Research Misconduct Procedure

Section 1 - Key Information

Policy Type and Approval Body	Academic - Academic Board
Accountable Executive – Policy	Deputy Vice-Chancellor (Research and Innovation)
Responsible Manager – Policy	Executive Director, Research Office
Review Date	19 November 2028

Section 2 - Purpose

(1) This Procedure governs the processes for managing complaints and allegations regarding potential breaches of the Australian Code for the Responsible Conduct of Research (the Code).

(2) It adopts the framework outlined in the Guide to Managing and Investigating Potential Breaches of the Code (the Investigation Guide) written by the National Health and Medical Research Council (NHMRC), the Australian Research Council (ARC) and Universities Australia.

(3) It applies the principles of procedural fairness to managing and investigating breaches of the Code. These principles include:

a. the hearing rule (an opportunity to be heard);
b. the rule against a bias (decision-makers must not have a person interest in the outcome); and
c. the evidence rule (decision must be based on evidence).

Section 3 - Scope

(4) This Procedure applies to all current and former staff, including honorary roles (see the Honorary Appointments Policy), partners, contractors, agents and other individuals (e.g. CONAGOTHS) engaging in research for and on behalf of the University (collectively referred to as 'researchers' in this Procedure) and their research.

(5) Higher Degree by Research (HDR) students are covered by the Research - Higher Degree Student Misconduct Procedure.

(6) This Procedure covers research which can reasonably be regarded as the responsibility of the University.

(7) Professional misconduct that falls outside the description defined by the Code should be handled under the University's processes for dealing with other forms of misconduct, for example harassment or bullying which is managed through People & Culture policies and procedures such as the Workplace Behaviours Policy and/or the Enterprise Agreement.

(8) When necessary, circumstances may require the University to deviate from the steps outlined in this Procedure, but the principles of procedural fairness will be applied and the parties involved or affected will be provided adequate details of the processes to be followed. This includes, where appropriate, suspension should there be external criminal, civil or other administrative tribunal inquiry in the same factual matters. If suspended, once any external inquiries are complete, where feasible and appropriate, the University may consider recommencing these procedures.

Section 4 - Key Decisions

Key Decisions	Role
Holds the final responsibility for receiving reports of the outcomes of processes of assessment or investigation of potential or found breaches of the Code and deciding on the course of action to be taken.	Responsible Executive Officer (currently Deputy Vice-Chancellor (Research and Innovation))
Receive complaints about the conduct of research or potential breaches of the Code and oversees their management and investigation where required.	Designated Officer (currently Pro Vice-Chancellor (Research))

Section 5 - Policy Statement

(9) In addition to the Code, a range of other internal and external policies, guidelines and codes impose requirements or provide guidance regarding the responsible conduct of research..

(10) Related La Trobe University research policies key to the responsible conduct of research include:

a. Conflict of Interest Policy
b. Honorary Appointments Policy
c. La Trobe University Enterprise Agreement 2023
d. Research Integrity Policy
e. Research Governance Policy
f. Research Authorship and Outputs Policy
g. Research Data Management Policy
h. Research Human Ethics Procedure
i. Research Animal Ethics Procedure
j. Research Biosafety and Biosecurity Procedure
k. Research Clinical Trials Policy
l. Research - Higher Degree Student Misconduct Procedure
m. Responsible AI Adoption Policy

(11) Key external research policies and guidelines that contribute to the responsible conduct of research include:

a. National Statement on Ethical Conduct in Human Research 2023
b. Australian Code for the Care and Use of Animals for Scientific Purposes 8th Edition 2013 (updated 2021)
c. Gene Technology Act and Regulations
d. Biosecurity Act 2015
e. NHMRC Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: guidelines for researchers and stakeholders, 2018
f. ARC Australian Research Integrity Policy 2019
g. NHMRC Research Integrity and Misconduct Policy (2019)

Section 6 - Procedures

Part A - Research Misconduct and Breaches of the Code

(12) Research misconduct is a serious breach of the Code, which is also intentional, reckless, or negligent. Repeated or persistent breaches will likely constitute a serious breach of the Code.

