and OHRP.

DEFINITIONS

Non-compliance: Any action or activity that does not comply with applicable federal, state, or local laws and regulations or the IRB requirements or determinations, including IRB and institutional policies governing human participant research. Non-compliant actions or activities may be unintentional or deliberate.

Serious Non-compliance: An action or omission by the investigator or the research staff support that affects the rights or welfare of the participants and places them at greater risk or
causes harm. Serious non-compliance includes deliberate compromise of the integrity or validity of the research. Examples of serious non-compliance may include, but not limited to,

1. Failure to obtain IRB approval before starting research or continuing research activities even though the IRB approval for the protocol has expired;
2. Failure to notify the IRB of changes in approved procedures, scope/intent of the study;
3. Failure to monitor data to ensure safety of participants;
4. Failure to report serious unanticipated problem involving risks to participants or others, including adverse events;
5. Failure to adequately protect participant privacy and confidentiality of data;
6. Failure to obtain informed consent;
7. Failure to protect vulnerable participants from coercion or undue influence;
8. Failure to recruit participants according to IRB approved protocol;
9. Failure to conduct research according to the IRB approved protocol;
10. Failure to maintain complete record of informed consent.

Continuing Non-compliance: Continuing non-compliance is a pattern of recurring non-compliance by the same investigator or research staff support.

The pattern of non-compliance is assessed by the number of incidents occurring during the course of a protocol, and whether the same non-compliant action was repeated or many different non-compliant events occurred.

Continuing non-compliance may involve lack of attention, knowledge, or understanding about the applicable regulations and IRB requirements or willingness to follow them.

Allegation of Non-compliance: Unproven assertion of non-compliance.

Report of Non-compliance: Non-compliance that has been proven or allegation of non-compliance that has been proven based on a preponderance of the evidence.

**PROCEDURES**

**Reporting Non-compliance Concerns**

1. Non-compliance concerns, including allegations, can come from several different sources, including but not limited to (1) investigators, (2) members of the research team, (3) study monitor, auditor, sponsor, (4) research participant, (5) individuals not directly involved with the research, and (6) IRB during the review of research studies.

2. Concerns of non-compliance about studies involving human participant may be directed to the IRB Chair, IRB Director, or designee.
3. Concerns of non-compliance may also be directed by calling (323) 563-5902 or (323) 563-4966 or sending an E-mail to irb@cdrewu.edu.

4. All concerns should be made in writing with supporting documentation and any information as to what actions were taken to protect the research participants. Any concerns should include sufficient information to assess non-compliance, including the description of non-compliance, circumstances, and names of individuals involved, if known.

5. All verbal concerns must be transcribed in writing by the receiving individual as soon as possible.

6. All concerns are treated as potential non-compliance until proven.

**Investigation of Allegation of Non-compliance**

1. All allegations of non-compliance will be reported to the IRB Director (or designee).

2. IRB Director and Office for the Protection of Human Subjects (OPHS) staff will compile all relevant information and present to the IRB Chair (or designee).

3. IRB Chair (or designee) and IRB Director (or designee) may find it necessary to contact the complainant, respondent, subjects, or the investigator to obtain information surrounding the allegation.

4. IRB Chair (or designee) and IRB Director (or designee) will determine whether the allegations are substantive. No further action will be taken, if the allegations are unproven. A report will be generated that documents the description of the allegation and all the communications and discussion, along with the final decision. This report will be sent to the complainant, respondent, and the investigator as appropriate and copies of the report will be placed in the IRB file. The IRB Chair or Director will present the report to the IRB during the next convened meeting.

5. If the IRB Chair (or designee) and IRB Director (or designee) determines that there is non-compliance, it will be handled as Reports of Non-compliance below.

**Review of Concerns and Reports of Non-compliance**

1. All concerns and reports of non-compliance will be investigated, including contacting the research subjects, if necessary. OPHS staff will forward the findings to the IRB Chair and IRB Director or their designee.
2. IRB Chair (or designee) in collaboration with IRB Director (or designee) may consult with other institutional units, including Grants and Contracts and Compliance, Institutional Biosafety Committee, Radiation Safety Committee, and other research offices as appropriate.

3. The IRB Chair (or designee) in collaboration with the IRB Director (or designee) will review all relevant documents and may request additional information. If the Chair and the Director determines that there is no non-compliance, no further action will be taken. The Chair will report to the IRB in the next convened meeting. If necessary, a letter will be generated by the OPHS and signed by the Chair (designee) to the individual who initially reported the concern with the final determinations.

4. If the report of non-compliance is not serious or continuing, IRB Chair (or designee) in collaboration with IRB Director (or designee) will recommend an appropriate corrective action plan. A letter will be generated to the investigator with the determination and the recommended corrective action plan. A written response from the investigator will be required within 72 hours of receipt. Minor non-compliance will be reported at the convened IRB meeting along with the investigator’s response. Some of the examples of corrective action are as follows:
   a. Require continuing review(s) more frequently than once a year
   b. Require remedial education
   c. Require more monitoring by OPHS
   d. Other actions as appropriate

5. If the report of non-compliance is serious or continuing as determined by IRB Chair (or designee) in collaboration with IRB Director (or designee), the non-compliance case will be reviewed by the full convened IRB Committee at the next scheduled meeting.

