1. PURPOSE

1.1. This procedure establishes the process by which the (IRB-01) serves as the affiliate IRB for the North Florida / South Georgia Veterans Health System (NFSG\VHS).

2. POLICY

2.1. This policy is to ensure that the University of Florida (UF) Human Research Protection Program (HRPP) applies the additional requirements for the review and approval of VHA-regulated human subjects research as set forth in 38 CFR Parts 16 and 17, as well as relevant portions of the VHA Handbooks 1200.01, 1200.05, 1108.04 and 1058.01. IRB-01 serves as a subcommittee to the NFSG\VHS Research & Development (R&D) Committee.

2.2. The VA R&D Committee must acknowledge the application in myIRB prior to the review and approval of research by the IRB-01. The R&D Committee may not approve human subject’s research until it has been approved by the IRB-01. After IRB-01 has approved a study, it cannot be initiated until the investigator has been notified in writing by the Associate Chief of Staff/Research (ACOS) for R&D that all applicable approvals have been obtained and the study may be initiated.

2.3. This policy is limited to VHA regulated research reviewed and approved by the UF IRB-01 and does not apply to non-VHA regulated research. Investigators should refer to applicable UF HRPP policies for issues not specifically addressed by this policy.

2.4. A memorandum of understanding (MOU) is in place between the University of Florida and the NF/SG VHS to outline the roles of IRB-01 and NF/SG VHS relating to the IRB-01 serving as the affiliate IRB.

2.5. General communications with NF/SG VHS are directed to the VA HRPP Program Administrator and/or the Research Compliance Officer within the Research Services Office. Additional information can also be found on the NF/SG VHS Research Website.

3. DEFINITIONS:

3.1. Continuing Noncompliance: Continuing noncompliance is the persistent failure to adhere to the legal and policy requirements governing human research.

3.2. NFSG\VHS: North Florida\South Georgia Veterans Health System, which relies upon IRB-01 to provide review and oversight of its human subjects research activities.

3.3. NFSG\VHS R&D Committee: The R&D Committee is a committee responsible, through the Chief of Staff (COS) to the VA facility Director, for oversight of the facility's research program and for maintenance of high standards throughout that program (see VHA Handbook 1200.01).

3.4. Legally Authorized Representative (LAR): An individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research 38 CFR 16.102(c), 45 CFR 46.102(c) and 21 CFR 50.3(l). An individual who is qualified as an LAR to provide informed consent on behalf of a prospective research subject may not always qualify as a personal representative for purposes of consent to use or disclose a subject’s Protected Health Information (PHI) (i.e., signing a HIPAA authorization). Therefore, in circumstances
involving authorization for use or disclosure of a human subject's PHI, the investigator must ensure the LAR meets the requirements of a personal representative in HIPAA and the Privacy Act of 1974 (legal guardian power of attorney) prior to the LAR signing a HIPAA authorization (see VHA Handbook 1605.01, section 5.b.).

3.5. **Office of Research Oversight (ORO):** ORO serves as the primary VHA office in advising the Under Secretary for Health on all matters of compliance and assurance regarding human subjects protections, animal welfare, research safety and security, research information protection and research misconduct.

3.6. **Principal Investigator (PI):** A principal investigator (PI) is a qualified individual who directs a research project or research program. The PI oversees scientific, technical, and day-to-day management of the research. In the event of research conducted by a team of individuals, the PI is the responsible leader of the research team.

3.6.1. Students and other trainees (including residents and fellows of any profession), may serve as participants, but not principal researcher within a VA facility, use VA human subjects data, or use human biological specimens that have been collected within VA for clinical, administrative, or research purposes only when:

- (1) The study has been approved by the local VA medical facility and IRB, if appropriate; and
- (2) Either they are: (a) Enrolled in an institution with an educational affiliation agreement with that VA facility; or (b) Directly appointed to a VA training program that has no external institutional sponsorship (e.g. VA Advanced Fellowship).

**NOTE:** A waiver may be obtained from the CRADO under special circumstances.

3.6.2. A VA investigator sufficiently experienced in the area of the trainee's research interest must serve as PI and is responsible for oversight of the research and the trainee/student. The PI is responsible for ensuring the trainee/student complies with all applicable local, VA and other federal requirements including those related to research, information security, and privacy.

- (1) If the trainee does not complete all aspects of the research prior to leaving VA, the VA investigator must ensure the protocol is completed or terminated in an orderly fashion, and in accordance with all applicable local, VA, and other federal requirements.
- (2) When the trainee leaves VA, the VA investigator is responsible for ensuring that all research records are retained by VA.

**NOTE:** All trainee issues above are assessed by VA Research Office.

3.7. **Serious Adverse Event (SAE):** A serious adverse event (SAE) is an AE in human subjects 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. An AE is also considered serious when medical, surgical, behavioral, social, or other intervention is needed to prevent such an outcome.

3.8. **Serious Noncompliance:** Serious noncompliance is a failure to adhere to the laws, regulations, or policies governing human subjects research that may reasonably be regarded as:

- 3.8.1. Involving substantive harm, or presenting a genuine risk of substantive harm, to the safety, rights, or welfare of human research subjects, research staff, or others; or Substantively compromising the effectiveness of a facility's human subjects
3.9. **Site Investigator or Local Site Investigator (LSI):** An investigator at a site participating in a multi-site research project who oversees scientific, technical, and day-to-day management of the research at the local site.

3.10. **Surrogate consent.** When the potential subject is determined to lack decision-making capacity, investigators must obtain consent from the LAR of the subject (i.e., surrogate consent).

3.11. **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. (see VHA Handbook 1058.01 section 4.y).

