

Section 5: Recordkeeping, Reporting, Non-Compliance, Unanticipated Problems, Adverse Events, Suspension, Termination

5.1. Recordkeeping

Policy

In accordance with federal regulations ([45 CFR 46.115](#) and [21 CFR 56.115](#)) Research Support Services (RSS) maintains an organized protocol file. The term “protocol file” will be used to designate both paper and electronic format documentation of records relevant to each study. The protocol file is available to IRB members and staff of RSS, and is accessible for inspection and copying by authorized representative of government oversight agencies and accrediting bodies.

Procedures

Minutes

Minutes of IRB meetings are the responsibility of the Research Support Services Specialist. Minutes are to reflect the agenda of each meeting, and are to record the discussion and action taken on each agenda item. The minutes are to include the following:

- Meeting attendance of members present and absent; initial and continued presence of a majority of members (i.e., quorum), including at least one non-scientist, and if a licensed physician was present for review of all FDA protocols.
- The deliberations, actions, and votes on each protocol that is subject to initial, or continuing review, and each amendment or revision that is subject to full Committee review. The votes are numerically recorded as for, against, abstain, and left room due to conflict of interest (must include name of member) not available during vote (must include name of member present at meeting but was not in the room when the final vote was taken).
- The actions the committee may vote on are:
 - Approved
 - Conditionally Approved
 - Deferred for further review by full IRB
 - Disapproved
 - Tabled
 - Modifications Required
 - Termination
- Discussions related to adverse events, deviations, violations and whether they are determined to be serious or continuing non-compliance.

- Discussion of any non-compliant incidents and whether they are determined to be serious or continuing non-compliance.
- Reports submitted as a serious or unexpected event involving risks to subjects or others which was determined to be an unanticipated event involving risks to subjects or others.
- Discussion of any administrative issues addressed during the meeting.
- Notation of all concerns raised about a protocol, including resolutions.
- Summaries of discussions of controversial issues and resolutions.
- Specific reasons for required changes to research, or for its disapproval.
- Notation of the duration of the approval period granted.
- Documentation of specific findings related to:
 - *Children*- A determination as to whether the Committee concurs that the research meets the federal regulations [45 CFR 46.404-46.407](#) and FDA [21 CFR 50.50-50.55](#).
 - *Assent*- A determination as to whether the Committee concurs that the requirements for permission by parents or guardians and for assent by children meets the requirements under [45 CFR 46.408](#).
 - *Wards of the State or Other Agency*- A determination as to whether the Committee concurs that the research meets the findings required by [45 CFR 46.409](#) and [21 CFR 50.56](#).
 - *Prisoners*- A determination as to whether the Committee concurs that the research meets the findings required by [45 CFR 46.305\(a\)](#) and represents one of the categories of research permissible under Department of Health and Human Services regulations required by [45 CFR 46.306 \(a\)](#).
 - *Pregnant Women, Fetuses, and Neonates*- A determination as to whether the Committee concurs that the research meets the findings required by [45 CFR 46 Subpart B](#).
 - *Research Involving Individuals with Impaired Consent Capacity*- A determination as to whether the Committee concurs that the research meets the findings required by [45 CFR 46.111\(b\)](#) and [21 CFR 56.111](#).
 - *Investigational New Devices*- A determination as to whether the Committee concurs that the significant or non-significant risk for Investigational New Device and rationale for that decision meets requirements under [21 CFR 812.3\(m\)](#).
 - *Waivers and Alterations of Informed Consent*- A determination as to whether the Committee concurs that the informed consent documents meets the findings required by [45 CFR 46.116](#)

Copies of the draft minutes are to be presented to the full IRB at a convened meeting, and if no objections are made minutes will stand as stated.

Informed Consent Documents

Approved consent documents will be maintained in the IRBNet package in which it was approved, and the Principal Investigator is responsible for maintaining originals of all signed informed consent documents for a minimum of three (3) years from the date the study is concluded (or longer depending on the requirements of certain funding agencies). In case of serious illness, death, or incapacitation of the PI, the Department Head of the PI will be responsible for maintaining the informed consent documents, or assigning someone within the Department to ensure this requirement is met.