6. The IRB Chair (or designee) or IRB Director (or designee) may suspend research activities immediately, if he/she believes that the rights and welfare of the subjects are affected and/or that the subjects are at increased risk of harm. OPHS will draft a letter to the investigator signed by the Chair to suspend the research with the reasons until the non-compliance incident can be reviewed and determined by the IRB committee, along with any questions that might be appropriate to clarify the situation. The IRB Chair may recommend or stipulate certain corrective action plans to be included in the letter. The letter will also require a response from the investigator in writing within 72 hours of receipt of the letter. During the suspension, all research activity must stop, including data analysis, collection of data, recruitment, enrollment, and any research interaction/intervention with the participants. If the investigator believes that the participants maybe at harm during the suspension period, he/she should contact the IRB Chair or IRB Director immediately.
7. If the non-compliance affects the rights and welfare of the participants and might cause immediate harm, the IRB Chair (or designee) will contact the PI to place interim measures and call an emergency meeting of the IRB, if necessary, in order to review the non-compliance.

8. The response from the PI will be reviewed at the convened IRB meeting.

9. The IRB Chair (or designee) can invite the PI to the convened meeting to request additional information or clarification before the IRB makes the final determination and appropriate course of action.

Review of Non-compliance by a Full IRB Committee

1. All members shall review the report of non-compliance and relevant supporting documents.

2. All members will receive the following, but not limited to:
   a. Initial report of noncompliance
   b. Written reports of findings, determinations, and recommendations by the IRB Chair and IRB Director (or designee)
   c. Final auditor’s report with major findings
   d. Any other reports or correspondences generated during the initial investigation
   e. Copies of most recently approved IRB application, research protocol, consent document, and any other study documents, relevant to the non-compliance issue
   f. Minutes of meetings in which the protocol was previously discussed
   g. Any other supporting material that might clarify the report of non-compliance
   h. PI’s written response to the Chair/Director’s determination and/or audit report

3. IRB Chair may request that the PI attend the IRB meeting in-person to respond to the non-compliance and provide additional information.

4. IRB committee decisions.
   a. If the research was suspended by the IRB Chair or IRB Director, IRB will vote to confirm or reverse the decision. IRB can also accept or revise any corrective action plan that was originally recommended.
   b. If there is insufficient information to make the decision, IRB can defer voting until additional information is presented.
   c. Vote on whether the non-compliance is serious and/or continuing.
5. The IRB determines appropriate course(s) of actions, which is dependent upon the seriousness of the non-compliance, the willfulness of the action, the frequency of occurrence, etc.

   a. Approve the research to continue pending fulfillment of the recommended corrective action plan
   b. Revisions to the recommended corrective action plan
   d. Modification to the research protocol/informed consent document
   e. Modification of the information disclosed during the consent process
   f. Updated information to participants who have completed the study
   g. Notification to current participants (required when such information may relate to participants’ willingness to continue to take part in the research)
   h. Requirement for the current participants to re-consent for participation
   i. Referral to other CDU departments (risk management, institutional officials)
   j. Require monitoring and/or audits
   k. Obtain more information pending a final decision
   l. Require continuing review more frequently than once a year
   m. Surrender of data/data not to be used for publication or presentation
   n. Suspension of the study (in whole or part) and/or research
   o. Termination of the study and/or research
   p. Remedial education
   q. Restrict conduct of research/research privileges

OPHS Responsibilities

1. Tracking and monitoring allegations, concerns, and non-compliance: A flag is placed next to the PI’s name and the IRB database that indicate the date in which allegation or concern of non-compliance was reported, date of non-compliance notification letter, date in which non-compliance was lifted, description of allegation, concerns or non-compliance.

2. Notifications: OPHS generates a letter to the PI with the IRB Committee’s determination and course of action. This letter is signed by the Chair (or designee).

3. Reporting: If the Board determines the non-compliance to be serious or continuing, non-compliance case will be reported to the appropriate entities. The letter will be signed by the IRB Director (or designee). The following is a list of individuals and entities that the letter may be sent, but not limited to,

   1) University President
   2) Provost
   3) Dean of College or School
   4) Vice President of Research and Health Affairs
5) PI’s superiors (Department Chair)  
6) OHRP  
7) FDA  
8) Funding agencies (NIH, private foundations, state agencies, etc.)  
9) Sponsors (pharmaceutical companies, etc.)  
10) Collaborating institutions or sites  
11) WIRB  
12) Others as appropriate

REGULATIONS

45 CFR 46.103(b)  
21 CFR 56.108(b)  
45 CFR 46.113  
21 CFR 56.113

REFERENCES

http://www.hhs.gov/ohrp/compliance/findings/findings.pdf

OHRP Guidance on Written IRB Procedures, July 1, 2011.  