3.12. **VA Investigator:** A VA investigator is any individual who conducts research approved by the VA R&D committee while acting under a VA appointment on VA time, including full and part-time compensated employees, trainees, without compensation (WOC) employees, and individuals appointed or detailed to VA under the Intergovernmental Personnel Act (IPA) of 1970. NOTE: Contractors cannot be VA Investigators.

3.13. **VHA Handbook 1058.01:** Current VHA policy which sets forth the requirements for VHA research compliance reporting.

3.14. **VHA Handbook 1200.05:** Current VHA policy which establishes procedures for the protection of human subjects involved in VA research.

3.15. **VHA Handbook 1200.01:** Current VHA policy which establishes the responsibilities for the R&D Committee.

3.16. **VHA Handbook 1108.04:** Current VHA policy which provides specific direction and procedures related to the appropriate handling of investigational drugs and supplies.

3.17. **VA Research.** VA research is research that is conducted by VA investigators (serving on compensated, WOC, or IPA appointments) while on VA time. The research may be funded by VA, by other sponsors, or be unfunded. VA research must have R&D Committee approval. NOTE: VA research is discussed in VHA Handbook 1200.01 and VHA Handbook 1200.2, Research Business Operations.

4. **PROCEDURES**

4.1. **IRB-01 Composition**

4.1.1. At least one VA voting member of the IRB must be in attendance when their facility’s research is discussed at a convened meeting. At least two VA members must serve on the IRB. VA members are appointed and serve as full members of UF IRB-01. At least one VA member must be present when VA research is reviewed. If there is a need to appoint other VA members to the IRB, the IRB Chair will contact the ACOS/R and then the member nominated by the VA will be reviewed under HRP-132 IRB Member Addition and Removal. VA representatives also serve at the pleasure of the Vice President for Research at UF, and are appointed for a period of up to (3) three years. They may be re-appointed to new terms of up to (3) three years without a
lapse in service at the end of each term. The VA has no formal provisions to
guarantee liability protection for IRB-01 members acting in performance of their
duties. However, such protection may be provided on a case-by-case basis at the
discretion of the VA and the Department of Justice. VA employees serving as IRB-01
members will be considered agents of UF and will receive liability coverage.

4.1.2. VA staff, including facility Directors and their administrative staff, COS, other facility
senior administrators such as Associate or Assistant Directors or Chief Nurse, and
NPC Administrative and research office staff including, but not limited to, the ACOS
for R&D, the AO for R&D, and IRB administrative staff may not serve as voting
members of IRB-01. They may serve as ex officio, non-voting members to IRB-01; however, they and the IRB must be sensitive to any potential, actual, apparent, or
perceived conflicts of interest and appropriately manage such conflicts. NOTE: Ex
officio members are for purposes of this Handbook not allowed to be voting members
of IRB-01. Research Compliance Officers (RCOs), and the Privacy Officer (PO), and
Information Security Officer (ISO) may act as consultants to IRB-01, but may not
serve as voting or non-voting members of IRB-01. RCOs may attend IRB meetings
when requested by the IRB-01 chair [or indicate who can make that request] RCO’s,
POs and ISOs must be aware of and manage any potential, actual, apparent, or
perceived conflicts of interest that arise because of their role. If alternate members
are appointed to the facility’s IRB, the IRB’s written procedures must describe the
appointment and function of alternate members, and the IRB membership roster
must identify by name the primary member(s) for whom each alternate member may
substitute. The alternate members must have qualifications similar to the member
they replace.

4.2 Initial Review of VHA Regulated Human Subjects Research

4.2.1 The NFSG\VHS requires the patient health record to be flagged under certain
circumstances to indicate the subject’s participation in a study. This includes the
exception for research projects that hold a Certificate of Confidentiality.

4.2.2 Studies cannot be initiated until IRB-01 has determined that the study does not
constitute human subjects research, is exempt from IRB-01 approval requirements,
or has satisfied all requirements for approval (38 CFR 16.101). All research that is
determined to be exempt or not to involve human subjects must be reviewed,
approved and remain active with the R&D Committee and receive approval from the
ACOS/Research.

4.2.3 IRB-01 is not required to perform a comprehensive scientific review of the study, but
is responsible for being sufficiently familiar with the science to perform its review,
including a sufficient understanding of the science to carry out its responsibilities
including, but not limited to, weighing the potential risks and benefits to the subjects.

4.3 IRB-01 Actions

4.3.1 Documentation of Convened IRB-01 Meetings:
4.3.1.1 For VA regulated research, quorum must include at least one VA voting
member

4.3.2 Minutes of the IRB, Records Retention and Accessibility:
4.3.2.1 UF IRB-01 maintains all studies that involve the VA for at least 6 years
after which time the records are transferred to the VA Research Service.
4.3.2.2 IRB minutes shall be submitted to the R&D Committee in accordance with
local SOPs and in a timely manner.
4.3.2.2.1 IRB-01 will provide the VA with unredacted copies of meeting minutes, or with redacted copies of meeting minutes and permit relevant VA personnel (including, but not limited to, ORO staff, local VA Research Office staff, local RCOs, and R&D Committee members) to review the unredacted meeting minutes within two business days of a written request from VA.

4.3.2.3 All VA related records, including correspondence between IRB-01 and VA investigators, including IRB-01’s requirements for modifications to the protocol or informed consent documents, IRB-01’s approval, and any other relevant correspondence about the study shall be accessible for inspection and copying by authorized representatives of VA, ORO, OHRP, FDA and other authorized entities at reasonable times and in a reasonable manner.

