Human Subjects Protection Office
Penn State College of Medicine | Penn State Milton S. Hershey Medical Center
Hershey | 717-531-5687 | hspo@hmc.psu.edu

STANDARD OPERATING PROCEDURE ADDENDUM
Handling of Allegations of Noncompliance

I. Introduction

Under institutional authority and federal regulations [Title 45 CFR 46.103(b)(5), Title 45 CFR 46.113, Title 21 CFR 56.113], Institutional Review Boards (IRBs) are responsible to oversee the safety of research participants and may suspend or terminate human research that: (1) is not being conducted in accordance with the federal, state and institutional requirements, or (2) has been associated with unexpected serious harm to participants. The Penn State College of Medicine (COM) IRB is supported in this process by the Human Subjects Protection Office (HSPO) and the Research Quality Assurance Office (RQA).

II. Applicability

The following policies apply to all research activities of faculty, staff, students and others who are involved in human research as defined by the Penn State University Policy RA14, "Protection of Human Participants in Research."

III. Definitions

A. Allegation of Noncompliance is an unproven assertion of noncompliance.

B. Noncompliance is defined as failure to comply with federal regulations, IRB policy or the determinations or requirements of the IRB.

1. Nonserious and Noncontinuing noncompliance involves isolated incidents, e.g. an unintentional mistake, an oversight, or a misunderstanding. The issue is not serious or continuing in nature.

2. Serious noncompliance: An action or omission, non-compliant with Federal regulations or IRB policy, taken by an investigator that any other reasonable investigator would have foreseen as increasing risks or compromising the rights and welfare of a participant or other persons.

3. Continuing noncompliance: 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, IRB policy or determinations or requirements of the IRB.

C. Protocol Deviations and Variances from the Protocol do not fall within these definitions until they meet the distinction of being serious and/or continuing.

D. Research Misconduct noncompliance that involves callous disregard for the protection of human participants or for the integrity of research may meet the definition of research misconduct as defined in PSU Policy RA10.

IV. Reporting Requirements for Suspected Noncompliance

Investigators, research staff, or other individuals affiliated with Penn State College of Medicine or Penn State Hershey Medical Center (HMC) are required to report all suspected noncompliance to the HSPO.

Additionally, information regarding noncompliance in studies that enroll human participants may come to the attention of the HSPO or the IRB through several pathways:

- new applications
- continuing reviews
- internal audits or post-approval reviews by the RQA
- FDA audit reports
- adverse event/safety reports
- reports from collaborators, employees, participants, family members, community members
- any other sources.

Each allegation is taken seriously and reviewed in a consistent, prompt, and professional manner. Additionally, care is taken to maintain confidentiality. All communications and documentations are to be factual and objective. All allegations are maintained in a secure, electronic file, sorted by investigator and IRB protocol number and contain information on the nature of the allegation, the date reviewed and the disposition of the allegation, per the policy below. This file is accessible to the Executive IRB Chair or designee(s), the Vice-Dean for Research, the Associate Dean for Research, the Associate Director of the HSPO, the HSPO IRB coordinators and the Research Quality Assurance staff (RQA). The designee for the Executive IRB Chair may be an IRB Chair, IRB Vice-Chair or an IRB member with relevant expertise and is selected by the Executive IRB Chair.

V. Procedures for Handling Concerns of Potential Noncompliance

1. All allegations of potential non-compliance and self-reported non-compliance are reviewed by the Executive IRB Chair or designee who will determine whether additional investigation is required.
2. For allegations or self-reported non-compliance requiring additional investigation, within one week of receiving a the report the Executive IRB Chair or designee contacts the RQA to investigate these concerns based upon the RQA's SOPs. ..
    a) The RQA may conduct interviews, review relevant records, and materials, solicit advice and opinion from consultants and take any other necessary steps to determine whether the non-compliance is serious or continuing.
    b) This non-compliance investigation, including preparation of any reports should be completed within 60 calendar days of initiation of the investigation.
    c) If circumstances warrant a longer period, the Institutional Official or designee may approve an extension. The reason for the extension is documented as part of the final report.
    d) A written report of the investigation is compiled and submitted to the Executive IRB Chair or designee.
3. The Executive IRB Chair or designee evaluates the allegation/self-reported non-compliance and RQA report (if applicable) and determines if the allegation is valid. If the allegation is not valid, no further action is taken under this policy.
4. If the allegation is valid the Executive IRB Chair or designee determines that the non-compliance is neither serious nor continuing or determines that the report might be serious or continuing noncompliance. This review process may include reports from RQA, PSU internal audits groups, and external audit groups.
5. If the Executive IRB Chair or designee determines the noncompliance is neither serious nor continuing, the process under "Procedures for Noncompliance Determined to be neither Serious nor Continuing" is followed.
6. If the Executive IRB Chair or designee determines the noncompliance might be serious or continuing, the process under "Procedures for Serious and/or Continuing Noncompliance" is followed.

