

**Policy Number: 53**

**Title: Noncompliance and Allegations of Noncompliance Regarding the Conduct of Human Subjects Research**

**Date of Last Revision: January 27, 2009**

## **I. General Overview**

This policy describes the OPRS Human Research Protection Program policies, Principal Investigator responsibilities and the HRPP and the Vice Chancellor of Research responsibilities and procedures for addressing allegations of suspected or actual noncompliance with federal regulations, state laws, University policies, and/or IRB requirements with respect to human subject research. The Quality Improvement Program unit of the HRPP with direction from the IRB is responsible for investigating any allegations of noncompliance related to human research protocols. Investigations related to allegations of suspected or actual IRB or other institutional noncompliance and the role of the Vice Chancellor of Research are also discussed in this policy.

## **II. Definitions**

**Investigator Noncompliance:** Failure to comply with federal regulations, state laws, University policies and/or the policies, requirements or determinations of the Institutional Review Board, or provisions of the approved research study.

**IRB or other Institutional Noncompliance:** Failure to comply with federal regulations, state laws, University of California, UCLA, or OPRS policies related to the protection of the safety, rights and welfare of human subjects in research.

**Allegation of Noncompliance:** An unproven assertion of noncompliance.

**Serious Noncompliance:** Instances that pose an increased risk to the safety, rights and welfare of human research subjects; when investigators or the institution either avoid or ignore UC, UCLA or OPRS HRPP policies related to the protection of human subjects or, in the case of the investigators, provisions of the approved research study; significant failure to comply with federal regulations, state laws, University policies and HRPP IRB requirements or determinations; or systemic failure of the Institution to follow or implement practices described in the University's policies and/or federal regulations or state laws related to the protection of the safety, rights and welfare of human subjects in research.

**Continuing Noncompliance:** Repeated instances of noncompliance by the same investigator or the Institution. Repetition may be of the same instance or repetition of different instances. For investigators, this repetition may be in the same or in different protocols by a single investigator. For the Institution, repetition may be of the same or different policies and/or procedures and/or regulations and/or laws.

### **III. Policy**

- A. All researchers are expected to comply with the provisions of the IRB-approved study as well as all federal regulations, University policies and state and local laws when conducting human research studies. If any allegations of noncompliance are made to the UCLA Human Research Protection Program, then those allegations must be investigated and it must be determined whether the allegation has a basis in fact or not. The procedures for this investigation and the outcome of the investigation are described.
- B. The Institution, which includes the IRB, is expected to comply with the University of California and UCLA the policies and procedures as well as all federal regulations and state laws related to the protection of the safety, rights and welfare of human subjects in research. If any allegations of noncompliance are made to the OPRS or to the Vice Chancellor for Research, then those allegations must be investigated and it must be determined whether the allegation has a basis in fact or not. The procedures for this investigation and the outcome of the investigations are described.
- C. UCLA personnel, including investigators, research team, faculty, staff, administration or students are responsible for reporting to the IRB suspected or actual noncompliance with the provisions of an IRB-approved study as well as with any applicable human research regulations, University policies and state and local laws when conducting human subjects research.
- B. Reports of suspected noncompliance may also be reported to the IRB or to the Vice Chancellor for Research by research subjects, subject's family members and others external to the University, including regulatory agencies. These reports may be in the form of complaints and may also be made anonymously.

### **IV. Principal Investigator Responsibilities**

- A. Investigators are required to self report to the IRB any instances of noncompliance that involves potential risk to subjects or other, or involves significant failure to comply with federal regulations, state laws, University policies, and/or IRB requirements, determinations or provisions of the approved research study. See [HRPP Guidance and Procedure #57: Post-Approval Reporting](#).
- B. Investigators are required to respond promptly to any inquiries, correspondence or directives from either the QIP or the IRB with respect to any allegations of or actual noncompliance. They are also expected to cooperate with any requests for information or any investigations.

