**RESEARCH COMPLIANCE REPORTING REQUIREMENTS**

STANDARD OPERATING PROCEDURE, VERSION 3.0

RESEARCH SERVICE

HUNTINGTON VA MEDICAL CENTER

1. PURPOSE

This Huntington VAMC (HVAMC) Standard Operating Procedure (SOP) references [VHA Handbook 1058.01 "Research Compliance Reporting Requirements"](http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=3116) revised by the Office of Research Oversight (ORO) on June 15, 2015. The revised handbook defines the requirements for reporting certain research events and further clarifies reporting requirements to research review committees, facility officials, and ORO. AUTHORITY: 38 U.S.C. 7307, and Federal Policy on Research Misconduct (65 FR 76260, December 6, 2000).

1. BACKGROUND

ORO serves as the primary VHA office for advising the Under Secretary for Health (USH) and exercising oversight on matters of research compliance. ORO routinely collaborates with other VA programs in areas of mutual concern (e.g., information security, privacy, radiation safety). *NOTE:* *See VHA Directive 1058 and the ORO SharePoint/Web sites at:* [*http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx*](http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx) *and*

[*http://www.va.gov/oro/*](http://www.va.gov/oro/)*. (The first link is to an internal Web site and is not available to the public).*

1. **SCOPE**

VHA Handbook 1058.01 describes requirements for reporting compliance events in VA research to research review committees, VHA officials, and ORO. These requirements do not alter or replace any additional requirements for reporting such events to other internal or external entities as mandated by law, regulation, policy, or agreement.

#  PROCEDURES:

* + - 1. The HVAMC Medical Center Director will ensure that local SOPs related to VA research:
1. Implement effectively the requirements of all applicable VA and VHA Directives and Handbooks, including requirements pertinent to the facility’s academic affiliate(s); and
2. Provide for timely and effective communications among all components of the research program, the research review committees, and other relevant offices and committees (e.g., environmental management, human resources, police service, radiation safety committee)
	* + 1. All components of the facility Research Program will follow the policies of VHA Handbook 1058.01 for reporting research compliance in coordination with Marshall University Office of Research Integrity.
			2. Appendices A to D summarize the research events that must be reported to ORO under VHA Handbook 1058.01; and
3. Identify the research events that must be reported to the HVAMC research review committees, Research Coordinator, and Medical Center Director.
4. Identify the research events that must be reported to ORO groups: Regional Office (RO), Research Animal Safety Welfare (RSAW), and Research Information Security Program (RISP).
5. Provide the methods and timelines for reporting such events, and
6. Specify the information that must be provided in reports of these events.
7. **DEFINITIONS**

The definitions found in the 1200 series of VHA Handbooks, notably including definitions related to human research, animal research, and research safety, also apply to Handbook 1200.01. In instances in which the definitions differ from the definitions in the VHA 1200 series Handbooks, the definitions below shall apply to VHA Handbook 1058.01 and this SOP.

