

COLUMBIA UNIVERSITY INSTITUTIONAL REVIEW BOARD POLICY NONCOMPLIANCE WITH HUMAN SUBJECT REGULATIONS

I. SCOPE:

This is a University-wide Policy for responding to allegations of noncompliance with laws, regulations, or institutional or governmental policies governing the protection of human subjects in research. This Policy applies to all individuals, including Officers of Instruction, Officers of Research, students and employees, who may be involved in human subjects research conducted under the auspices of either Columbia University (the “University”), including Columbia University Medical Center (“CUMC”), or New York Presbyterian Hospital (“NYP”) and all human subjects research conducted by such individuals.

This Policy does not relate to research misconduct involving fabrication, falsification or plagiarism of research or research results which is covered by the Columbia University Institutional Policy on Misconduct in Research.

**II. EFFECTIVE DATE: January 23, 2006; Revised December 1, 2009;
Revised February 26, 2010; Revised November 15, 2012**

III. BACKGROUND:

The University is responsible for protecting the safety and welfare of human subjects participating in research conducted under the auspices of the University. In addition, NYP has designated the CUMC IRB for the review of human subjects research and the University and NYP share the responsibility for protecting the safety and welfare of human subjects participating in research at NYP. These responsibilities include establishing a policy for responding to allegations of noncompliance with laws, regulations or institutional or governmental policies concerning human subjects research and taking appropriate action(s) with respect to such allegations. This Policy is designed to address these issues.

Definitions of certain key terms used in this Policy are provided in Section VIII.

For purposes of this Policy, “Noncompliance” means a failure to comply with University policy (including requirements imposed by the IRB during review of a research study) or applicable federal and state laws, regulations and policies governing the protection of human subjects in research.

This Policy covers two types of Noncompliance: Research Noncompliance and IRB Noncompliance. “Research Noncompliance” means Noncompliance by anyone other than a member of the IRB (IRB staff or member in his/her capacity as such). “IRB

Noncompliance” means Noncompliance by any member of the IRB (IRB staff or member in his/her capacity as such).

A response to an allegation of Noncompliance consists of three phases:

1. **Inquiry:** the gathering of preliminary information and fact-finding to assess whether an allegation has substance and, if so, whether an Investigation is warranted (an “Inquiry”);
2. **Investigation:** following an Inquiry, the further investigation of facts with respect to whether Noncompliance has occurred (an “Investigation”); and
3. **Outcome:** following an Investigation, the determination as to whether Noncompliance has occurred and what corrective action(s), if any, are required (an “Outcome”).

IV. RESEARCH NONCOMPLIANCE:

A. THE MAKING OF AN ALLEGATION

1. Concerns about possible Research Noncompliance may be discussed with an IRB Chair, the Executive Director (ED), the Associate Director (AD), an IRB Manager, or staff member of the IRB Compliance Oversight Team (COT). If the concerns involve serious and/or continuing or recurrent Noncompliance or Noncompliance that affects studies reviewed by more than one IRB, such concerns may also be discussed with the Executive Vice President for Research (EVPR).

Serious Noncompliance is defined as a failure to follow the regulations and policies of the IRB or the IRB-approved protocol and increases risks to subjects, compromises the rights and welfare of the subjects, and/or compromises the integrity of the research study. Serious Research Noncompliance may include, but is not limited to: (a) the failure to obtain or maintain IRB approval before conducting any Human Subjects Research; (b) the enrollment of subjects in a study without obtaining legally effective informed consent; or (c) the failure to report serious or recurring problems involving risks to Human Subjects.

Continuing Noncompliance is defined as any Noncompliance that consistently or intermittently continued after the Noncompliance was confirmed by the designated IRB or the COT or any regulatory or sponsoring entity and the Principal Investigator was notified of such Noncompliance.

