

STANDARD OPERATING PROCEDURE
Protocol Violation, Deviation, and Non-Compliance Reporting

1 PURPOSE

- 1.1 This policy establishes the IRB-reporting requirements for protocol violations, deviations, and non-compliance.

2 DEFINITIONS

- 2.1 Continuing Noncompliance: Repeated occurrences of Noncompliance by the same investigator or by the institution.
- 2.2 Deviation: Any change, divergence, or departure from the approved study design or procedures of a research protocol that is under the investigator's control and that has not been approved by the IRB, and does not affect the participant's safety, rights, or welfare and/or the completeness, accuracy and integrity of the study data. This term, though sometimes used interchangeably with the term "violation," is (i) most often used when the variance is intended for the safety of one or more research participants or is an unintended change that is not considered as serious as a violation, (ii) is considered minor or administrative, and (iii) may involve no more than minimal risk to participants or others.
- 2.3 Noncompliance: Failure to comply with federal regulations, state laws, institutional policies, requirements or determinations of the IRB, and/or provisions of the approved research study. It is not considered noncompliance when there is a need to deviate from the approved protocol in order to protect the welfare of research participants.
- 2.4 Protocol Violation: Any deviation that may affect the subject's rights, safety, or welfare, and/or the completeness, accuracy and integrity of the study data. This term though sometimes used interchangeably with "deviation" is often considered a major, more serious, variance from an approved protocol than a deviation.
- 2.5 Serious Noncompliance: Failure to comply with federal regulations, state laws, institutional policies, requirements or determinations of the IRB, and/or provisions of the approved research study, where the occurrence involves *substantive* potential or actual increased risk to the safety, rights and welfare of research subjects.

3 POLICY

- 3.1 It is the policy of The Christ Hospital IRB to be notified of any Protocol Violation and Serious and/or Continuing Non-Compliance.

4 RESPONSIBILITY

- 4.1 The Principal Investigator is responsible for reporting Protocol Violations and Non-Compliance to the IRB Office in a timely manner.
- 4.2 The IRB Office staff is responsible for directing the information to the Chair and IRB for review, as applicable, documenting discussion in the meeting minutes, and all correspondence regarding the matter.

- 4.3 The IRB Chair is responsible for reviewing and investigating Reportable Events and leading the discussion of such events at the convened meeting.
- 4.4 The IRB is responsible for reviewing and making determinations regarding Reportable Events.

5 PROCEDURE

- 5.1 Principal Investigator (PI), or their research team on their behalf, performs the following:
 - 5.1.1 Protocol Deviation Reporting Requirements
 - 5.1.1.1 Documents the deviation in the study file, preferably on a log, to be reviewed at study specific intervals by the PI to determine if continuing noncompliance has occurred and becomes reportable. These logs are not required to be submitted to the IRB. Though, the IRB Office may audit these files at any time.
 - 5.1.2 Protocol Violation Reporting Requirements
 - 5.1.2.1 Documents the Protocol Violation using the Reportable Event submission form and submits to the IRB through Mentor IRB within 10 business days. PI must develop a corrective action plan to present to the IRB for review and approval. This corrective action plan will outline what steps the PI has taken or will take to resolve the event and to prevent such events from occurring in the future.
 - 5.1.3 Non-Compliance Reporting Requirements
 - 5.1.3.1 Non-Compliance
 - 5.1.3.1.1 Documents the non-compliance, if not serious or continuing, in the study file, preferably on a log, to be reviewed at study specific intervals by the PI to determine if continuing noncompliance has occurred and becomes reportable. These logs are not required to be submitted to the IRB. Though, the IRB Office may audit these files at any time.
 - 5.1.3.2 Serious and/or Continuing Non-Compliance
 - 5.1.3.2.1 Documents the non-compliance, the using the Reportable Event submission form, if applicable, or by notifying the IRB through Mentor IRB within 10 business days. PI must develop a corrective action plan to present to the IRB for review and approval. This corrective action plan will outline what steps the PI has taken or will take to resolve the event and to prevent such events from occurring in the future.
- 5.2 The IRB Office staff and/or Chair review the submission and perform the following:
 - 5.2.1 Protocol Violations and Serious and/or Continuing Non-Compliance
 - 5.2.1.1 Upon receipt of Reportable Event, the submission is assigned to the Chair for review.
 - 5.2.1.2 The Chair reviews the Reportable Event submission and determines if it is reportable

- 5.2.1.2.1 If reportable, the Chair sends to the Full Board for review and determination.
- 5.2.1.2.2 If reportable, the IRB Office completes the *Non-Compliance & UAP Reporting Checklist* to determine which entities require reporting after the determination of the convened IRB. The incident must be reported within 30 days of initial IRB determination.
- 5.2.1.3 If not reportable, the Chair sends notification to the PI and makes a note to file of determination.
- 5.3 The IRB reviews the Reportable Event at a convened meeting and performs the following:
 - 5.3.1 Protocol Violations and Serious and/or Continuing Non-Compliance
 - 5.3.1.1 Upon receipt of Reportable Event submission, the document is forwarded to the Chair for review.
 - 5.3.1.2 The Chair reviews the Reportable Event submission and determines if it is reportable.
 - 5.3.1.2.1 If not reportable, the Chairman sends notification to the PI and makes a note to file of determination.
 - 5.3.1.2.2 If reportable, study enrollment is placed on hold and the Reportable Event is assigned to the Full Board for review and determination.
 - 5.3.1.2.2.1 The IRB determines the appropriate action(s) to be taken based on information provided and the additional facts gathered by the Chair during the investigation. The PI is notified in writing.
 - 5.3.1.2.3 If reportable AND serious and/or continuing non-compliance, study enrollment is placed on hold and depending on severity, the Chair may audit the study and/or call a Board of Inquiry, consisting of the Chair, Institutional Official, and one scientific board member to discuss the violation. The Chair and/or Board of Inquiry will meet with the PI to discuss facts of the case being evaluated. The Chair and/or Board of Inquiry reports findings to the Full Board for review and determination. If the research is conducted or supported by HHS or a federal agency that has adopted the Common Rule, an incident report will

be submitted to the Office for Human Research Protections (OHRP) promptly. If the research is FDA-regulated, an incident report will be submitted FDA promptly.

5.3.1.2.3.1 The IRB determines the appropriate action(s) to be taken based on information provided and the additional facts gathered by the Chair and/or Board of Inquiry during its investigation. The PI is notified in writing.

7 DOCUMENTS

7.1 None.

8 REFERENCES

- 8.1 [45 CFR 46.108\(a\)\(4\)\(i\)](#)
- 8.2 [21 CFR 56.108\(b\)](#)
- 8.3 [21 CFR 312.32](#)
- 8.4 [21 CFR 812.150](#)
- 8.5 [Guidance for Clinical Investigators, Sponsors, and IRBs Adverse Event Reporting to IRBs Improving Human Subject Protection](#), DHHS, FDA, January 2009
- 8.6 TCH IRB Reference Manual- Section 12.0 “Allegations of Non-Compliance”
- 8.7 TCH IRB SOP- 2.05 “Reporting Unanticipated Problems”
- 8.8 TCH IRB SOP- 3.06 “Compliance with Human Subjects Regulations or IRB Requirements”
- 8.9 TCH IRB SOP- 3.10 “Misconduct in Research”