4.4 Investigator Responsibilities

4.4.1 In addition to Investigator Responsibilities outlined under POLICY: Human Research Protection Program (HRP-010), VA investigators must ensure:

4.4.1.1 All applicable VA and other Federal requirements, including the local VA facility’s SOPs and UF HRPP policies regarding the conduct of research and the protection of human subjects. The PI’s and LSI’s responsibilities include, but are not limited to (see VHA Handbook 1200.05 Investigator Responsibilities):

4.4.1.2 The most current version of VA Form 10-1086, VA Research Consent Form, is used as the informed consent document for each study;

4.4.1.3 HIPAA Authorization (form 10-0493) is obtained;

4.4.1.4 Reporting local unanticipated problems involving risks to human subjects or others, and all unanticipated internal SAEs, when related or possibly related to the research, in accordance with VHA Handbook 1058.01;

4.4.1.5 Research records include all written information given to subjects, along with the consent forms. Investigator’s research records are to be retained indefinitely, until disposition instructions as approved by NARA, are published in VHA RCS 10-1.

4.4.1.5.1 If the investigator leaves the VA, all research records must be retained by the VA facility where the research was conducted. If the grant is ongoing and the investigator leaves one VA facility to go to another, the investigator must obtain approval for a copy of relevant materials to be provided to the new VA facility’s research office;

4.4.1.6 Use Preparatory to Research. Data repositories may be used by VA investigators for activities that are preparatory to VA research without the requirement to obtain either a HIPAA authorization from the subject or waiver of HIPAA authorization by an IRB or a PB. This includes use of PHI for the preparation of a research protocol prior to submission to the IRB or R&D Committee. "Preparatory to Research" activity is the only instance of access for research purposes allowed in VHA without a written HIPAA authorization signed by the individual, a waiver of HIPAA authorization by an IRB or PB, or approval by the R&D Committee and the IRB. This access is granted only to VHA researchers. Non-VHA researchers may not access VHA data for reviews preparatory to research.
4.5 Informed Consent Process and Procedures

4.5.1 The most current IRB-01-approved version of VA Form 10-1086, VA Research Consent Form, must be used for each study.

4.5.2 When appropriate, VA requires one or more of the following elements of information be provided to each subject. Also, when any of these additional elements are appropriate, VA requires them to be documented in the IRB-01-approved informed consent form, unless documentation of informed consent is waived:

4.5.2.1 **Payment for Treatment**: Informed consent must include a statement that veteran-participants shall not be required to pay for treatment received as a participant in a VA research program.

4.5.2.2 **Authorization for Use of Bodily Fluids, Substances, or Tissues**: If the investigator believes that bodily fluids, substances, or tissues could be part of or lead to the development of a commercially viable product, the informed consent information should include the following verbatim statement: "I authorize the use of my bodily fluids, substances or tissues in this research. It is possible that commercially profitable products may someday be developed from these bodily fluids, substances, or tissues. There are no plans to share any profits from such products with the participants who were the source of these bodily fluids, substances, or tissues."

4.5.2.3 **Future Use of Specimens**: If the specimens are to be retained after the end of the study for future research, where the specimens will be retained, who will have access to them, and how long they will be retained must be included in the consent document. Current applicable institutional, VA, and other Federal requirements must be met for handling, use, and storage of biologic specimens and data (see VHA Handbook 1200.12).

4.5.2.4 **Future Use of Data**: Information on any plans to use the current data and the data obtained from the proposed project for future research. If data is to be retained for future research, the protocol must describe the repository in which they are to be maintained, its location, and its security measures. NOTE: If the data are retained for future research, the data repository must be established and maintained in accordance with this Handbook (1200.12).

4.5.2.5 **Re-contact**: Include a statement in the consent if the subject will be re-contacted for future research whether within VA or outside VA.

4.5.2.6 **Payment for Participating in the Study**: If appropriate, a statement regarding any payment the subject is to receive for participating in the study and how the payment is to be made. Since VA regulations at 38 CFR 16.116(a)(8), the Common Rule, and FDA regulations all state that participants may withdraw from research at any time without penalty of loss of benefits to which they are otherwise entitled, completing the research may not be made a condition of payment. For this reason, there should be a description of how payment will be prorated and calculated for participants who withdraw early.

4.5.2.7 **Disclosure of Results**: If the subject will receive a report of the aggregate results or any results specific to the subject, this information must be included in the consent.

4.5.3 IRB-01 approval of the wording of the consent document must be documented through the use of a stamp on each page of Form 10-1086 that indicates the date of the most recent IRB-01 approval of the document.
4.5.4 If the consent document is amended during the protocol approval period, IRB-01 stamps the informed consent form with the approval date of the amendment rather than the date of the approved protocol.

4.5.5 If the principal researcher or the local site researcher does not personally obtain consent, the researcher must formally and prospectively designate to another research team member in writing the protocol or the application for IRB approval the responsibility for obtaining consent, whether a waiver of documentation of the consent process has been approved by the IRB.

4.5.5.1 If the researcher contracts with a firm to obtain consent, the firm must have its own IRB.

4.5.6 A copy of the consent form must be provided to the subject or the subject’s LAR (38 CFR 16.117(a)). Where applicable, a copy of the informed consent form must be placed in the medical record in accordance with VHA Handbook 1907.01 except when a Certificate of Confidentiality applies.

4.5.7 When appropriate, VA requires one or more of the following elements of information be provided to each participant. Also, when any of these additional elements are appropriate, the VA requires them to be documented in the IRB-approved consent document, unless documentation of consent is waived.

4.5.7.1 Any payments the subject is to receive for participating in the study;

4.5.7.2 Any real or apparent conflict of interest by investigators where the research will be performed;

4.5.7.3 A statement that VA will provide treatment for research related injury in accordance with applicable federal regulations;

4.5.7.4 A statement that informs VA research subjects that they or their insurance will not be charged for any costs related to the research.

4.5.7.5 VA medical facilities must provide medical treatment (not just emergency treatment) for research participants injured as a result of participation in VA research, except if the participant has been non-compliant with the protocol, or if the research has been conducted under a contract with an individual or non-VA institution.