If the PI is a student and the student has graduated, the advisor is responsible for maintaining the originals of all signed informed consent documents for the prescribed timeframe.

Policy & Procedures

Research Support Services maintains copies of all policies and procedures pertinent to the UIR Human Subject Protection Program. These policies and procedures are made available to investigators and research staff on the Research Support Services website. As deemed necessary or appropriate to ensure fulfillment of institutional responsibilities under the existing assurance, to improve operational efficiency, or to address other concerns that may arise, the policies and procedures may be revised as needed.

Contents of Protocol Files

Upon initial submission of a protocol to RSS, an IRBNet ID is generated by IRBNet and the Research Support Services Specialist will add a local board reference number. This file will be maintained in IRBNet from initial submission to closure of the protocol. All subsequent submissions will be a “package” which is associated with the initial submission. The files are to contain official records, as described below, and may also contain notes that document conversations that take place between the investigator and RSS staff. The RSS staff is responsible for assuring that the appropriate documentation is maintained.

RSS protocol files are to include the following official records and documentation in IRBNet:

- Initial application and appropriate appendices.
- Recruitment materials, posters, flyers, letters.
- Letters of Support (if necessary).
- Informed Consent, Parental Permission, Assent, HIPAA Authorization (if applicable).
- Approval notifications from the Radiation Safety Committee (RSC) and Institutional Biosafety Committee (IBC) if applicable.
- Assessments, surveys, and questionnaires.
- Continuing review forms, correspondence, and subsequent approvals, including updated approved consents.

- Unanticipated problem reports including subject complaints and subsequent correspondence.
- Amendment and/or revisions, subsequent correspondence regarding such, and notification of approval.
- Reports of any injuries and subsequent correspondence.
- Reports of any deviations and violations, and subsequent correspondence.
- Reviewer worksheets.
- Drug/device/biologic investigational plans, brochures, package inserts, and sample consents (if applicable).
- Closure of Study.
- CV for first time Principal Investigator.

5.2. Non-Compliance: Investigations and Determinations

Policy

It is the policy of UIR to comply with all applicable local, state, and federal regulations in the conduct of research involving human subjects. Principal investigators (PI's) and Department Heads or any staff members are required to report regulatory non-compliance to either the Chair of UIR IRB, the Director of Healthcare Compliance & Risk Management, or to the Institutional Official, and to participate in institutional efforts to address and resolve non-compliance. The RSS, UIR IRB, the Director of Healthcare Compliance & Risk Management, and the Institutional Official are responsible for investigating and assessing non-compliance, reporting to RSS and requesting further remedies from RSS itself. The IRB will make a final determination that an event is serious or continuing non-compliance. The "Reporting Policy" ([See Section 5.5](#)) will be followed for all reportable events.

Definitions

Non-compliance is defined as any violation of any regulation that governs human subject research, any deviation from the study protocol approved by the UIR IRB, or any violation of any conditions imposed by the UIR IRB on the approval of the study or conduct of the research.

Minor non-compliance is a non-compliant event that does not impact the subject safety, compromise the integrity of study/data, violate a subject's rights or welfare or affect the subject's willingness to participate in the research.

Serious non-compliance is a non-compliant event that may impact the subject safety, increase the risks to the subjects, affect the integrity of the data, violate a subject's rights or welfare or affect the subject's willingness to participate in the research.

Continuous non-compliance is defined as a series of more than one non-compliant event, in reasonable close proximity, that indicates the need for evaluation of the methods and systems used to protect human subjects. Continuous non-compliance need not involve a sequence of similar events if the events, taken as a whole, indicate that examination of the methods and systems used is warranted.

Procedures

Principal Investigators are responsible for reporting in writing, all suspected incidents of non-compliance within 2 business days of discovery. Investigators may make an initial report in person, but must follow up with a written report. In addition, any person may report suspected non-compliance, in person or in writing. The reports should be sent to the RSS Specialist who will send them to the UIR IRB Chair, the Director of Healthcare Compliance & Risk Management, or the Institutional Official. Any allegation regarding non-compliance or any concern about human subject protections will be fully investigated. If at any time during an investigation there are concerns regarding scientific misconduct, it will immediately be referred to the Institutional Official.