2. All incidents of possible Research Noncompliance should be documented in writing and reported promptly (ideally within five business days of discovery) to the COT Manager and copied to the ED and AD in accordance with the terms of this Policy. Any individual may make an allegation of Noncompliance.

B. THE INQUIRY PHASE

1. The Inquiry with respect to any alleged Research Noncompliance shall be conducted by the COT, with the exception of inquiries of certain non-serious, or minor, noncompliance that is identified and addressed by the IRB of record as outlined in Appendix 1.
2. The Inquiry shall be completed promptly and, at its conclusion, the COT Manager shall discuss with the ED the COT's findings as to whether or not there is sufficient evidence to undertake an Investigation (i.e., alleged noncompliance was possible given the reported information; for example, the investigator is conducting the study and the alleged infraction was possible for the given study).
3. The ED¹ will authorize an Investigation if there is sufficient evidence after the Inquiry Phase that the allegation is plausible, and he/she or the COT Manager shall so notify the Respondent, the Relevant IRB Chair, at the discretion of the ED, the appropriate Responsible Academic Officer of such a decision. The ED may, in his/her discretion, also notify one or more of the other Need to Know Individuals (see Definitions in section VIII). If the ED does not agree with the findings of the inquiry he/she may decide that an investigation will not be conducted. If the COT Manager disagrees with the ED, the matter shall be discussed by the IEC².

C. THE INVESTIGATION PHASE

1. If the ED decides that an Investigation is warranted, he/she shall direct the COT to proceed with such Investigation. As noted in B.1 above the investigation of certain non-serious, or minor, noncompliance that is identified by the IRB of record may be investigated by that IRB as outlined in Appendix 1.
2. The COT shall complete the Investigation promptly and, at its conclusion, shall submit a draft written report (the "Draft COT Report") to the ED for review. The Draft COT Report shall include the COT's determination as to whether a finding of Noncompliance should be made and, if so, the COT's recommendation as to which corrective action(s) should be taken.
3. The ED may accept, reject or modify the conclusions of the COT in the Draft COT Report.
4. For cases involving serious noncompliance, the COT Manager shall notify the Respondent with an opportunity to review and respond to the Draft COT Report within a specified time period. At the end of such period, the ED and the COT Manager shall promptly review the Respondent's response and shall make a final decision as to the finding of Research Noncompliance and the corrective action(s)

¹ All references to ED that follow should be read a "ED or designee".

² At any phase of the COT process, the COT Manager may request review by the IEC if he/she disagrees with the determinations or actions of the ED.

required, if any. The COT Report will then be finalized and the COT Manager will release the report to the Respondent and copy the Need to Know Individuals on the notification.

D. THE OUTCOME PHASE

This section describes the process for the Outcome Phase for cases managed by the COT. For minor Research Noncompliance that was managed by the IRB in accordance with Appendix 1, the alleged noncompliance will be reported to the COT for tracking purposes.

1. If a finding of Research Noncompliance has been made, the finding(s) will be reported to the ED and the Chair of the designated IRB for determination as to whether the case requires full Board or expedited review. For cases that are reviewed by the full Board, the full Board will make a determination of any necessary corrective action(s) based on the recommendations in the COT Report. For cases that are reviewed by expedited review, the IRB Chair of the designated Board and the ED will make a determination of any necessary corrective action(s) based on the recommendations in the COT Report.

For consistency of corrective action plans and outcomes of noncompliance cases (especially for noncompliance cases that involve studies reviewed by more than one IRB), the ED shall make final decisions regarding which corrective action(s) should be taken. If the Chair, or the IRB in the case of full-board review, disagrees, then the matter will be discussed and resolved by the IEC³.

If a finding of serious Research Noncompliance is made involving any IRB member who is involved in the conduct of the research, the finding will be reviewed solely by the IEC and not the designated IRB (in order to eliminate any conflicts of interest that may exist on behalf of the designated IRB).