VI. Procedures for Noncompliance Determined to be neither Serious nor Continuing

1. The issue is resolved among any combination of the Executive IRB Chair or designee, IRB Coordinator(s), RQA staff, principal investigator(s), and student advisor, if applicable.
2. The Executive IRB Chair or designee determines whether any corrective actions are needed.
3. An IRB Coordinator documents the outcome of all communications in writing. This report includes any sanctions, corrective actions required on the part of the investigator and the timelines for resolution.
4. A copy of this report is sent to the principal investigator(s) involved in the noncompliance activities, associated research staff and others as deemed appropriate.
5. A written response from the principal investigator acknowledging the report and describing corrective actions is required within 5 week days from the date of the corrective report.
6. If the principal investigator and study personnel are unable to effectively implement the corrective action plan, the matter is considered to be continuing noncompliance and the "Procedures for Serious and/or Continuing Noncompliance" are followed.
7. The complainant is provided information as deemed appropriate by the Executive IRB Chair or designee.
8. All communications are documented in the IRB study file and are added to the electronic database that is accessible to the IRB Executive Chair, IRB staff and the RQA staff as defined in Section IV above.

VII. Procedures for Serious and/or Continuing Noncompliance

1. The Executive IRB Chair or designee determines if immediate suspension of study procedures and/or study enrollment is required for the project in question, as well as for other projects under the same investigator. This initial decision is based on preliminary review of available information, communication with the principal investigator(s) involved in alleged noncompliance activities, and the seriousness of the allegations. For additional information, see the IRB SOP Manual, Section IX. "Suspensions or Terminations of IRB Approved Research" and "Reporting of Unanticipated Problems, Terminations, Suspensions and Non-compliance"..
    a) The principal investigator(s) involved in the allegations and associated research staff personnel, appropriate Department Head(s), and Institutional Official (IO) are notified in writing about any suspension.
    b) Federal regulatory agencies are notified, if applicable.
    c) In case of externally funded studies, notice is sent to the sponsor and to the Office of Research Affairs (HMC/COM).
    d) If a study is suspended, further fact-finding and a timely review by a convened IRB determines the length of any suspension.
2. The issue is presented to the next appropriate convened IRB. For urgent issues, Senior IRB Administration may convene an emergency meeting of the IRB.
3. The IRB receives a copy of the most recently approved consent form; any necessary sections from the IRB approved protocol and the written report from the RQA. The complete IRB protocol is available at the IRB meeting.
4. The Principal Investigator is invited to attend the meeting to provide an opportunity to respond to the allegation(s).
5. The IRB may also meet with the complainant (if not anonymous) and others as needed.
6. The convened IRB confirms by vote whether the noncompliance is serious or continuing.
7. If the IRB does not find the noncompliance to be serious or continuing, the process under "Procedures for Noncompliance Determined to be neither Serious nor Continuing" is followed.
8. If the convened IRB confirms that the noncompliance is serious and/or continuing, the IRB determines the appropriate course of actions, such as:
    - Modification of the research protocol;
    - Modification of the informed consent form or process;
    - Additional information provided to past participants;
    - Notification of current participants (required when such information may related to participants' willingness to continue to take part in the research;
    - Requirement that the current participants re-consent to participation;

- Modification of the continuing review schedule;
- Monitoring of research;
- Monitoring of the consent process;
- Suspension of the research;
- Termination of the research;
- Obtaining more information pending a final decision;
- Referral to other organizational entities (e.g., legal counsel, risk management, institutional official, etc.);
- Requirement of additional training or re-training;
- Other actions appropriate for the local context

9. All communications are documented in the IRB study file and are added to the electronic database that is accessible to the IRB Executive Chair, IRB staff and the RQA staff as defined in Section IV above.

VIII. IRB staff follows the IRB's Standard Operating Procedure Section IX. Reporting of Unanticipated Problems, Terminations, Suspensions and Non-compliance. RQA also receives a copy of the report/letter.

IX. If the noncompliance involves callous disregard for the protection of human participants or for the integrity of research, the HSPO Director notifies the Vice Dean for Research and Graduate Studies for further action according to Penn State Policy RA10, "Handling Inquiries/Investigations into Questions of Ethics in Research and Other Scholarly Activities. This does not preclude the IRB Chair(s) or any member of the IRB from independently contacting the Vice Dean for Research and Graduate Studies about any allegation of research misconduct. Inquiries or investigations into research misconduct do not preclude IRB review and actions.

Version Date: September 1, 2011

Most recent changes:

- September 1, 2011 – Revisions made to include interactions with the Research Quality Assurance Office. Revision History added. Approved by IRB Executive Committee 09/14/2011; published 09/23/2011.

Revision History:

- March 6, 2009
- October 27, 2006