

RESEARCH COMPLIANCE REPORTING REQUIREMENTS

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook sets forth the requirements for reporting research compliance events to research review committees, facility officials, and the Office of Research Oversight (ORO).
- 2. SUMMARY OF MAJOR CHANGES:** This revised VHA Handbook clarifies and simplifies research compliance reporting requirements.
- 3. RELATED ISSUES:** VA Directive 6500, VA Handbook 6500, VA Directive 6609, VHA Directive 1058, VHA Handbook 1058.02, VHA Handbook 1058.03, VHA Handbook 1058.04, VHA Handbook 1058.05, VHA Directive 1200, VHA Handbook 1200.01, VHA Handbook 1200.05, VHA Handbook 1200.06, VHA Handbook 1200.07, VHA Handbook 1200.8, VHA Handbook 1605.1, and VHA Handbook 1605.02.
- 4. RESPONSIBLE OFFICE:** ORO is responsible for the contents of this Handbook. Questions may be referred to (202) 632-7620.
- 5. RESCISSIONS:** VHA Handbook 1058.01, Research Compliance Reporting Requirements, dated November 15, 2011, is rescinded.
- 6. RECERTIFICATION:** This VHA Handbook is scheduled for recertification on or before the last working day of June 2020.

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RESEARCH COMPLIANCE REPORTING REQUIREMENTS

1. PURPOSE: This Veterans Health Administration (VHA) Handbook sets forth the requirements for reporting research compliance events to research review committees, facility officials, and the Office of Research Oversight (ORO). **AUTHORITY:** 38 U.S.C. 7307, and Federal Policy on Research Misconduct (65 FR 76260, December 6, 2000).

2. 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://vawww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public.*

3. SCOPE: This Handbook 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. **NOTE:** *Should the requirements of this Handbook conflict with any applicable Collective Bargaining Agreement(s), the Agreement(s) shall govern. ORO must be notified immediately upon identification of any such conflict and may suspend affected research where warranted to ensure adequate research protections.*

4. 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 this Handbook. In instances in which the definitions below differ from the definitions in the VHA 1200 series Handbooks, the definitions below shall apply to this Handbook only.

a. **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.*

b. **Assurance of Compliance.** An Assurance of Compliance is a written commitment to a Federal department or agency to ensure compliance with applicable requirements.

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

d. **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.

e. **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.

f. **Investigator.** An investigator is any individual who conducts research. **NOTE:** For more information, see VHA Handbook 1200.01.

g. **Local.** Local means occurring at the reporting facility's own research site(s).

h. **Noncompliance.** Noncompliance is any failure to adhere to the requirements for conducting VA research covered by this Handbook.

i. **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.

j. **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.

k. **Reportable.** A reportable event is any situation that requires an official report to ORO or any other regulatory entity beyond the local level.

l. **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.

m. **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.

n. **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.

o. **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.

p. **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.

q. **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.

r. **Serious Adverse Event.** 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.

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. **NOTE:** For examples, see the ORO SharePoint/Web sites at <http://vawww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public.

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 or research information security program. **NOTE:** For examples of possible serious problems, see the ORO SharePoint/Web sites at <http://vawww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public.

u. **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.

v. **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.

w. **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.

x. **Systemic Deficiency**. A systemic deficiency is a fundamental, underlying problem that jeopardizes the effectiveness of the facility's research protection system(s).

y. **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.

z. **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.

aa. **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.

5. SYSTEMIC REQUIREMENTS AND RESPONSIBILITIES: Open and ongoing communication with ORO promotes the development and maintenance of robust research protection programs and is strongly encouraged. As IO, the VA facility Director is responsible for fostering a culture of accountability and transparency relative to research compliance.

a. **Standard Operating Procedures (SOP).** The VA facility Director must ensure that local SOPs related to 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).

b. **Reports to ORO.** The VA facility Director must report to ORO within 5 business days (except as otherwise specified below) after receiving notification of any situation that is reportable to ORO under this Handbook.

(1) The VA facility Director's report is required regardless of whether or not the situation has been resolved at the time of the report. Reports to ORO should be directed to the appropriate ORO regional office or subject matter group(s) as specified on the ORO SharePoint/Web sites at

<http://vawww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. **NOTE:** *The first link is to an internal Web site and is not available to the public.*

(2) The VA facility Director must ensure that ORO is notified by e-mail or telephone as soon as possible, but no longer than 2 business days, after becoming aware of:

(a) Any research-related citation or determination of regulatory noncompliance issued by any State or Federal agency; or

(b) Any situation covered by this Handbook that has generated media attention or Congressional interest.

c. **Remedial Actions.** The VA facility Director must ensure timely implementation of remedial actions in response to identified noncompliance or as otherwise found warranted by ORO.

