McLaren HEALTH CARE		Policy Title:	Complaints and Non-Compliance in Human Subject Research
Effective Date:	January 16, 2012	**Policy Number:**	MHC_RP0123
Review Date:	December 18, 2015	**Section:**	Human Research Protections Program (HRPP)
Revised Date:	December 1, 2015	**Oversight Level:**	Corporate
Administrative Responsibility:	Corporate Director, HRPP Institutional Official, HRPP		

1. Purpose

1.1 The purpose of this policy is to establish guidelines for identifying and reporting all allegations of noncompliance in human subjects research, including but not limited to, allegations of serious and/or continuing noncompliance. This policy describes how complaints and allegations of non-compliance are handled by the IRB.

2. Scope

2.1 This policy applies to all faculty, staff, and students of the MHC and its subsidiary hospitals, our affiliate researchers, or other individuals who are involved in human subjects' research which has been reviewed and approved by the MHC IRB.

2.2 Any individual who is involved in conducting a human subject research study that is under the jurisdiction of the McLaren Human Research Protections Program (MHC HRPP).

3. Definitions

3.1 Refer to Appendix I "Definitions"

4. Policy

4.1 As part of its commitment to protecting the rights and welfare of human subjects in research, McLaren Health Care (MHC) IRB reviews all complaints and allegations of non-compliance and takes any necessary action to ensure the ethical conduct of research.

4.2 All Investigators and other study personnel involved in human subjects' research are required to comply with all laws and regulations governing their research activities, as well as with requirements and determinations of the MHC IRB.

4.2.1 Study personnel include the principal Investigator and any staff member directly involved with participants or the informed consent process.

4.3 Non-compliance with human subject protection requirements (e.g., U.S. Department of Health and Human Services (DHHS) regulations, Institutional Review Board (IRB) requirements) is a violation of McLaren Healthcare Corporation and its subsidiary hospitals.

4.4 Non-compliance presents a serious challenge to the IRB and to McLaren.

4.5 Regardless of investigator intent, unapproved research activities involving human subjects places those subjects at an unacceptable risk.

4.6 Investigators and their study staff are required to report instances of possible non-compliance. The Principal Investigator is responsible for reporting any possible non-compliance by study personnel to the IRB.

4.6.1 Common reports to the IRB that are not serious or continuing are typically protocol violations. However, any individual or employee may report observed or apparent instances of noncompliance to the MHC IRB Office Hotline. In such cases, the reporting party is responsible for making these reports in good faith, maintaining confidentiality, and cooperating with any MHC IRB and/or institutional review of these reports.

4.7 If an individual, whether investigator, study staff, or other, is uncertain whether there is cause to report noncompliance, he or she may contact the IRB Chair directly to discuss the situation informally.

4.8 Reports of non-compliance must be submitted to the MHC IRB Office within 10 working days of discovery of this noncompliance directly to the MHC IRB.

4.8.1 The report must include a complete description of the noncompliance, the personnel involved, and a description of the non-compliance. Complainants may choose to remain anonymous.

4.9 No one in the MHC and its subsidiary hospitals may approve research that has been disapproved by the IRB (45 CFR 46.112).

4.10 Investigators who believe that the IRB has acted contrary to provisions of 45 CFR 46 or 21 CFR 50 and 56 may contact either the Corporate Director of HRPP or the Institutional Office.

5. Procedure

5.1 Complaints:

5.1.1. The Chair of the MHC IRB will promptly handle (or delegate staff to handle), and, if necessary, investigate all complaints, concerns, and appeals received by the MHC IRB. This includes complaints, concerns, and appeals from investigators, research participants, and others.

5.1.2. All complaints, written or verbal (including telephone complaints), regardless of point of origin, are recorded in writing and forwarded to the IRB Chair and Corporate Director of HRPP.

5.1.3. Upon receipt of the complaint, the Chair in consultation with the Corporate Director of HRPP will make a preliminary assessment whether the complaint warrants immediate suspension of the research project. If a suspension is warranted, policy *MHC_RP0111_Study Suspension, Termination, Investigator Hold* will be followed.