* 1. **Adverse Event -** An Adverse Event (AE) is any untoward physical or psychological occurrence in a human subject participating in research. ***NOTE:*** *For more information, see VHA Handbook 1200.05.*
	2. **Assurance of Compliance -** An Assurance of Compliance is a written commitment to a Federal department or agency to ensure compliance with applicable requirements.
	3. **Continuing Non-Compliance -** Continuing noncompliance is the persistent failure to adhere to the legal and policy requirements governing human research.
	4. **Exposure -** Exposure refers to a research-related contact with hazardous and/or toxic materials, including any biological material, infectious agent, hazardous chemical, toxin, radioactive materials, or radiation source.
	5. **Institutional Official -** The Institutional Official (IO) is the legally authorized Signatory Official for a research program and provides all official communications to external agencies and ORO. Facility Directors are the IOs for VA facility research programs. The Principal Deputy Under Secretary for Health is the IO for the VHA Central Office (VHACO) Human Research Protection Program (HRPP). References to facility Directors in this Handbook also apply to the Principal Deputy Under Secretary for Health when acting as the IO for the VHACO HRPP.
	6. **Investigator -** An investigator is any individual who conducts research. ***NOTE:*** *For more information, see VHA Handbook 1200.01.*
	7. **Local** - Local means occurring at the reporting facility’s own research site(s).
	8. **Noncompliance** - Noncompliance is any failure to adhere to the requirements for conducting VA research covered by this Handbook.
	9. **Protected Health Information** - Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA), is individually identifiable health information transmitted or maintained in any form or medium by a covered entity, such as VHA. ***NOTE:*** *For more information, see VHA Handbook 1605.1.*
	10. **Related AE, Death, or Problem** - A related AE, death, or problem is an AE, death, or problem that may reasonably be regarded as caused by, or probably caused by, the research. ***NOTE:*** *For more information, see 21 CFR 312.64.*
	11. **Reportable** - A reportable event is any situation that requires an official report to ORO or any other regulatory entity beyond the local level.
	12. **Research** - Research is a systematic investigation including research development, testing, and evaluation designed to develop or contribute to generalizable knowledge. Research involves the testing of concepts by the scientific method of formulating a hypothesis or research question, systematically collecting and recording relevant data, and interpreting the results in terms of the hypothesis or question. ***NOTE:*** *For more information, see VHA Directive 1200.*
	13. **Research Compliance Officer** - A Research Compliance Officer (RCO) is an individual who reports directly to the facility Director and whose primary responsibilities are auditing documentation related to facility research projects and informing the facility Director and research review committees about compliance concerns.
	14. **Research Misconduct** - Research Misconduct is fabrication, falsification, or plagiarism in proposing, performing, or reviewing research, or reporting research results. ***NOTE:*** *For more information, see VHA Handbook 1058.02.*
	15. **Research Review Committee** - A research review committee is any committee or subcommittee designated by a VA facility to ensure compliance with the requirements for research.
	16. **Select Agents and Toxins** - Select agents and toxins are regulated biological agents or toxins that could pose a severe threat to public health and safety or to animal or plant health as determined by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Agriculture (USDA). ***NOTE:*** *For more information, see VHA Handbook 1200.06, as well as 42 CFR Part 73, 7 CFR Part 331, and 9 CFR Part 121.*
	17. **Serious Accident/Injury** - Serious accidents/injuries include those that require medical attention or treatment, other than basic first aid provided at the site where the accident/injury occurred; those that require extended medical surveillance of the affected individual(s) that may include sequential serology or other medical testing; and those that lead to a serious long term health complication or death.
	18. **Serious Adverse Advent** - A Serious Adverse Event (SAE) is an untoward occurrence in human research that results in death, a life-threatening experience, inpatient hospitalization, prolongation of hospitalization, persistent or significant disability or incapacity, congenital anomaly, or birth defect, or that requires medical, surgical, behavioral, social, or other intervention to prevent such an outcome.
	19. **Serious Noncompliance** - Serious noncompliance is any failure to adhere to requirements for conducting human research that may reasonably be regarded as:
1. Presenting a genuine risk of substantive harm to the safety, rights, or welfare of human research subjects, research personnel, or others, including their rights to privacy and confidentiality of identifiable private information; or
2. Substantively compromising a facility’s HRPP. ***NOTE:*** *For examples, see the ORO SharePoint/Web sites at:* [*http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx*](http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx) *and*  [*http://www.va.gov/oro/*](http://www1.va.gov/oro/). *The first link is to an internal Web site and is not available to the public.*
	1. **Serious Problem** - A serious problem is a problem in human research or research information security that may reasonably be regarded as:
		* + 1. Presenting a genuine risk of substantive harm, to the safety, rights, or welfare of human research subjects, research personnel, or others, including their rights to privacy and confidentiality of identifiable private information; or
				2. Substantively compromising a facility’s HRPP or research information security program. ***NOTE****:**For examples of possible serious problems, see the ORO SharePoint/Web sites at:* [*http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx*](http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx) *and*  [*http://www.va.gov/oro/*](http://www1.va.gov/oro/)*.*

 ***(****The first link is to an internal Web site and is not available to the public)*

* 1. **Suspension (Animal Research)** - In animal research, suspension refers to the withdrawal of Institutional Animal Care and Use Committee (IACUC) approval for use of animals in research (relative to a procedure, protocol, or program), as determined by a majority vote at a convened meeting. Suspension of an animal activity requires the IO, in consultation with the IACUC, to review the reasons for the suspension, implement appropriate corrective actions, and report the actions and the circumstances surrounding the suspension to relevant regulatory authorities in accordance with USDA regulations at 9 CFR 2.31(d)(6-7) and paragraph IV.C.7 of the Public Health Service (PHS) Policy on Humane Care and Use of Laboratory Animals. ***NOTE:*** *For more information, see VHA Handbook 1200.07.*
	2. **Suspension (All Other Research)** - Except in animal research (see paragraph 4.u.), suspension refers to a temporary interruption in selected research activities (e.g., new enrollments or specific interventions) due to concerns about the safety, rights, or welfare of human subjects, research personnel, or others, regardless of whether the action to suspend was taken by an investigator, facility official, research review committee, or external entity. Suspension does not refer to interruptions for other reasons, including the expiration of project approval periods.
	3. **Termination** - Termination refers to a permanent halt in all research activities due to concerns about the safety, rights, or welfare of human subjects, research personnel, or others, or about the welfare of laboratory animals, regardless of whether the action to terminate was taken by an investigator, facility official, research review committee, or external entity. Termination does not refer to interruptions for other reasons, including the expiration of project approval periods.
	4. **Systemic Deficiency** - A systemic deficiency is a fundamental, underlying problem that jeopardizes the effectiveness of the facility’s research protection system(s).
	5. **Unanticipated and Unexpected** - Unanticipated and unexpected refer to an event or problem in human research that is new or greater than previously known in terms of nature, severity, or frequency, given the procedures described in protocol documents and the characteristics of the study population.
	6. **VA Research** - VA research is research conducted by an investigator under a VA appointment (i.e., a compensated, work without compensation (WOC), or Intergovernmental Personnel Agreement (IPA) appointment) on VA time. The research must be approved by the Research and Development (R&D) Committee.

