UNIVERSITY OF ILLINOIS CHICAGO
Office of the Vice Chancellor for Research

Office for the Protection of Research Subjects (OPRS)
Institutional Review Board
FWA# 00000083

203 AOB (MC 672)
1737 West Polk Street
Chicago, IL 60612-7227
Phone: 312 996-1711
Fax: 312 413-2929
http://research.uic.edu/compliance/irb

Handling Complaints and Allegations of Potential Non-Compliance with Human Subjects Protection Regulations

Version: 6.6; Date: 12/06/2016
Approved by: Human Protections Administrator,
Director of OPRS,
and Executive IRB Chair
AAHRPP REF #: 131
AAHRPP Elements: I.5.D., III.2.D.

POLICY:

I. Federal regulations [45 CFR 46 .103(b) (5) and 21 CFR 56.108(b)] require each institution to have "*…written procedures for ensuring prompt reporting to the IRB, appropriate institutional officials, and the department or agency head of (i) … any serious or continuing non-compliance with this policy or the requirements or determinations of the IRB; and (ii) any suspension or termination of IRB approval.*" This document describes UIC's policy and procedures for addressing complaints and allegations of potential non-compliance with Federal and State regulations, with University policies regarding research, and with the requirements of the HSPP.

II. It is UIC policy that investigators, research team members, faculty and staff must report any allegations or observations of apparent serious or continuing non-compliance in human subject research. Complaints or allegations of non-compliance may be directed to the OPRS, IRB, ORS Director, OPRS Associate Directors, HPA or IO. Research subjects and individuals not directly involved with conducting or overseeing the research are also encouraged to report suspected non-compliance.

III. This policy is applicable to all human subject research activities of UIC faculty, staff, students, or others within the jurisdiction of the UIC HSPP. The policy extends to adjunct and/or volunteer faculty when their appointment is listed among the investigator's credentials in study documents.

DEFINITIONS:

I. NON-COMPLIANCE: Conducting research involving human subjects in a manner that intentionally or unintentionally fails to comply with federal or state regulations, VA policies for VA research overseen by CHAIRb, UIC HSPP policies, or the requirements or determinations of the IRB. Examples include, but are not limited to, initiating research prior to IRB approval, implementing changes in the IRB-approved protocol without prior IRB approval, using inadequate procedures for informed

consent, failing to meet education and training requirements and lapses in IRB approval.

II. SERIOUS NON-COMPLIANCE: Non-compliance that results in either substantive harm (or genuine risk of substantive harm) to the safety, rights or welfare of human subjects, research staff or others, substantively compromises the effectiveness of the HSPP or substantively impacts the integrity of the research.

III. CONTINUING NON-COMPLIANCE: Persistent failure to conduct research in compliance with federal or state regulations, VA policies for VA research overseen by CHAIRb, or requirements or determinations of the IRB.

IV. PROTOCOL VIOLATION: Any deviations, whether accidental, unintentional or intentional, from the IRB-approved protocol that are implemented prior to IRB approval.

V. **Major protocol violations** are those that cause harm to subjects or others, place them at increased risk of harm, impact the scientific integrity of the research, compromise the human subject protection program, have the potential to recur or represent possible serious or continuing non-compliance. Major protocol violations may represent an unanticipated problem (particularly when unintentional) and/or potential serious noncompliance and require prompt reporting.

VI. **Minor protocol violations** are those not meeting at least one of the criteria in the preceding sentence.

PROCEDURE:

I. Reporting occurrences or allegations.

   A. Investigators are required to promptly report to the IRB using the *Prompt Reporting to the IRB* form all findings and allegations of apparent serious or continuing non-compliance, including major protocol violations, subject complaints, and changes to the protocol made without IRB approval to eliminate apparent immediate harm to subjects. The timeframe for reporting is within 5 working days of becoming aware of the event.

   B. Non-compliance may be uncovered by the IRB, the OPRS, and Associate Director for Compliance (e.g., during ongoing review or monitoring of research or through audits or other quality improvement activities). These findings are forwarded to Director, Associate Director of Compliance and the applicable IRB Chair and Assistant Director.

   C. Allegations of non-compliance may also be reported by members of the research team, UIC faculty, staff or administrators, sponsors, study participants, participating organizations, or other knowledgeable parties. The complaints or allegations may be provided to the Director of OPRS, OPRS staff, IRB Chair (or designee), the HPA, or IO. To facilitate reporting, informed consent documents provide a contact phone number and e-mail to discuss concerns or complaints with the research with OPRS staff. The OPRS website also provides telephone and e-mail contacts for OPRS staff members and administration, including the IO and HPA.