(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.

(2) Where remedial actions cannot be completed in 120 calendar days, the VA facility Director must provide ORO with an acceptable written justification and an acceptable timeline for completion.

d. **VA Facility Director Certifications.** The VA facility Director is responsible for completing the annual VA facility Director Certification of Research Oversight. Certification requirements are updated annually and posted on ORO's SharePoint/Web sites at <http://vawww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and

<http://www.va.gov/oro/>. **NOTE:** The first link is to an internal Web site and is not available to the public.

e. **Research Compliance Officers.** The VA facility Director must appoint at least one full-time RCO to conduct annual informed consent and triennial regulatory audits unless the Under Secretary for Health approves a waiver to permit a part-time appointment.

(1) The lead RCO must report directly to the VA facility Director. RCO activities may not be determined or managed by the Associate Chief of Staff (ACOS) for Research and Development (R&D) or any other research entity.

(2) RCOs may perform additional research oversight duties assigned by the VA facility Director, including assisting in compliance education, accreditation activities, VA facility Director Certifications, and monitoring or auditing individual studies or programs for the research review committees. Such duties may not conflict with, or hinder completion of, the RCO's audit responsibilities.

(3) RCOs may serve as non-voting consultants to research review committees (but not as voting or non-voting members) and may attend meetings by invitation of the committee or as specified by local SOPs.

(4) RCO audits must be conducted in accordance with a written audit plan that includes procedures for soliciting the investigator's response to preliminary audit findings, timelines for providing all audit results to the relevant research review committees, and procedures for documenting resolution of audit findings, including relevant research review committee determinations.

(5) The VA facility Director must report any RCO appointment, resignation, or substantive change in duties to ORO within 5 business days after the action takes effect.

f. **Distribution of Compliance Reports.** The VA facility Director must ensure that all research compliance reports from any State or Federal oversight entity (including ORO), regardless of findings, are provided to the ACOS/R&D, the R&D Committee, any other relevant research review committees, and the RCO within 5 business days after receipt. **NOTE:** This does not include reports from clinical trial study monitors.

g. **Notifications to VA Facility Directors.** Notifications required under this Handbook from research review committees and RCOs to VA facility Directors must be made in writing without intermediaries (i.e., notifications may not be routed "through" or require approval from any other officials). Committee Chairs may themselves perform the committee notifications or may designate any member of their committee or its administrative staff to perform notifications in accordance with local operating procedures.

h. **Systemic Deficiencies.** VA personnel, including WOC and IPA appointees, must ensure written notification of the VA facility's R&D Committee within 5 business

days after becoming aware of any apparent systemic deficiency that has a reasonable likelihood of substantially compromising the facility's research protection programs, including persistent failure by any subcommittee of the R&D Committee to adhere to the requirements governing VA research.

i. **R&D Committee Responsibilities.** The R&D Committee:

(1) Must review any notification under paragraph 5.h. at its earliest practicable convened meeting, not to exceed 30 business days after the date of notification.

(2) May hold unscheduled meetings in response to emergent issues in accordance with VHA Handbook 1200.01.

(3) Must determine whether the notification involves an actual systemic deficiency that could substantially compromise the VA facility's research protection programs, and if so:

(a) The R&D Committee must determine what remedial actions, if any, are warranted to ensure effective research protections;

(b) The R&D Committee must notify the VA facility Director and the ACOS/R&D within 5 business days after the determination; and

(c) The VA facility Director must report the determination and the resultant remedial actions to ORO within 5 business days after receiving the notification.

NOTE: Reports and questions related to VA facility R&D Committees should be directed to ORO as specified on the ORO SharePoint/Web sites at <http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The SharePoint site is an internal Web site and is not available to the public.

j. **Voluntary Alerts to ORO.** In addition to the required reporting described in this Handbook, ORO welcomes voluntary "preliminary" alerts about incidents that are unusual or likely to result in reportable events, as well as voluntary "near miss" alerts about incidents that could have resulted in a reportable event had the facility not taken timely action. Voluntary "preliminary" alerts facilitate efficient review and effective mitigation, while voluntary "near miss" alerts validate local oversight mechanisms and help identify emerging compliance challenges.

k. **Research Misconduct.** ORO must be notified within 1 business day of any Research Misconduct allegations received by the facility. NOTE: For more information on the definition of research misconduct, see VHA Handbook 1058.02. Reports and questions related to research misconduct should be directed to ORO as specified on the ORO SharePoint/Web sites at <http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and

<http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public.