(13) A breach of the Code is defined as a failure to meet the principles and responsibilities of the Code and may refer to a single breach or multiple breaches. Examples of breaches of the Code include, but are not limited to, the following:

a. Not meeting required research standards:
    i. conducting research without ethics approval as required by the National Statement on Ethical Conduct in Human Research 2023, the Australian Code for the Care and Use of Animals for Scientific Purposes 8th Edition 2013 (updated 2021), the Gene Technology Act and Regulations, the Biosecurity Act 2015;
    ii. failing to conduct research in accordance with the approval from an appropriate ethics review body;
    iii. conducting research without the requisite approvals, permits or licences under relevant Codes, regulations or legislation;
    iv. misuse of research funds;
    v. concealment or facilitation of breaches (or potential breaches) of the Code by others such as not reporting potential breaches and/or facilitation of the above practices which breach the Code.
b. Fabrication, falsification, misrepresentation:
    i. fabrication of research data or source material;
    ii. falsification of research data or source material;
    iii. misrepresentation of research data or source material;
    iv. falsification and/or misrepresentation to obtain funding.
c. Plagiarism:
    i. plagiarism of another's work, including theories, concepts, research data and source material;
    ii. duplicating a publication (also known as redundant or multiple publication, or self-plagiarism) without acknowledgment of the source.
d. Research data management:
    i. failure to appropriately maintain research records;
    ii. inappropriate destruction of research records, research data and/or source material;
    iii. inappropriate disclosure of, or access to, research records, research data and/or source material.
e. Supervision:
    i. failure to provide adequate guidance or mentorship on responsible research conduct to researchers, research trainees or research students under their supervision.
f. Authorship:
    i. failure to acknowledge the contributions of others fairly;
    ii. misleading ascription of authorship including failing to offer authorship to those who qualify or awarding authorship to those who do not meet the requirements.
g. Conflicts of interest:
    i. failure to disclose and manage conflicts of interest.
h. Peer review:
    i. failure to conduct peer review responsibly.

(14) Breaches range in severity. The severity of a breach is determined on a case-by-case basis. Consideration of the type of behaviour may be used to infer whether the breach is intentional, reckless or negligent and therefore represents potential research misconduct. Fabrication and falsification are types of breaches that are commonly recognised as being undertaken intentionally or recklessly and are examples of research misconduct. Repeated or persistent breaches, especially after repeated corrective actions from preliminary assessments or as requested by the approving ethics committee and/or other delegated authority will likely constitute a serious breach of the Code, and therefore consideration of potential research misconduct.

(15) Factors that will be considered in determining whether a Breach represents a minor or major Breach include:

a. the extent to which the principles and responsibilities outlined in the Code or relevant law, regulation, disciplinary standard, ethics, guideline, contractual agreement or policy have been Breached;
b. the extent to which research participants, the wider community, animals and the environment are or may have been affected by the potential Breach;
c. the extent to which the Breach affects the trustworthiness of research;
d. whether the conduct represents a significant departure from accepted standards within the research and scholarly community for proposing, conducting or reporting research.

(16) Consideration will also be given to any mitigating or extenuating circumstances that may have contributed to the Breach, including:

a. systemic failures such as where the university has not provided appropriate resources or facilities to researchers;
b. the level of experience of the Researcher;
c. whether there is a pattern of Breaches by the Researcher;
d. whether the behaviour was accidental or intentional.

(17) Honest differences in judgement and unintentional errors do not usually constitute research breaches of the Code unless they result from behaviour that is reckless or negligent.

(18) Authorship concerns and disputes that do not meet the criteria for intentional, reckless or negligent action should be considered under the University Research Authorship and Outputs Policy.

(19) Complaints of a potential breach of the Code may overlap with allegations of fraud that relates to funding (for example, where it is alleged that falsified data was used in an NHMRC funded project).

Part B - Responsibilities of the University

(20) The University has the responsibility to facilitate the prevention and detection of potential breaches of the Code. The University must ensure that the process for managing and investigating concerns or complaints about potential breaches of the Code follows the principles of procedural fairness (also referred to as natural justice).

(21) These processes encapsulate:

a. the hearing rule (an opportunity to be heard);
b. the rule against a bias (decision-makers must not have a person interest in the outcome); and
c. the evidence rule (decision must be based on evidence.

