Title: INVESTIGATING AND MANAGING POTENTIAL ISSUES OF NON-COMPLIANCE

1.0 Purpose:

The purpose of this Standard Operating Procedure (SOP) is to outline the process for assuring the prompt reporting and management of any serious or continuing non-compliance with 45 CFR 46 or the requirements or determinations of the Syracuse University (SU) Institutional Review Board (IRB).

2.0 Policy:

It is the policy of the SU IRB to uphold its role in assuring prompt reporting of any serious or continuing non-compliance with 45 CFR 46 or the requirements or determinations of the IRB.

- **2.1** All reports of alleged non-compliance or inappropriate involvement of humans in research are investigated. Such reports may come from any source such as an IRB Member, an Investigator, a participant or their family members, institutional personnel, other institutional Committees, the media, anonymous sources, or the public. Goals of the IRB, in general, in investigating and managing issues of potential noncompliance include:
  - **2.1.1** Assuring the safety of human participants;
  - **2.1.2** Developing action plans to prevent reoccurrence, and promote future compliance;
  - **2.1.3** Educating research staff to assure the understanding of OHRP guidelines and regulations, and SU IRB Policy;
  - **2.1.4** Reporting serious or continuing noncompliance.
    - **2.1.4.1** To constitute serious or continuing non-compliance one or both of the following findings must be made:
      - **2.1.4.1.1** An action or omission taken by an Investigator that any other reasonable Investigator would have foreseen as compromising the rights and welfare of a participant; or
      - **2.1.4.1.2** A pattern of repeated actions or omissions taken by an Investigator that indicates a deficiency in the ability or willingness of an Investigator to comply with Federal regulations, SU IRB Policy, or determinations or requirements of the SU IRB.
- **2.2** The IRB Chair will report allegations of research misconduct to the Vice President for Research.
- **2.3** Attempts to unduly influence an IRB Member or IRB staff are considered research misconduct.
  - **2.3.1** IRB members or staff who believe that they have been subject to undue influence must report this to the ORIP Director.
  - **2.3.2** The ORIP Director will report undue influence to the Vice President for Research.
  - **2.3.3** Research misconduct will be reported to the Dean of the Investigator's school by the Vice President for Research.

3.0 References and Reference Documents:

45 CFR 46
SOP 002, Institutional Commitment to HRPP
SOP 004, Activities Subject to IRB Jurisdiction
SOP 014, Amendments to Previously Approved Applications or Claims for Exemption
SOP 024, IRB Compliance Activities
SOP 027, Reporting of Unanticipated Problems Involving Risk to Participants or Others
SOP 029, Suspension or Termination of IRB Approval

4.0 Procedure:

4.1 Investigator Responsibilities.

4.1.1 It is the Investigator's responsibility to adhere to the IRB approved protocol and not to initiate any changes or amendments to the protocol prior to IRB review and approval of the change or amendment, unless there is an apparent need to minimize risk to the participants. In this case the Investigator must notify the IRB within 10 working days of the amendment (See *SOP 014* and *SOP 027*).

4.1.2 The Investigator is responsible for the ethical management, accurate documentation, and the protection of human participants in their research.

4.1.3 Between IRB continuing reviews of a protocol and at the time of continuing review of a protocol, it is the Investigator's responsibility to keep ORIP informed of any unanticipated problems involving risks to participants or others even if the event occurred at a location for which the SU IRB is not the IRB of record. Investigators are also responsible for the accurate documentation, investigation, reporting, and follow-up of all unanticipated events to participants or others, as appropriate (See *SOP 027*).

4.1.4 The Investigator complies with all requests from the IRB for further information or clarification regarding concerns or issues under investigation.

4.1.5 The investigator and research staff are responsible to notify the IRB of any non-compliance within 10 working days.

4.2 ORIP Responsibilities.

4.2.1 When the ORIP Director receives a report of alleged non-compliance the ORIP Director verifies whether detailed explanation from the Investigator accompanies the report and notifies the IRB Chair of the receipt of the documentation.

4.2.1.1 If a detailed explanation from the Investigator accompanies the report the ORIP Director forwards the information to the IRB Chair for review.

4.2.1.2 If a detailed explanation from the Investigator does not accompany the report the ORIP Director or IRB Chair contacts the Investigator to request additional information.

4.2.2 If the report contains no explanation from the Investigator or comes from a source other than the Investigator:

4.2.2.1 The ORIP Director forwards the information to the IRB Chair for review and determination; and

4.2.2.2 The ORIP Director notifies the Vice President for Research within 1 working day.

4.2.3 If the report contains an explanation from the Investigator and comes from a source other than the Investigator, the ORIP Director forwards the information to the IRB Chair for review.