6. HUMAN RESEARCH:

a. **Local Research Deaths.** VA personnel, including WOC and IPA appointees, must ensure oral notification of the Institutional Review Board (IRB) immediately upon becoming aware of any local research death that is both unanticipated and related to the research.

(1) The IRB must alert ORO by e-mail or telephone within 2 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.

(2) VA personnel, including WOC and IPA appointees, must ensure written notification of the IRB within 5 business days of becoming aware of the death.

(3) Within 5 business days after receiving written notification of the death, 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.

(4) The IRB must review the death 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 death was both unanticipated and related to the research; or

(b) There is insufficient information to determine whether the death was both unanticipated and related to the research; or

(c) The death was not unanticipated and/or the death was not related to the research.

(5) Regardless of the determination under paragraph 6.a(4), the convened IRB must also determine and document whether any protocol or informed consent modifications are warranted. If modifications are warranted, the convened IRB 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.

(6) The IRB must notify the VA facility Director and the ACOS/R&D of its determinations under paragraphs 6.a(4) and 6.a(5) within 5 business days of the determinations.

(7) The VA facility Director must report the determinations to ORO within 5 business days after receiving the IRB's notification.

b. **Local SAEs.** VA personnel, including WOC and IPA appointees, must ensure written notification of the IRB within 5 business days after becoming aware of any local SAE that is both unanticipated and related to the research.

c. **Serious Problems.** 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. **NOTE:** For examples, see the ORO SharePoint/Web sites at <http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public.

d. **IRB Review of SAEs and Serious Problems.** Within 5 business days after receiving written notification of an SAE or serious problem under paragraph 6.b. or 6.c., 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.

(1) 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 to the research; or

(c) The incident was not serious, and/or the incident was not unanticipated, and/or the incident was not related to the research.

(2) Regardless of the determination under paragraph 6.d(1), the convened IRB must also determine and document whether any protocol or informed consent modifications are warranted. If modifications are warranted, the convened IRB 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.

(3) The IRB must notify the VA facility Director and the ACOS/R&D in writing within 5 business days after its convened meeting if:

(a) Actions were taken to eliminate apparent immediate hazards to subjects; or

(b) The IRB determined that 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.

(4) The VA facility Director must report the situation to ORO within 5 business days after receiving the IRB's notification.

e. **Other AEs, SAEs, and Problems.** The IRB must be notified of, and review, other AEs, SAEs, and unanticipated problems involving risks to subjects or others (i.e., not covered by paragraphs 6.a. through 6.c.) in accordance with local SOPs.

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).*

NOTE: *For additional examples of apparent serious noncompliance, see the ORO SharePoint/Web sites at <http://vawww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public.*

(1) The convened IRB must review any such notifications at the earliest practicable opportunity, not to exceed 30 business days after the notification. The IRB Chair may take interim action as needed to eliminate apparent immediate hazards to subjects.

(2) The convened IRB must determine and document whether or not serious or continuing noncompliance actually occurred.

(3) If the IRB determines that serious or continuing noncompliance occurred:

(a) A documented IRB determination is also required as to whether remedial actions are needed to ensure present and/or future compliance.

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

(c) The VA facility Director must report the determination to ORO within 5 business days after receiving the IRB's notifications.

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

(e) The IRB must track the determinations required under paragraphs 6.f.(2) and 6.f.(3) for use in the VA facility Director Certification.

g. **Other Apparent Noncompliance.** The IRB must be notified of, and review, other apparent noncompliance (not covered by paragraph 6.f) in accordance with local SOPs.

h. **Suspensions and Terminations of Research by the VA Facility.** VA facility officials and research review committees must notify the VA facility Director, the ACOS/R&D, and the RCO within 5 business days of suspending or terminating any VA human research study. The VA facility Director must report the suspension/termination to ORO within 5 business days after receiving the notification.

i. **External Suspensions/Terminations of Research.** 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 suspension or termination of VA research by, or at the direction of, any entity external to the facility.