UIR IRB Chair and Research Support Services Responsibilities

The UIR IRB Chair and/or Research Support Services are responsible for obtaining as much information as possible from the individual who initially reports the event. The IRB Chair and Research Support Services Specialist are then to meet and discuss the following:

- The incident and the facts presented to date.
- Identification of those individuals involved in the incident or likely to be involved in the investigation and resolution of the incident. If necessary, a meeting should be scheduled as soon as possible after the incident is reported (within 72 hours, when feasible) to begin to discuss and resolve the incident. Attendees may include the investigator(s), the investigator's Department Head, the UIR IRB Chair, the RSS Specialist, the Director of Healthcare Compliance & Risk Management, the Institutional Official, and any other staff member thought to be involved in the non-compliance incident and required resolution.
- Whether there are sufficient facts to demonstrate serious or continuing non-compliance that is reportable in accordance with the "Reporting" policy ([See Section 5.5](#)). If so, this will be immediately reported to the IRB who, based on a completed investigation, will make a final determination. If the UIR IRB determines it is serious or continuing non-compliance the Reporting Policy will be followed. (In most cases, more information will be required before a determination is made that the event is either serious or continuing non-compliance).

Upon discussion and investigation of the non-compliant incident the IRB Chair may take the following actions:

- Determine that the incident is minor non-compliance and requires either no further action, or compliance with a corrective action plan that is acceptable to the Chair and agreed upon by the investigator;
- Require that preliminary steps be immediately taken to further investigate and take corrective action of the non-compliant incident and report to RSS;
- Determine if the incident is to represent serious or continuing non-compliance and recommend to the IRB that the protocol be suspended or terminated in whole or in part. This step may be taken as a final measure or as an interim measure where investigatory conclusions, although incomplete, are conclusive enough in pertinent part to justify IRB actions.

UIR IRB Responsibilities

The UIR IRB is responsible for making a final determination as to whether serious or continuing non-compliance has occurred. The UIR IRB is to receive notification of any incident that the Chair has determined that a potential incident of serious or continuing non-compliance exists. This should occur at the earliest possible time which is usually the next scheduled meeting. The UIR IRB should be advised by the Chair about the actions taken thus far and determine further actions to be taken. All members will be given a summary of the incident prepared by the RSS Specialist and important supporting documents. The UIR IRB, directly or through a delegate, such as the RSS Specialist or a sub-committee formed for the purpose, may request any documents it deems necessary to conduct the investigation. As determined by the specifics of the situation, the UIR IRB reserves the right to conduct any type of investigation deemed necessary in order to obtain the required information. Moreover, the UIR IRB may delegate any component of the investigation to those individuals best suited to perform the functions of the investigation. At any time during the investigation the UIR IRB may take any one or more of the following actions:

- Suspend or terminate the protocol.
- If further investigation is warranted a designated individual or a sub-committee will be formed to review and investigate the incident and provide information and recommendations for resolution back to the UIR IRB.
- Require additional information.
- Require modifications to the protocol and/or consent form.
- Require that subjects currently or previously on protocol be notified of the non-compliance when such information might relate to their willingness to continue to take part in the research.
- Require subjects to be re-consented.

- Modify the continuing review schedule.
- Require remedial education.
- Require oversight by a senior investigator.
- Monitor the informed consent process.
- Require immediate or periodic audits.
- Refer concerns or findings to areas of the organization that administer other policies, laws, and regulations implicated by the non-compliance.
- Any other action deemed necessary by the UIR IRB.

The UIR IRB will be continually updated as information becomes available until the final resolution. If it determined the incident represents serious or continuing non-compliance the “Reporting” policy ([See Section 5.5](#)) will be followed.