5.1.4. If the complaint meets the definition of non-compliance, it will be considered an allegation of non-compliance.

5.1.5. If the complaint meets the definition of an unanticipated problem involving risk to subjects or others, it will be handled according to Policy *MHC_RP0121_ Reporting Adverse Events and Unanticipated Problems Involving Risks to Subjects or Others (UPIRSO).*

5.1.6. Within 3 business days of receipt of the complaint, the IRB Chair and/or Corporate Director of HRPP will generate a letter to acknowledge that the complaint has been received and is being investigated, providing a follow-up contact name.

5.1.7. If the complaint is actually a query from a subject regarding study procedures, payments not received, etc., it will be forwarded to the investigator/study team for handling. The investigator/study team will be required to inform the IRB when the matter is closed (and the subject is satisfied with the answer).

5.1.8. Complainants may choose to remain anonymous.

5.2 **Review of Allegations of Non-compliance:** All allegations of non-compliance will be reviewed by the IRB Chair, who will review:

5.2.1 All documents relevant to the allegation.

5.2.2 The last approval letter from the IRB.

5.2.3 The last approved IRB application and protocol;

5.2.4 The last approved consent document.

5.2.5 The grant, if applicable; and

5.2.6 Any other pertinent information (e.g., questionnaires, DSMB reports, etc.).

5.3 The IRB Chair will review the allegation and make a determination as to the truthfulness of the allegation.

5.4 The IRB Chair may gather more information through discussions or correspondence with the principal investigator.

5.5 The IRB Chair may request review by others (e.g., IRB member(s) or the IRB). If the IRB Chair determines that such review is necessary, the individual will receive all relevant materials (e.g., IRB file, communications, relevant research

materials [e.g., survey, consent], and audit reports). If any individual feels that he/she is not qualified to review the research study, the IRB staff should be notified.

5.6 The IRB Chair will be consulted to determine an appropriate replacement.

5.7 The investigator(s) may submit in writing his/her account and explanation of the events possibly constituting noncompliance. At his/her request, the investigator(s) may also appear before the IRB. Investigator(s) under investigation for noncompliance may choose to be accompanied, or represented, by faculty or legal counsel in presenting to the convened IRB. The investigator must notify the IRB in advance if this is the case. Or, the investigator(s) may have a member of the IRB, typically the representative from his/her college, institution, or the Chair of the IRB, present on their behalf to the convened IRB.

5.8 The IRB Chair, alone or in consultation with the IRB, determines whether the allegation is substantiated or has a basis in fact (incident involved noncompliance).

5.8.1 If the IRB Chair determines that noncompliance did not occur because the incident was within the limits of an approved protocol for the research involved, the determination is reported in writing to the PI and, if applicable, the reporting party.

5.8.2 If in the judgment of the IRB Chair, any allegation or findings of non-compliance warrants suspension of the research before completion of any review or investigation to ensure protection of the rights and welfare of participants.

5.8.3 The Chair may determine that additional expertise or assistance is required to make these determinations and may form an ad hoc committee to assist with the review and fact gathering process. When an ad hoc committee assists in the review process, the Chair is responsible for assuring that minutes of the meeting are generated and kept to help support any determinations or findings made by the ad hoc committee.

5.8.4 If the IRB Chair (or designee) determines that the allegation of noncompliance has no basis in fact, then no further action will be taken under this policy. If the IRB Chair (or designee) determines that the allegation of noncompliance is confirmed noncompliance, then Section 5.2 will be followed.

5.9 Review of Findings of Non-compliance

5.9.1 **Non-compliance is not serious or continuing:** When the Chair or Designee determines that the noncompliance occurred, but the noncompliance does not meet definition of serious or continuing noncompliance, the determination is reported in writing to the PI and, if applicable, the reporting party. The Chair will work with the PI to develop a corrective action plan to prevent future noncompliance. The report of noncompliance and corrective action is reported to the IRB in writing. If, however, the PI refuses to cooperate with the corrective action plan, the matter is referred to a convened meeting of the IRB with notification to the IO. Corporate Compliance Department will be notified of this as well.

5.9.2 Serious or Continuing Noncompliance: When the Chair or Designee determines that noncompliance has occurred and that the noncompliance meets the definition of serious or continuing noncompliance, the report of noncompliance is referred for review by the IRB at the next convened available meeting. However, the Chair may use discretion and call an emergency IRB meeting should the circumstances warrant such an urgent meeting.