4.5.7.6 Consent for research must describe any photographs, video, or audio recordings obtained for research purposes; how they will be used, and whether they will be disclosed outside the VA.

4.5.7.7 Consent to take a photograph, video, or audio recording for research cannot be waived by the IRB.

4.5.8 Consent is limited by a legally authorized representative to situations where the prospective participant is incompetent or has impaired decision-making capacity, as determined and documented in the person’s medical record in a signed and dated progress note.

4.5.9 Consent from the legally authorized representative of the participant can only be obtained from the following: a healthcare agent (i.e., an individual named by an individual in a durable power of attorney for health care); legal guardian or special guardian; next of kin in this order: a close relative of the patient 18 years of age or older, in the following priority: spouse, child, parent, sibling, grandparent, or grandchild; or close friend, unless otherwise specified by applicable state law.

4.5.10 If there is any question as to whether a potential adult participant has decision-making capacity, and there is no documentation in the medical record that the individual lacks decision-making capacity, and the individual has not been ruled incompetent by a court of law, the researcher must consult with a qualified practitioner (who may be a member of the research team) about the individual’s decision-making capacity before proceeding with the consent process.
4.5.11 Individuals, who because of a known condition, are at high risk to temporary or fluctuating lack of decision-making capacity must be evaluated by a qualified practitioner to determine the individual’s ability to provide consent. This evaluation must be performed as described in the IRB-approved protocol.

4.5.12 If the individual is deemed to lack decision-making capacity at the time of their participation in the study, a legally authorized representative must provide consent.

4.5.13 If the participant regains decision-making capacity, the researcher must repeat the consent process with the participant, and obtain the participant’s permission to continue with the study.

4.5.14 Disclosures to be made to the participant must be made to the participant’s legally authorized representative.

4.5.15 The participant’s legally authorized representative must be told that that his or her obligation is to try to determine what the participant would do if able to make an informed decision. If the prospective participant’s wishes cannot be determined, the legally authorized representative must be told that he or she is responsible for determining what is in the participant’s best interest.

4.5.16 Have the researcher explain the proposed research to the prospective participant when feasible even when the participant’s legally authorized representative gives consent.

4.5.17 Have the practitioner explain the proposed research to the prospective participant when feasible.

4.5.18 Ensure the study includes appropriate procedures for respecting dissent. Prohibit participants from being forced or coerced to participate in a research study.

4.6 HIPAA Authorization

4.6.1 A written HIPAA authorization (10-0493) signed by the individual to whom the information or record pertains is required when VA health care facilities need to utilize individually-identifiable health information for a purpose other than treatment, payment, or health care operations (e.g., research) (VHA Handbook 1605.1). In accordance with 45 CFR 164.508(b)(3)(ii), an authorization for a use or disclosure of psychotherapy notes may not be combined with any other authorization for a use or disclosure unless the other authorization is also for a use or disclosure of psychotherapy notes.

4.6.2 The HIPAA authorization for the use or disclosure of individually-identifiable health information for a VA research study must be a standalone document (i.e., not combined with any other type of written permission for the same research study, including the research informed consent form). Since VHA Handbook 1200.05 requires the HIPAA authorization and the informed consent form to be separate documents, IRB-01 cannot approve a HIPAA authorization for a VA research study. However, IRB-01 may waive the requirement for a HIPAA authorization if certain criteria are met. IRB-01 must ensure the protocol and informed consent form are consistent with the HIPAA authorization. A copy of the signed HIPAA Authorization must be provided to the subject or the subject’s LAR.

4.7 Vulnerable Populations

4.7.1 IRB-01 must also be cognizant of the vulnerable nature of many VA patient-participants. To the extent that such participants are economically dependent upon the VA for medical treatment, suffer from cognitive, affective, or other psychological afflictions, or have substance abuse problems, VA patient-participants may be
particularly vulnerable to unintended coercive influences relative to participation in research. Likewise, persons who primarily look to the VA for treatment of their medical problems may not fully understand the implications of research participation, especially when it is offered by someone they consider a provider of clinical care.

4.7.2 While all protocols need to be assessed for vulnerability of subjects within the context of the specific protocol, the populations named below must always have the additional protections specified in this paragraph applied. VA considers the following populations to be categorically vulnerable:

4.7.2.1 **Fetuses** - Research in which the focus is either fetuses, or human fetal tissue, in-utero or ex-utero (or uses human fetal tissue) is not conducted at the NFSG\VHS.

4.7.2.2 **Neonates** - Research in neonates is not conducted at the NFSG\VHS.

4.7.2.3 **Pregnant Women** - Women who are known to be pregnant and/or their fetuses may be involved in research if all of the requirements of 45 CFR 46.204 are met including informed consent requirements and the following ethical and scientific criteria: (1) Where scientifically appropriate, preclinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risks to pregnant women and fetuses; (2) The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or fetus. If there is no such prospect of benefit, then the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means; (3) Any risk is the least possible for achieving the objectives of the research; and (4) The VA medical facility Director certifies that the medical facility has sufficient expertise in women's health to conduct the proposed research (see guidance at [http://www.research.va.gov/resources/policies/default.cfm](http://www.research.va.gov/resources/policies/default.cfm)).

4.7.2.3.1 Research involving stem cells shall be governed by the policy set by NIH

4.7.2.3.2 Research involving the provision of in vitro fertilization services is not allowed

4.8.3.7 **Research Involving Prisoners as Subjects**: Research involving prisoners cannot be conducted by VA investigators while on official VA duty, at VA facilities, or at VA-approved off-site facilities unless a waiver has been granted by the CRADO. If such a waiver is granted, the research must comply with the requirements of 45 CFR 46.301 - 46.306. NOTE: A link to these requirements is provided on the ORD Web site at: [http://www.research.va.gov/resources/policies/default.cfm](http://www.research.va.gov/resources/policies/default.cfm).

