Protocol Deviations and Non Compliance	
HSC SOP No:	021
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1. PURPOSE

1.1. The IRB will review and respond to allegations, complaints and/or concerns of potential protocol deviations and/or noncompliance received by an investigator, research participant, staff member, university official, or any individual who has raised concerns regarding an approved or unapproved research protocol.

1.2. Reported incidents will be treated as possible noncompliance until a final determination has been made by the IRB. The IRB will assess the severity of the incident (e.g., if the incident was an unanticipated problem involving risks to subjects or others), and/or will review the allegation or complaint to determine if an event meets any of the definitions in Section 2 below, and if necessary, require a corrective action. Unanticipated problems involving risks to subjects or others, serious and/or continuing noncompliance will be reported to the appropriate institutional officials and regulatory agencies.

1.3. HHS regulations at 45 CFR 46 additionally require that institutions have written procedures to ensure that the following incidents (defined in Section 2 below) related to regulatory requirements pertaining to research conducted under an OHRP-approved assurance are promptly reported to OHRP:

a. Any unanticipated problem involving risks to subjects or others;
b. Any serious or continuing noncompliance with applicable regulations or requirements or determinations of the IRB; and
c. Any suspension or termination of IRB approval.
(Note this topic is covered under HSC SOP 022 *Suspension or Termination.)*

2. DEFINITIONS

2.1. *Protocol deviation* means an unapproved change, deviation, or departure from the study design or approved procedures and are under the investigator's control and have not been reviewed and approved by the IRB. *Protocol deviations* are divided into two categories: non-*serious (minor) noncompliance*, or *serious noncompliance*. Noncompliance may also be continuing.

2.2. *Unanticipated problem involving risks to participants or others* means an unexpected, research-related event where the risk exceeds the nature, severity, or frequency described in the protocol, study consent form, or other study information previously reviewed and approved by the IRB.
(Note unanticipated problems are covered in depth under HSC SOP 023 *Unanticipated Problems or Adverse Event*s.)

2.3. *Noncompliance* means a failure (intentional or unintentional) to comply with applicable federal regulations, state or local laws, special conditions or the requirements or determinations of the IRB, or university policy regarding research involving human subjects.

2.3.1. *Noncompliance* can result from action or omission and it may be non-serious (minor) or serious and/or it may be *continuing*.

2.3.2. Examples of noncompliance include, but are not limited to, failure to obtain/maintain approval for research, coercion of human subjects, performing unapproved procedures; and conducting research at unapproved sites.

2.4. *Non-serious (minor) noncompliance* means the noncompliance does not increase the risk to research participants or others, nor does the noncompliance compromise the participants' rights or welfare, or affect the integrity of the research/data or the human research protection program or the University.

2.5. *Serious noncompliance* means a failure (intentional or unintentional) to follow state or federal regulations or University policies or determinations of the IRB for the protections of the rights and welfare of study participants and that, in the judgment of the IRB, results in, or indicates a potential for (a) an increased risk to enrolled or potential participants or others, or (b) compromises the participants' rights or welfare, or (c) affects the integrity of the research/data or the human research protection program or the University.

2.6. *Continuing noncompliance (serious or non-serious)* means a pattern of noncompliance (whether intentional or unintentional) that has been previously reported to the IRB, or a pattern of ongoing activities that indicate an inability, or unwillingness to comply with applicable requirements federal regulations, state or local laws, special conditions or the requirements or determinations of the IRB, or lack of understanding of human subjects protection requirements that may affect research participants or the validity of the research and suggest the potential for future noncompliance without intervention.

3. POLICY and PROCEDURE

3.1. The IRB will investigate and endeavor to resolve complaints and concerns from research participants and/or any individual lodging a complaint. All allegations, complaints, and concerns will be evaluated promptly and any required investigation will occur in a timely manner.

3.2. The HSC will adhere to general University policy pertaining to due process in dealing with alleged academic, professional, or staff misconduct.

3.3. Any UC employee reporting a concern in good faith is protected against reprisals according to federal and state law (whistleblower protection).

3.4. Deviations from an IRB-approved protocol as well as noncompliance with applicable University policies, regulatory requirements, and/or IRB determinations must be reported to the IRB. Such occurrences can have a negative impact on the research participants and the research study. Protocol deviations and noncompliances can alter the risk-benefit ratio for participants or otherwise jeopardize the safety, rights, and welfare of the subjects.

3.4.1. Nevertheless, there may be instances when it is necessary to deviate from an approved research plan to protect the research subjects. These instances must either be made in consultation with the IRB Chair/Designee or Research Integrity Director or reported to the IRB within 10 working days of initiation.

