



University of Connecticut Health Center

**POLICY NUMBER 2003-41
September 4, 2008**

POLICY: REVIEW OF ALLEGED MISCONDUCT OF RESEARCH

All staff, faculty, students and trainees in the Health Center are bound by this policy. It is the clear obligation of all members of the research community to report incidents of suspected research misconduct. In order to provide an orderly disposition of charges of misconduct that is thorough, rapid, and fair to all parties, the following system has been developed. The process proceeds through four stages. These are described in the body of this policy.

Definitions:

- **Allegation** – An allegation is a disclosure of possible research misconduct through any means of communication. The disclosure may be by written or oral statement, or other communication to the Director of Research Compliance (DRC or the Corporate Compliance Integrity Officer (CCIO)).
- **Complainant** – The Complainant is a person who in good faith makes an allegation of research misconduct.
- **Evidence** – Evidence is any document, tangible item, or testimony offered or obtained during a research misconduct proceeding that tends to prove or disprove the existence of an alleged fact.
- **Good Faith** – Good faith as applied to a Complainant or witness, means having a belief in the truth of one's allegation or testimony that a reasonable person in the complainant's or witness' position could have, based on the information known to the complainant or witness at the time. Making an allegation, or cooperating with a research misconduct proceeding is not in good faith if one knowingly or recklessly disregards information that would negate the allegation or testimony. Good faith as applied to a committee member means cooperating with the research misconduct proceeding by impartially carrying out the duties assigned for the purpose of helping an institution meet its responsibilities. A committee member does not act in good faith if his/her acts or omissions on the committee are dishonest or influenced by personal, professional, or financial conflicts of interest with those involved in the research misconduct proceeding.
- **Inquiry** – An inquiry is a preliminary information gathering and preliminary fact finding conducted by the Standing Committee on Research Misconduct.
- **Investigation** – An investigation is the formal development of a factual record and the examination of that record leading to either (a) a decision not to make a finding of research misconduct or (b) a recommendation for a finding of research misconduct which

may include a recommendation for other appropriate actions, including administrative actions.

- **Person** – A person means any individual, corporation, partnership, institution, association, unit of government or legal entity, however organized.
- **Pertinent others** – Any other individuals who the Research Misconduct Committee (Faculty Standing Committee) or the Special Review Board determine are likely to have precise or logical relevance to an inquiry or investigation.
- **Preponderance of the evidence** - Preponderance of the evidence means that more likely than not, the evidence leads to the conclusion that the information at issue is probably true.
- **Research** - Research means a systematic experiment, study, evaluation, demonstration or survey designed to develop or contribute to general knowledge (basic research) or specific knowledge (applied research) relating broadly to public health by establishing, discovering, developing, elucidating or confirming information about, or the underlying mechanism relating to, biological causes, functions or effects, diseases, treatments, or related matters to be studied.
- **Research Misconduct** - Research misconduct means fabrication, falsification, or plagiarism in proposing, performing, or reviewing research, or in reporting research results.
 - a. Fabrication is making up data or results and recording or reporting them.
 - b. Falsification is manipulating research materials, equipment, or processes, or changing or omitting data or results such that the research is not accurately represented in the research record.
 - c. Plagiarism is the appropriation of another person’s ideas, processes, results, or words without giving appropriate credit. Authorship disputes are not defined as plagiarism in this policy.
 - d. Research misconduct does not include honest error or differences of opinion.
- **Research misconduct proceeding** - Research misconduct proceeding means any actions related to alleged research misconduct taken by the institution, including but not limited to, allegation assessments, inquiries, investigations, Office of Research Integrity (ORI) oversight reviews, hearings, and administrative appeals.
- **Research record** - Research record means the record of data or results that embody the facts resulting from scientific inquiry, including but not limited to, research proposals, laboratory records, both physical and electronic, progress reports, abstracts, theses, oral presentations, internal reports, journal articles, and any documents and materials provided to Health and Human Services (HHS) or an institutional official by a respondent in the course of the research misconduct proceeding. The research record could include instrumentation which store research records.
- **Respondent** - Respondent means the person against whom an allegation of research misconduct is directed or who is the subject of a research misconduct proceeding.
- **Retaliation** - Retaliation for the purpose of this part means an adverse action taken against a complainant, witness, or committee member by the Health Center, or anyone associated with it, in response to:
 - a. A good faith allegation of research misconduct; or,
 - b. Good faith cooperation with a research misconduct proceeding.