Any final determinations or decisions regarding Serious Research Noncompliance made by the ED, or determinations made by the IEC when the case was reviewed by the IEC that are not consistent with the determinations made by the designated IRB will be reported back to the designated IRB. Any concerns raised by the designated IRB regarding the final determinations made by the ED or the IEC should be reported to the IEC for reconsideration.

2. Corrective action(s) may include any of the following:

- a. suspension or termination of the Principal Investigator's research protocol(s);
- b. required training with respect to Human Subjects Research and the regulatory requirements for the conduct of such Research;

³ Referral to the IEC can be requested for all phases of the process if an IRB Chair or the full Board disagrees with an action or determination.

- c. imposition of changes in such research protocol(s) to further protect Human Subjects;
- d. imposition of restrictions as a condition for the continuation of research by the Principal Investigator;
- e. destruction of data collected during the period of Noncompliance;
- f. disallowance of the publication of data collected during the period of Noncompliance;
- g. oversight monitoring by the COT; and
- h. any other appropriate action.

E. APPEAL

1. A Respondent shall have the right, within 30 days after his/her receipt of notification of the decision of the ED or the IEC at the end of the Outcome Phase, to file a written appeal with the EVPR as to either the finding of Noncompliance or the corrective action(s) required. If the Principal Investigator is at CUMC, the EVPR shall send a copy of the appeal to the Senior Vice Dean, College of Physicians and Surgeons (SVD) and shall consult with the SVD as to the merits of the appeal. The EVPR may affirm, reject or modify the decision of the ED or the IEC. The decision of the EVPR shall be final in all respects and the Respondent shall have no further right of appeal.
2. Notice of the decision of the EVPR with respect to any appeal shall be given to the Need to Know Individuals.

V. IRB NONCOMPLIANCE:

A. THE MAKING OF AN ALLEGATION

1. Concerns about possible IRB Noncompliance may be discussed with an IRB Chair, the ED or the AD. If the concerns involve Noncompliance by the ED or the failure by any member of an IRB or the IRB staff to correct serious and/or continuing or recurrent incidents of Noncompliance ("Serious IRB Noncompliance"), such concerns may also be discussed with the EVPR.
2. Any individual may make an allegation of IRB Noncompliance. An allegation of IRB Noncompliance can be made in writing to the ED, AD, IRB Chair, or the EVPR. Any allegation in writing to the ED, AD, or IRB Chair must copy the EVPR.

3. Notice of any allegation of Serious IRB Noncompliance shall be promptly reported to the EVPR, the IEC and, in the case of Serious Noncompliance at CUMC, to the CUMC Institutional Official.

B. THE INQUIRY PHASE

1. The Inquiry with respect to any alleged IRB Noncompliance shall be conducted by the COT or, at his/her discretion, the ED. In the case of Serious IRB Noncompliance, the Inquiry shall be conducted in consultation with the EVPR or Vice President of Research Operations (VPRO). The EVPR may require that the Inquiry be conducted by such qualified persons as the EVPR shall select (the “Inquirers”).

2. The Inquiry shall be completed promptly and, at its conclusion, the ED shall decide or, if the Inquiry has been conducted by the COT, the COT Manager shall discuss its findings with the ED as to, whether or not there is sufficient evidence to undertake an Investigation. In the case of Serious IRB Noncompliance, the Inquirers shall consult with the EVPR or VPRO prior to undertaking an Investigation.

3. If the ED or the EVPR decides that an Investigation is warranted, he/she shall so notify the Respondent. The ED or the EVPR/VPRO, as the case may be, may, in his/her discretion, also notify one or more of the other Need to Know Individuals.

C. THE INVESTIGATION PHASE

1. If the ED decides that an Investigation is warranted, it shall be conducted by the COT or, at his/her discretion, by the ED. In the case of Serious IRB Noncompliance, the Investigation shall be conducted in consultation with the EVPR or VPRO. The EVPR may require that the Investigation be conducted by such qualified persons as the EVPR shall select (the “Reviewers”).