4.8.3.8 **Research Involving Children As Research Subjects**: VA is authorized to care for Veterans and to conduct research that supports the mission of VHA and that enhances the quality of health care delivery to Veterans. Therefore, research involving children must be reviewed carefully by the IRB for its relevance to VA and must not be greater than minimal risk. The VA medical facility Director must approve participation in the proposed research that includes children (see guidance at: [http://www.research.va.gov/resources/policies/default.cfm](http://www.research.va.gov/resources/policies/default.cfm)). Research involving biological specimens or data obtained from children is considered to be research involving children even if de-identified. If the biological
specimens or data were previously collected, they must have been collected under applicable policies and ethical guidelines.

4.8.3.9 Subjects Lacking Decision-Making Capacity: Individuals who lack decision-making capacity may be enrolled in VA research. IRB-01 must determine the following:

4.8.3.9.1 Does not present greater than minimal risk, or
4.8.3.9.2 Presents a greater probability of direct benefit to the participant than harm to the participant, or
4.8.3.9.3 Poes greater than minimal risk and no prospect of direct benefit to individual participants, but is likely to yield generalizable knowledge about the participant’s disorder or condition that is of vital importance to understanding or amelioration of the participant’s disorder or condition
4.8.3.9.4 In addition, the IRB determines the research cannot be performed solely on adults who can consent, and the focus of the research is the disorder leading to the lack of decision-making capacity, or
4.8.3.9.5 Where the subject of the research is not directly related to the participant’s lack of decision-making capacity, the researcher has presented a compelling reason for including adults unable to consent.
4.8.3.9.6 The research protocol must address how the researcher will assess capacity and determine when surrogate consent is required.

4.9 Compensation to Human Research Subjects

4.9.3 The VA facility research office must ensure IRB-01-approved payment to subjects is made from a VA-approved source for funding research activities.

4.9.4 Compensation for Human Subjects Research Injury

4.9.4.1 The VA will provide necessary medical treatment to any research participant injured as a result of participation in a research project approved by the NFSG/VHS R&DC and conducted under the supervision of one or more VA employees. This requirement does not apply to treatment for injuries due to noncompliance by the participant with study procedures or research conducted for the VA under a contract with an individual or non-VA institution.

4.10 Investigational Drugs in Research with Human Subjects

4.10.1 For proposed human subjects research involving an investigational drug or biological product, investigators are responsible for complying with all applicable FDA, DHHS, and VA regulations and UF HRPP policies. Please note that the VA defined investigational drugs to include FDA approved drugs used in an investigational setting (VAHB 1108.04). Investigators who hold the Investigational New Drug (IND) or Biologics License Application (BLA) for the proposed research must comply with applicable regulations pertaining to both the sponsor and the investigator. Investigators must ensure compliance with the VA human subject regulations, as well as with all applicable regulations and requirements regarding storage and security procedures for investigational agents. FDA regulations supersede VA requirements for human subjects research under FDA jurisdiction unless VA requirements are more restrictive than applicable FDA regulations.
4.10.2 To receive an investigational drug as defined by VHA Handbook 1108.04, the investigator must:

4.10.2.1 Provide the Pharmacy Service or Research Investigational Pharmacy information on each subject receiving an investigational drug through the electronic medical record or other locally approved means. Documentation is to include allergies, toxicities, or adverse drug events related to the investigational drug, or the potential for interaction with other drugs, foods, or dietary supplements, i.e., herbals, nutriceuticals (see VHA Handbook 1108.04).

4.10.2.2 Ensure the local Pharmacy Service or Research Service Investigational Pharmacy receives:

- 4.10.2.2.1 Documentation of IRB-01 and any other relevant approvals;
- 4.10.2.2.2 A copy of VA Form 10-9012, Investigational Drug Information Record, when applicable;
- 4.10.2.2.3 A copy of the current approved protocol;
- 4.10.2.2.4 A copy of the informed consent form for each participating subject with all appropriate signatures;
- 4.10.2.2.5 Documentation of the IRB-01 continuing review approval;
- 4.10.2.2.6 Copies of sponsor-related correspondence specific to the drug(s) as appropriate; and
- 4.10.2.2.7 Copies of all correspondence addressed to the investigator from the FDA (and other involved authorities) specific to the investigational drug(s) as appropriate.

4.10.2.3 Inform the Chief of the Pharmacy Service, the research pharmacy when applicable, and IRB-01 in writing when a study involving investigational drugs has been suspended, terminated, or closed.

4.10.2.4 Comply with all dispensing requirements.

4.10.2.5 Comply with all documentation requirements and make relevant records accessible to the investigational drug pharmacist when requested (VHA Handbook 1108.04).

4.10.2.6 Comply with all VHA pharmacy requirements regarding receiving, dispensing, storing, and record-keeping for investigational drugs.

4.11 Investigational Devices in Research with Human Subjects

4.11.1 The investigator must conduct VA human subjects research involving investigational drugs and devices in accordance with all applicable VA policies and other federal requirements including, but not limited to: this Handbook, VHA Handbook 1108.04, and applicable FDA regulations. The storage and security procedures for test articles used in research must be reviewed and approved by the IRB and follow all applicable federal rules.

4.11.2 No research involving an investigational device can be approved by IRB-01 if it is unclear whether the device requires an IDE, or if the IDE status for an investigational device is unknown.

4.11.3 Comply with all VHA Handbook 1108.04 requirements regarding receiving, dispensing, storing, and record-keeping for investigational devices.