Time Limitations

- A. ***Six-year limitation.*** Unless otherwise required by law, this Policy applies only to research misconduct occurring within six years of the date the DRC or CCIO receives an allegation of research misconduct.
- B. ***Exceptions to the six-year limitation.*** Paragraph A of this section does not apply in the following instances:
1. Subsequent use exception. The Respondent continues or renews any incident of alleged research misconduct that occurred before the six-year limitation through the citation, republication or other use for the potential benefit of the Respondent of the research record that is alleged to have been fabricated, falsified, or plagiarized.
 2. Health or safety of the public exception. If a federal oversight agency with appropriate jurisdiction or the institution, following consultation with said federal agency, determines that the alleged misconduct, if it occurred, would possibly have a substantial adverse effect on the health or safety of the public.
 3. “Grandfather” exception. If the DRC or CCIO received the allegation of research misconduct before the effective date of this Policy.

STAGES:

1. Stage I: Contact.

- A. To speed reports of research misconduct individuals reporting will follow the UCHC policy titled [Reporting Compliance Concerns \(#2003-33\)](#). **All reports related to Research Misconduct should be immediately referred to the DRC or the CCIO.** Upon receipt of a report of misconduct the DRC or the CCIO will:
1. explain the rights of the individual wishing to make the report (complainant) including UCHC’s obligations to the complainant; Refer to The University of Connecticut’s Non-retaliation Policy;
 2. inform the complainant that the report may be submitted anonymously. The complainant must also be informed that confidentiality cannot be guaranteed: the identity of the complainant may be revealed on a need to know basis, or may be inferred, during the investigation;
 3. notify the complainant that if the report has not been made in written form it will be put in writing by the DRC or the CCIO. The complainant will be encouraged to provide as much detail as possible in this initial allegation, If possible the complainant will be asked to review the written document and attest that it is accurate;

4. notify the complainant that once a report is made known to an individual in the UHC Compliance structure, it cannot be withdrawn;
 5. notify the complainant that the DRC or CCIO will keep a written log of all reports; and
 6. notify the complainant that in accordance with federal policies on research misconduct, the complainant should not participate in the fact-finding phase, or in any other aspect of the determination of misconduct, other than as a witness;
 7. inform the complainant that the CCIO or DRC do not make any determination of merit or provide any opinion with regards to the complaint;
 8. ask the complainant if he/she believes the chair or other members of the Faculty Standing Review Committee have a conflict of interest. The DRC or CCIO will decide if any member of the committee so identified should be recused.
- B. The DRC or the CCIO will then submit the written allegation to the Chairperson of the Faculty Standing committee. If it is determined that the Chairperson must be recused, the CCIO or the DRC will discuss with the VP which other member should receive the written allegation.

2. Stage II: Initial Review by Chairperson of the Faculty Standing Committee.

- A. The Standing Committee consists of five senior faculty who are scientists, two from the School of Dental Medicine and three from the School of Medicine. They will be appointed by the Vice President for Health Affairs (VP) in consultation with the Dean of the School of Medicine and the Dean of the School of Dental Medicine. When a new appointee is required, the relevant Council (School of Medicine Dean's Council or School of Dental Medicine Faculty Senate) will be asked to submit the names of three senior faculty members who are scientists, and the appointee will be chosen from amongst them. The term of membership will be three years and can be renewed. The Associate Vice President for Research Administration and Finance (AVPRAF), or his/her designee will serve, *ex-officio*, as a non-voting member of the Committee and will be Executive Secretary for the Committee.
- B. The Chairperson of the Standing Committee will be selected by the VP.
- C. Special duties of the Chairperson:
1. The written allegation will be hand delivered by the DRC or CCIO to the Chairperson of the Standing committee in a sealed envelope marked "confidential".