2. The Investigation shall be completed promptly and, at its conclusion, if the Investigation has been conducted by the COT, the COT Manager shall submit a written report (the “Draft Compliance Oversight Team Report”) to the ED. If the ED has conducted the Investigation, he/she shall prepare the Draft Compliance Oversight Team Report. If the EVPR charged others to conduct the Investigation, the Draft Compliance Oversight Team Report shall be submitted by the Reviewers to the EVPR. The Draft Compliance Oversight Team Report shall include a determination as to whether a finding of Noncompliance should be made and, if so, a recommendation of the ED or the Reviewers, as the case may be, as to what corrective action(s) should be taken.

3. If the Investigation has been conducted by the COT, the ED may accept, reject or modify the conclusions in the Draft Compliance Oversight Team. The EVPR may also accept, reject or modify such conclusions.

D. THE OUTCOME PHASE

1. If a finding of IRB Noncompliance has been made, the ED shall decide which corrective action(s) should be taken. The recommendations for corrective actions will first need to be approved by the IEC and the EVPR.
2. Corrective action(s) may include any of the following:
 - a. required training with respect to Human Subjects Research and the regulatory requirements relating to such Research;
 - b. if the Respondent is a member of the IRB staff, suspension or termination of employment;
 - c. if the Respondent is a member of an IRB, suspension or termination of appointment to the IRB; and
 - d. any other appropriate action.
3. Following the decision of the ED or the EVPR, as the case may be, as to the appropriate corrective action(s), a written report (the “Compliance Oversight Team”) shall be prepared, incorporating the decisions of the ED or the EVPR with respect to the finding of IRB Noncompliance and the corrective action(s), if any.
4. The ED or, at the discretion of the EVPR, the EVPR shall promptly notify the Respondent of his/her decision and shall provide the Respondent with an opportunity to respond to the Investigation Report within a specified time period. At the end of such period, the ED or, at the discretion of the EVPR, the EVPR shall promptly review the Respondent’s response and shall make a final decision as to the finding of IRB Noncompliance and the corrective action(s) required, if any. The ED or, at the discretion of the EVPR, the EVPR shall notify the Need to Know Individuals of his/her decision.

E. RECONSIDERATION

1. A Respondent with respect to whom a finding of IRB Noncompliance has been made shall have the right, within 30 days after his/her receipt of the notification of the ED’s or the EVPR’s decision at the end of the Outcome Phase, to request a reconsideration of the decision by the EVPR as to either the finding of Noncompliance or the corrective action(s) imposed. The EVPR may or may not reconsider the decision. The decision of the EVPR shall be final in all respects and the Respondent shall have no further right of reconsideration or appeal.
2. Notice of the decision of the EVPR with respect to any request for reconsideration shall be given to the Need to Know Individuals.

VI. SAFEGUARDS:

A. Confidentiality: To the extent possible consistent with a fair and thorough investigation and as allowed by law, knowledge about the identity of a Complainant, a Respondent and any witnesses shall be limited to those persons identified in this Policy and others who need to know and all written materials and information with respect to any proceedings shall be kept confidential.

B. Evidence: During each phase of the administrative proceedings described in this Policy, such evidence shall be reviewed and such persons shall be interviewed as shall be necessary to make a reasonable determination as whether an allegation of Noncompliance does or does not merit an Investigation, whether a finding of Noncompliance should be made or what corrective action(s) should be imposed.

C. Sequestration: During any Inquiry or Investigation, a determination should be made if any information, including any IRB files, should be sequestered and, if sequestered, the terms under which such information may be accessed.

D. Safeguards for a Complainant: If an allegation of Noncompliance has been made in good faith, the University shall ensure that a Complainant is treated fairly and reasonably, that diligent efforts are made to protect the position and reputation of the Complainant and that the Complainant is not subject to retaliation.