Investigator Responsibilities (if applicable)

Investigators are responsible for reporting non-compliance on their protocols. Investigators may choose to voluntarily initiate a suspension or termination until the potential issue is investigated and/or resolved. Investigators will also be informed, in writing, when allegations of non-compliance are made on their protocols. Investigators are required to fully cooperate with any fact finding and subsequent investigation, and maintain all potentially useful records pending investigation, even if regulations or other policies would otherwise permit destruction of those records. The investigator is responsible for responding promptly, in writing, to all issues and questions raised. This may include an explanation of the non-compliance event, answers to questions raised by the UIR IRB, and a plan of action to ensure that similar incidents do not occur in the future. Investigators are responsible for complying fully with all directives of the UIR IRB, whether investigatory or remedial. If the UIR IRB has determined that subjects must be contacted with regards to the non-compliance incident, the investigator will be responsible for doing so if the UIR IRB directs.

Institutional Official Responsibilities

The IO is responsible for submitting a report on behalf of the institution in accordance with the “Reporting: policy ([See Section 5.5](#)).

The Final Report

For incidents determined to be serious or continuing non-compliance, the “Reporting” policy will be followed. A file of the non-compliance incident, regardless of the ultimate determination, will be maintained in IRBNet.

5.3. Unanticipated Problems Involving Risks to Research Subjects and Others Including Adverse Events

Policy

Federal regulations [45 CFR 46.103\(b\)\(5\)\(i\)](#) and [21 CFR 56.108\(b\)\(1\)](#) require IRB's to have written procedures for ensuring prompt reporting to the IRB, appropriate institutional officials, and the federal department or agency head of any unanticipated problems involving risks to subjects or others. In keeping with this regulatory requirement, investigators are required to promptly report to the IRB unanticipated problems involving risks to subjects or others. Serious and unexpected events that are related or possibly related to research is one type of unanticipated problem involving risks to subjects or others.

Incidents that may potentially be considered unanticipated problems that involve risk to subjects or others may also become apparent during continuing renewals, incidents of non-compliance, quality improvement initiatives and reports, protocol violations, deviations, complaints or concerns from subjects or family members, concerns raised by research staff or investigators, participant injuries, deaths, and hospitalizations.

This policy is in line with guidance documents from both the Department of Health and Human Services (DHHS) Office for Human Research Protections (OHRP) and the FDA that clearly indicate that IRB's are only required to be promptly notified of unanticipated problems involving risks to subjects or others, as opposed to being informed of all adverse events. In fact, most adverse events do not constitute unanticipated problems involving risks to subjects or others, and therefore do not require reporting to the IRB. Additionally, some unanticipated problems that require prompt reporting to the IRB do not involve actual harm to subjects or others. It is also important to note that there are additional categories of events that require reporting that do not involve drugs, devices, or research interventions.

Definitions

Unanticipated problem that involves risks to subjects or others (UP)

An "Unanticipated Problem Involving Risks to Participants or Others," or UP, is any event that 1) is unanticipated; not expected given the nature of the research procedures and the population being studied and, 2) suggests that the research places subjects or others at a greater risk of harm related to the research than was previously known or recognized. To be defined as an *unanticipated problem that involves risks to subjects or others*, the event must meet all of the following three criteria:

1) **Unanticipated:** The event is unexpected or unforeseen in type, frequency, scope, consequences, or severity; or, if anticipated or referred to in part, is not fully addressed or specified within the initial protocol application, any amendments, consent forms, investigator brochures, minutes, and any existing documentation regarding the research conducted to date under the protocol.

2) **Potential for Risk: Caused Harm or Placed a Person at Increased Risk of Harm.** As a result of the event, participants or other individuals are either placed or are likely to be placed at physical, psychological, social, or emotional harm that has increased since the time the research was approved by the IRB.

3) **Problem Related to the Research:** The event, situation, or issue arises from the conduct of the research and is determined to be related or probably related to the research and is of concern for the research participants or others directly affected by the research. Problems may:

- Be attributable to the conduct of the research or,
- May result from failures or errors in general systems outside of the research, or factors that are not controlled by the researcher under the protocol, but on which ethical conduct of the research depends, according to the protocol.

Unanticipated problems that involve risks to subjects or others include risks, not only materialized adverse events and include risks to persons who are not research subjects.

Investigators should note that this definition also includes problems that arise from general system failures that contribute to such risks, not simply events that arise from the investigator's conduct of the research according to the protocol.