2. The Chairperson, in consultation with any one other member of the Standing Committee, will determine if there is sufficient justification in the written allegation to proceed with an initial inquiry.

The following criteria will be used to determine whether an inquiry is warranted:

1. The allegation falls within the definition of research misconduct as noted above; and,
2. The allegation is sufficiently credible and specific so that the potential evidence of research misconduct may be identified.

D. Result of the Chairperson's review:

1. If the process outlined in section C. above determines that an inquiry is not warranted, the allegation will not be brought before the Standing Committee. In this case, all records of the preliminary review, the written allegation and a report detailing the reasons why further review was deemed unnecessary, will be labeled, dated, sealed and deposited with the AVPRAF, or his/her designee, who will retain this material in a secure fashion for at least three (3) years or in accordance with the State of CT Records Retention Schedule whichever is longer and provide to Health and Human Services authorized personnel upon request. Copies of the report will be given to the DRC and the CCIO.
2. All other allegations will be forwarded to the Standing Committee.
3. The VP, the CCIO, the DRC, and the complainant (if possible), and any individual who has been notified of the allegation per UCHC policy will be notified regarding the disposition of the allegation following the Chairperson's review. This notification will include what allegations were considered and the rationale for dismissing them at this stage.

3. Stage III: Conduct of an Inquiry by the Standing Committee.

- A. The Standing Committee will conduct an inquiry to determine if cause exists for the creation of a Special Review Board (SRB) to investigate the allegation of misconduct.

The criteria warranting an investigation are as follow:

1. There is a reasonable basis for concluding that the allegation falls within the definition of research misconduct; and,
2. Preliminary information-gathering and preliminary fact-finding from the inquiry indicates that the allegation may have substance.

- B. The Respondent(s) and the Complainant (s) if known, will be notified immediately by the Standing Committee, through the AVPRAF, or his/her designee, of the nature of the charges and that an inquiry has begun. If the inquiry subsequently identifies additional Respondents, the Standing Committee, through the AVPRAF, or his/her designee, will notify the additional Respondents of the nature of the charges and that an inquiry has been initiated. Copies of these communications will be given to the DRC and the CCIO.
- C. On or before the date on which the Respondent(s) and/or pertinent others are notified or the inquiry begins, whichever is earlier, the AVPRAF, or his/her designee, will promptly take all reasonable and practical steps to obtain custody of all the research records and evidence needed to conduct the research misconduct proceeding, inventory the records and evidence, and sequester them in a secure manner. Where the research records or evidence encompass scientific instruments shared by a number of users, custody may be limited to copies of the data or evidence on such instruments, so long as those copies are substantially equivalent to the evidentiary value of the instruments. In the event that the Respondent(s) and/or pertinent others do not cooperate with requests for research record sequestration, the AVPRAF, or his/her designee, has the authority to enter any Health Center location, accompanied by the Health Center Police, to accomplish the sequestration.

If requested, the Respondent(s) will be provided copies of, or reasonable, supervised access to the research records.

The AVPRAF, or his/her designee, shall take all reasonable and practical efforts to take custody of additional research records or evidence that is discovered during the course of a research misconduct proceeding, except that where the research records or evidence encompass scientific instruments shared by a number of users, custody may be limited to copies of the data or evidence on such instruments, so long as those copies are substantially equivalent to the evidentiary value of the instruments. The research records and evidence shall be maintained as required by regulation.