***NOTE: For more information, see VHA Directive 1200 and the 1200 series of VHA Handbooks.***

* 1. **Written or In Writing** - Written, or in writing, means conveyed on paper or electronically, including by e-mail, in a manner that creates a documented record.

# REFERENCES:

* + - 1. 9 CFR Part 2.
			2. 38 CFR Part 16.
			3. 45 CFR Part 164.
			4. U.S. Public Health Service, Policy on Humane Care and Use of Laboratory Animals, last updated August 1, 2002, available online at: <http://grants.nih.gov/grants/olaw/references/PHSPolicyLabAnimals.pdf>.
			5. VA Directive 6500, Managing Information Security Risk: VA Information Security Program.
			6. VA Directive 6609, Mailing of Sensitive Personal Information.
			7. VA Handbook 6500, Risk Management Framework for VA Information Systems—Tier 3: VA Information Security Program.
			8. VHA Directive 1058, The Office of Research Oversight.
			9. VHA Directive 1200, Veterans Health Administration Research and Development Program.
			10. VHA Handbook 1058.02, Research Misconduct.
			11. VHA Handbook 1058.03, Assurance of Protection for Human Subjects in Research.
			12. VHA Handbook 1058.04, Debarments and Suspensions Based on Research Impropriety in VA Research.
			13. VHA Handbook 1058.05, Veterans Health Administration Operations Activities That May Constitute Research.
			14. VHA Handbook 1200.01, Research and Development Committee.
			15. VHA Handbook 1200.05, Requirements for the Protection of Human Subjects in Research.
			16. VHA Handbook 1200.06, Control of Hazardous Agents in VA Research Laboratories.
			17. VHA Handbook 1200.07, Use of Animals in Research.
			18. VHA Handbook 1200.08, Safety of Personnel Engaged in Research.
			19. VHA Handbook 1605.1, Privacy and Release of Information.
			20. VHA Handbook 1605.02, Minimum Necessary Standard for Protected Health Information.
1. **APPENDICES**

 **Appendix A** - Summary of Requirements **/** Acronym Definitions

Research Compliance Education Program (RCEP)

Institutional Review Board (IRB)

Adverse Events (AEs)

Research Compliance Officer (RCO)

Research Safety and Animal Welfare Program (RSAW)

Institutional Animal Care and Use Committee (IACUC)

Subcommittee on Research Safety (SRS)

Research Information Security Program (RISP)

**Appendix B** - Examples and Guide for Reporting Apparently Serious or Continuing Noncompliance in Human Research

**Appendix C** - Examples and Guide for Reporting Apparently Serious Research Information Security Problems

**Appendix D -** Reporting Local Deaths, Local Serious Adverse Events (SAEs), and Serious Problems in VA Research.

**APPENDIX A**

**SUMMARY OF REQUIREMENTS FOR REPORTING RESEARCH INCIDENTS UNDER VHA HANDBOOK 1058.01**

**Reports should be directed to ORO as specified on the ORO SharePoint and Web sites at:** [**https://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx**](https://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx) **and** [**http://www1.va.gov/oro/**](http://www1.va.gov/oro/)

**Note: This Table provides a CONDENSED SUMMARY of reporting requirements. See VHA Handbook 1058.01 for complete details.**

**APPENDIX A**

|  |
| --- |
| **Unless otherwise indicated,****#1. VA employees (including WOC and IPA employees) must notify the relevant research review committee in writing within 5 BUSINESS DAYS (BD) after becoming aware of reportable incidents.****#2. Research review committee must notify the Facility Director (FD) and Associate Chief of Staff for Research (ACOS/R) within 5 BUSINESS after making certain required determinations (DTMs).****#3. FD must report to ORO within 5 BUSINESS DAYS after receiving notification.** |
| **HUMAN RESEARCH –****Report to ORO Regional Office (or ORO RCEP1 where indicated)** | **LABORATORY ANIMAL WELFARE –****Report to ORO RSAW2** | **RESEARCH SAFETY –****Report to ORO RSAW2** | **RESEARCH LABORATORY SECURITY –****Report to ORO RSAW2** | **RESEARCH INFORMATION SECURITY –****Report to ORO RISP3** |
| **§6a. Local Research Deaths that are unanticipated and related to the research.**●Immediate oral notice to IRB.●IRB alert to ORO, FD, and ACOS/R within 2 BD.●Written notice to IRB per #1.●IRB Chair DTMs within 5 BD of written notice.●Convened IRB DTMs.●IRB notice of all DTMs to FD and ACOS/R per #2.●FD report to ORO per #3.**§6b-d. Local SAEs and Serious Problems that are both unanticipated and related to the research.**●Written notice to IRB per #1.●IRB Chair DTMs within 5 BD of written notice.●Convened IRB DTMs.●IRB notice of DTMs to FD and ACOS/R per #2.●FD report to ORO per #3.**§6f. Apparent Serious or Continuing Noncompliance.**●Written notice to IRB per #1.●Convened IRB DTMs.●IRB notice of DTMs to FD AND ACOS/R per #2.●FD report to ORO per #3.●Notification of, and tracking by RCO, if from RCO audit.●IRB tracking for Facility Director Certification.**§6h. Suspension/Termination by VA.**●Notice to FD, ACOS/R, & RCO within 5 BD.●FD report to ORO per #3.**§6i. Suspension/Termination by External Entity.**●Written notice to IRB per #1.●Convened IRB DTMs.●IRB notice of DTMs to FD AND ACOS/R per #2.●FD report to ORO per #3.**§6j. Program Changes.**●FD report to ORO per #3. | **§7c. Human Deaths.**●Immediate oral notice to IACUC.●IACUC alert to ORO, FD, and ACOS/R within 2 BD.●Written notice to IACUC per #1.**§7a. Unanticipated Deaths of Research Animals.****§7b. Animal Theft, Escape, or Unexplained Disappearance.****§7d. Human Accident, Injury, Illness, or Exposure.****§7e. Reportable Incidents Under Federal Standards.**●Written notice to IACUC per#1.**§7f. IACUC Review of Incidents Reported under §§7a-7e.*** DTMs by convened IACUC.