II. Receipt and initial review of allegations of non-compliance.
   A. When complaints or allegations of non-compliance are received via telephone, in person or e-mail by OPRS staff from sources outside of the research team, the information is recorded on the *Telephone/Email Report for Subject Complaint/Unanticipated Problem* and forwarded to the Assistant Director of the relevant IRB.
   B. The Assistant Director performs an initial review of the allegation including examination of the complaint form and IRB protocol file (i.e., protocol, consent documents) and, if warranted, conducts discussions with the investigator, other research team members and complainant.
   C. If the Assistant Director, in consultation with the Associate Director/Director and IRB Chair, determines that the allegation has no basis in fact or the complaint is a minor administrative issue that is able to be resolved by the Assistant Director and does not represent non-compliance (e.g., isolated subject payment complaint), no further action is taken.
   D. Complaints and allegations that are found not to be non-compliance, including minor administrative issues resolved by the Assistant Director, are entered into a log. A compilation of these complaints is provided to Director, and the Associate Director for Compliance, annually to make them aware of issues and/or recurring concerns that may require new or revised policies and procedures.
   E. If the Assistant Director determines that the allegation represents potential non-compliance, the Assistant Director compiles any collected information for subsequent review by the Chair (or designee).
   F. If the investigator is asked to provide a response to the complaint, this information is included with the material provided the Chair.
   G. Complaints or allegations of non-compliance received directly by the IO or HPA are referred to OPRS and handled as described above.

III. Receipt and initial review of investigator reports of non-compliance (including protocol violations) or changes to the protocol made without IRB approval to eliminate apparent immediate harm to subjects.
   A. Investigator reports of non-compliance are submitted to OPRS via the *Prompt Reporting to the IRB* form and forwarded to the Assistant Director of the relevant IRB.
   B. The Assistant Director reviews the report for completeness, contacts the investigator if necessary for additional information and makes a preliminary assessment of whether the event represents non-compliance.
   C. The report is then forwarded to the IRB Chair or designee.
   D. Changes to the protocol to eliminate apparent immediate harm to subjects: the Assistant Director considers whether the change was necessary to eliminate apparent immediate hazards to the subject and whether there was insufficient time for IRB review.
      1. If these conditions are both true, the incident is referred to the convened IRB for a final determination.

2. If these conditions are **not** both true, the incident represents a major protocol violation (i.e., serious non-compliance) and is forwarded to the IRB chair or designee.

IV. IRB Chair (or designee) review.

A. The minimum materials provided to the IRB Chair (or designee) to facilitate their review and evaluation of the non-compliance event:
   1. Original report of non-compliance;
   2. Any follow-up information gathered about the non-compliance issue; and
   3. Access to the complete research protocol file.

B. Determinations that may be made by the Chair (or designee) are:
   1. The event does not represent non-compliance;
   2. The event represents non-serious and non-continuing non-compliance and no action is required;
   3. The event represents non-serious and non-continuing non-compliance and corrective action is required;
   4. The event represents apparent serious and/or continuing non-compliance and the allegation or report of non-compliance is referred to the convened IRB for the final determination to be made; or
   5. The event likely represents a change to the protocol to eliminate apparent immediate harm to subjects and is referred to the convened IRB.

C. When the non-compliance is non-serious and non-continuing, corrective actions implemented by the Chair (or designee) may include, but are not limited to:
   1. Oversight or educational measures;
   2. Changes to the protocol and/or consent process to prevent future occurrences of non-compliance;
   3. More frequent monitoring of the research; or
   4. Changes to the continuing review schedule.

   If the investigator is unable or unwilling to work with the IRB Chair, then the non-compliance is handled as continuing non-compliance.

D. When the non-compliance is judged likely to be serious or continuing, the Chair (or designee) will determine if immediate action is needed to protect the rights and welfare of human subjects until the meeting of the convened board. Immediate actions to be considered include:
   1. Suspension of part (e.g., new subject recruitment) or all of the research (refer to UIC HSPP policy *Administrative Hold, Suspension, or Termination of IRB Approval*);
   2. Notification of currently enrolled subjects when information related to the compliance issue may relate to the subject's willingness to continue to participate in the research.

E. If the Chair (or designee) deems that further investigation of the matter is warranted, they may request the OPRS Director to conduct an investigation or

audit of the event. The request should describe the the charge for the inquiry (i.e., why the investigation or audit is being requested, what additional information the IRB is requesting to be obtained during the investigation or audit).