(1) The convened IRB must review the suspension/termination at the earliest practicable opportunity, not to exceed 30 business days after notification, to determine whether it:

(a) Resulted from a local adverse event(s), local noncompliance, or other local issue(s); or

(b) Requires local action (in addition to the suspension/termination) to ensure the safety, rights, or welfare of local human research subjects, personnel, or others or the effectiveness of the local HRPP.

(2) If the IRB determines that either 6.i.(1)(a) or 6.i.(1)(b) applies,

(a) The IRB must notify the VA facility Director and the ACOS/R&D within 5 business days after the determination;

(b) The VA facility Director must report the suspension/termination to ORO within 5 business days after receiving the IRB's notification.

j. **Program Changes.** The VA facility Director must report to ORO as follows.

(1) Any change in the status (e.g., expiration, restriction, suspension, or termination) of the facility's Federalwide Assurance (FWA) must be reported within 5 business days.

(2) Any proposed changes to the FWA, including changes in designated IRB(s) and changes in IRB membership, must be reported prior to submission to the Office for Human Research Protections (OHRP). **NOTE:** *VA facilities designating VHA-approved Central IRBs need not report Central IRB membership changes to ORO.*

(3) New or substantially revised MOUs related to human research protections or oversight must be reported within 5 business days after the final concurrence/signature. ORO strongly encourages contacting ORO early in the development of new or revised MOUs.

(4) Failure of a VA facility to achieve or maintain the HRPP accreditation required under VHA Handbook 1200.05 must be reported to ORO within 5 business days.

NOTE: *For more information, see VHA Handbook 1058.03.*

NOTE: Also see VHA Handbooks 1058.03 and 1058.05. Reports and questions related to HRPPs should be directed to ORO as specified on ORO's SharePoint/Web sites at <http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public.

7. ANIMAL RESEARCH:

a. **Unanticipated Death of Research Animals.** VA personnel, including WOC and IPA appointees, must ensure written notification of the IACUC within 5 business days after becoming aware of any apparent unanticipated death(s) of animals used for research including, deaths due to physical plant deficiencies, engineering failures, worker errors, test article toxicity, anesthetic or surgical complications, and other mishaps. **NOTE:** *The IACUC is not required to respond to reports of experimental animal deaths that are within expected mortality ranges, normal mortalities that occur in large rodent colonies, or individual deaths due to aggression when incompatible rodents are inadvertently housed together. However, these types of losses should be monitored and periodically reported to the IACUC, as part of an animal health surveillance program.*

b. **Animal Theft, Escape, or Unexplained Disappearance.** VA personnel, including WOC and IPA appointees, must ensure written notification of the IACUC within 5 business days after becoming aware of any theft of research animals or of the escape or unexplained disappearance of research animals that could potentially pose a danger or risk to workers, the public, or the environment.

c. **Human Deaths.** VA personnel, including WOC and IPA appointees, must ensure oral notification of the IACUC immediately upon becoming aware of any human death that may be the result of working with, caring for, or other contact with research animals.

(1) The IACUC must alert ORO by e-mail or telephone within 2 business days after receiving such notification. The VA facility Director and the ACOS/R&D must receive concurrent notification.

(2) VA personnel, including WOC and IPA appointees, must ensure written notification of the IACUC within 5 business days of becoming aware of the death.

d. **Human Accident, Injury, Illness, or Exposure.** VA personnel, including WOC and IPA appointees, must ensure written notification of the IACUC within 5 business days after becoming aware of any serious accident, injury, illness, or exposure of a human (other than resulting in death) that may be the result of working with, caring for, or other contact with research animals.

e. **Reportable Incidents Under Applicable Federal Standards.** VA personnel, including WOC and IPA appointees, must ensure written notification of the IACUC within 5 business days after becoming aware of any incident that is reportable under relevant VHA Handbooks or applicable Federal requirements related to laboratory animal welfare or research safety.

f. **IACUC Review of Reported Incidents.** The IACUC must review any incident described at paragraphs 7.a. through 7.e. at its next convened meeting.

(1) Incidents that involve a human death or present a significant risk to the safety of research personnel, live animals used in research, or the environment may call for immediate attention and require the IACUC to convene an emergency session prior to the next scheduled meeting.

(2) The IACUC must notify the VA facility Director and the ACOS/R&D within 5 business days after reaching a determination that a reportable incident has occurred. Per VHA Handbook 1200.07, no official or committee may reverse or overrule the IACUC's determination that a reportable incident has occurred.