●Notice of IACUC DTMs to FD AND ACOS/R per #2.●Notice to FD of DTMs by other officials of a reportable event.●FD report to ORO per #3.**§7h. Delayed Determinations.****§7i. Memoranda of Understanding.****§7j. Public Health Service Assurances.****§7k. Accreditation Status Change.**●FD report to ORO per #3. | **§8a. Human Deaths.**●Immediate oral notice to SRS.●SRS alert to ORO, FD, and ACOS/R within 2 BD.●Written notice to SRS per #1.**§8b. Human Accident, Injury, Illness, or Exposure.****§8c. Reportable Incidents Under Federal Standards.**●Written notice to SRS per #1.**§8d. Review of Incidents.**●DTMs by convened SRS.●Notice of SRS DTMs to FD AND ACOS/R per #2.●Notice to FD of DTMs by other officials of a reportable event.●FD report to ORO per #3.**§8e. Delayed Determinations.****§8g. Memoranda of Understanding.**●FD report to ORO per #3.**§8h. Lab Decommissions and Reassignments.**●Written request to SRS and ACOS/R 1 month prior to implementation●SRS DTMs.●Notice to facility Safety Officer from ACOS/R.●Notice to FD from ACOS/R of unauthorized decommissions or reassignments within 5 BD.●FD report to ORO of unauthorized decommissions or reassignments per #3. | **§9a. Research Laboratory Security Incidents.**1. Intrusion, physical security breach, break-in, or other security violations in dedicated research areas.
2. Noncompliance findings by any entity other than ORO.
3. Unplanned suspensions or terminations of research due to security concerns.
4. Other deficiencies that substantively compromise the research laboratory security program.

●Written notice to ACOS/R within 5 BD.●Immediate notice to VA Police Service.**§9b. Reporting.**●Notice to FD and VA Police Service from ACOS/R within 5 BD.●FD report to ORO per #3. | **§10a. Research Information Security Incidents.**●Immediate notice to ACOS/R, ISO, and PO of information security incidents related to research including inappropriate access, loss, theft of PHI; noncompliant storage, transmission, removal, or destruction of PHI; theft, loss, noncompliant destruction of equipment containing PHI.●Immediate ACOS/R&D notice to relevant research review committee(s).●Immediate ACOS/R&D notice to Records Management Officer if VA records destroyed.●Written notice to ACOS/R within 5 BD.**§10b. Review of Incidents Reported under §10a.**●Review and DTMs by relevant research review committee(s) within 30 BD.●Notice of serious problem DTM to FD AND ACOS/R per#2.●FD report to ORO of serious problem DTM per #3.**§10c. FD report to ORO within 5 business days of**:●An Issue Brief on the incident for VA central office●An NSOC requirement to notify individuals of an information breach or to provide credit monitoring●Breach notification required under the Health Information Technology for Economic and Clinical Health (HITECH) Act●Notification to or from the OIG regarding the incident. |

**SUMMARY OF REQUIREMENTS FOR REPORTING RESEARCH INCIDENTS UNDER VHA HANDBOOK 1058.01**

**Reports should be directed to ORO as specified on the ORO SharePoint and Web sites at:** [**https://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx**](https://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx) **and** [**http://www1.va.gov/oro/**](http://www1.va.gov/oro/)

**Note: This Table provides a CONDENSED SUMMARY of reporting requirements. See VHA Handbook 1058.01 for complete details.**

**APPENDIX B**

**OFFICE OF RESEARCH OVERSIGHT**

**Examples and a Brief Guide for Reporting**

**Apparently Serious or Apparently Continuing Noncompliance in Human Research That May Be Reportable to ORO under VHA Handbook 1058.01**