### **V. Quality Improvement Program Procedures**

- A. Upon receipt of the reported allegation of suspected noncompliance, the Quality Improvement Program (QIP) staff of the OPRS HRPP will be responsible for conducting the initial inquiry into the allegation.
  - 1. The inquiry is fact-finding and may involve an extensive review of the study records, interviews with associated researchers or administrators, interviews with the complainant, and may include correspondence to the principal investigator or to the

an appropriate person within the Institution, including the IRB office, to obtain additional information.

2. Correspondence to the Principal Investigator or the appropriate person within the Institution will provide the investigator or the Institution with an opportunity to respond to the allegations of suspected noncompliance.
- B. Upon completion of the initial inquiry into the allegation, the QIP staff will prepare a written report describing the allegation and the outcome of the inquiry and forward that report to the IRB Chair or Vice Chair for initial review, and/or to the Vice Chancellor for Research if the allegation of noncompliance involves the IRB or another component of the Institution.

## **VI. IRB Procedures**

- A. The IRB Chair or Vice Chair will make an initial determination as to whether the allegation of noncompliance:
1. Has possible basis in fact, but is not serious and not continuing noncompliance.
    - a. Full Committee review shall proceed as described in this policy in VI.B.
    - b. The IRB Chair or Vice Chair may request additional information from the Principal Investigator or from the QIP prior to review by a convened IRB meeting in order to facilitate the review process.
  2. Has possible basis in fact, and is serious and/or continuing noncompliance.
    - a. Full Committee review shall proceed as described in this policy in VI.B.
    - b. The IRB Chair or Vice Chair may request additional information from the Principal Investigator or from the QIP prior to review by a convened IRB meeting in order to facilitate the review process.
  3. Has no basis in fact.
    - a. If the allegation of suspected noncompliance has no basis in fact, no further review is required.
    - b. The outcome and determination made will be documented in correspondence and forwarded to the Principal Investigator or to the appropriate person within the Institution within ten working days of the IRB Chair/Vice Chair's determination.
    - c. The HRPP staff will oversee and coordinate with the IRB Chair/Vice Chair all written correspondence from the IRB.
  4. Is of such a nature that the safety, rights and welfare of subjects are at immediate risk or hazard. In this case the IRB Chair/Vice Chair will contact the PI in order to establish an interim measure to be taken to protect subjects until such a time that the Full Committee can review the study. An example of such a measure is to suspend all new subject enrollments.

- B. Noncompliance that is self-reported to the IRB by the principal investigator will be processed and reviewed according to [HRPP Guidance and Procedure #57: Post-Approval Reporting](#). If it is determined that the noncompliance is serious and/or continuing, then the applicable procedures in this policy will also apply.
- C. Review of an allegation of noncompliance by a convened IRB meeting, that is, review by the Full Committee, will occur as follows:
1. The reported allegation of suspected noncompliance and appropriate review materials will be distributed to the primary reviewer(s) and all IRB panel members approximately one week prior to the meeting.
  2. Appropriate review materials may include but are not limited to the following: the written report prepared by the QIP, inquiry correspondence (to and from investigator or to the appropriate person at the institution), study protocol, IRB application, current approval notice, current approved informed consent document, investigator brochure (if applicable), and other pertinent documents. The entire IRB study file is available for review by IRB members upon request. Other IRB records are also available as needed.
  3. The IRB may request additional information from the Principal Investigator, the appropriate person in the Institution, or from the QIP regarding the reported allegation of suspected noncompliance in order to facilitate a thorough review before a final determination is made.
  4. The Full Committee may determine that a subcommittee composed of selected IRB members and IRB staff is necessary to investigate the allegation further and prepare a written report and recommendations to present to the Full Committee for final determination. In the case of an allegation of or actual Institutional noncompliance, the Full Committee may ask the Vice Chancellor for Research to appoint a subcommittee to investigate the allegation and prepare a written report and recommendations to present to the Full Committee.
  5. The IRB shall make one of the following determinations:
    - a. There is no basis in fact for the allegation of noncompliance.
    - b. There is a basis in fact for the allegation of noncompliance, but the noncompliance is neither serious nor continuing.
    - c. There is a basis in fact that the noncompliance is serious and/or continuing.
  6. The IRB will consider which of the following actions is required. This consideration may include but is not limited to the following:
    - a. Require no further action;
    - b. Accept and approve the Principal Investigator's or the Institution's proposed corrective action plan or changes;