(3) The VA facility Director must report the incident to ORO within 5 business days after receiving the IACUC's notification.

(4) The IACUC must also notify the VA facility Director and the ACOS/R&D within 5 business days after any determination that an incident brought to its attention under paragraphs 7.a. through 7.e. was not reportable.

g. **Additional Review of Reported Incidents.** The VA facility Director and others acting within their areas of responsibility may also investigate animal research incidents and make separate determinations as to reporting, but cannot reverse or overrule a determination by the IACUC that a reportable incident has occurred.

(1) The VA facility Director must be notified within 5 business days after any such separate determination that a reportable incident has occurred.

(2) The VA facility Director must report to ORO within 5 business days after making or receiving any separate determination that a reportable incident has occurred, and the IACUC must receive a concurrent copy of the report.

h. **Time Period for Required Determinations.** If the IACUC is unable to make a determination required under paragraph 7 within 60 calendar days after receiving notification of the relevant event, it must immediately notify the VA facility Director who, within 5 business days after receiving the IACUC's notification, must provide ORO with an acceptable justification for the delay and an acceptable completion timeline.

i. **Memoranda Of Understanding.** New or substantially revised MOUs related to the use of animals in research must be reported to ORO within 5 business days after final concurrence or signature. ORO strongly encourages contacting ORO early in the development of new or revised MOUs.

j. **Public Health Service Animal Welfare Assurances.** The VA facility Director must notify ORO within 5 business days after:

(1) Any substantial revision to the PHS Animal Welfare Assurance that covers the facility's animal care and use program, whether held by the facility or an academic affiliate.

(2) The submission to the National Institutes of Health (NIH) Office of Laboratory Animal Welfare (OLAW) of routine renewals of the Assurance.

(3) Any change in the status (e.g., expiration, restriction, suspension, or termination) of the Assurance.

k. **Accreditation.** The VA facility Director must report to ORO within 5 business days after any failure of the facility to achieve or maintain the accreditation status that is required by VA, or after any change in the status of an affiliate institution upon which the facility relies.

NOTE: *Although the Subcommittee on Research Safety (SRS) has primary authority in investigating, reviewing, and managing safety reports (paragraph 8), the SRS and IACUC must interact effectively to ensure safety in animal research. Reports and questions about animal research should be directed to ORO as specified on the ORO SharePoint/Web sites at <http://vaww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public. Questions about reporting to other Federal agencies should be directed to those agencies.*

8. RESEARCH SAFETY:

a. **Human Deaths.** VA personnel, including WOC and IPA appointees, must ensure oral notification of the SRS immediately upon becoming aware of any human death that may be the result of work (or other activity) in a research laboratory or dedicated research area (e.g., research specimen storage area).

(1) The SRS must alert ORO by e-mail or telephone within 2 business days after receiving such notification. The VA facility Director and the ACOS/R&D must receive concurrent notification.

(2) VA personnel, including WOC and IPA appointees, must ensure written notification of the SRS within 5 business days of becoming aware of the death.

b. **Human Accident, Injury, Illness, or Exposure.** VA personnel, including WOC and IPA appointees, must ensure written notification of the SRS within 5 business days after becoming aware of any serious accident, injury, illness, or exposure (other than those that result in death) that may be the result of work (or other activity) in a research laboratory or dedicated research area (e.g., research specimen storage area).

c. **Reportable Incidents Under Applicable Federal Standards.** VA personnel, including WOC and IPA appointees, must ensure written notification of the SRS within 5 business days after becoming aware of any incident related to research safety that is reportable under relevant VHA Handbooks or applicable Federal requirements, including Occupational Safety and Health Administration (OSHA) requirements.

d. **SRS Review of Reported Incidents.** The SRS must review any report of an incident described at paragraphs 8.a. through 8.c. at its next convened meeting.

(1) Incidents that involve a human death or present a significant risk to the safety of research personnel or the environment may call for immediate attention and require the SRS to convene an emergency session prior to the next scheduled meeting.

(2) The SRS must notify the VA facility Director and the ACOS/R&D within 5 business days after any determination that a reportable incident has occurred. No individual or committee may reverse or overrule the SRS's decision that a reportable incident has occurred.

(3) The VA facility Director must report the incident or event to ORO within 5 business days after receiving the SRS notification.