**VHA Handbook 1058.01: Research Compliance Reporting Requirements**

***§4.c. Continuing Noncompliance.*** *Continuing noncompliance is the* ***persistent failure*** *to adhere to the legal and policy requirements governing human research.*

***§4.s. Serious Noncompliance.*** *Serious noncompliance is any failure to adhere to requirements for conducting human research that may reasonably be regarded as:*

1. ***Presenting a genuine risk of substantive harm*** *to the safety, rights, or welfare of human research subjects, research personnel, or others, including their rights to privacy and confidentiality of identifiable private information; or*
2. ***Substantively compromising a facility’s HRPP*** *[Human Research Protection Program].*

***§6.f. Apparent Serious or Continuing Noncompliance.*** *VA personnel, including WOC and IPA appointees, must ensure that the IRB is notified, in writing,* ***within 5 business days*** *after becoming aware of any apparent serious or continuing noncompliance with IRB or other human research protection requirements.*

***NOTE:*** *HIPAA Privacy Rule deficiencies, including uses and disclosures of PHI for research without legal authority (e.g., without a valid authorization or waiver of authorization), are to be reported in accordance with paragraph 6.f. Such deficiencies should also be reported to the facility Privacy Officer (PO).*

**IMPORTANT NOTE: It is the role and responsibility of the Institutional Review Board (IRB) to determine whether a particular situation actually constitutes serious or continuing noncompliance in human research. However, VA personnel are required to report to the IRB any situation that appears to represent serious or continuing noncompliance. Examples are provided here to assist in identifying such noncompliance, but the examples should be not considered either exhaustive or definitive. ORO strongly recommends that IRBs clearly document case-specific determinations and justifications related to their evaluations of apparently serious or apparently continuing noncompliance.**

# Examples of Apparently Serious Noncompliance in Human Research That May Be Reportable to ORO under VHA Handbook 1058.01 §6.f:

* 1. Initiation of human research without required IRB approval.
	2. Initiation of human research without R&D Committee approval.
	3. Initiation of human research without ACOS/R notification that the research may begin.
	4. Failure to obtain informed consent for one or more subjects (where required, unless waived by the IRB).
	5. Failure to obtain documentation of informed consent (where required, unless waived by the IRB).
	6. Failure to obtain HIPAA authorization for one or more subjects (where required, unless waived by the IRB).
	7. Substantive informed consent or HIPAA authorization deficiencies.
	8. Substantive deviations from IRB-approved protocols, including substantive violations of inclusion or exclusion criteria.
	9. Modification of a protocol without IRB approval (except to prevent immediate hazards to subjects).
	10. Failure to implement, in a timely fashion, any protocol or informed consent modifications, or other

 changes required by the IRB.

* 1. Failure to notify the IRB of a death, SAE, or problem as required.
	2. Unfounded labeling of a death, SAE, or problem as “anticipated” or “not related” to the research.
	3. Conduct of research without required credentialing, privileging, or initial training.
1. Conduct of research involving women known to be pregnant, prisoners, or children, or of international research, without required approvals from the Facility Director or Chief Research and Development Officer, as applicable.
2. Continuation of human research beyond the specified IRB approval period (except where in subjects’ best interests as determined by the IRB Chair).
	1. Any finding by any entity, including clinical trial monitors, of apparent serious noncompliance as listed here.
3. Substantive programmatic noncompliance (e.g., violation of IRB quorum requirements; improper approval or documentation of exemptions or waivers; failure to ensure review of proposed research sufficient to identify and address privacy or data security concerns).

***NOTE: Apparent noncompliance on the part of the IRB should also be reported to the facility Research and Development (R&D) Committee and the Associate Chief of Staff for Research and Development (ACOS/R&D).***

1. Any combination of noncompliant actions that collectively present a genuine risk of substantive harm to the safety, rights, or welfare of human research subjects, research personnel, or others, or substantively compromise a facility’s HRPP.

# Examples of Apparently Continuing Noncompliance in Human Research That May Be Reportable to ORO under VHA Handbook 1058.01 §6.f:

* 1. Persistent failure by the relevant investigator(s) to ensure timely remediation of any noncompliance, identified by or made known to the investigator(s), with requirements for the conduct of human research.
	2. Persistent failure by the responsible official(s) to ensure timely remediation of any programmatic noncompliance identified by or made known to the official(s), with requirements for the conduct or oversight of human research.
	3. Any noncompliance that, due to its persistence over time, results in a genuine risk of substantive harm to the safety, rights, or welfare of human research subjects, research personnel, or others, or substantively compromises a facility’s HRPP.

# Brief Guide for Reporting Apparently Serious or Apparently Continuing Noncompliance in VA Research. For detailed requirements, see VHA Handbook 1058.01 §6.f.