- D. The initial inquiry by the Standing Committee will be conducted in confidence and should be completed within 60 calendar days of the initiation of the inquiry. Under unusual circumstances a longer period may be warranted. This period of extension should not exceed 60 days, and the basis for the extension must be explained in the Standing Committee's report of the inquiry.
- E. Before an inquiry is conducted, any member of the committee who believes he/she has a conflict of interest must declare said conflict. Any member of the committee may identify other committee member(s) as having a conflict of interest. In addition, the complainant or the accused may identify committee member(s) as having a conflict of interest. If only one committee member is identified as having a conflict of interest, the committee members who have not been identified as having a conflict of interest will decide by a simple majority vote whether the named member must be recused from the inquiry. If more than one committee member is identified as having a conflict of interest, all committee members will decide by a simple majority vote

whether any of the named members must be recused from the inquiry. In cases where such conflict exists for more than two of the five members the remaining members of the committee shall nominate faculty, and the VP will name substitute members in consultation with the appropriate Dean.

- F. The appropriate Department Head, Center Director, Dean, and appropriate Dean's office staff will be notified when an initial inquiry is undertaken; testimony from the Department Head, Center Director, Dean, and Dean's office staff will either be solicited at the discretion of the Standing Committee, or offered by the Department Head, Center Director, Dean, and Dean's office staff at his/her discretion.
- G. The VP will make legal counsel available to the Standing Committee.
- H. Nature of the inquiry by the Standing Committee:
 - 1. The initial inquiry will be conducted by at least three of the five members of the Standing Committee and will be based on a preliminary objective analysis of research records. Interviews with technicians, research associates or collaborators should be limited in the initial inquiry to those essential to define a need for an investigation. If the Standing Committee does not have the requisite scientific expertise to carry out the initial inquiry, it may solicit additional expertise.
 - 2. The complainant, if known, must be offered the opportunity to interview with the Standing Committee. The complainant may choose not to participate.
 - 3. The Respondent(s) has the right to hear the allegation, to raise written questions and to testify, accompanied by legal counsel if desired, on all matters relevant to the inquiry. The Respondent(s) must be invited, in writing, to participate in the review. The Respondent(s) may choose not to participate.
 - 4. The Standing Committee will prepare a report of its inquiry, including a summary of the evidence reviewed, interview summaries, whether the allegation was made in good faith, and the conclusions of the inquiry. If the committee finds the complaint was not made in good faith, the complainant may be subject to disciplinary action under the University's Code of Conduct. The Respondent(s) and all individuals interviewed will be offered the opportunity to review the summary of his/her interview and comment on its accuracy. The Respondent(s) will be offered an opportunity to comment on the findings of the inquiry, and those comments shall be included in the report.
 - 5. Confirmatory finding. Should the Standing Committee find by majority vote that there is reason to suspect misconduct, a recommendation for further investigation will be made to the VP, appropriate Dean, and Dean's office staff in its written report. Copies of this report will be made to the CCIO and DRC. The complainant will be notified that the inquiry will proceed to investigation.

6. Within 30 days of finding that an investigation is warranted, but before the investigation is started, the Health Center, through the AVPRAF, or his/her designee, will provide agencies with a statutory right of notification, with the written finding by the VP, appropriate Dean, and Dean's office staff and a copy of the inquiry report which will include the following information:
 - The name and position of the Respondent(s);
 - A description of the allegations of research misconduct;
 - The source of research support, including, for example, grant numbers, grant applications, contracts, and publications listing the agency's support;
 - The basis for recommending that the alleged actions warrant an investigation; and,
 - Any comments on the report by the Respondent(s) or the complainant.

Upon request, the Health Center will, through the AVPRAF, or his/her designee, provide the following information to agencies having a statutory right:

- A copy of this Policy;
- The research records and evidence reviewed, transcripts or recordings of any interviews, and copies of all relevant documents; and,
- The charges for the investigation to consider.

Any communications to agencies with a statutory right of notification will be copied to the DRC, CCIO, VP, the appropriate Dean, and Dean's office staff, Department Head, and Center Director.