E. Safeguards for a Respondent:

1. To the extent consistent with the protection of Human Subjects, a Respondent is assumed not to have been Noncompliant until a finding of such has been made in accordance with this Policy. The Respondent in turn shall cooperate with the administrative procedures described in this Policy, including by providing information, records and evidence to the University representatives referred to herein when so requested.
2. The University shall not impede the ability of a Respondent to continue to involve Human Subjects in his/her research, to remain employed as an IRB staff member or to serve as an IRB Member, as applicable, during the period of any of the administrative procedures described in this Policy unless the ED, the IEC or the EVPR determines that there are compelling reasons to suspend the Respondent's right to do so during all or a portion of such period.
3. During an Inquiry, the Respondent shall be provided the opportunity to meet with the persons responsible for the Inquiry and to respond to the allegation orally and in writing.
4. During an Investigation, the Respondent shall have the right to present testimony and documents on his/her behalf.

F. Responsibilities of the COT Manager: The COT Manager shall notify the EVPR directly if, in his/her judgment, any allegation and/or subsequent Inquiry, Investigation and/or Outcome failed to be conducted in good faith and/or to comply with University policy or applicable law or regulations.

G. Conflicts of Interest: Any individual who undertakes any action(s) outlined in this Policy shall do so without conflict or personal involvement in the alleged Noncompliance. If such a personal conflict is identified, that individual shall recuse him/herself from the administrative procedures described in this Policy.

VII. NOTIFICATION TO REGULATORY AGENCIES OR FUNDING SOURCES:

The ED, or at the discretion of the EVPR for Serious IRB Noncompliance the EVPR, shall report allegations of serious Research Noncompliance to the appropriate regulatory agency and sponsors as required by applicable law or regulations.

All serious Research Noncompliance and Serious IRB Noncompliance will minimally be reported to OHRP, Director of Compliance Oversight. If the research involves an investigational drug, the case will also be reported to FDA, Division of Scientific Investigations, Office of Compliance. If the research involves an investigational device, the case will also be reported to the FDA/Center for Devices and Radiological Health (CDRH), Director, Division of Bioresearch Monitoring.

Allegations that fall outside of the mandatory reporting requirements shall be reported to the regulatory agency, the funding source, or any other relevant person(s) involved in the research project at the discretion of the Executive Director or the EVPR, as the case may be.

VIII. DEFINITIONS:

“Associate Director”: the Associate Director of the IRB.

“Complainant”: the person bringing an allegation of Noncompliance.

“Continuing noncompliance”: any Noncompliance that consistently or intermittently continued after the Noncompliance was confirmed by the designated IRB or the COT or any regulatory or sponsoring entity and the Principal Investigator was notified of such Noncompliance.

“COT”: the Compliance Oversight Team of the IRB.

“COT Manager”: the Manager of the COT.

“EVPR”: the Executive Vice President for Research of the University.

“Executive Director”: the Executive Director of the University’s Human Research Protection Program and the IRB.

“Human Subject”: (a) a living individual about whom an investigator (whether professional or student) conducting Research obtains (i) data through intervention or interaction with the individual or (ii) identifiable private information or (b) a living individual who is or becomes a participant in Research, either a recipient of a test article or is a control.

“Human Subjects Research”: Research involving Human Subjects.

“Institutional Official”: (a) the Executive Vice President for Research (EVPR), (b) with respect to CUMC, the Senior Vice Dean, College of Physicians and Surgeons (SVD), and (c) with respect to NYP, the Group Senior Vice President, Chief Operating Officer and Chief Medical Officer.

“IRB”: any of the University’s Institutional Review Boards or all of the University’s Institutional Review Boards, collectively, as the context requires.

“IRB Executive Committee”: the Executive Committee of the IRB (IEC), consisting of the Executive Director, the Associate Director, the IRB Chairs, the IRB Vice Chairs and the Vice President for Research Operations.