3.5. **Reporting Requirements and Procedures**

3.5.1. Reports made by the investigator:

1) Protocol deviations and noncompliance should be reported to the IRB as soon as possible. An initial report should be made to the IRB staff, IRB Chair, and/or Research Integrity Director within 1 week (7 calendar days) of when the investigator became aware of the event. A formal report should be submitted by the investigator within 2 weeks (14 calendar days) of when the investigator became aware of the event.
2) In some instances, reporting requirements may be met by submitting an initial report to the IRB staff, IRB Chair, and/or Research Integrity Director with a follow-up report submitted at a later date when more information is available. These determinations will be made on a case-by-case basis with the IRB Chair, Research Integrity Director, and/or other officials as appropriate. The primary consideration in making these judgements will be the need to take timely action to prevent any harm to the subjects and others.

3.5.2. Reports made by other parties (e.g., research staff, research subjects, general public, etc.):
1) Whenever possible, reports should be submitted via the investigator. However, if the reporting party deems it necessary and/or would like to remain anonymous to the investigator, they may also contact the IRB directly.
2) Protocol deviations and/or noncompliance incidents may be discovered by the IRB members, or IRB staff as part of continuing review of non-exempt protocols, incidental awareness (e.g., due to a news article, errant email, incidental finding of material, etc.) Such discoveries should be promptly reported to the IRB Chair and/or Research Integrity Director.

3.5.3. The reporting party should use their judgment when determining if an event is reportable. If an individual is unsure of whether they should report an event, they may call the IRB office or Research Integrity Director to discuss the situation informally.

3.5.4. Alternatively, individuals always have the option of making reports through the UC Whistleblower process.

3.5.5. Reports of possible protocol deviations or noncompliance should include a complete description (in so much as possible) of the event and include sufficient detail to allow the IRB to make an assessment.

3.5.6. If UCSB is not the IRB of Record, reports must be submitted to the Reviewing IRB. The IRB of Record (or Reviewing IRB) will notify the UCSB IRB when a determination of an anticipated problem, serious, and/or continuing noncompliance is made.

3.6. **Special Considerations**

3.6.1. Deviations from the IRB approved protocol that cannot wait for IRB review because of the immediate need to eliminate apparent risks of harm to the subject are not considered noncompliance per HSC SOP 018 *Amendments*.

3.6.2. The continued participation of enrolled subjects in research for which continuing approval has expired is also not considered a noncompliance per HSC SOP 017

Continuing Review if it is determined that it is necessary to protect the best interest of currently enrolled subjects.

3.6.3. The determination of whether it is necessary to deviate from the approved protocol or to continue aspects of the research to protect subjects from apparent risks of harm may initially be made by the investigator in consultation with the IRB Chair/Designee or Research Integrity Director. This determination may be made for enrolled subjects as a group or for individual subjects. However, the investigator must submit a report to request IRB confirmation of this agreement as soon as possible (see 2.5.1. above).

3.7. **IRB Review and Actions**

The IRB will fully investigate and review reports of allegations, complaints or concerns to determine if there were any possible protocol deviations and/or noncompliance. The IRB will determine if the reported information was (1) not noncompliance, (2) an unanticipated problem involving risks to subjects or others, (3) a non-serious (minor) noncompliance, (4) serious noncompliance, and/or (5) a continuing noncompliance.

3.7.1. If the IRB finds that no noncompliance occurred because: (1) the reported noncompliance was unsubstantiated, (2) the investigator deviated from the protocol in order to eliminate immediate and apparent risks of harm or hazards to the subjects, or (3) the continued participation of enrolled subjects in research for which approval has expired was necessary to protect the best interest of the currently enrolled subjects, actions by the IRB may include, but are not limited to:

- Requiring no further action.
- Requiring the submission of an amendment to the protocol or consent form(s).
- Requiring submission of a continuing review application.

3.7.2. If a non-serious (minor) noncompliance is found to have occurred, actions by the IRB Chair/Designee may include but are not limited to:

- Requiring no further action.
- Requiring remedial training (e.g., online educational program, attendance at a workshop or seminar, one-on-one training).
- Requiring re-consent of the subjects.
- Requiring the submission of an amendment to the protocol or consent form(s).

3.7.2.1. Whenever appropriate, investigators will be assisted so they can achieve compliance without the need for sanctions. However, if the investigator fails to cooperate with the IRB requests to correct a non-serious (minor) noncompliance, this inaction may be considered a continuing noncompliance.

3.7.3. If an unanticipated problem involving risks to subjects or others, serious and/or continuing noncompliance is found to have occurred, actions by the IRB may include by are not limited to:

- Establishing a corrective action plan.

- Requiring the investigator and/research team to participate in and complete further training.
- Requiring more frequent review of the project.
- Limiting the investigator's human subject research privileges.
- Writing letters of censure.
- Making recommendations of the Institutional Official (IO) for further sanctions, stipulations, or restrictions to the investigator's privilege to conduct human subjects research.
- Sharing information of noncompliance with other institutional units (e.g., Conflict of Interest Committee, Research Integrity, Sponsored Projects, etc.) as deemed necessary.
- Protocol suspension.

3.7.4. The IRB and, when appropriate, the institution will act promptly to ensure remedial action regarding any breach of regulatory or institutional human subject protection requirements. The IRB has the authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB policies, procedures, with federal regulations, or deviates from the approved research (see HSC SOP 022 *Suspension or Termination*).