A VA employee becomes aware of apparently **SERIOUS NONCOMPLIANCE** or apparently

**CONTINUING NONCOMPLIANCE** with IRB or other human research requirements in VA research.

* The employee must ensure that the **IRB is notified in writing** of the apparently serious noncompliance or apparently continuing noncompliance within **5 business days**.
* **The IRB Chair may take interim action** as needed to eliminate apparent **immediate hazards**

to subjects.

* If **serious noncompliance** or **continuing noncompliance occurred**, the IRB must notify the
* **Facility Director and ACOS/R&D within 5 business days** after its determination.
* The **Facility Director** must report the determination to **ORO within 5 business days** after receiving the IRB’s notification.
* The **convened IRB** must review any notification of apparently serious or apparently continuing noncompliance within **30 business days** after notification.
* The IRB must **determine and document** whether or not serious or continuing noncompliance occurred.
* If so, the IRB must **determine and document** whether remedial actions are warranted.
* The IRB must track the **number of notifications** of apparently serious or apparently continuing noncompliance it receives and the **number resulting in IRB determinations** of serious or continuing noncompliance.
* If the **notification** of apparently serious or apparently continuing noncompliance resulted from an **RCO audit**, the IRB must also **notify the RCO within 5 business** days after making its determination, **regardless of outcome**.
* Additional reporting may be required under local SOPs or by external agencies or sponsors. If in doubt, check with the relevant entities.

**APPENDIX C**

**OFFICE OF RESEARCH OVERSIGHT**

**Examples and a Brief Guide for Reporting Apparently Serious Research Information Security Problems**

**That May Be Reportable to ORO under VHA Handbook 1058.01**

# VHA Handbook 1058.01: Research Reporting Requirements

***§4.t. Serious Problem.*** *A serious problem is a problem in human research1or research information security that may reasonably be regarded as:*

* + - * 1. ***Presenting a genuine risk of substantive harm****, to the safety, rights, or welfare of human research subjects, research personnel, or others, including their rights to privacy and confidentiality of identifiable private information; or*
				2. ***Substantively compromising a facility’s*** *HRPP [Human Research Protection Program] or* ***research information security program.***

***§10.a. Notification Requirements.*** *VA personnel, including WOC and IPA appointees, must ensure notification of the ACOS/R&D, Information Security Officer (ISO), Privacy Officer (PO), and relevant investigators* ***immediately (i.e., within one hour)*** *upon becoming aware of any information security incidents related to VA research, including any inappropriate access, loss, or theft of PHI; noncompliant storage, transmission, removal, or destruction of PHI; or theft, loss, or noncompliant destruction of equipment containing PHI.*

***IMPORTANT NOTE:*** *It is the role and responsibility of the relevant* ***research review committee(s)*** *[i.e., Institutional Review Board (IRB), Institutional Animal Care and Use Committee (IACUC), Subcommittee on Research Safety (SRS), and/or Research and Development Committee (R&DC)] to determine whether a particular situation actually* ***constitutes*** *a serious research information security problem. However, VA personnel are required to* ***report*** *any situation that* ***appears*** *to represent a serious research information security problem. Examples are provided here to assist in identifying such problems, but the examples should be not considered either exhaustive or definitive. ORO strongly recommends that research review committees clearly* ***document case-specific determinations and justifications*** *related to their evaluations of apparently serious research information security problems.*

# Examples of Apparently Serious Problems in Research Information Security That May Be Reportable to ORO under VHA Handbook 1058.01 §10.a:

* 1. Inappropriate access, loss, or theft of protected health information (PHI); noncompliant storage, transmission, removal, or destruction of PHI; or theft, loss, or noncompliant destruction of equipment containing PHI. Issues for the research review committee to consider in evaluating any information security incident may include the following:
		1. What level of subject identification was contained in the pertinent PHI (e.g., name, SSN, address, phone number)?
		2. How sensitive and specific was the pertinent PHI (e.g., HIV diagnosis, alcohol/drug dependence)?
		3. What is the likelihood of a permanent loss versus temporary displacement?
		4. What is the likelihood of actual unauthorized access?
		5. Who and how many (other Veterans, researchers, sponsors, etc.) accessed the PHI?
		6. How many documents, individual subject records, and/or pieces of equipment were accessed/lost/stolen/stored/transmitted/removed/destroyed in this one incident?
		7. Is this a repeated instance of noncompliance (same type, investigator, research group)?
	2. Unauthorized destruction (accidentally or intentionally) of research documents or records.

*Additional* issues for the research review committee to consider may include the following:

* + 1. Was the sole copy of the record destroyed?
		2. How many records were destroyed in this one incident?
		3. Is the National Archives and Records Administration (NARA) required to be notified?
	1. Loss, theft, or unauthorized destruction of equipment (e.g., laptops, other mobile devices, external storage media) containing VA research-related PHI. *Additional* issues for the research review committee to consider may include the following:
		1. Was the equipment encrypted according to VA standards?
		2. Did the equipment contain the only copy of the research record?
	2. Transmission of VA research-related PHI not encrypted according to VA standards.