5.9.3 All findings of serious or continuing non-compliance referred to the IRB will be reviewed at a convened meeting. All IRB members will receive all documents relevant to the allegation and:

5.9.3.1 The last approval letter from the IRB.

5.9.3.2 The last approved IRB protocol; and

5.9.3.3 The last approved consent document.

5.9.4 At this stage, the IRB may:

5.9.4.1 Find that there is no issue of non-compliance.

5.9.4.2 Find that there is noncompliance that is neither serious nor continuing and an adequate corrective action plan is in place.

5.9.4.3 Find that there is serious or continuing non-compliance and approve any changes proposed by the Chair and/or ad hoc committee.

5.9.4.4 Find that there may be serious or continuing non-compliance and direct that a formal inquiry (described below) be held; or

5.9.4.5 Request additional information.

5.10 Inquiry Procedures

5.10.1 A determination may be made by the IRB that an inquiry is necessary based on several issues that may include but are not limited to:

5.10.1.1 Subjects' complaint(s) that rights were violated;

5.10.1.2 Report(s) that investigator is not following the protocol as approved by the IRB;

5.10.1.3 Unusual and/or unexplained adverse events in a study;

5.10.1.4 Repeated failure of investigator to report required information to the IRB.

5.10.2 A subcommittee is appointed consisting of IRB members and non-members if appropriate, to ensure fairness and expertise. The subcommittee is given a charge by the IRB, which can include any or all of the following:

5.10.2.1 Review of protocol(s) in question;

5.10.2.2 Review of sponsor audit report of the investigator, if appropriate;

5.10.2.3 Review of any relevant documentation, including consent documents, case report forms, subject's investigational and/or medical

files etc., as they relate to the investigator's execution of her/his study involving human subjects;

5.10.2.4 Interview of appropriate personnel if necessary;

5.10.2.5 Preparation of either a written or oral report of the findings, which is presented to the full IRB at its next meeting;

5.10.2.6 Recommend actions if appropriate.

5.11 Final Review

5.11.1 The results of the inquiry will be reviewed at a convened IRB meeting where the IRB will receive a report from the subcommittee. If the results of the inquiry substantiate the finding of serious or continuing non-compliance, the IRB's possible actions could include, but are not limited to:

5.11.1.1 Request a correction action plan from the investigator.

5.11.1.2 Verification that participant selection is appropriate and observation of the actual informed consent.

5.11.1.3 An increase in data and safety monitoring of the research activity.

5.11.1.4 Request a directed audit of targeted areas of concern.

5.11.1.5 Request a status report after each participant receives intervention.

5.11.1.6 Modify the continuing review cycle.

5.11.1.7 Require additional Investigator and staff education.

5.11.1.8 Notify current subjects, if the information about the non-compliance might affect their willingness to continue participation.

5.11.1.9 Require modification of the protocol.

5.11.1.10 Require modification of the information disclosed during the consent process.

5.11.1.11 Require the PI to re-consent participants for continued participation.

5.11.1.12 Suspend the study; or

5.11.1.13 Terminate the study.

5.11.2 In cases where the IRB determines that the event of noncompliance also meets the definition of unanticipated problem involving risks to subjects or others, the policy and procedure for review of such events will also be followed.

5.11.3 The investigator is informed of the IRB determination and the basis for the determination in writing and is given a chance to respond. If the IRB determines that the non-compliance was serious or continuing, the results of the final review will be reported as described Policy MHC_RP124 *"Reporting to Regulatory Agencies and Institutional Officials"*.

6. References

6.1 21 CFR 50

6.2 21 CFR 56

6.3 45 CFR 46

6.4 HRPP MHC_RP0124 *"Reporting to Regulatory Agencies and Institutional Officials*"

6.5 OHRP Guidance on Reporting Incidents to OHRP

6.6 Appendix I *"Definitions"*

7. Previous Revisions: December 20, 2012, March 22, 2013

8. Supersedes Policy: *MHC_RP0117 Non-Compliance in Human Subject Research*

9. Approvals:

MHC Institutional Review Board Initial Review: February 17, 2012

MHC Institutional Review Board acknowledgement: December 18, 2015

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Michael McKenna, MD Date
Executive Vice President/Chief Medical Officer
Institutional Official of Research