(4) The SRS must also notify the VA facility Director and the ACOS/R&D within 5 business days after any determination that an incident brought to its attention under paragraphs 8.a. through 8.c. was not reportable.

e. **Time Period for Required SRS determinations.** If the SRS is unable to make a determination required under paragraph 8 within 60 calendar days after receiving notification of the relevant event, it must immediately notify the VHA facility Director who, within 5 business days after receiving the SRS's notification, must provide ORO with an acceptable justification for the delay and an acceptable completion timeline.

f. **Additional Review of Reported Incidents.** The VA facility Director and others acting within their areas of responsibility may also investigate such incidents and make separate determinations as to reporting, but cannot reverse or overrule a determination by the SRS that a reportable incident has occurred.

(1) The VA facility Director must be notified within 5 business days after any such separate determination that a reportable incident has occurred.

(2) The VA facility Director must report to ORO within 5 business days after making or receiving any separate determination that a reportable incident has occurred, and the SRS must receive a concurrent copy of the report.

g. **Memoranda of Understanding.** New or substantially revised MOUs related to research safety must be reported to ORO within 5 business days after the final concurrence/signature. ORO strongly encourages contacting ORO early in the development of new or revised MOUs.

h. **Laboratory Decommissions and Reassignments.** The investigator or laboratory director must obtain authorization (i.e., permission) from the SRS and the ACOS/R&D prior to decommissioning or reassigning existing laboratory space (including modifying, vacating, or converting to non-laboratory use) that requires identification and disposal of hazardous materials, infectious agents, or equipment between uses.

(1) The request for authorization to decommission or reassign laboratory space must be made in writing to the SRS and the ACOS/R&D at least 1 month prior to implementation.

(2) Upon receiving such a request the SRS, in collaboration with the ACOS/R&D, must evaluate the space and determine if there are any specific hazards that require remediation.

(3) The ACOS/R&D must notify the facility Safety Office to ensure coordination of efforts in the inventory and efficient removal of hazardous materials, infectious agents, or equipment.

(4) The ACOS/R&D must notify the VA facility Director and the facility Safety Office of any unauthorized decommissioning or reassignment of laboratory space within 5 business days after becoming aware of the unauthorized decommissioning or reassignment.

(5) The VA facility Director must report any unauthorized decommissioning or reassignment of laboratory space to ORO within 5 business days after being notified.

NOTE: *The SRS has the lead in investigating, reviewing, and managing safety reports. However, the SRS and the IACUC must interact effectively to ensure safety in animal research (paragraph 7), and the SRS and IRB must interact effectively to ensure safety in human research (paragraph 6). Reports and questions related to research safety should be directed to ORO as specified on the ORO SharePoint/Web sites at <http://vawww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public.*

9. RESEARCH LABORATORY SECURITY:

a. **Research Laboratory Security Incidents.** VA personnel, including WOC and IPA appointees, must ensure written notification of the ACOS/R&D within 5 business days after becoming aware of any physical security concerns that pertain to research laboratories or other areas used exclusively for research, including:

(1) Any intrusion, physical security breach, break-in, or other security violation that occurs in dedicated research areas.

(2) Any finding by any entity other than ORO of noncompliance with research laboratory security requirements. **NOTE:** *Related reports to ORO must include all findings and all pertinent documentation.*

(3) Any unplanned suspension or termination of research by the ACOS/R&D or another facility official due to concerns about research laboratory security.

(4) Any other deficiency that substantively compromises the effectiveness of the facility's research laboratory security program.

NOTE: The VA Police Service must be notified immediately of all laboratory security incidents.

b. **Reports to the VA Facility Director and ORO.** The ACOS/R&D must notify the VA facility Director and the VA Police Service (if not previously notified) within 5 business days after becoming aware of any situation described at paragraph 9.a. Concurrent notification must be provided to other authorities in accordance with local reporting requirements.

(1) The VA facility Director must report the incident to ORO within 5 business days of being notified.

(2) These incidents are not subject to the SRS deliberation required under paragraph 8.d. and must be reported to ORO. However, the SRS must carefully review all incidents involving research laboratory security and determine if any changes in the Research Security Plan or other local policies are necessary to prevent future occurrences.

NOTE: This paragraph pertains to areas used **exclusively** for research. The facility must also ensure appropriate oversight of **other** areas whose use for research is limited or infrequent. Reports and questions related to research laboratory security should be directed to ORO as specified on the ORO SharePoint/Web sites at <http://vawww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public. Also see paragraph 10 relative to research information security incidents.