4.11.3.1 All investigational devices are required to be received and stored by the VA Investigational Drug Service.

4.12 Planned Emergency Research
4.12.1 VHA does not conduct planned emergency research (see 21 CFR 50.24) or classified research involving human subjects. (2100.05)

4.13 Human Subjects Protection Education

4.13.1 All individuals involved in conducting VA human subjects research are required to complete training in ethical principles on which human subjects research is to be conducted. Specific requirements regarding the type and frequency of training are found on ORD’s Web site at: http://www.research.va.gov/pride/training/options.cfm. All other applicable VA and VHA training requirements at the local and national level must be met (e.g., privacy and information security training). Training must be updated every three years. All other applicable VA and VHA training requirements at the local and national level must also be met and may be required on a more frequent basis (e.g., privacy training). The VA Research Office verifies all VA human subjects required training.

4.14 Apparent Serious or Continuing Noncompliance (see Appendix C)

4.14.1 In accordance with VHA Handbook 1058.01, members of the VA research community must report any apparent serious or continuing noncompliance with applicable human research protection requirements (e.g., 38 CFR 16, VHA Handbook 1200.05, FDA regulations) in writing to IRB-01 within (5) five business days. The determination that noncompliance is serious or continuing rests with IRB-01. Decision charts related to such reporting are provided on the ORO Web site at http://www.va.gov/ORO/oropubs.asp.

4.14.2 Examples of apparent serious noncompliance in human research that may be reportable are provided in Appendix A of this Policy.

4.14.3 Research Compliance Officer (RCO) Reports of Apparent Serious or Continuing Noncompliance:

4.14.3.1 Within five business days of identifying apparent serious or continuing noncompliance based on an informed consent audit, regulatory audit, or other systematic audit of VA research, an RCO must report the apparent noncompliance directly, in writing, to IRB-01.

4.14.3.2 An initial report of apparent serious or continuing noncompliance based on an RCO informed consent audit, regulatory audit, or other systematic audit is required regardless of whether disposition of the matter has been resolved at the time of the report.

4.14.4 IRB-01 Review of Apparent Serious or Continuing Noncompliance:

4.14.4.1 VA personnel, including WOC and IPA appointees, must ensure that IRB-01 is notified, in writing, within (5) five business days after becoming aware of any apparent serious or continuing noncompliance with IRB-01 or other human research protection requirements. The convened IRB-01 must review any such notifications at the earliest practicable opportunity, not to exceed 30 business days after the notification. The IRB-01 Chair may take interim action as needed to eliminate apparent immediate hazards to subjects.

4.14.4.2 The convened IRB-01 must determine and document whether or not serious or continuing noncompliance actually occurred. If IRB-01 determines that serious or continuing noncompliance occurred:
4.14.4.2.1 A documented IRB-01 determination is also required as to whether remedial actions are needed to ensure present and/or future compliance.

4.14.4.2.1.1 Except where remediation requires substantial renovation or fiscal expenditure, hiring, legal negotiations, or other extenuating circumstances, remedial actions must be completed within 120 calendar days after any determination of noncompliance.

4.14.4.2.2 IRB-01 must notify the VA facility Director and the ACOS/R&D within (5) five business days after making its determinations.

4.14.4.2.3 If the apparent serious or continuing noncompliance was identified by an RCO audit, IRB-01 must notify the RCO within (5) five business days after its determinations under paragraphs 6.f.(2) and 6.f.(3)(a) of the VHA Handbook (1058.01), regardless of outcome.

4.14.4.2.4 IRB-01 must track the determinations required under paragraphs 6.f.(2) and 6.f.(3) of the VHA Handbook (1058.01) for use in the VA facility Director Certification.

4.15 Local SAEs (see Appendix C)

4.15.1 Within (5) five business days of becoming aware of any local (i.e., occurring under the auspices of NFSG\VHS approved research) unanticipated and related/probably related SAE in VA research, members of the VA research community are required to ensure that the SAE has been reported in writing to IRB-01.

4.15.2 IRB-01 must notify the VA Facility Director and the ACOS/R&D in writing within (5) five business days after its convened meeting if actions were taken to eliminate apparent immediate hazards to subjects, or the convened IRB-01 determined the event was serious and unanticipated and related to the research, or if there was insufficient information to make the determination.

4.16 Local Research Deaths (see Appendix C)

4.16.1 VA personnel, including WOC and IPA appointees, must ensure oral and email notification to IRB-01 immediately upon becoming aware of any local research death that is both unanticipated and related to the research. IRB-01 must alert ORO by e-mail or telephone within (2) two business days after receiving such notification and provide relevant information as requested. The VA facility Director and the ACOS/R&D must receive concurrent notification.

4.16.2 VA personnel, including WOC and IPA appointees, must ensure written notification to IRB-01 within (5) five business days of becoming aware of the death. Within (5) five business days after receiving written notification of the death, the IRB-01 Chair or a qualified IRB-01 member-reviewer must determine and document whether any actions are warranted to eliminate apparent immediate hazards to subjects.

4.16.3 IRB-01 must review the death and the determination of IRB-01 Chair or qualified IRB-01 member-reviewer at its next convened meeting and must determine and document that:

4.16.3.1 The death was both unanticipated and related to the research; or
4.16.3.2 There is insufficient information to determine whether the death was both unanticipated and related to the research; or
4.16.3.3 The death was not unanticipated and/or the death was not related to the research.

4.16.4 Regardless of the determination under paragraph 6.a(4) of the VHA Handbook (1058.01), the convened IRB-01 must also determine and document whether any protocol or informed consent modifications are warranted. If modifications are warranted, the convened IRB-01 must determine and document whether or not investigators must notify or solicit renewed/revised consent from previously enrolled subjects; and if so, when such notification or consent must take place and how it must be documented.