7. Non-confirmatory finding. If the inquiry by the Standing Committee determines that the allegations are unfounded, this is conveyed in the Committee's final report. The Respondent(s) may request that the conclusions of the initial inquiry be made public. However, every reasonable effort will be made not to identify publicly the individual making the initial allegation. In addition the Health Center will undertake diligent efforts to protect the positions and reputations of those persons who, in good faith, made the initial allegation.
8. The AVPRAF, or his/her designee, shall keep sufficiently detailed documentation of inquiries to permit a later assessment by agencies with a statutory right of the reasons why the Health Center decided not to conduct an investigation.
9. Notification of the Standing Committee's findings. The Standing Committee's findings, whether confirmatory or non-confirmatory are written in a final report and sent to the VP, with a copy to the accused. The CCIO, the DRC, the appropriate Dean, and Dean's office staff, Department Head, Center Director, the complainant (if known), and any individuals known by the Standing Committee to have knowledge of the allegation will be sent notification of the disposition of the review by the AVPRAF, or his/her designee.

10. Early termination of inquiry. Should the Standing Committee decide to terminate the initial inquiry for any reason, a report of such planned termination, including a description of the reasons for such termination, will be made to the appropriate federal oversight office. Copies of such communication will be provided to the DRC, CCIO, VP, the appropriate Dean, and Dean's office staff, Department Head, Center Director, and the complainant (if known).
11. Records of all inquiries by the Standing Committee, including a copy of its final report, shall be kept on file and in a secure fashion in the Office of the AVPRAF, or his/her designee, for a period of at least seven (7) years or in accordance with the State of CT Records Retention Schedule, whichever is longer. These records, upon appropriate and reasonable request, will be made available to those agencies which have a statutory right of access.

4. Stage IV: Full Review by Special Review Board (SRB)

- A. In the case of allegations of research misconduct identified by the Standing Committee as warranting further review, a full investigation will be initiated within 30 days of the completion of the inquiry. This investigation will be carried out by an *ad hoc* Special Review Board (SRB) appointed by the VP with advice from the appropriate Dean(s). The VP will make a reasonable effort to not appoint members to the SRB who have a conflict of interest. An opportunity will be provided to both the complainant and the accused to challenge the composition of the SRB by the complainant or the accused. If it is determined by the VP that there is a reasonable basis for the challenge, the composition of the committee may be altered.
- B. SRB Membership. The SRB will consist of two faculty members from the involved School, and one member of the Standing Committee. Every attempt will be made to appoint the SRB in a manner that will guarantee that it has the requisite scientific expertise needed to conduct an investigation. In the event that it is necessary, individuals with appropriate scientific expertise from institutions other than the University of Connecticut Health Center will be added to the membership of the SRB. The AVPRAF, or his/her designee, will serve as a non-voting, ex-officio member and Executive Secretary of the SRB. The VP will make legal counsel available to the SRB.
- C. The AVPRAF, or his/her designee, will notify the Respondent(s) and the Complainant(s) (if known) in writing, of the allegations within a reasonable amount of time after determining that an investigation is warranted, but before the investigation begins. The AVPRAF, or his/her designee, will give the Respondent(s) written notice of any new allegations of research misconduct within a reasonable amount of time of deciding to pursue allegations not addressed during the inquiry or in the initial notice of investigation.
- D. To the extent not already done so at the allegation or inquiry stages, the AVPRAF, or his/her designee, will take all reasonable and practical steps to obtain custody of all

the research records and evidence needed to conduct the research misconduct proceeding, inventory the records and evidence, and sequester them in a secure manner, except that where the research records or evidence encompass scientific instruments shared by a number of users, custody may be limited to copies of the data or evidence on such instruments, so long as those copies are substantially equivalent to the evidentiary value of the instruments. Whenever possible, the AVPRAF, or his/her designee, must take custody of the records:

