Human Research Protection Program Departmental Policy and Procedure

5.1 Principal Investigator Responsibilities in the Conduct of Human Research

Responsible Office: Human Research Protection Program Department (HRPPD)

Effective Date: June 12, 2026

I. Policy Statement

a. The purpose of this policy is to provide an outline of responsibilities of the principal investigator (PI) involved in the conduct of human subjects' research.

b. The term Principal Investigator is used to identify a researcher with primary responsibility for a research project

II. Scope

a. This policy applies to the following:

i. Individuals with faculty appointments qualify as PIs by the nature of their appointments.

ii. Adjunct faculty are not eligible to serve as the Principal Investigator on human subjects research protocols.

iii. Individuals with other appointments may be able to serve as PI under certain circumstances.

1. UT Southwestern individuals without faculty appointments may qualify as PI only with a faculty sponsor. The HRPPD will consult with leadership on a case- by-case basis to determine eligibility.

iv. Refer to the institutional policies to learn more about other staff appointments that can serve as the PI on the Institutional Review Board (IRB) protocol submission.

III. PROCEDURES FOR POLICY IMPLEMENTATION

a. Compliance with Applicable Regulations, Laws, and Policies Governing Human

Subjects Research

i. For UT Southwestern to receive federal funding to support human subjects research, the institution must have a Federalwide Assurance (FWA) with the U.S. Department of Health and Human Services (DHHS), Office for Human Research Protections (OHRP). The FWA states that **all human subjects research activities will be guided by the ethical principles** outlined in the Belmont Report and that federally supported research activities comply with the Common Rule. Investigators should become familiar with these principles and regulations to ensure that their research complies with them. Failure to comply with these principles can place both subjects and the institution at risk.

ii. For research involving genomic sequencing or genomic data from Texas residents, the PI is responsible for ensuring compliance with Texas state requirements governing genetic information security, including verification of allowable genome-sequencing equipment/software, U.S.-based data storage, and the prevention of access from foreign-adversary countries, as required by applicable law.

b. Conflict of Interest Policy

i. Investigators are required to file a UT Southwestern Outside Activities Report/Conflict of Interest (COI) disclosure prior to the submission of a protocol to an IRB for review and are responsible for keeping these disclosures current. Additionally, investigators must comply with the campus COI policies related to human subjects research, including disclosing potential conflicts of interest to the IRB and abiding by any management plans issued by the campus COI Committee. See HRPP 5.3 Financial Conflict Of Interest Management

c. Oversight and Supervision

i. Although PIs may delegate certain research-related tasks to other

members of the research team, they retain **ultimate responsibility** for the conduct of the study. The PI is the person ultimately responsible for the legal and ethical conduct of the study in accordance with the protocol, signed investigator agreements, and applicable regulations. The PI must be qualified by education, training, and/or experience to assume this responsibility.

ii. Oversight and responsibility for the study extend to the affiliated performance sites. PI is responsible for conducting the study in compliance with affiliate sites policies and procedures and notifying sites of unanticipated events or complaints.

iii. Investigators are responsible for certifying that key personnel have received adequate training to ensure they are aware of the regulations governing human subjects research and **understand and adhere to the IRB-approved research protocol**. Compliance with these standards provides assurance that the rights, safety, and well-being of human subjects and the integrity of the data collected are protected.

iv. Certain tasks may be delegated to qualified members of the research team, but the responsibility for ensuring tasks are performed in accordance with the protocol and regulations is the PI's, and cannot be delegated.

v. The PI should ensure that a member of the research team to whom a task is delegated is qualified by education, training, and/or experience (and state licensure where relevant) to perform the delegated task(s).

d. PIs must ensure that adequate resources are available for the conduct of the study throughout the entire life of the protocol. This includes maintaining sufficient time and resources to properly and safely conduct the research. In addition, PIs are responsible for implementing a plan to ensure continuity of oversight and study operations during any period of absence. This plan should

designate qualified personnel and outline procedures to maintain compliance with all regulatory and institutional requirements during the PI's absence.

e. Obtaining IRB Approval or Exemption to Conduct Human Subjects Research (See HRPP Policy 2.1 Initial Review of Research)

i. A PI must obtain approval by the IRB to conduct human subjects research before initiating a study and may not make a determination that the study is exempt from IRB review.

ii. To be considered "human subjects research", a project must meet both the federal definitions of "research" and "human subjects" as defined in the glossary of this Policy and Procedure Manual.

iii. Exempt Human Subjects Research (See HRPP Policy 1.3. Exempt Review Of Research)

The federal Common Rule identifies eight categories of human subjects research that may be eligible for exemption from IRB review. UT Southwestern IRBs apply these eight exemption categories only to studies determined to be no more than minimal risk and are not FDA-regulated.