- c. Require that the Principal Investigator modify the protocol to minimize risk;
  - d. Require the interval at which continuing review is conducted to be modified to less than one year as appropriate to the degree of risk;
  - e. Require that the Principal Investigator modify the recruitment or consent documents;
  - f. Require that currently enrolled subjects be reconsented with the additional relevant information provided;
  - g. Require notification of previously enrolled subjects of new information;
  - h. Require notification of currently enrolled subjects of new information, as such information may relate to a subject's willingness to continue participation in the research;
  - i. Require observation of the research or the consent process;
  - j. Require submission of status reports on a defined set schedule to the IRB;
  - k. Require additional education and training for the investigators and support staff;
  - l. Require additional monitoring of the research or the Institution;
  - m. Refer the Principal Investigator of one or all of the researchers to another University entity (i.e., Institutional Official, Campus Counsel, Risk Management);
  - n. Suspend any or all components of the research (i.e., new enrollment, treatment, follow-up and data analysis) until a corrective action plan can be developed and implemented or until additional review can occur;
  - o. Terminate the research;
  - p. Require a directed for-cause investigation by QIP;
  - q. Require an outside consultant or consultants to conduct a for-cause investigation of the Institution.
  - r. Require an outside consultant or consultants to help develop and implement a corrective action plan for the Institution.
- C. The outcome of the IRB meeting will be documented in the correspondence to the principal investigator or the appropriate persons in the Institution and/or the IRB meeting minutes.
- D. Written correspondence from the IRB will be forwarded to the Principal Investigator, and/or the appropriate persons within the Institution and the complainant if applicable, within ten working days of the final IRB determination.

- E. The HRPP senior staff will coordinate with the IRB Chair/Vice Chair to send out all written correspondence from the IRB to the Principal Investigator or the appropriate persons within the Institution.

## **V. IRB Reporting Requirements**

Any IRB determination of serious and/or continuing noncompliance; any suspension or termination of IRB approval; and the outcome of the IRB's actions are reportable to the appropriate federal department or agency head(s) and Institutional Official according to [HRPP Guidance and Procedure #60: IRB Reporting Procedures for Post Approval Reporting, Noncompliance, Suspension, or Termination.](#)

Any IRB and/or Vice Chancellor for Research determination of serious and/or continuing noncompliance with respect to the IRB or the Institution and the outcome of the IRB or Vice Chancellor's actions are also reportable to the appropriate federal department or agency head(s) and appropriate institutional officials according to [HRPP Guidance and Procedure #60: IRB Reporting Procedures for Post Approval Reporting, Noncompliance, Suspension, or Termination.](#)

### **Regulations:**

- 45 CFR 46.103(b)(5)
- 21 CFR 56.108(b)
- 45 CFR 46.116(b)(5)
- 21 CFR 50.25(b)(5)

### **References:**

- U.S. Office for Human Research Protections' (OHRP, formerly OPRR) *Protecting Human Research Subjects Guidebook* (1993). [http://www.hhs.gov/ohrp/irb/irb\\_guidebook.htm](http://www.hhs.gov/ohrp/irb/irb_guidebook.htm)
- OHRP, *Compliance Oversight Activities: Significant Findings and Concerns of noncompliance*, October 12, 2005. <http://hhs.gov/ohrp/compliance/findings.pdf>
- OHRP, *Guidance on Reporting Incidents to OHRP*, May 27, 2005. [http://hhs.gov/ohrp/policy/procedures\\_for\\_reporting\\_052505.pdf](http://hhs.gov/ohrp/policy/procedures_for_reporting_052505.pdf)
- OHRP, *Guidance on Written IRB Procedures*, January 15, 2007. <http://hhs.gov/ohrp/humansubjects/guidance/irbqd107.pdf>
- FDA, *IRB Information Sheet- Continuing Review After Study Approval*, September 1998. <http://www.fda.gov/oc/ohrt/irbs/review.html>