*Additional* issues for the research review committee to consider may include the following:

* + 1. Was the PHI transmitted outside of VA?
		2. Was the PHI transmitted to its intended (authorized) recipient?
		3. Was the PHI encrypted, but not according to VA standards?
	1. Use or connection of unauthorized equipment (e.g., non-VA thumb drive, unauthorized personally owned equipment) to store, process, or transmit VA research-related PHI. *Additional* issues for the research review committee to consider may include the following:
		1. Was the equipment connected to the VA network?
		2. Was the equipment subsequently taken outside of the VA facility or connected to non- VA information systems?
	2. Malicious attack on or unauthorized access to VA information system containing VA research- related PHI. *Additional* issues for the research review committee to consider may include the following:
		1. Was VA PHI compromised or potentially compromised (confidentiality, integrity, and/or availability of the system affected)?
		2. Was the attack/access isolated or widespread?

ˡ For detailed requirements related to human research problems, see VHA Handbook 1058.01 §6.c. and ORO

Decision Chart “Reporting Local Death, Local Serious Adverse Events (SAEs), and Serious Problems in VA Research” (Revised September 14, 2015). Examples of apparently serious problems in human research that may be reportable to ORO include the following:

1. Any situation that requires action to prevent an immediate hazard to subjects or others.
2. Any serious research-related injury to human research subjects, research personnel, or others.
3. Any problem described in a VA Pharmacy Benefits Management alert relevant to local human subjects.
4. Any problem described in a Data Monitoring Committee report.
5. Any combination of problems that collectively present a genuine risk of substantive harm to the safety, rights, or welfare of human research subjects, research personnel, or others, or substantively compromise a facility’s HRPP
6. **Brief Guide for Reporting Apparently Serious Information Security Problems in VA Research.** For detailed requirements, see VHA Handbook 1058.01 §10.

**A VA employee becomes aware of an apparently SERIOUS INFORMATION SECURITY PROBLEM in VA research.**

* + **The employee must ensure IMMEDIATE NOTIFICATION (with 1 hour) of the ACOS/R&D, the Information Security Officer (ISO), the Privacy Officer (PO), and any relevant investigators.**
* If the immediate notification was not in writing, the employee must also ensure **written notification** of the **ACOS/R&D within 5 business days.**
	+ - If the incident results in an **Issue Brief** sent to VHACO, an **individual breach notification,** the provision of **credit monitoring**, a **HITECH breach notification,** or **notification to/from OIG**, the **Facility Director** must report the incident **to ORO within 5 business days** after the action.
	+ If VA **records** were **destroyed**, the **ACOS/R&D** must **IMMEDIATELY** notify the **Records Management** official.
	+ The **ACOS/R&D** must also **IMMEDIATELY** notify any relevant **research review committees**.
	+ If the problem also involves **human research**, see Footnote 1 on page 2.
* Each relevant **research review committe**e must review the incident **at its next convened meeting within 30 business days.**
	+ The committee must **determine and document whether a serious problem occurred** and **whether/what remedial actions** are warranted.
	+ If a serious problem occurred, the committee must notify the **Facility Director** and the **ACOS/R&D** within

**5 business days** after its determination

* + The **Facility Director** must report the serious problem to **ORO** within **5 business days** after receiving the notification.
	+ If the research review committee makes additional determinations under its authority, **reporting requirements pertinent to those determinations must also be satisfied.**
	+ Additional reporting may be required under local SOPs or by external agencies or sponsors. If in doubt, check with the

relevant entities.

**APPENDIX D**

**OFFICE OF RESEARCH OVERSIGHT**

**Reporting Local Deaths, Local Serious Adverse Events (SAEs), and Serious Problems in VA Research**

 The unanticipated related incident involves a **LOCAL DEATH.**

 The unanticipated related incident involves a **LOCAL SAE.**

The individual must ensure **WRITTEN NOTIFICATION OF THE IRB WITHIN 5 BUSINESS DAYS.**

**YES**

 The unanticipated related incident involves a **SERIOUS PROBLEM.**

The individual must ensure **IMMEDIATE ORAL NOTIFICATION OF THE IRB** and **WRITTEN NOTIFICATION WITHIN 5 BUSINESS DAYS.**

• The **IRB MUST ALERT ORO** (by e-mail or telephone) within **2 BUSINESS DAYS AFTER RECEIVING ORAL NOTIFICATION.**

• The Facility Director and ACOS/R&D must receive notification concurrent with ORO.

**WITHIN 5 BUSINESS DAYS** after receiving written notification, the IRB Chair or a qualified IRB member-reviewer must **DETERMINE** and **DOCUMENT** whether any actions are warranted to eliminate apparent **IMMEDIATE HAZARDS** to subjects.

The **IRB MUST REVIEW** the incident and the determination of the IRB Chair or qualified IRB member-reviewer at its next **CONVENED MEETING** and must **DETERMINE** and **DOCUMENT** that:

(a) The incident was **SERIOUS AND UNANTICIPATED AND RELATED** to the research; ***or***

(b) There is **INSUFFICIENT INFORMATION** to determine whether the incident was serious and unanticipated and related; **o*r***

(c) The incident was **NOT SERIOUS** and/or the incident was **NOT UNANTICIPATED** and/or the incident was **NOT RELATED**.