1. Before or at the time the institution notifies the respondent; and
 2. Whenever additional items become known or relevant to the investigation.
- E. **Purview of the Investigation.** The SRB will evaluate the report of the Standing Committee and examine data books, records, publications and other research records relevant to the charge of misconduct. The investigation will be conducted in confidence, and reasonable efforts will be made to protect the privacy of the accused and complainant. The SRB will use diligent efforts to ensure that the investigation is thorough and sufficiently documented and includes examination of all research records and evidence relevant to reaching a decision on the merits of the allegations. The SRB will take reasonable steps to ensure an impartial and unbiased investigation to the maximum extent practicable, including participation of persons with appropriate scientific expertise who do not have unresolved personal, professional, or financial conflicts of interest with those involved with the inquiry or investigation. The SRB will interview each respondent, complainant, and any other available person who has been reasonably identified as having information regarding any relevant aspects of the investigation, including witnesses identified by the respondent, and transcribe each interview, provide the recording or transcript to the interviewee for correction, and include the recording or transcript in the record of the investigation. The SRB will pursue diligently all significant issues and leads discovered that are determined relevant to the investigation, including any evidence of additional instances of possible research misconduct, and continue the investigation to completion.
- F. The Respondent(s) has the right to give testimony on all aspects of the report by the Standing Committee and on all of the evidence acquired by the SRB. The Respondent(s) has the right either individually or through his/her representative to raise written questions and demand answers in written form from the individual(s) who made the original allegations (assuming the identity of those individuals is known to the SRB); to examine in writing or orally, those who give testimony to the SRB; to call witnesses, and to be represented by legal counsel as appropriate. The Respondent(s) must be invited, in writing, by the SRB to participate in the investigation. The Respondent(s) may choose not to participate.
- G. An investigation should ordinarily be completed within 120 calendar days of its initiation. This includes conducting the investigation, preparing the report of findings,

making that report available for comment by the subjects of the investigation, and submitting the report to the applicable federal oversight agencies. If delays occur affecting the completion of the investigation past the 120-calendar day completion deadline, the procedure noted in 5. A. below in this policy will be followed.

H. Evidentiary Standards. The following evidentiary standards apply to findings made under this Policy.

- Standard of proof. A finding of research misconduct must be proved by a preponderance of the evidence.
 - Burden of proof.
1. The Health Center has the burden of proof for making a finding of research misconduct. The destruction, absence of, or Respondent's failure to provide research records adequately documenting the questioned research is evidence of research misconduct where the Health Center establishes by a preponderance of the evidence that the Respondent intentionally, knowingly, or recklessly had research records and destroyed them, had the opportunity to maintain the records but did not do so, or maintained the records and failed to produce them in a timely manner and that the Respondent's conduct constitutes a significant departure from accepted practices of the relevant research community.
 2. The Respondent has the burden of going forward with and the burden of proving, by a preponderance of the evidence, any and all affirmative defenses raised. In determining whether the Health Center has carried the burden of proof imposed by this part, the SRB shall give due consideration to admissible, credible evidence of honest error or difference of opinion presented by the Respondent.
 3. The Respondent has the burden of going forward with and proving by a preponderance of the evidence any mitigating factors that are relevant to a decision to impose administrative actions following a research misconduct proceeding.

I. Requirements for Findings of Research Misconduct

A finding of research misconduct made under this part requires that:

1. There be a significant departure from accepted practices of the relevant research community; *and*,
2. The misconduct be committed intentionally, knowingly, or recklessly; *and*,
3. The allegation be proven by a preponderance of the evidence.

J. Early Termination of Review. If the SRB decides to terminate its investigation for any reason without completing all relevant requirements of applicable federal law, a report

of such planned termination, including a description of the reasons for such termination, shall be made to the appropriate federal oversight office.

K. Report of the Investigation. The SRB will report its findings and recommendations to the VP, the Dean(s) of the involved School(s), appropriate Dean's office staff, the Department Head(s), Center Director(s), the DRC, the CCIO, applicable federal oversight offices, and the Respondent(s). Prior to submitting this report, however, the Respondent(s) will be given an opportunity to comment on the findings, and those comments will be included in the final report. The comments of the Respondent(s), if any, must be submitted to the SRB within 30 days of the date on which the Respondent(s) received the draft investigation report. The AVPRAF, or his/her designee, will concurrently give the Respondent(s) a copy of, or supervised access to, the evidence on which the report is based.