“IRB Noncompliance”: Noncompliance by any member of the IRB (IRB staff or member in his/her capacity as such).

“Need to Know Individuals”: (a) with respect to any allegation of Research Noncompliance, (i) the Principal Investigator, (ii) the Respondent, (iii) the IRB Chairs and Vice Chairs, (iv) the appropriate Responsible Academic Officer, (v) the appropriate Institutional Official, (vi) the Director of the Clinical Trials Office and the Director of the IND/IDE Assistance Program in the case of Noncompliance with FDA-regulated research; and (vii) such other persons as the Executive Director or, in the case of serious Research Noncompliance, the IEC shall select; and

(b) with respect to any allegation of IRB Noncompliance, (i) the Respondent, (ii) the appropriate Institutional Official, (iii) in the case of Serious IRB Noncompliance, the IEC and (iv) such other persons as the Executive Director or, in the case of Serious IRB Noncompliance, the EVPR shall select.

“Noncompliance”: a failure to comply with University policy (including requirements imposed by the IRB during review of a research study) or applicable federal and state laws, regulations and policies governing the protection of human subjects in research.

“Principal Investigator”: with respect to any allegation of Noncompliance, the principal investigator of the research study to which such allegation relates.

“Relevant IRB Chair”: with respect to any allegation of Noncompliance, the Chair of the relevant IRB.

“Research”: a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to general knowledge.

“Research Noncompliance”: Noncompliance by anyone other than a member of the IRB (IRB staff or member in his/her capacity as such).

“Respondent”: the person, including a Principal Investigator, who is the subject of an allegation of Noncompliance.

“Responsible Academic Officer”: with respect to any Principal Investigator, the Chair, Dean or Director of the Department, School, Institute or Center of which such Principal Investigator is a member.

“Serious Noncompliance”: a failure to follow the regulations and policies of the IRB and in the judgment of the COT or the designated IRB increases risks to subjects, compromises the rights and welfare of the subjects, and/or compromises the integrity of the research study.

Appendix 1

Policy for IRB Review of Minor Noncompliance

This Policy provides direction as to which incidents of potential noncompliance should be handled by the IRB rather than the Compliance Oversight Team (COT). All types of minor noncompliance that are listed in this policy and were discovered by an IRB upon review of a submission may be reviewed by the designated IRB Chair, or the Board if the minor noncompliance is being considered during an IRB meeting, rather than the COT. Alternatively, the IRB may choose to submit a minor noncompliance case to COT for investigation. If Continuing and/or Serious Noncompliance is identified during the review, then the case must be referred directly to the COT for an investigation.

I. Types of Noncompliance that may be reviewed by the IRB:

Potential minor non-compliance including but not limited to some protocol violations and situations described below should generally fall under the IRB of record's purview. These situations are usually considered to be not reportable to OHRP.

A. Over-enrollment of Subjects

For a minimal risk study, over-enrollment is generally considered to be minor noncompliance.

Over-enrollment in a greater than minimal risk study, or a pattern of over-enrollment that is observed in any study, should be referred to the COT for consideration of whether an investigation may be appropriate and whether it constitutes Continuing or Serious noncompliance.

B. Performance of Research Activities During a Lapse in IRB Approval

1. Performance of data analysis during a lapse in IRB approval:

Data analysis that occurred during a lapse is considered to be minor noncompliance. The IRB Manager/IRB Staff should determine if any data analysis occurred and establish the extent of study-related activity during the lapse. If any study-related procedures (e.g., follow-up interaction with subjects) were conducted during the lapse, then proceed to item 2 below.