F. Documentation and PI notification of IRB Chair (or designee) review and determinations.
    1. For events determined to be neither serious nor continuing, the finding of the Chair (or designee) is documented in writing and provided to the investigator, Academic Department Head, other relevant UIC oversight committees (e.g., Investigational Drug Service, Radiation Safety, Cancer Center), UIC HPA, and UIC OPRS protocol file. The IRB is notified of the Chair's actions at the next scheduled meeting via the agenda.
    2. For events being referred by the Chair to the convened IRB, the investigator is notified of the determination, including any immediate actions taken by the Chair (i.e., suspension) and solicited by the Chair or IRB staff for any updated information.
    3. For events being referred by the Chair to the Director for investigation or audit , the investigator is notified by OPRS on behalf of the Chair of the determination and informed that they will be contacted by a member of the audit team.

V. Convened IRB review.
    A. When apparent serious or continuing non-compliance is reviewed by the convened IRB, two primary reviewers are assigned to conduct a thorough review of the packet of information and present the compliance issue to the full board. The IRB members receive at a minimum:
        1. Original report of non-compliance;
        2. Follow-up information gathered about the non-compliance issue;
        3. Protocol summary;
        4. audit findings(as applicable); and
        5. Access to the complete research protocol file.
    B. For reports involving changes to the protocol made without IRB approval to eliminate apparent immediate harm to subjects, the IRB should consider whether the change was necessary to eliminate apparent immediate hazards to the subject, and whether there was insufficient time for IRB review. If these conditions are both true, the incident does not represent non-compliance. If these conditions are not both true, the incident represents a major protocol violation (i.e, serious non-compliance).
    C. The IRB may make any of the following determinations:
        1. No non-compliance has occurred;
        2. Non-compliance has occurred, but the non-compliance is neither serious nor continuing (refer to IV.C. for possible corrective actions);
        3. Non-compliance has occurred that is serious and/or continuing.

D. When the non-compliance is determined by the convened IRB to be serious and/or continuing, the IRB considers whether to implement one or more of the following actions:
    1. Suspension of research approval (refer to UIC HSPP policy, *Administrative Hold, Suspension, or Termination of IRB Approval*);
    2. Termination of research approval (refer to UIC HSPP policy, *Administrative Hold, Suspension, or Termination of IRB Approval*);
    3. Notification of currently enrolled subjects when information related to the non-compliance issue may relate to the subject's willingness to continue to participate in the research.

E. Other actions the IRB may take include, but are not limited to:
    1. Imposition of ethics and/or human subjects research education for the investigator and/or research staff;
    2. Revisions to the protocol;
    3. Revisions to the consent process;
    4. Providing information to past participants;
    5. Requiring re-consent of current participants;
    6. Revisions to the continuing review schedule;
    7. Monitoring of the research;
    8. Monitoring of the consent process; and/or
    9. Referral to other UIC officials or committees for possible review.

F. The corrective action plan should include timelines for the investigator to respond to the IRB and follow-up evaluation of the implementation and completion of the actions by the investigator.

G. Review of the non-compliance issue is documented in the IRB meeting minutes.

H. A communication documenting the IRB's determination, the reason for the determination and the corrective action plan is generated and sent to the investigator within 10 working days of the convened IRB's determination. The communication is also sent to the Director of OPRS, Academic Department Head, HPA, other relevant UIC oversight committees (e.g., Investigational Drug Service, Radiation Safety, Cancer Center), relevant IRB and the UIC OPRS protocol file.

I. Serious or continuing non-compliance is reported by the Director of OPRS to appropriate IOs and federal agencies as described in the policy, *Reporting of Unanticipated Problems/Events, Suspensions, Terminations, and Non-compliance*.

J. Reports to IOs, OHRP, FDA and other federal agencies will be made promptly. In the event a situation requires extended time to investigate or resolve, a preliminary report will be sent and followed by a final report. In no event will a preliminary report to IOs, the supporting agency head, or OHRP be delayed beyond 30 days of the OPRS receiving notice of a reportable event.

K. Research Reviewed by CHAIRb
    1. Research reviewed by CHAIRb are required to submit a table or list of minor protocol violations as part of the Continuing Review submission.

This will provide CHAIRb with the ability to determine if the minor protocol violations are actually non-compliance events.