3.7.5. All serious and/or continuing noncompliance must be reported promptly by the IRB to the Vice Chancellor for Research (IO) and, for federally funded research, the appropriate department (e.g., Sponsored Projects), agency head, and sponsor, where applicable. Reports will only be made to OHRP for research that is regulated by these oversight agencies per UCSB's Federal-Wide Assurance (FWA).

4. SCOPE

These policies and procedures apply to all research submitted to the IRB or under the jurisdiction of the institution.

5. RESPONSIBILITY

The investigator, or other reporting party, is responsible for reporting allegations, complaints, observed or apparent protocol deviations or noncompliance in good faith, and maintaining confidentiality and cooperating with any internal inquires.

The IRB staff, IRB Chair, or Research Integrity Director, are responsible for receiving allegations, complaints, or reports of noncompliance or concerns about the conduct of human subjects research. However any person may make a report to any individual of which may be routed to the IRB staff, IRB Chair, or Research Integrity Director for review.

The IRB staff facilitate review of the possible noncompliance, maintain records related to the incident, and notify investigators in consultation with the IRB/IRB Chair of the review outcome in writing.

The IRB staff and/or Research Integrity Director are responsible for assisting the IRB Chair with the initial fact gathering and review of the possible noncompliance. The IRB staff and/or Research Integrity Director may make recommendations to the IRB Chair for aiding in the review of the possible noncompliance. The IRB Chair reviews the potential noncompliance and may make a decision on the action to be taken, may convene an ad hoc committee to conduct an investigation, and/or ask the convened IRB to make a decision based upon the facts gathered. Incidents of potentially serious and/or continuing noncompliance will generally be referred to the convened IRB for deliberation and a final decision on the process and/or outcome.

The ad hoc IRB committee (if appointed by the Chair) is responsible for reviewing the possible noncompliance and information gathered, conducting interviews as needed, reviewing pertinent data or findings of the investigation, deliberating, and making recommendations to the convened IRB as to a course of action.

The convened IRB is responsible for reviewing information gathered about the possible noncompliance, reviewing pertinent data or findings of the investigation, deliberating, and determining a course of action for implementation by the investigator. The convened IRB may also make recommendations to the IO on a course of action following review of the noncompliance.

The IRB staff in conjunction with the IRB Chair and/or Research Integrity Director will confirm that any corrective action (if applicable) has been taken. The Research Integrity Director will be responsible for coordinating and notifying the appropriate funding agency, regulatory bodies, and departments about the noncompliance, as appropriate. The IRB Chair and/or Research Integrity Director may also designate an IRB staff member or Research Integrity Specialist to assist with and/or complete these tasks.

6. PROCESS OVERVIEW

Allegations, complaints, concerns, or reports of noncompliance may be submitted to any IRB staff member, IRB Chair, and/or Research Integrity Director. Reports may also be submitted to an IRB member, department staff member, or any individual which should be routed to the IRB for review. Reports may be transmitted by any media (e.g., mail, phone, email, during an office visit, etc.)

6.1. The individual receiving the information may gather some basic information from the individual reporting the possible noncompliance such as:

- What occurred?
- When did it occur?
- Where did it happen?
- Who were the University personnel involved in the research project?

- What is the contact information of the individual submitting the possible noncompliance? Does this individual request anonymity? (Note that anonymous complaints or concerns will be evaluated, but it may be difficult to establish matter of facts)

6.1.1. The individual will also document how the information was received and the date it was received.

6.1.2. If the IRB staff received the reported possible noncompliance, they will coordinate with the IRB Chair and/or Research Integrity Director to begin evaluating the information received.

6.2. Based on the information, the IRB Chair will make a decision on the action to be taken (as described in 2.7 above) or bring the information to the convened IRB to vote on a course of action. Incidents of serious or continuing noncompliance are generally referred to the convened IRB for review. The IO may be notified by the IRB Chair and/or Research Integrity Director that a serious or continuing noncompliance has occurred.

6.3. Following the decision of the IRB/IRB Chair, the IRB staff will notify the investigator in writing of the review outcome and the report will be filed. The IRB staff may work with the IRB Chair as needed to write the review outcome.

6.4. If the IRB determines that the noncompliance is serious and/or continuing, the IRB Chair, in conjunction with the Research Integrity Director, will report the IRB review to the IO along with any further recommendation, corrective action plans, etc. from the IRB for institutional action. Regulatory authorities or sponsors may also be notified as applicable and required.

6.5. The Research Integrity Director will submit a written report to OHRP when the IRB has determined that incident was (a) an unanticipated problem involving risks to subjects or others, (b) serious and/or (c) continuing noncompliance.

References:

45 CFR 46 Regulations
NIH Policy Manual, section 3014-802
UCSB Research Misconduct Policy and Procedures
UC Berkeley Glossary of Terms
UC Berkeley Guidelines and Policies
UC San Francisco Protocol Violation or Incident
UCOP Whistleblower Policy
OHRP – Guidance on Reporting Incidents to OHRP (June 2011)