Related/Probably Related

An event is determined to be definitely related to the use of the drug, device, or intervention, if there is a reasonable probability that the event may have been caused by the drug, device, or intervention. A related or probably related event has a strong temporal relationship to the study protocol and an alternative etiology is unlikely or significantly less likely.

Possibly Related

An event is possibly related to the drug, device, or intervention if there is a reasonable possibility that the event may have been caused by the research protocol, even if there is insufficient information to determine the likelihood of this possibility.

Overdose/Error of Drug or Biologic

Report if there is an error or an overdose of a drug or biologic administered as part of a research protocol. (Ex. A miscalculation of a drug dose, a mix-up that results in a wrong drug being administered e.g., a placebo instead of intervention drug).

Source

OHRP Guidance Document: *Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events*. U.S. Department of Health and Human Services: Office for Human Research Protections, Jan. 15, 2007.

FDA Guidance Document: *Guidance for Clinical Investigators, Sponsors, and IRBs Adverse Event Reporting—Improving Human Subject Protection (Draft Guidance)*. U.S. Department of Health and Human Services: Food and Drug Administration, April 2007.

Procedures

Criteria for Reporting

Investigators are required to report only the following events to the UIR IRB:

- **Death** of research subject thought to be related to research study or possibly related to research study.
- **Adverse Event-** Both the following must apply in order to be reportable:
 - **Unexpected** (in terms of nature, severity, or frequency) given the research procedures that are described in the protocol related documents, such as the IRB approved research protocol and informed consent document; and the characteristics of the subject population being studied, **AND**
 - **Related or possibly related** to a subject's participation in the research.
- **Medication or laboratory errors** that have or could have caused risk to subjects or others.
- **Breach of confidentiality/HIPAA Violation-** resulting from disclosure of confidential information or identifiable private information or loss/stolen confidential information (lost laptop, inadvertent email distribution).
- **Significant protocol deviation/non-compliance-** an intentional or unintentional change without IRB approval that deviates from the approved protocol, consent document, study procedures, recruitment process or study materials that has or had the potential to:
 - Impact subject rights, welfare or safety of present, past or future subject(s);
 - Increase the risks and/or decrease the benefit for research subject(s);
 - Compromise the integrity of the study data or;
 - Affect the subject's willingness to participate in the study.
- **Complaint-** A research related complaint by a research subject or another person.
- **Intentional change to protocol without IRB approval** to eliminate apparent immediate hazard to research subject(s).
- **Interim findings, publication, or safety report-** An interim safety report (including Data and Safety Monitoring report), publication in the literature, report of interim results, or another finding that indicates an unexpected adverse change to the risks or potential benefits of the research.
- **Enforcement Action-** e.g., an unfavorable audit report; suspension or disqualification of an investigator; FDA form 483 or Warning letter.
- **Study personnel misconduct**

- **Incarceration of a research subject** during study participation (required for regulatory purposes, so additional mandated IRB review can be accomplished in order for the participant to remain in the trial).
- **Required prompt reporting-** An event that required prompt reporting to the sponsor or IRB in accordance with the protocol.
- **Other-** Any other event the PI thinks (or is unsure if it) may represent an unanticipated problem involving risk to subject's or others.

These events should be reported within two business days of being known. Events that do not meet the criteria as defined in this policy do not require submission to the UIR IRB. However, investigators must continue to meet their obligations to report events to the sponsor, the Food and Drug Administration (FDA), and the data safety monitor.

How to Report

In accordance with the criteria listed above investigators are required to complete a "Prompt Reporting to IRB" form.

The form must be completed regardless of whether other forms e.g., sponsor IND safety reports, etc. have already been completed. Information such as a summary of the event, reports from the coordinating center or drug company may be attached and submitted with the form.

