

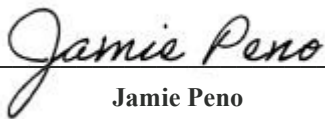


**Institutional Review Board
Standard Operating Procedures**

Title: Reporting Incidents
(Noncompliance, Unanticipated Problems, Serious Adverse Events)

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Approval/Date:

 <hr/> Jamie Peno Assistant Vice President, Research Integrity and Compliance	4/1/2021 <hr/> Date
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REVISION HISTORY

Date	Section	Author

PURPOSE

This Standard Operating Procedure (SOP) is to outline the general responsibilities of Investigators engaged in human subjects research to report Incidents of Noncompliance, Unanticipated Problems, or Serious Adverse Events and to define the review process and corrective action to be taken upon receipt of these items by the Office of Research Integrity and Compliance.

SCOPE

This SOP delineates systematic process activities and functions for compliance with the US Department of Health and Human Service, Office for Human Research Protections (OHRP) and Common Rule requirements, and University of North Texas requirements for the management, coordination, and operation under the oversight of the Institutional Review Board program. It applies to all Investigators and research staff involved in conducting human subjects research, as well as all IRB Members, IRB staff reviewing research involving human subjects, and Research Integrity and Compliance.

DEFINITIONS/ ABBREVIATIONS

1. Definitions

- 1.1 *Allegation of Noncompliance*- An unconfirmed report of Noncompliance with local, state, or federal regulations, IRB SOPs, or with the IRB approved protocol.
- 1.2 *Corrective Action Plan*- A plan developed to summarize the steps that will be taken by the Principal Investigator and study team to prevent a recurrence of the reported Incident.
- 1.3 *Continuing Noncompliance*- Incidents of Noncompliance that have been previously

reported and that occurred after the Investigator was provided with the education of said Incident. Continuing Noncompliance is evidenced by a trend or history of Noncompliance with the protocol or against regulations, regardless of how small or egregious the infraction may be. This pattern of Noncompliance may suggest a lack of understanding of Investigator responsibilities, regulations, IRB SOPs, or with the IRB approved protocol.

- 1.4 *Designated Reviewer*- Member of Research Integrity and Compliance or IRB, identified at the request of the IRB Chair, to conduct a thorough review of IRB submissions or Incidents.
- 1.5 *Human Subject*- A living individual about whom an Investigator is conducting research by obtaining, generating, using, or analyzing information or biospecimens through intervention or interaction with the individual or their data.
- 1.6 *Incident*- Any reported Unanticipated Problem, Serious Adverse Event or Noncompliance.
- 1.7 *Researcher*- An individual performing various tasks related to the conduct of human subjects research activities, such as obtaining informed consent from participants, interacting with participants, collecting data and communicating with the IRB.
- 1.8 *IRB Analyst*- Staff member of Research Integrity and Compliance that perform administrative activities, pre-reviews, reviews, and approvals for the Institutional Review Board program.
- 1.9 *Key Personnel*- IRB approved members of the study team who are engaged in the research project and who are considered by the Principal Investigator as essential resources for the conduct of the research project.
- 1.10 *Noncompliance*- The failure of any member of the research team (from PI to Key Personnel) to follow the regulatory guidelines (federal, state, or institutional guidelines related to human subjects research) or the approved structure of the research protocol, including any and all recruitment, planned participant numbers, interventions, or confidentiality protections. Noncompliance allegations may come from a number of sources, such as an IRB member, RIC staff, an Researcher or Key Personnel, a subject or their family members, anonymous complaints or reports, the media, or the public.
- 1.11 *Principal Investigator*- The individual who is actively leading and/or supervising the initiation, execution, and completion of a research project in compliance with applicable laws, regulations, and institutional policy governing the conduct of research. It is ultimately the PI's responsibility to ensure that all personnel actively working on the project and interacting with human subjects are following the guidelines of the approved protocol and are treating subjects in a manner befitting ethical use of human subjects. The PI should be the party responsible for submitting the research protocol, providing the RIC or the IRB with requested changes in order to garner approval, and for following the guidelines stipulated for annual review of the protocol and submission of any modification requests.
- 1.12 *Research*- A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.
- 1.13 *Serious Adverse Event*- Any untoward physical or psychological occurrence in human subject participating in research that results in death, a life-threatening experience, inpatient hospitalization, prolongation of hospitalization, persistent or significant disability or incapacity, congenital anomaly, or birth defect, or that requires medical, surgical, behavioral, social, or other intervention to prevent such an outcome.
- 1.14 *Serious Noncompliance*- Noncompliance that has the potential to increase participant risks or adversely affect the rights and well-being of participants.
- 1.15 *Unanticipated Problem*- Any Incident, experience, or outcome that is unexpected in

nature, related or possibly related to the research study, and places the research participants at a different or greater risk of harm than was previously known or understood.