10. RESEARCH INFORMATION SECURITY:

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.

(1) The above notification requirements, and the requirements listed below at paragraphs 10.a.(2) through 10.a.(4), take precedence when incidents are also reportable under paragraphs 6 through 9 of this Handbook.

(2) The ACOS/R&D must immediately notify the records management official if VA records were destroyed.

(3) The ACOS/R&D must immediately notify the IRB, IACUC, and SRS where relevant. If the incident is not relevant to at least one of these committees, the ACOS/R&DC must immediately notify the R&D Committee as the relevant committee.

(4) VA personnel, including WOC and IPA appointees, must ensure written notification of the ACOS/R&D within 5 business days of becoming aware of any research information security incidents described in paragraph 10.a.

b. **Review of Incidents.** Notifications of information security incidents must be reviewed by each relevant research review committee at its earliest practicable convened meeting, not to exceed 30 business days from the date of notification.

(1) Each relevant research review committee must determine:

(a) Whether or not the incident constitutes a serious problem (see paragraph 4.t); and

(b) In conjunction with the ISO and/or PO as applicable, whether and what remedial actions are warranted by the facility or the relevant investigator(s).

(2) If the research review committee determines that the incident constitutes a serious problem:

(a) The committee must notify the VA facility Director and the ACOS/R&D within 5 business days after the determination.

(b) The VA facility Director must report the determination to ORO within 5 business days after receiving the committee's notification.

(3) If the research review committee makes additional determinations under its authority (e.g., if the IRB determines that the incident also involves serious noncompliance with human research protection requirements), any reporting requirements pertinent to such determinations must also be satisfied.

c. **Additional Reporting Requirements.** The VA facility Director must report the following circumstances related to research information security incidents to ORO within 5 business days after taking or becoming aware of such action(s), regardless of any determination under paragraph 10.b.(1):

(1) Provision of an Issue Brief for VA Central Office regarding the incident;

(2) Any notification to individual(s) of an information breach or provision of credit monitoring as required by the Network Security Operations Center (NSOC);

(3) Any breach notification required under the Health Information Technology for Economic and Clinical Health (HITECH) Act;

(4) Any notification to or from the Office of Inspector General (OIG) regarding the incident.

NOTE: *The requirements in paragraph 10 do not alter additional reporting requirements under other applicable regulations or policies, including the VA National Rules of Behavior and VA Handbook 6500. Reports and questions related to research*

information security should be directed to ORO as specified on ORO's SharePoint/Web sites at <http://vawww.vha.vaco.portal.va.gov/sites/ORO/RCO/default.aspx> and <http://www.va.gov/oro/>. The first link is to an internal Web site and is not available to the public.

NOTE: Reports and questions related to HIPAA authorizations and deficiencies (such as invalid HIPAA authorizations, deficient waivers of authorization, and other uses and disclosures of PHI for research without legal authority) are to be reported to ORO in accordance with paragraph 6 rather than paragraph 10.

11. REFERENCES:

- a. 9 CFR Part 2.
- b. 38 CFR Part 16.
- c. 45 CFR Part 164.
- d. 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>.
- e. VA Directive 6500, Managing Information Security Risk: VA Information Security Program.
- f. VA Directive 6609, Mailing of Sensitive Personal Information.
- g. VA Handbook 6500, Risk Management Framework for VA Information Systems—Tier 3: VA Information Security Program.
- h. VHA Directive 1058, The Office of Research Oversight.
- i. VHA Directive 1200, Veterans Health Administration Research and Development Program.
- j. VHA Handbook 1058.02, Research Misconduct.
- k. VHA Handbook 1058.03, Assurance of Protection for Human Subjects in Research.
- l. VHA Handbook 1058.04, Debarments and Suspensions Based on Research Impropriety in VA Research.
- m. VHA Handbook 1058.05, Veterans Health Administration Operations Activities That May Constitute Research.
- n. VHA Handbook 1200.01, Research and Development Committee.

- o. VHA Handbook 1200.05, Requirements for the Protection of Human Subjects in Research.
- p. VHA Handbook 1200.06, Control of Hazardous Agents in VA Research Laboratories.
- q. VHA Handbook 1200.07, Use of Animals in Research.
- r. VHA Handbook 1200.08, Safety of Personnel Engaged in Research.
- s. VHA Handbook 1605.1, Privacy and Release of Information.
- t. VHA Handbook 1605.02, Minimum Necessary Standard for Protected Health Information.