REVIEW OF PROTOCOL DEVIATIONS AND VIOLATIONS
08/05/08

The purpose of this document is to define the work flow and review process in the Duke University Health System (DUHS) Institutional Review Board (IRB) office for protocol deviations and violations reported by DUHS investigators.

Definitions

“Protocol deviation” means an inadvertent act (from the perspective of the PI and study staff) in which the protocol is not followed. Examples of protocol deviations include the accidental destruction of a bone marrow sample intended for phenotyping to characterize the subject's type of leukemia in order to determine study eligibility, or an accidental misread of a laboratory value as being within the reference range when it actually is sufficiently abnormal to preclude study participation by the subject.

“Protocol violation” means an intentional act (from the perspective of the PI and study staff) in which the protocol is not followed. Examples of protocol violations include the PI prescribing or administering the wrong drug on the study, or the study subject being scheduled to return for follow-up intervention outside the protocol-dictated window as a convenience to the PI or the study staff.

“Corrective Action” means an action, usually required of the Principal Investigator, which is necessary to reduce the risk to the subjects and/or prevent a recurrence of the reported protocol deviation/violation. Examples of corrective actions include revision of the protocol and/or consent form, re-consent of subjects, further training of study staff, or formal notification to the appropriate government oversight agencies.

“Reportable Event” means a protocol deviation or violation that is likely to adversely affect the rights and welfare of the research subjects, the safety of the research subjects, or the integrity of the research data.

“IRB Management Team” means the Executive Director, Director of IRB Education Programs, Chairs and Vice Chairs.

Procedure

The Protocol Deviation/Violation Report is received via the eIRB. The IRB Executive Director performs an initial review of the report. In the absence of the Executive Director, the initial review function will be assumed by the Director of IRB Education Programs.
The Executive Director or designee completes the initial review within 2 business days of receipt using the following criteria:

- If the reported deviation/violation involves a drug, device or biologic or other interventional activity, the Executive Director will assign it to a Chair/Vice Chair or designee with clinical experience. For the purposes of this document, “interventional activity” shall mean any activity described in the protocol that directly involves the administration of a drug/device/biologic or that comprises a clinical or research procedure administered to the research subject.
- If the reported deviation/violation involves the consent process or other non-interventional activity, the Executive Director can either complete the review and define the corrective actions or assign it to a Chair/Vice Chair or other IRB Management Team member. Deviations/violations that meet the qualifications for expedited review as defined by 45 CFR 46.110(b)(2) can be reviewed and finalized by the Executive Director or Director of IRB Education Programs. All other deviations/violations will be assigned to a Chair/Vice Chair for review and presentation at a convened IRB meeting.
- If the reported deviation/violation involves an event that requires prompt reporting to the IRB, the policy titled “Problems or Events that Require Prompt Reporting to the IRB” will be followed.
- If the reported deviation/violation involves a failure to follow federal regulations, institutional policies governing human subject research, or requirements or determinations of the IRB, then the policy titled “Non-Compliance with the Requirements of the Human Research Protection Program” will be followed.

The assigned reviewer will complete his/her review and define corrective actions, if any, within 5 business days of receipt. If no (further) reply is required from the Principal Investigator, the assigned reviewer will complete the review process. If a reply is required, the assigned reviewer will attach his/her comments for the Principal Investigator.

If a reply is required from the Principal Investigator, the Principal Investigator will be instructed to provide any requested information or documents via the eIRB. When a reply from the Principal Investigator has been submitted via the eIRB, the assigned reviewer will review the proposed corrective actions.

If the Principal Investigator fails to agree to any part of the corrective action plan, the assigned reviewer will consider the failure to agree using the policy titled “Non-Compliance with the Requirements of the Human Research Protection Program”. If the reviewer concludes that the deviation/violation does not need to be reviewed according to either the Prompt Reporting policy or the Non-Compliance Policy, and no further action is required according to this Deviation/Violation Policy, then the reviewer completes the form containing a Clearance signature.

On the first business day of each month, a query will be executed by the IT/Board Specialist for a report of all open and finalized protocol deviation/violation activities in
the IRB database. This report will be forwarded to the Executive Director for review and follow-up with a copy provided to the Clinical Trials Quality Assurance (CTQA) office.