- The form will ask the investigator to independently determine whether the event was thought to be related or possibly related to the research study.
- The form will ask the investigator to independently determine whether the event was thought to be anticipated or unexpected. In some cases the PI may not agree with a sponsor's assessment of the relationship between the study drug and the unanticipated problem (UP). If either the PI or the Sponsor considers the event to be an UP, then a report should be filed. The contrary opinions can be elaborated in the report.
- Any other individual (e.g., research staff, subject, IRB member, or the general public) may report an event, issue, or situation for a research protocol that they are concerned represents a potential UP that involves risk to subjects or others to the UIR IRB Chair, IO, or Research Support Services Specialist.

Investigation and Evaluation of the Reports

Once a "Prompt Reporting to IRB" form is received in the RSS Office the following actions will occur:

- The form or report will be initially screened by the RSS Specialist to determine whether it is a report of any unexpected and related event for a subject enrolled under the auspices of UIR as defined above or from another institution.

- If based on the information received, there is any immediate concern that subjects already enrolled or subjects to be enrolled in the trial may be subject to immediate increased harm to their health, safety, or welfare, the IRB Chair will be immediately contacted. If necessary, the IRB Chair will require that the protocol be suspended or terminated in accordance with the UIR IRB “Suspensions and Terminations” policy ([See Section 5.5](#)). In most situations this will not be necessary.
- All related unanticipated events will be reviewed by the Chair of the IRB who will determine if the event should be placed before the full IRB.
 - **IRB Chair Review:**
 1. The IRB Chair will review the event and ask for any associated documentation he/she feels necessary to review the event. The chair may ask for additional information from the PI or any additional person he/she feels necessary to understand the event.
 2. The investigator will receive notification as to whether the report was accepted, whether additional information or action is required.
 - **Full IRB Review:**
 1. A copy of the approved informed consent document and any other pertinent documents will be placed with the event report.
 2. Each event, including the approved informed consent and other pertinent documents will be assigned a primary reviewer. All UIR IRB members will receive a copy of the form and informed consent. Any member may request access to the full protocol and associated correspondence in IRBNet.
 3. At the IRB meeting the reviewer will report on the event to the full committee and determine whether any further action as listed below is required. The IRB will make a final determination as to whether the event needs to be reported as an unanticipated problem involving risks to participants or others. If the IRB determines that the event is an unanticipated problem involving risks to participants or others, the event will be reported according to the IRB “Reporting” ([See Section 5.5](#)) policy.
 4. The investigator will receive written notification as to whether the report was accepted, whether additional information or action is required, and whether reporting is required.

Determinations Concerning Appropriate Remedies

In reviewing and addressing any unanticipated problem that involves risk to others, the IRB committee or Chair may impose any remedy, or take any action, authorized by law or regulation, including:

- Initiate immediate corrective action, if necessary.
- Delegate a subcommittee or individual to perform further investigation.
- Require that individuals who have already consented to participation be notified.

- Require modification of any other aspect of the conduct of the research including recruitment, informed consent, research and clinical procedures, monitoring and safety assurance, and continuing review.
- Alter the frequency of continuing review.
- Require that enrolled subjects be provided with an amended informed consent document, and that the process of providing for informed consent be repeated with revised information. This will be required whenever the information may relate to the participants willingness to continue participating.
- Determine the incident involves serious or continuing non-compliance (See Section 5.2).
- Determine the protocol should be terminated or suspended (See Section 5.4).
- Require the investigator to inform other research participants or individuals who may be affected by the event or problem.
- Notification of investigators at other sites (if applicable).
- Observation of the consent process.
- Refer concerns or findings to other parts of the organization that administer other policies, laws, and regulations.

Other Reporting Requirements

This policy concerns only what needs to be submitted to the IRB and does not impact what investigators need to record or document as part of their research records. There may be additional reporting requirements. Depending upon the protocol, the sponsor or coordinating center, and requirements of regulatory authorities (DHHS or FDA), the investigator may be required to report other events that are not required by the IRB.

In addition, the annual IRB application for continuing review will ask whether based on these reports the risk profile has changed for the protocol and to summarize these events as part of the continuing review.

5.4. Suspensions, Terminations, Administrative Closures, Investigator Initiated Voluntary Suspension or Termination

Policy

It is the policy of UIR to comply with all applicable local, state, and federal regulations in the conduct of human subject research.