2. Abbreviations

- 2.1 VPR- Vice President of Research and Innovation
- 2.2 IO- Institutional Official (at UNT, this is the VPR)
- 2.3 IRB- Institutional Review Board
- 2.4 OHRP- Office for Human Research Protections
- 2.5 RIC- Research Integrity and Compliance
- 2.6 PI- Principal Investigator
- 2.7 SOP/SOPs - Standard Operating Procedure(s)

RESPONSIBILITIES

This SOP is applicable to all Researchers who are involved in conducting human subjects research at the University of North Texas.

PROCEDURE

1. Reporting

- 1.1 All Researchers conducting human subjects research are responsible for promptly reporting Incidents to RIC.
 - 1.1.1 The Principal Investigator should be notified immediately by the Researchers, Key Personnel or members of the study team upon identification of a suspected Incident.
 - 1.1.2 Incidents must be reported regardless of relatedness to the research, within 10 business days of becoming aware of the event.
 - 1.1.3 Incidents should be reported in the electronic IRB system on an Incident form. All studies that predate the electronic IRB system, may submit an Incident form by emailing the form to untirb@unt.edu.
- 1.2 Noncompliance
 - 1.2.1 Allegations of Noncompliance may come from several sources, such as an IRB member, RIC staff, a PI, Researcher, or Key Personnel, a subject or their family members, anonymous complaints or reports, the media, or the public. Noncompliance can be reported on approved IRB protocols, or on situations where proper approval was not sought or given for what is deemed to be human subjects research.
 - 1.2.2 For Noncompliance or Allegations of Noncompliance related to a specific study, these Incidents may be reported on an Incident form in the electronic IRB system. All studies that predate the electronic IRB system, may submit an Incident form by emailing the completed form to untirb@unt.edu.
 - 1.2.3 Noncompliance or Allegations of Noncompliance that are not related to a specific study may be reported to RIC by sending an email to oric@unt.edu or by calling the UNT Trust Line at (877)606-9187.
- 1.3 Any research project may be immediately suspended by RIC or the IRB pending investigation, if participant health or welfare is perceived to be at an increased risk, or if the alleged Incident has the potential to lead to increased risk.

2. IRB Review

- 2.1 The IRB analyst, as designated by the Assistant Vice President of RIC and the

- Chair of the IRB, is responsible for initial intake and review of all Incidents that are received by RIC.
- 2.2 Upon receipt of the Incident report, the IRB analyst will perform a thorough review of the reported Incident to:
 - 2.2.1 Evaluate the risks and benefits of the study.
 - 2.2.2 Ensure the safety of current and future study participants protected.
 - 2.2.3 Request additional information if follow-up or clarification is needed.
 - 2.3 A research project may be immediately suspended pending investigation, if participant health or welfare is at an increased risk, or if the alleged Noncompliance has the potential to lead to increased risk.
 - 2.4 Unanticipated Problem or Adverse Event:
 - 2.4.1 The IRB Analyst may request additional review by the full IRB Board or an additional IRB Reviewer.
 - 2.4.2 Following review, the IRB may do one of the following:
 - 2.4.2.1 Request for additional information from the Principal Investigator.
 - 2.4.2.2 Note the occurrence of the Incident but take no action.
 - 2.4.2.3 Implement a corrective action plan.
 - 2.4.2.4 Suspend or terminate the project, if it is in the best interest of the study participants or the University.
 - 2.5 Noncompliance
 - 2.5.1 If Noncompliance is alleged, the IRB Analyst, IRB members, RIC, and IO will review the allegations and determine if Noncompliance has occurred.
 - 2.5.2 The IRB will review the circumstances and will determine if the Noncompliance appears to either:
 - 2.5.2.1 Cause injury or other Unanticipated Problems which may cause increased risk
 - 2.5.2.2 Constitutes serious Noncompliance with federal regulations or IRB determinations.
 - 2.5.3 Once the review and report summarizing findings is completed, a copy of the summary report will be provided to the PI in writing, within 30 days of the completion of the review and report. The PI has the right to comment on the findings and ask for justification of the findings.
 - 2.5.4 If an allegation of Noncompliance warrants further review or action is needed, the allegation will go through full investigation. The Assistant Vice President of Research Integrity and Compliance will work to designate a review committee. This may include the IRB Chair, the VPR, members of RIC, or the full IRB Board.
 - 2.5.5 Depending on the nature of the allegation, the Office of General Counsel or legal department may be requested to perform an independent review.
 - 2.5.6 The committee or designated reviewers will review the allegations through one or all of the following
 - 2.5.6.1 Reviewing available written material
 - 2.5.6.2 Interviewing involved parties such as PIs, Researchers, or Key Personnel
 - 2.5.6.3 Collecting relevant documentation of the allegation of Noncompliance
 - 2.5.7 Additionally, if the alleged Noncompliance is found to be valid, serious and/or continuing, the issue will be reviewed with the full IRB at the next convened meeting