4.16.5 IRB-01 must notify the VA facility Director and the ACOS/R&D of its determinations under paragraphs 6.a(4) and 6.a(5) of the VHA Handbook (1058.01), within 5 business days of the determinations. The VA facility Director must report the determinations to ORO within (5) five business days after receiving IRB-01’s notification.

4.17 Serious Problems (see Appendix C)

4.17.1 VA personnel, including WOC and IPA appointees, must ensure written notification of the IRB within 5 business days after becoming aware of any serious problem that is both unanticipated and related to the research. (VHA Handbook 1058.01). Examples of apparent serious problems in human research information security that may be reportable are provided in Appendix B of this Policy.

4.18 IRB-01 Review of Serious Problems (see Appendix C)

4.18.1 Within (5) five business days after receiving written notification of an SAE or serious problem under paragraph 6.b. or 6.c. of the VHA Handbook (1058.01), the IRB-01 Chair or a qualified IRB-01 member-reviewer must determine and document whether any actions are warranted to eliminate apparent immediate hazards to subjects. IRB-01 must review the incident and the determination of the IRB-01 Chair or qualified IRB-01 member-reviewer at its next convened meeting and must determine and document that:

4.18.1.1 The incident was serious and unanticipated and related to the research; or
4.18.1.2 There is insufficient information to determine whether the incident was serious and unanticipated and related to the research; or
4.18.1.3 The incident was not serious, and/or the incident was not unanticipated, and/or the incident was not related to the research.

4.18.2 Regardless of the determination under paragraph 6.d(1) of the VHA Handbook (1058.01), the convened IRB-01 must also determine and document whether any protocol or informed consent modifications are warranted. If modifications are warranted, the convened IRB-01 must determine and document whether or not investigators must notify or solicit renewed/revised consent from previously enrolled subjects; and if so, when such notification or consent must take place and how it must be documented.

4.18.2.1 IRB-01 must notify the VA facility Director and the ACOS/R&D in writing within (5) five business days after its convened meeting if:
4.18.2.1.1 Actions were taken to eliminate apparent immediate hazards to subjects; or
4.18.2.1.2 IRB-01 determined that the incident was serious and unanticipated and related to the research, or there was insufficient information to make the determination; or
4.18.2.1.3 Protocol or informed consent modifications were (or were not) warranted.

4.19 Terminations or Suspensions of Research (see Appendix C)

4.19.1 Any termination or suspension of research by IRB-01 or other research review committee, or by the ACOS for Research or other facility official related to concerns about the safety, rights, or welfare of human research subjects, research staff, or others must be reported directly, without intermediaries, to the facility Director within (5) five business days after the termination or suspension occurs. The report must be made in writing with simultaneous copies, as applicable, to the ACOS for Research, the R&DC, IRB-01, and any other relevant research review committee.

4.20 Privacy and Confidentiality

4.20.1 PIs must comply with VA handbooks for all VA regulated research and adhere to the recommendations for securing electronic research data. IRB-01 is responsible for reviewing the information that will be collected during the course of the research and determining the degree of privacy of the information and adequacy of the measures to be taken to protect the confidentiality of the data. IRB-01 will consider the nature, probability, and magnitude of harms that likely would result from a disclosure of collected information outside the research as it ensures the protection of privacy of subjects and confidentiality of data of all research proposals in accordance with 45 CFR 46.111(a)(7), 38 CFR 16.111(a)(7) and 21 CFR 56.111(a)(7), and VA Handbooks.

4.21 Radiology Devices and Radioactive Materials

4.21.1 Oversight of use of radiologic and radioactive materials conducted by the VA Radiation Safety Committee (RSC). RSC advises the VA R&DC and other applicable subcommittees to ensure safe use and proper disclosure to potential subjects in those studies where these agents are utilized. Consultation to IRB-01 for reviews of human subjects research involving these agents will be sought from the VA Radiation Safety Officer, for initial studies and amendments, as applicable.

4.22 Safety Subcommittees

4.22.1 Oversight at the NFSG VHS is handled by the VA Subcommittee on Research Safety (SRS) and the UF Institutional Biosafety Committee (IBC) which is a subcommittee of the VA R&DC. Consultation to IRB-01 for reviews of human subjects research activities will be sought from the VA Safety subcommittee or the UF IBC, for initial studies and amendments, as applicable.

4.22.2 Participation of Non-Veterans as Research Subjects:

4.22.2.1 The investigator must justify including non-Veterans in a VA research protocol, and IRB-01 must review the justification for inclusion of non-
Veterans and specifically approve entering non-Veterans into the study before non-Veterans can be recruited. IRB-01 must appropriately document in IRB-01 minutes or IRB-01 regulatory file its determinations regarding participation of non-Veterans in the study.

5 REFERENCES

5.10 21 CFR Parts 50 and 56
5.11 21 CFR 812
5.12 38 CFR Parts 16
5.13 38 CFR Parts 17
5.14 42 CFR 493
5.15 45 CFR 46.102(c)
5.16 45 CFR 46.103(b)(2)
5.17 45 CFR 46.204
5.18 45 CFR 46, Subpart C 46.301–46.306
5.19 45 CFR 46.111(a)(7) VA form 10-1086
5.20 VA Form 10-9012
5.21 VA Handbook 1605.1
5.22 VA Handbook 1200.01
5.23 VA Handbook 1200.05
5.24 VA Handbook 1058.01
5.25 VA Handbook 1108.04
5.26 VA Handbook 1907.01
5.27 VA Handbook 1106.01
5.28 VA Handbook 1200.12
5.29 VA Handbook 1200.05 section 16.f - Photography, Video and/or Audio Recording for Research Purposes.
5.30 The informed consent must include IRB-01’s “Consent to be Photographed, Video and/or Audio Recorded” addendum for research involving any photographs, video, and/or audio recordings to be taken or obtained for research purposes.
Appendix A

Examples and a Brief Guide for Reporting
Apparently Serious or Apparently Continuing Noncompliance in Human Research

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.