4.2.4 If an investigation is necessary the ORIP Administrator or designee conducting the investigation may take any of the actions necessary to determine whether allegations are valid, and to determine the seriousness or number of occurrences of the actions:

4.2.4.1.1 Review of the written materials;

4.2.4.1.2 Interviewing knowledgeable sources; or

4.2.4.1.3 Collect relevant documentation.

4.2.5 During the fact-finding process, the ORIP Director or designee communicates as appropriate with the Investigator or representative about the progress of the review and investigation. A factual and objective written record of findings and evidence is made by ORIP and stored in the appropriate files.

4.2.6 If the non-compliance is to be reviewed by the convened IRB, the ORIP/IRB Administrator prepares the following documents to be forwarded to all members of the Committee for review:

4.2.6.1 The audit report (investigation report);

4.2.6.2 The alleged notification of potential noncompliance, if applicable;
4.2.6.3 The last approval letter from the IRB;
4.2.6.4 The last approved IRB application; and
4.2.6.5 The last approved consent document.

Additionally, the primary reviewer receives:

4.2.6.6 The last approved protocol;
4.2.6.7 The last approved Investigator's recruitment materials, if applicable;
4.2.6.8 The Grant, if applicable; and
4.2.6.9 Any pertinent information (e.g., questionnaires, reports, etc.).

4.2.7 The ORIP/IRB Administrator facilitates and maintains documentation of all communications between the Investigator and the IRB. The ORIP/IRB Administrator notifies the PI in writing of IRB determinations. The letter requires a signature of the IRB Chairperson or his/her designee.

4.2.8 The ORIP/IRB Administrator maintains and updates the IRB database appropriately with current study information.

4.3 IRB Responsibilities.

4.3.1 When the IRB Chair receives an alleged report of non-compliance, the Chair either:

4.3.1.1 Reviews the information, determines that the allegation is valid, but the noncompliance is not serious and not continuing. The IRB Chair:

4.3.1.1.1 Formulates a corrective action plan;
4.3.1.1.2 Forwards the corrective action plan to the Investigator; and
4.3.1.1.3 Forwards the information to be included in the IRB agenda as an information item; or

4.3.1.2 Reviews the information, determines that more information is needed, and directs an investigation by the IRB. The Investigator is notified in writing of the directed investigation (audit); or

4.3.1.3 Reviews the information, determines that the allegation has no basis in fact. The IRB chair documents this in writing and takes no further action; or

4.3.1.4 Reviews the information, determines that the allegation is valid, determines the noncompliance is serious or continuing, and forwards the information to the full IRB for review and final determination.

4.3.2 If the Chair determines the allegation is valid and determines the noncompliance is serious or continuing, the determination is sent to the Investigator including a summary of the findings. The Investigator will be given the option to provide in writing, and within 10 working days, additional information for the full IRB.

4.3.3 The investigator may be invited by the Chair to attend the full board meeting at which the allegation of noncompliance is presented. The investigator is invited for the purpose of answering questions and communicating with board members. The investigator leaves prior to the IRB's discussion and vote on the issue(s).

4.3.4 The IRB reviews the materials provided at a convened meeting, to determine:

4.3.4.1 There is noncompliance that is neither serious nor continuing;
4.3.4.2 There is serious or continuing noncompliance. The IRB office will report this determination according to IRB Policy on Reporting to the Appropriate Institutional Officials, Dean or Department Chair (see *SOP 030*);
4.3.4.3 There is insufficient information to make a determination. In this case, the IRB will request additional information and defer a determination to a later date.

4.3.5 The IRB determines the following added protections, if applicable:

4.3.5.1 Verification that participant selection is appropriate and observation of the actual informed consent process by ORIP Director or designee;
4.3.5.2 An increase in monitoring of the research activity via a data safety monitor or board and intervention as necessary through steps such as visits to the activity site and continuing evaluation of the site by ORIP Director or designee;
4.3.5.3 Request an off-cycle data and safety monitor or board review;

4.3.5.4 Request a directed audit of targeted areas of concern;
4.3.5.5 Request a status report after each participant receives intervention from the Investigator;
4.3.5.6 Modify the continuing review cycle;
4.3.5.7 Request additional Investigator and staff education focused on human research protections from available sources (e.g., OHRP conferences, NIH tutorial, human research protections seminars);
4.3.5.8 Notify current participants, if the information about the non-compliance might affect their willingness to continue participation;
4.3.5.9 Suspend the study (*See SOP 029*); or
4.3.5.10 Terminate the study (*See SOP 029*).

Approved by:

Gina Lee-Glauser, Ph.D.
Institutional Official
Vice President for Research
Syracuse University

6-14-10
Date

Kathleen King, Ph.D.
Chair of the Institutional Review Board
Syracuse University

11 June 2010
Date

Tracy Cromp, M.S.W.
Director of Office of Research and Integrity Protections
Syracuse University

6-11-2010
Date