3. Corrective Action:

- 3.1 All Incidents will have a corresponding corrective action plan, developed by the IRB Board, designated reviewer, or committee. This may include:
 - 3.1.1 A description of actions that must be taken to address, correct, or resolve the Problem or event.
 - 3.1.2 A description of actions that should be implemented to minimize the likelihood of future recurrence of the Incident or risk to participants.
 - 3.1.3 A description of the plans to reconsent, notify, or inform current or past participants of the Problem or event, if deemed necessary.
 - 3.1.4 If the Incident occurred inconsistent with the IRB approved study, or the frequency or severity of the Incident requires revisions the IRB approved study, a description of the necessary modifications needed to the current study.
- 3.2 All corrective action plans must be implemented immediately by the PI upon receipt of the plan. Further research activity prior to the implementation of the corrective action plan may result in Continued Noncompliance.
- 3.3 No Further Action Needed
 - 3.3.1 An Incident may need no further action in the following instances:
 - 3.3.1.1 It was self-reported by the PI, immediately upon discovery or occurrence;
 - 3.3.1.2 It was determined to be neither serious nor continuing;
 - 3.3.1.3 And it was addressed through a corrective action plan to remedy the possibility of repeat Incident.
 - 3.3.2 A report with no action required will be documented in writing and the documentation stored by the RIC, and the PI will be notified in writing. The IRB will notify the designated reviewers, committee, or IO as needed.
- 3.4 Serious or Continuing Noncompliance
 - 3.4.1 If serious or continuing Noncompliance is confirmed, the IRB will take appropriate action for the situation, follow the procedures for Noncompliance detailed in regulations 45 CFR 46, will notify the IO immediately upon final review and determination of Noncompliance, and will notify the funding agency per their guidelines as applicable.
 - 3.4.2 The IRB will seek to correct the Noncompliance, attempt to mitigate any effects that have already occurred or may continue to occur. The IRB may request any or all of the following in the process of, or at the completion of, their review:
 - 3.4.2.1 Verification that subject selection is appropriate and that the informed consent process is being followed;
 - 3.4.2.2 An increase in ongoing monitoring of data collection in the form of a data safety monitoring board or continued evaluation of the research site;
 - 3.4.2.3 Request a comprehensive audit of the area(s) of concern;
 - 3.4.2.4 Request a status report at each stage of the research project or at the completion of certain interventions;
 - 3.4.2.5 Modification of the continuing review cycle;
 - 3.4.2.6 Notify current subjects, if the existence of confirmed Noncompliance may affect their willingness to continue to consent in participation;
 - 3.4.2.7 Require modification of the protocol;

- 3.4.2.8 Require additional information be added to the consent form or processes, and re-consent of all subjects.
- 3.4.2.9 Suspend or terminate the study;
- 3.4.3 Per the UNT Policy 13.004 on the Use of Human Subjects in Research, sanctions for Noncompliance by the UNT IRB may include but are not limited to:
 - 3.4.3.1 Destruction of all data improperly collected.
 - 3.4.3.2 Required additional training for the Principal Investigator and Key Personnel.
 - 3.4.3.3 Temporary suspension of the Principal Investigator's eligibility to conduct human subjects research.
 - 3.4.3.4 Notification to subjects regarding the Noncompliance.
 - 3.4.3.5 Letters of reprimand to persons involved in the Noncompliance.
- 3.4.4 If the allegations also involve research misconduct (such as plagiarism or fabrication), RIC, the IRB Board, designated review, or committee will report this to the Dean of the PI's school.
- 3.4.5 Reporting for Federal Oversight Agencies
 - 3.4.5.1 The IO or designated staff will notify the Office for Human Research Protections of any serious Noncompliance issue when needed, and when applicable, will report to the FDA or any relevant funding agencies any serious or continuing Noncompliance issues, any Unanticipated Problems, suspension, or termination of IRB approval, within 30 days of completion of the review.
- 3.4.6 The IRB has the authority to administratively halt, suspend, or terminate approval of a project which is not being conducted in accordance with the approved human subjects use protocol, UNT policies, or federal guidelines which provide oversight for human subjects research. The IRB authority to halt or terminate research is governed by 45 CFR 46.113. Any suspension or termination of research will include, in writing, the reasons for the IRB's decision and action, and will be reported to the IO, any funding agency or sponsor, and other applicable entities as warranted. The IO does not have the authority to reinstate a terminated or suspended protocol.

REFERENCES

1. US Department of Health and Human Service, Office for Human Research Protections (OHRP)
2. 45 CFR part 46
3. UNT Policy 13.004 - Use of Human Subjects in Research

APPENDICES

1. IRB SOPs
2. Incident Form