1. The Respondent(s) will be provided with a copy of the final report.
2. The Complainant will be notified of the findings of the investigation.

L. The final investigation report must be in writing and include:

1. The nature of the allegations of research misconduct.
2. Describe and document the project's funding support, including, for example, any grant numbers, grant applications, contracts, and publications listing support.
3. Describe the specific allegations of research misconduct for consideration in the investigation.
4. Include the institutional policies and procedures under which the investigation was conducted.
5. Identify and summarize the research records and evidence reviewed, and identify any evidence taken into custody but not reviewed.
6. For each separate allegation of research misconduct identified during the investigation, provide a finding as to whether research misconduct did or did not occur, and if the former,
 - a. identify whether the research misconduct was falsification, fabrication, or plagiarism, and if it was intentional, knowing, or in reckless disregard;
 - b. summarize the facts and the analysis which support the conclusion and consider the merits of any reasonable explanation by the respondent;
 - c. identify the specific funding support;
 - d. identify whether any publications need correction or retraction;
 - e. identify the person(s) responsible for the misconduct; and,

f. list any current support or known applications or proposals for support that the respondent has pending with all extramural agencies.

7. Include and consider any comments made by the Respondent (s), Complainant and/or pertinent others regarding their respective interview summaries, as well as any comments made by the Respondent on the draft investigation report.

M. Responses to the Report.

1. **Allegation is Confirmed.** Should the allegation of misconduct be confirmed by the vote of a majority of the members of the SRB, appropriate action will be taken by the VP with advice from the appropriate Dean of the involved School and the relevant Dean's office staff, Department Head(s) or Center Director(s). Funding agencies directly involved in the support of the research in question will be notified, by the AVPRAF, or his/her designee, that an allegation of misconduct has been confirmed by formal investigation. If the research involves human subjects, the Institutional Review Board and the Office of Human Subject Research Protection will be notified of the findings. Copies of all such communications will be given to the DRC and the CCIO. Reports to funding agencies will include the following:

- a. **Investigation Report.** A copy of the report, all attachments, and any appeals.
- b. **Final institutional action.** A statement of whether the SRB found research misconduct, and if so, who committed the misconduct.
- c. **Findings.** A statement of whether the VP accepts the investigation's findings.
- d. **Institutional administrative actions.** Describe any pending or completed administrative actions against the Respondent(s).

2. **Allegation is not Confirmed.** In this case, the Health Center will undertake reasonable efforts to restore the reputation of the accused. The accused has the right to request widespread dissemination of the findings, and the Health Center will exercise reasonable efforts to do so. Reasonable efforts will also be made not to identify the individual(s) making the allegation. The Health Center will make reasonable efforts to protect the positions and reputations of persons who, in good faith, made allegations of research misconduct.

N. All records of the SRB will be sealed and deposited with the AVPRAF, or his/her designee. He/she will keep these records secure according to the State of Connecticut Records Retention Schedule or seven (7) years, whichever is longer. If required by federal regulation, documentation of the SRB's investigation will be made available to the appropriate federal oversight office.

OTHER CONSIDERATIONS FOR THIS POLICY:

1. Protection of the Complainant and the Respondent

A. **Complainant** – It is the policy of the Health Center to protect all employees, students and other individuals associated with the Health Center who have made an allegation of research misconduct in accordance with this policy from retaliation in accordance with the requirements of federal and state law. See The University of Connecticut’s Policy on Non-retaliation. Similarly, inquiries and investigations will be conducted in a manner that will ensure fair treatment to the respondent(s) in the inquiry or investigation. Confidentiality will be maintained to the extent possible without compromising public health and safety or the necessary thoroughness of the inquiry or investigation.

2. **Failure to Cooperate**

A. Whenever individuals (including the respondent and any other individuals) fail to cooperate either with the Standing Committee or with the SRB, the review process will be conducted without their participation.