- The UIR IRB may suspend or terminate some or all of a research protocol as a result of the following:
 - There is serious or continuing non-compliance;
 - There are unanticipated problems that may involve risks to subjects or others.

Definitions

Suspension: Some or all activities on a protocol are stopped while a full investigation is completed, based on a determination that there is substantial reason to believe serious or continuing non-compliance or unanticipated problems involving risks may have occurred, and that suspension in whole or part is appropriate in order to protect human subjects pending completion of the investigation. Once the investigation is complete, a determination is made as to whether the suspension may be revoked and protocol activities resumed.

Termination: Some or all activities on a protocol are permanently discontinued. There has been a determination that serious or continuing non-compliance or unanticipated problems involving risks have occurred and no further work on the protocol may continue.

Administrative Closure: The process by which the Research Support Services Specialist close a research protocol if an investigator does not submit the required continuing review materials. Administrative closure occurs after the IRB approval period expires and the investigator does not make efforts in a timely manner to come back in compliance. Administrative closures are not reportable events since the protocol approval is already expired and there is no withdrawal of IRB approval.

Investigator Initiated Voluntary Suspension or Termination: An investigator may choose to voluntarily suspend or terminate some or all activities of an approved protocol. This should be reported to the UIR IRB and is not considered to be a reportable event unless the IRB independently determines that suspension or termination has occurred because there was an unanticipated problem involving risks to subjects or others, or an incident of serious and continuing non-compliance. In these situations the appropriate policies will be followed.

Procedures

Authority to Suspend or Terminate Approval of Research Protocols

The IRB may suspend or terminate some or all of the research conducted by a principal investigator (PI) as a result of the following:

- Serious or continuing non-compliance with the research.
- There are unanticipated problems that may involve risks to subjects or others.

In addition, the IRB Chair or the Institutional Official may suspend a protocol on an urgent basis in between IRB meetings. Suspensions are to be used when the evidence is sufficiently clear that the IRB determines that a suspension is warranted based upon the need to protect human subjects, and the significant likelihood, based on the evidence, that one or both of those criteria have been met. Terminations are based upon a completed investigation substantiating one or

both of those criteria and the IRB's determination that termination is the appropriate step to take to protect human subjects.

Reporting Suspensions and Terminations

- The IRB Chair, Research Support Services Specialist, or the Institutional Official is to directly notify the PI the IRB has suspended or terminated the research. If the PI is unavailable, the IRB Chair, Research Support Services Specialist, or the Institutional Official is to directly notify the PI's Department Chair or other appropriate supervisor of the action taken.
- The Research Support Service Specialist is to send the PI and the Department Chair written notification of the suspension or termination of the research. The reasons for the action are to be included in the notification.
- Any suspension or termination made by the IRB, Research Support Services Specialist, or the Institutional Official will be reported to the IRB at the next scheduled meeting.
- If there is a suspension or termination of a research protocol the "Reporting" ([See Section 5.5](#)) policy will be followed.

Subject Protection after Suspension or Termination

Suspension and termination do not preclude other remedies to be considered as appropriate in order to protect human subjects, such as:

- Notification to subjects (via phone, email, mail) of the protocol's suspension or termination that includes the reasons for the suspension or termination and any course of action necessary.
- Notification to the subject's health care providers.
- In special circumstances, the gradual withdrawal of subjects from a protocol if abrupt discontinuation may put them at risk.
- Follow-up assessments and referrals, as required.
- Required PI submission of follow-up information regarding the welfare of the research subjects.
- Temporary or permanent transfer of the responsibility of the research to another principal investigator.
- Any adverse events or outcomes are reported to the IRB.

Investigator Initiated Voluntary Suspension or Termination

An investigator may choose to voluntarily suspend or terminate some or all activities of an approved protocol. This should be reported to RSS and is not considered to be a reportable event unless the IRB independently determines that suspension or termination has occurred because

there was an unanticipated problem involving risks to subjects or others, or there was an incident of serious or continuing non-compliance.

When an investigator voluntarily suspends or terminates a protocol, the IRB will be notified about the reason for the investigator initiated voluntary suspension or termination. The IRB may request any additional information required in order to make a determination.