2. Complaints or allegations of noncompliance related to human subjects research approved by the CHAIRb may originate at any of the participating institutions.
3. As indicated in the IRB Service Agreements, the participating institutions have agreed to notify the OPRS Director and/or CHAIRb Assistant Director if an oversight agency or organization initiates any action regarding non-compliance.
4. Site liaisons, IRB members, IOs, research subjects, and other members of the research community may file complaints or report potential non-compliance to the CHAIRb/OPRS staff or OPRS Director.
5. Complaints or allegations of noncompliance for research overseen by CHAIRb will be submitted to CHAIRb via the CHAIRb Portal by the a) lead site investigator if the complaint or allegation of noncompliance is more generalized or not site-specific; or b) site investigator if the complaint or allegation of noncompliance is site specific.
6. The Prompt Report form and all correspondence between the lead and/or site investigators and IRB are available in the Portal for the lead investigator, site investigators, and site liaisons to review.
7. The participating lead investigator, site investigators, and participating site liaisons all receive the correspondence from the IRB via email.
8. All complaints and allegations of potential non-compliance will be processed as per the above-stated policy and procedures, with the exception that the CHAIRb Portal will be utilized.
9. Additional Considerations for Non-Compliance Occurring for VA Research activities overseen by CHAIRb.
    a) The participating VA local site investigator must submit a Prompt Report to the CHAIRb within 5 business days after becoming aware of any apparent serious or continuing noncompliance.
    b) The convened IRB must review any such notification at the earliest practicable opportunity, not to exceed 30 business days after the submission of the Prompt Report. The Chair may take interim action as needed to eliminate apparent immediate hazards to subjects.
    c) The convened IRB must determine and document whether or not serious or continuing noncompliance occurred.
    d) If the IRB determines that serious or continuing noncompliance occurred:
        (1) A documented IRB determination is also required as to whether remedial actions are needed to ensure present and/or future compliance.
        (2) The IRB must notify the VA Facility's Medical Center Director and the ACOS/R&D in writing within 5 business days after its convened meeting.

(3) If the apparent serious or continuing noncompliance was identified by an RCO audit, the IRB must notify the RCO within 5 business days after the convened meeting regardless of outcome.

(4) The IRB must track the determinations for use in the VA facility Director Certification.

e) The UIC Human Protection Administrator (HPA) serve as the Chair's designee for reporting on behalf of CHAIRb to the Medical Center Director and/or ACOS/R&D.

VI. Roles of the IO and the IRB.

A. No other entity within the UIC may override a decision by the IO that limits, imposes conditions or in any way restricts an investigator's privileges, or imposes conditions or restrictions upon an investigator or their research.

B. Likewise, no other entity, including the IO, may override determinations or corrective actions related to the investigator's human subject research protocols imposed by the IRB that limits, imposes conditions or in any way restricts an investigator's privileges, or imposes conditions or restrictions upon an investigator's research protocols.

VII. Confidentiality and retaliation.

A. The prompt review of complaints and allegations of non-compliance is critical for maintaining the integrity of UIC's HSPP and the IRB's ability to protect the human research subjects. A climate free from fear of sanction is required to foster reporting and ensure a fair review of complaints and allegations. Retaliation against any person who in good faith reports potential non-compliance (i.e., "whistleblower") is prohibited. Whistleblowers who report human subject protection concerns also have access to other mechanisms at UIC for protection from retaliation under The State Officials and Employees Ethics Act (Ethics Act) 5 ILCS 430/15-5. See the University of Illinois Office of Business and Financial Services Policies and Procedures.

B. Allegations of non-compliance should remain confidential to the extent possible. Generally, complainants decide if they wish to remain unidentified or have their identity known. However, in order for a respondent involved in an allegation of non-compliance to have a meaningful opportunity to be heard, it may be necessary to identify the complainant. If the complainant is a subordinate of the respondent, the IRB will, to the best of its ability, protect the identity of the complainant while conveying the substance of the allegations and information gained to the respondent. The IRB cannot guarantee the anonymity of the complainant.

REFERENCES:

21 CFR 50.25(b)(5), 21 CFR 56.108(b)(2)
45 CFR 46.103(b)(5)(i), 45 CFR 46.116(b)(5)

REVISION LOG:

Version (#, date)	Replaces (#, date)	Summary of changes
6.0, 10/01/08	5.0, 04/17/07	Describe the procedures for IRB evaluation, handling and making a determination of allegations of non-compliance; describing the process for coordinating activities between the IO and IRB.
6.1, 04/03/09	6.0, 10/01/08	Revised Procedure Section II.D. to include the OVCR Associate Director of Research Compliance. Added procedure steps for notifying the HSEIC that action is needed.
6.2, 06/18/09	6.1, 04/03/09	Added Assistant Director of Quality Assurance/ Quality Improvement title.
6.3, 01/25/11	6.2, 06/18/09	Updated to bring into compliance with VHA Handbook 1058.01, dated 5/21/10.
6.4, 04/27/12	6.3, 01/25/11	Removal of all references to the HSEIC, HSIC, and Appeals Committee as these committees are disbanded. Addition of the QIP and RCO as resources. Correction of titles within the policy.
6.5, 03/01/16	6.4, 04/27/12	Removal of references to the JBVAMC/IRB #4. Addition of references to CHAIRb.
6.6, 12/06/16	6.5, 03/01/16	Correction to name of Telephone/Email Report. Correction of title from Associate Director for Compliance to Associate Director, Investigator Outreach and Quality Improvement. Addition of hyperlinks.