3. **Interim Administrative Actions**

A. In the event that any of the following conditions are determined to exist, the AVPRAF, or is/her designee will be responsible for immediate reporting to the relevant research sponsors:

- There is an immediate health hazard involved;
- There is an immediate need to protect Federal or other funds or equipment;
- There is an immediate need to protect the interests of the person(s) making the allegations or of the individual(s) who is the subject of the allegations as well as his/her co-investigators and associates, if any;
- It is probable that the alleged incident will be reported publicly;
- There is a reasonable indication of possible criminal violation, in which case relevant research sponsors will be notified within 24 hours, if so required by law.

B. A copy of such report shall be sent to the DRC and the CCIO, the VP, the appropriate Dean(s) of the involved School(s) and the relevant Dean’s office staff, Department Head(s) or Center Director(s).

C. In situations where there is an apparent need to take additional interim administrative actions to protect Federal funds and insure that the purposes of the Federal financial assistance are carried out, the VP, and/or his/her designee(s) will be responsible for taking such action. While circumstances may require immediate action, the administration must inform either the Standing Committee or the SRB (as appropriate for the stage of review) of its action in a timely manner. The relevant Committee (Standing Committee or SRB) will review the administration’s action and provide its recommendation as to its propriety.

- D. The AVPRAF, or his/her designee, will, as required by appropriate federal law, notify the appropriate federal oversight office(s) that a specific interim action has been taken in a given investigation, what that action is and the rationale for taking it.
- E. The AVPRAF, or his/her designee will advise the appropriate federal oversight office of any developments during the course of the investigation which disclose facts that may affect current or potential Department of Health and Human Services funding for individual(s) under investigation or that the federal oversight office needs to know to ensure appropriate use of Federal funds.
- F. In the event that the SRB is unable to complete its investigation in 120 calendar days, the AVPRAF, or his/her designee will submit a written request for extension, as required by federal regulation, with the appropriate federal oversight office. Such a request will include an explanation for the delay, an interim report on progress of the investigation, an outline of what remains to be done, and an estimated date of completion of the investigation.

4. Sanctions

- A. Sanctions and penalties for those engaged in fraudulent scientific activities will be determined by the VP with advice by the appropriate Dean of the involved School and the relevant Dean's office staff, Department Head(s) or Center Director(s). Sanctions may include, but are not restricted to:
 - Letter of reprimand
 - Notification to professional and/or scientific societies
 - Notification to journals which may have published research determined to be fraudulent
 - Reassignment of duties
 - Termination of grant support
 - Termination of fellowship support
 - Adjustment of research space allocation
 - Adjustment of salary
 - Suspension
 - Dismissal
- B. When required by relevant federal regulation, a report of the sanctions imposed will be provided to the appropriate federal oversight office.

5. Appeals of Process and/or Sanctions

- A. Appeals by the Respondent(s) can be made in accordance with the University of Connecticut's laws and by laws for faculty or non-faculty professional staff or through applicable union contracts. The appeals process will not delay the completion of the investigation past the normal 120-calendar day completion deadline. However, since the appeals process could result in a reversal, or modification, of the findings of research misconduct in the investigation report, or sanctions applied by the VP, the

appeals process must be completed within 120 days of filing by the Respondent. If the Health Center cannot complete the appeals process within this 120 day limit, the AVPRAF, or his/her designee, will write to any agency with statutory oversight of the research misconduct investigation process, requesting an extension of this time limit, and providing an explanation for the request. Copies of such communications will be given to the DRC and the CCIO, The VP, the appropriate Dean(s) of the involved School(s) and the relevant Dean's office staff, Department Head(s) or Center Director(s).

6. Promulgation of the Policy for Review of Alleged Misconduct of Research.

A. This policy will be made available to all faculty members of the Schools of Medicine and Dental Medicine, research assistants and associates, graduate students, medical students, dental students, postdoctoral trainees, technicians and administrative staff involved in the Health Center's research program via the UHC website, along with other institutional policies.

7. Revision of Policy Guidelines

A. This document will be periodically reviewed and revised.

Cato T. Laurencin (signed)

9/15/08

Vice President for Health Affairs

Date

Revised Policy: October 1, 2003