A. 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.
10) Modification of a protocol without IRB approval (except to prevent immediate hazards to subjects).
11) Failure to implement, in a timely fashion, any protocol or informed consent modifications, or other changes required by the IRB.
12) Failure to notify the IRB of a death, SAE, or problem as required.
13) Unfounded labeling of a death, SAE, or problem as “anticipated” or “not related” to the research.
14) Conduct of research without required credentialing, privileging, or initial training.
15) 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.
16) Continuation of human research beyond the specified IRB approval period (except where in subjects’ best interests as determined by the IRB Chair).
17) Any finding by any entity, including clinical trial monitors, of apparent serious noncompliance as listed here.
18) 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).
19) 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.

B. 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.
Examples and a Brief Guide for Reporting Apparently Serious or Apparently Continuing Noncompliance in Human Research

C. 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.

- 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 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.

- 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 B
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 Compliance Reporting Requirements

§4.t. 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 [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.

A. 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:**

a) What level of subject identification was contained in the pertinent PHI (e.g., name, SSN, address, phone number)?

b) How sensitive and specific was the pertinent PHI (e.g., HIV diagnosis, alcohol/drug dependence)?

c) What is the likelihood of a permanent loss versus temporary displacement?

d) What is the likelihood of actual unauthorized access?

e) Who and how many (other Veterans, researchers, sponsors, etc.) accessed the PHI?

f) How many documents, individual subject records, and/or pieces of equipment were accessed/lost/stolen/stored/transmitted/removed/destroyed in this one incident?

g) Is this a repeated instance of noncompliance (same type, investigator, research group)
Decision chart for reporting UPRs and AEs to the IRB and ORO. Reports should be sent to the appropriate ORO Regional Office.

- A PROBLEM occurs that may affect individuals associated with VA research.
  - Is the AE “SERIOUS” as defined by FDA, i.e., Did the AE result in (or need medical or surgical intervention to prevent) death, a life-threatening experience, inpatient hospitalization, prolongation of hospitalization, persistent or significant disability or incapacity, congenital anomaly or birth defect, or jeopardy to any subject's rights, safety, or welfare?
    - NO
      - Does the PROBLEM involve or suggest RISKS to VA research SUBJECTS?
        - NO
          - Facility has flexibility in setting requirements for reporting to the IRB.
        - YES
          - Does the PROBLEM involve or suggest RISKS to ANYONE ELSE in VA research (e.g., family members, researchers, others)?
            - NO
              - VHA REQUIRES that the PROBLEM or AE be REPORTED to the IRB within 5 DAYS. A QUALIFIED IRB MEMBER has 5 DAYS to CATEGORIZE it.
            - YES
              - Was the PROBLEM or AE actually SERIOUS?
                - NO
                  - Was the PROBLEM or AE ANTICIPATED as to NATURE, SEVERITY, OR FREQUENCY as stated in the protocol, consent document, investigators' brochure, or other IRB-approved materials?
                    - YES
                      - IRB CHAIR MUST REPORT TO FACILITY DIRECTOR WITHIN 5 DAYS. FACILITY MUST REPORT TO ORO REGIONAL OFFICE (RO) WITHIN 5 DAYS.
                    - NO
                      - Was the PROBLEM or AE RELATED or POSSIBLY RELATED to the research?
                        - YES
                          - IRB CHAIR MUST REPORT TO FACILITY DIRECTOR WITHIN 5 DAYS. FACILITY MUST REPORT TO ORO REGIONAL OFFICE (RO) WITHIN 5 DAYS.
                        - NO
                          - DO NOT REPORT TO ORO

- A "LOCAL" ADVERSE EVENT (AE) occurs (i.e., an AE occurs at a site for which the VA investigator's IRB of Record is responsible).

* Risks may reflect potential physical, psychological, social, or economic harm.
** See subparagraph 6a(3) of the Handbook.
### Appendix C

**Summary of IRB 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 and http://www1.va.gov/oro/

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

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**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.

<table>
<thead>
<tr>
<th>Event</th>
<th>Time to report to IRB by PI</th>
<th>Time IRB must review</th>
<th>Action Taken by IRB</th>
<th>Report to VA (Time and to Whom)</th>
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<tr>
<td>Apparent Serious or Continuing Noncompliance.</td>
<td>Per #1 above</td>
<td>Must be reviewed by Full Board at next convened meeting not to exceed 30 days</td>
<td>Must be reviewed by Full Board at next convened meeting to make DTMs</td>
<td>Per #2 above</td>
</tr>
<tr>
<td>Local Research Deaths that are unanticipated and related</td>
<td>Oral notification immediately once PI becomes aware. Written per #1 above.</td>
<td>Review by Chair or qualified designee within 5 days of written receipt</td>
<td>Must be reviewed by Full Board at next convened meeting to make DTMs</td>
<td>By email or telephone ORO, VA Director and ACOS/R within 2 days. Written determination within 5 days</td>
</tr>
<tr>
<td>• Local Research Deaths</td>
<td>Written notice within 5 days of PI becoming aware</td>
<td>Review by Chair or qualified designee within 5 days of receipt</td>
<td>Must be reviewed by Full Board at next convened meeting to make DTMs</td>
<td>To ORO, VA Director and ACOS/R within 5 days of determination</td>
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<tr>
<td>• Local SAEs</td>
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<td>Suspensions or Terminations of VA Research</td>
<td>Written notice within 5 days of PI becoming aware</td>
<td>Reviewed by Full Board at next convened meeting not to exceed 30 days</td>
<td>Must be reviewed by Full Board at next convened meeting to make DTMs</td>
<td>To VA Director, ACOR/R, and RCO within 5 days of determination</td>
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