The convened **IRB MUST also DETERMINE** and **DOCUMENT**:

(a) Whether any **PROTOCOL OR INFORMED CONSENT MODIFICATIONS** are warranted, and if so,

(b) Whether investigators must **NOTIFY** or **SOLICIT RENEWED/REVISED CONSENT** from previously enrolled subjects, and if so, **WHEN** and **HOW** consent is to be **DOCUMENTED**.

**For DEATHs,** the **IRB** must notify the **FACILITY DIRECTOR** and **ACOS/R&D OF ALL DETERMINATIONS WITHIN 5 BUSINESS DAYS**.

• For **SAEs** or **PROBLEMS,** the **IRB** must notify the **FACILITY DIRECTOR** and **ACOS/R&D WITHIN 5 BUSINESS DAYS** after meeting if:

(a) **ACTIONS** were taken to **ELIMINATE HAZARDS** to subjects, or

(b) The incident was **SERIOUS AND UNANTICIPATED AND RELATED TO THE RESEARCH** or there was **INSUFFICIENT INFORMATION** to make the determination, or

(c) **PROTOCOL OR INFORMED CONSENT MODIFICATIONS** were warranted.

• The **FACILITY DIRECTOR MUST REPORT** the incident to **ORO WITHIN 5 BUSINESS DAYS** after notification.

Additional reporting may be required under local SOPs or by external agencies (such as FDA or OHRP) or sponsors. If in doubt, check with the relevant entities.

 **VA employee becomes aware of a LOCAL DEATH,2 a LOCAL SAE,3 or a SERIOUS PROBLEM4 in** VA research that appears to be **both UNANTICIPATED** (i.e., new or greater than previously known in terms of nature, severity, or frequency,

given the procedures described in protocol documents and the characteristics of the study population)**5**

**and RELATED to the research** (i.e., reasonably regarded as caused by, or probably caused by, the research) **6**

**NO**

**NO**

**YES**

**YES**

**NO**

**REPORTING TO ORO AS A DEATH, SAE, OR PROBLEM IS NOT REQUIRED.\***

* Report to the IRB per local SOPs.
* Reporting to other entities may be required.

**NOTES**

For complete details, see 38 CFR 16.103(b)(5)(i); 21 CFR 56.108(b)(1), 312.32(a), & 812.3(s); and VHA Handbook

1. §4g, §4j, §4r, §4t, §4y, & §§6a-6.d. This chart does not cover other reportable situations (e.g., program changes, suspensions/terminations). Also see the following ORO guidance;
	* *Examples and a Brief Guide for* ***Reporting Apparently Serious Research Information Security Problems*** *That May Be Reportable to ORO under VHA Handbook 1058.01 (Revised September 14, 2015)*.
	* *Examples and a Brief Guide for* ***Reporting Apparently Serious or Apparently Continuing Noncompliance*** *in Human Research That May Be Reportable to ORO under VHA Handbook 1058.01 (Revised September 14, 2015).*

² **Local** means occurring at the reporting facility’s own research site(s). (VHA Handbook 1058.01§4g)

³ An **SAE** is an untoward occurrence in human research that results in death, a life-threatening experience, inpatient

hospitalization, prolongation of hospitalization, persistent or significant disability or incapacity, congenital anomaly, or birth defect, or that requires medical, surgical, behavioral, social, or other intervention to prevent such an outcome. (VHA Handbook 1058.01§4r)

4 A **serious problem** is a problem in human research or research information security that may reasonably be regarded

as: (1) Presenting a genuine risk of substantive harm, to the safety, rights, or welfare of human research subjects, research personnel, or others, including their rights to privacy and confidentiality of identifiable private information; or (2) Substantively compromising a facility’s HRPP or research information security program. (VHA Handbook 1058.01§4t)

Examples of apparently serious problems in human research that may be reportable to ORO include the following:

1. Any situation that requires action to prevent an immediate hazard to subjects or others.
2. Any serious research-related injury to human research subjects, research personnel, or others.
3. Any problem described in a VA Pharmacy Benefits Management alert relevant to local human subjects.
4. Any problem described in a Data Monitoring Committee report.
5. Any combination of problems that collectively present a genuine risk of substantive harm to the safety, rights, or welfare of human research subjects, research personnel, or others, or substantively compromise a facility’s HRPP.

5 **Unanticipated / Unexpected** refer to an event/problem in human research that is new or greater than previously

known in terms of nature, severity, or frequency, given the procedures described in protocol documents and the characteristics of the study population. (VHA Handbook §4y)

6 A **related** adverse event (AE, VHA Handbook §4a), death, or problem is one that may reasonably be regarded as **caused by**, or **probably caused by**, the research. [(HA Handbook §4j)