2. Performance of study related procedures other than data analysis during a lapse in IRB approval

a) Minimal risk research

If an investigator actively recruits or enrolls subjects or conducts study interventions or procedures during a lapse in approval or there is reason to suspect

that study-related procedures may have been conducted during a lapse, the IRB Manager/Chair should determine the extent of noncompliance (e.g., the procedures conducted, the number of subjects that were involved in the research conducted during the lapse, the individuals who conducted the procedures during the lapse, any other relevant information). The noncompliance may be considered minor noncompliance only if minimal risk research procedures were performed during the lapse in IRB approval.

b) Greater than minimal risk research

If an investigator actively recruits or enrolls subjects or conducts study interventions or any procedures that are greater than minimal risk during a lapse in approval, or there is reason to suspect that study-related procedures may have been conducted during a lapse, the study should be referred to the COT for further investigation.

C. Exempt Research

If an investigator conducts study interventions or procedures (or there is reason to suspect that study-related procedures may have been conducted) in a manner whereby the research study would no longer qualify as exempt, the IRB should determine whether the noncompliance is minor in accordance with this policy.

D. Protocol Violations

As defined in the IRB Standard Operating Procedures (SOPs), a protocol violation is a change or modification that was not approved prospectively by the IRB and is identified by the research staff after the change was implemented. Protocol violations may be considered as noncompliance with the federal regulations for the protection of human subjects.

Major and minor protocol violations are defined in the IRB SOPs. Minor protocol violations may be reviewed by the IRB to which the protocol is assigned; major protocol violations should generally be managed by the COT.

The IRB should determine whether or not the protocol violation(s) performed are minor noncompliance. If it appears that the protocol violation(s) may be minor noncompliance, the violation(s) may be reviewed by the IRB. Otherwise, the violation(s) should be referred to the COT for further investigation.

All protocol violations, regardless of compliance considerations, should be reviewed promptly by the designated IRB for consideration of how the protection of human subjects may be affected by the violations. For situations in which the IRB requires more information about the violations in order to make such determinations, the IRB may request an investigation from the COT.

E. Procedural Noncompliance with Consent or HIPAA Forms

The following examples can be considered minor noncompliance and reviewed by the IRB Chair:

- 1) the PI did not sign a consent document and the PI's signature is specifically requested on the IRB-approved consent document;
- 2) a subject did not sign the appropriate IRB-stamped consent document but all of the content of the consent document is the same;
- 3) failure to have a HIPAA Form A signed by one or two subjects (failure to have a HIPAA Form A signed by more than two subjects should be referred to COT and reported to the Privacy Officer). Use of any Protected Health Information (PHI) for research purposes for which a HIPAA Authorization Form was not signed by the subject is considered noncompliance and must be referred to the COT and reported to the Privacy Officer.

F. Other incidents of noncompliance that may be considered minor noncompliance

Other incidents of minor noncompliance that are not listed above and that are discovered by a designated IRB upon review of a submission may be reviewed by the IRB Chair of the designated IRB after consultation between the ED or AD.

II. Processing of potential minor noncompliance by the IRB

The IRB Manager/Chair should notify the Principal Investigator (PI) that the incident was minor noncompliance with federal regulations, state law, applicable policies, and/or the IRB-approved protocol. IRB staff should inform the PI that the incident was found to be minor noncompliance, and when appropriate (e.g., there are multiple occurrences of minor noncompliance) obtain a written acknowledgement from the investigator that he/she is now aware that the incident was minor noncompliance and will attempt to prevent such noncompliance in the future.

The IRB Chair, or the Board if the minor noncompliance is being considered during an IRB meeting, will then:

- confirm that the incident was minor noncompliance, or refer the case to the COT;
- determine whether to allow use of the data that was collected out of compliance;
- determine if a corrective action plan is required, and if so, the IRB Manager/Chair should request it for immediate review;
- document the findings in RASCAL (e.g., notes, minutes, correspondence, internal documents, etc.);
- for all minor noncompliance cases, a copy of the corrective action plan received by the IRB should be attached in RASCAL.

All incidents of potential minor noncompliance that will be handled by the IRB in accordance with this policy must be reported to the COT in the Minor Noncompliance Database for tracking purposes.