1. Human subjects research that qualifies as exempt under one of the federal categories must nonetheless satisfy UT Southwestern's ethical standards for the protection of human research participants.

2. Only an IRB can determine whether the human subjects research is exempt. The IRB has the right not to exempt a protocol and to require full review by the convened IRB or expedited review by an IRB member or IRB subcommittee, particularly if the research involves a sensitive population or sensitive topic.

3. If a study is determined to be exempt from IRB review, it is not subject to continuing review or other rules governing human research, such as

rules on informed consent. However, the HIPAA Privacy Rule applies to all exempt research that uses or discloses protected health information (PHI). HIPAA Privacy Rule requirements do not apply to exempt research using or disclosing information that has been de-identified.

f. Study Initiation and Participant Enrollment

   i. PIs must ensure that the studies requiring expedited or convened IRB review may not be initiated and no subject may be enrolled in a study until:

      1. the IRB has approved the study for human subject enrollment;
      2. the involved study sites (e.g., Parkland health, Children's health, UTSW, Scottish Rite for Children, Texas Health Resources, etc.) have approved the study; and
      3. all study agreements or grant documentation has been finalized and appropriately executed.

g. Informed Consent (See HRPP Policy 3.1. Informed Consent Requirements)

   i. Unless the IRB determines that a waiver of informed consent or waiver of a signed informed consent document is appropriate for a study or has determined a study to be exempt, an investigator is responsible for ensuring:

      1. informed consent is obtained and documented using only current IRB-approved consent forms, and
      2. the subject or their legally authorized representative receives a copy of the informed consent document, and
      3. informed consent is obtained and documented prior to the conduct of research procedures.

   ii. Consent documents with the IRB approval stamp should be used to obtain written consent from subjects.

h. PIs are responsible for ensuring the conduct of an adequate and appropriate consent process. When referring to “Informed Consent”, it is important to differentiate between the informed consent document and the informed consent process. Obtaining informed consent is a process and not solely obtaining a signature on a form. PIs are required to ensure that the consent process is conducted according to the IRB approved plan and is appropriate for the research study and subject population.

i. PIs are responsible for ensuring the consent process is documented appropriately. Unless the IRB has granted a waiver of informed consent or a waiver of informed consent documentation, the study team should have a process in place to document the consent process, and any assent process (in the case where minors or individuals with impaired decision-making capacity are enrolled) in the research files for each subject according to the IRB approved plan.

j. HIPAA Privacy Rule (See Office of Compliance Policies: 7.22 Research Authorizations and 7.23 Waiver or Alteration of Research Authorizations.

    i. All researchers who are part of the UT Southwestern Health Care Component (UCC) or Affiliated Covered Entity (ACE) or collaborating with someone within the UCC or ACE and who are using or disclosing protected health information (PHI) must obtain written permission (i.e., an authorization) from subjects for the use of the PHI or obtain a waiver or alteration of authorization from the IRB.

k. Compliance with the IRB Approved Protocol and Application

    i. Research teams must adhere to the conditions of IRB approval, which includes the information provided in the IRB application and any supporting materials such as a formal study protocol. **This means the research team cannot perform any procedures, visits, or interactions that are not in the IRB approved protocol and they must also perform**

what is specified in the protocol.

l. Requirements after IRB Approval: Changes of Protocol (See HRPP Policy: 2.3 Modifications To Research))

i. If modifications to the IRB approved materials are necessary, a change of protocol must be submitted to, and approved, by the IRB prior to implementing the change. Failure to conduct the study according to the IRB approved protocol is considered noncompliance.

ii. To change any aspect of a research study, including revisions to an approved protocol, consent documents, HIPAA authorization forms, instruments, and recruitment methods and materials, a change of protocol must be submitted to the IRB for review and approval.

m. Requirements after IRB Approval: Continuing Review (See HRPP Policy: 2.2. Continuing Review Of Research)

i. 45 CFR 46 requires IRBs to review and approve all more than minimal risk research protocols at intervals appropriate to the degree of risk, but not less than once per year. 21 CFR 56 requires IRBs to review and approve all research protocols at least one per year. As a courtesy, the IRB sends email reminder notices to study teams, including PIs, prior to the expiration of approval date. However, investigators are responsible for monitoring their approval periods and submitting a *Continuing Review* form for IRB review in a timely manner (i.e., within 2 months prior to the expiration date). If IRB approval of a protocol expires, research activities must cease until re-approval of the protocol is obtained unless the PI demonstrates that procedures are necessary to ensure subject safety.

n. Closure Report: When the research is completed, investigators are expected to provide the IRB with a *Protocol Closure* report. (See HRPP Policy: 1.4. Study Closure And Inactivation)

o. Requirements after IRB Approval: Unanticipated Problems (See HRPP Policy:

9.2 UPIRSO and UADE)

i. Federal regulations and institutional policies require that investigators report to the IRB any unanticipated problems that pose risks to subjects or others that are related to the research. These should be reported to the IRB in accordance with the campus unanticipated problems policy.

ii. Unanticipated problem is a broad term that includes not only unfavorable outcomes that have occurred that were not expected, but also the development of potentially increased risks of harm occurring in the future. According to guidance developed by the Office for Human Research Protections (OHRP), an unanticipated problem is an incidence, experience, or outcome that meets all 3 of the following criteria:

   1. The incidence, experience, or outcome is unexpected given the research procedures described in protocol-related documents (e.g., the study protocol, the consent documents) and the characteristics of the subject population being studied. An event may be considered unexpected if it exceeds the nature, severity, or frequency described in the study-related documents.

   2. The incidence, experience, or outcome is related or probably related to participation in the research study. Probably related means the incidence, experience, or outcome is more likely than not to be caused by the research study procedures.

   3. The occurrence of the incidence, experience, or outcome suggests that the research places subjects or others at a greater risk of harm (physical, psychological, economic, or social) than was previously known or recognized.

iii. The phrase “unanticipated problems involving risks to subjects or others” is found but not defined in the HHS regulations at 45 CFR part 46. OHRP considers unanticipated problems, in general, to include any incident,

experience, or outcome that meets all of the following criteria:

1. unexpected (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the IRB- approved research protocol and informed consent document; and (b) the characteristics of the subject population being studied;
2. related or possibly related to participation in the research (in this guidance document, possibly related means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research); and
3. suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

p. Requirements after IRB Approval: Noncompliance (See HRPP Policy: 9.3 Noncompliance Review))

   i. Federal regulations and institutional policies require that investigators report noncompliance with IRB approved documents or research regulations to the IRB. Noncompliance means any failure to follow (1) federal regulations, state laws or institutional policies relevant to human subjects' research, or (2) the requirements and determinations of the reviewing IRB.

q. Record Keeping and Record Retention

   i. State and federal regulations require study teams to maintain complete and accurate study records. Study records should be stored in a secure manner to protect the privacy of subjects and to reduce the risk of damage. Any or all of the study related documents may be subject to, and should be available for, audit or inspection by a regulatory authority Study records can be archived after completion, but must be maintained for a

specified amount of time, depending on the requirements of the funding agency, sponsor, FDA or entity providing oversight. There may be other requirements that researchers must look into before disposing of research records; for example, the institution recommends maintaining records for at least seven years to dispute any allegations of research misconduct.

r. Clinicaltrials.gov Registration and Results Reporting

i. Many clinical research studies involving human subjects must be registered on and have results posted to ClinicalTrials.gov as mandated by the Food and Drug Administration (FDA), National Institutes of Health (NIH) and/or International Committee of Medical Journal Editors (ICMJE).

ii. The ICMJE requires registration of any interventional health outcome studies – including Phase I trials – prior to subject enrollment. Failing to register trials covered by the ICMJE requirements in a timely manner can result in the rejection of publications based on the failure to register the trial.

s. **Additional Responsibilities for Multi-Site Research** (See HRPP Policy: 1.6. Reliance On Non-UT Southwestern IRB)

i. When IRB review of a study is deferred to a non-UT Southwestern IRB, the PI and study team must still comply with relevant UT Southwestern requirements and must also be familiar with the requirements of the IRB of record, which may differ from that required by UT Southwestern. These responsibilities include complying with the requirements of the reviewing IRB in addition to those of the PI's own institution and ensuring all institutional requirements are met in addition to the PI's own institution.

ii. When UT Southwestern IRB serves IRB of Record or as the coordinating center for a study, some of the additional PI and study team responsibilities include ensuring IRB approvals for all sites are in place before human subjects research occurs at those sites and promptly

communicating changes of protocol, new information, and unanticipated problems to all study sites and ensuring that any changes are implemented.

IV. Definitions

See glossary of human research terms

V. References

a. UT Southwestern Human Research Protection Program Departmental Policies and Procedures

b. 21 CFR 50: Protection Of Human Subjects

c. 45 CFR 46: Protection Of Human Subjects

d. 45 CFR 164: Security And Privacy (HIPAA Privacy Rule)

e. 21 CFR 56: Institutional Review Boards

VI. Revision and Review History

a. Revision Date: June 2026; Author: HRPP; Description: Clarified who may serve as PI and updates based on Texas genomics law.

b. Revision Date: June 2021; Author: HRPP; Description: Separated policy from P&P manual. Updated references to AVPHRA and IRB Director. Minor administrative edits.

c. Revision Date: January 2019; Author: HRPP; Description: Revision to reference 2019 common rule.

d. Revision Date: August 2017; Author: HRPP; Description: New Policy Development

e. Revision Date: March 2012; Author: Research Administration; Description: PI Responsibilities