Records

The date the research is suspended, terminated, or voluntarily suspended or terminated by the investigator is to be indicated in the protocol records. All correspondence associated with the suspension or termination is to be maintained in the protocol record.

Administrative Closure of Protocols

According to DHHS regulations [45 CFR 46.109\(d\)](#) a continuing review must be conducted once a year for all expedited and full board approved protocols. If this requirement is not met the RSS Specialist will administratively close a research protocol. Administrative closures occur after the IRB approval period expires and the PI has not come back into compliance. When the RSS Specialist administratively closes a research protocol, the investigator receives notification of this action through IRBNet and a letter of administrative closure will be posted, and no further work may continue on the protocol. Administrative closures that occur as a result of an investigator's failure to submit the required continuing review materials are not reportable in accordance with the "Reporting" ([See Section 5.5](#)) policy.

In order to open this study a PI will have to submit a continuing review form and all initial application materials as a new package in IRBNet.

5.5. Reporting

Policy

UIR complies with all local, state, and federal regulations that pertain to reporting requirements. These regulations require that the following be reported to the appropriate agency:

- Unanticipated problems that involve risk to participants or others;
- Suspension or termination of UIR IRB approval of research; and
- Serious or continuing non-compliance with regulations or the requirements of the UIR IRB.

The specific procedures for investigating and making pertinent determinations concerning those situations are addressed in the following sections:

- *Non-compliance: Investigations and Determinations*

- *Adverse and Unexpected Events and Unanticipated Risks to Research Subjects and Others*
- *Suspensions and Terminations*

UIR assurance of compliance is required to report all federally funded research to OHRP. The same criteria and process for conducting investigations, making determinations about reporting, and actions taken will apply to all research regardless of funding source. If an event involves research that is not federally funded the report will be sent to the IRB Chair and the Office of Compliance rather than OHRP or any of the federal agencies. All other reporting requirements listed below will remain the same as pertinent. Research Support Services (RSS) reserves the right to voluntarily report any event that is not associated with federal funding to OHRP.

Procedures

All reporting actions are to occur within the minimal amount of time necessary to conduct complete and conclusive investigations, with a final report goal of no more than 30 days from the time an event is identified and an initial report made. If additional time is necessary to complete the final report, the time frame is to the extent practicable to be specified in the initial report. If federally funded, the Institutional Official (IO) will submit any report on behalf of the institution.

Reportable Events

UIR IRB determines that an event represents an unanticipated problem that involves risks to participants or others; suspends or terminates research; or an event represents serious or continuing non-compliance.

Report Content

Following a complete investigation of the situation or incident, the RSS Specialist prepares a final report that includes the following:

- An overview of the situation or incident
- A description of the manner in which the investigation was conducted
- The findings of the investigation
- A full explanation as to why and how the incident occurred
- The actions determined, including any corrective actions
- Any sanctions invoked

The UIR IRB Chair, the Institutional Official, the Dean of Academic Affairs, Office of Compliance, and any other individual(s) deemed appropriate by RSS are to review the report. The IO makes the final determination regarding the report's content.

Report Recipients

A copy of the final report will be shared with government agencies as applicable, sponsors to the extent legally and contractually required, and with any others in the sole discretion of RSS and the Institutional Official. Possible recipients of the full report, excerpts or summaries, include:

- Office of Human Research Protections (OHRP) if federally funded.
- Food and Drug Administration (FDA) when the research is subject to regulation by the FDA.
- Funding agency when funded by a government entity (e.g., the Departments of Defense, Education, and Justice require copies of such reports), or non-federal funding agency.
- Licensing and accrediting bodies, where the report or some portion thereof implicates standards or regulations administered by those bodies.
- UIR IRB Chair and members.
- Principal Investigator (PI).
- PI's Department Head or supervisor
- Dean of College of Medicine and Dean of College of Pharmacy
- Grants and Contracts Office, when the research is funded by a grant or contract.
- Any other external sponsor, when the research is sponsored.

A copy of the report is to be placed in the protocol file, as well as any other files that are maintained during an investigation to determine whether an event is reportable.