(22) The principles supporting these rules include:

a. Proportional: Investigations and subsequent actions need to be proportional to the extent of the potential

breach of the Code.

b. Fair: The respondents and, where appropriate, complainants and others who may be adversely affected by any investigation must be treated fairly and in accordance with the current La Trobe University Enterprise Agreement 2023.
c. Impartial: Investigators and decision-makers are to be impartial and declare any interests that do, may, or may be perceived to jeopardise their impartiality. These interests are to be appropriately managed.
d. Timely: Investigations into potential breaches should be conducted in a timely manner to avoid undue delays and to mitigate the impact on those involved.
e. Transparent: Information about institutional processes should be readily available and/or provided to respondents, complainants, all employees and students engaged in research. Institutions need to ensure accurate records are maintained for all parts of the process, with records held centrally and in accordance with the relevant legislation.
f. Confidential: Information will be treated as confidential and not disclosed unless required.

Part C - Institutional Roles

Responsible Executive Officer

(23) The Responsible Executive Officer (REO) is the senior officer appointed by the University to have the final responsibility for receiving reports of the outcomes of processes of assessment or investigation of potential or found breaches of the Code and deciding on the course of action to be taken.

(24) The Deputy Vice-Chancellor (Research and Innovation) has been appointed by the Vice-Chancellor as the Responsible Executive Officer.

The Designated Officer

(25) The Designated Officer (DO) is a senior professional or academic officer or officers within the University appointed to receive complaints about the conduct of research or potential breaches of the Code and to oversee their management and investigation where required.

(26) The Pro Vice-Chancellor (Research) has been appointed by the Deputy Vice-Chancellor (Research and Innovation) as the Designated Officer to whom all complaints of a potential breach must be reported.

(27) The Designated Officer may delegate the role in specific cases as appropriate due to circumstances and the seriousness of the breach of the Code.

Assessment Officer

(28) The Assessment Officer (AO) is the person or persons appointed by the Designated Officer on behalf of the University to conduct a preliminary assessment of a complaint about a potential breach of the Code.

(29) The Senior Manager, Ethics Integrity and Biosafety will assist the Designated Officer to assign a qualified senior staff within the Research Office and / or a senior academic to the Assessment Officer role based on the nature of the complaint.

(30) The Assessment Officer:

a. conducts a preliminary assessment overseen by the Designated Officer;
b. consults with the Designated Officer, others in the institution and external experts where necessary;
c. liaises with the respondent and other relevant parties as appropriate;
d. secures evidence and manages records through the Ethics, Integrity and Biosafety team;

e. provides a written report to the Senior Manager, Ethics Integrity and Biosafety, who will ensure it becomes part of the record and forward to the Designated Officer as decision-maker.

(31) Research Ethics, Integrity and Biosafety has the responsibility for the management of research integrity. All concerns or complaints should be initially directed to the Senior Manager, Ethics Integrity and Biosafety. Any concerns or complaints related to a potential breach of the Code will be directed by the Senior Manager, Ethics Integrity and Biosafety to the Designated Officer.

Research Integrity Advisors

(32) Research Integrity Advisors (RIAs) are individuals with knowledge of the Code and institutional processes nominated by the University to promote the responsible conduct of research and provide informal advice to those with concerns about issues relating to the conduct of research.

(33) Research Integrity Advisors:

a. may explain the options open to a person considering, making or having made a formal complaint of research misconduct;
b. may provide individuals with connections to the Ethics, Integrity and Biosafety team and other advisors across the University research community;
c. have a responsibility to report instances of potential breaches of the Code that may constitute research misconduct.

(34) Research Integrity Advisors do not:

a. become involved in assessing the merits of any complaint of research misconduct;
b. advise on matters where they have a potential, perceived or actual conflict of interest;
c. investigate or assessment of the complaint, including contacting the person who is the subject of that complaint or become involved in any subsequent investigation other than as witness or to provide testimony.

(35) Contact details of the University's Research Integrity Advisors are available on the Research Integrity Hub.

(36) All parties involved in this procedure are expected to disclose and manage conflicts of interests related to the matter, in accordance with the Conflict of Interest Policy.

(37) A conflict of interest refers to circumstances in which someone's personal interests may conflict with their professional obligations. A conflict of interest exits when a reasonable person might perceive that an individual's personal interest(s) could be favoured over their professional obligations.

(38) If any person involved in this procedure has a perceived, potential or actual conflict of interest, they must declare the conflict at the earliest possible stage to the Senior Manager, Ethics Integrity and Biosafety, the Designated Officer or the Responsible Executive Officer as appropriate and the matter must be managed according to the Policy. The Deputy Vice-Chancellor (Research and Innovation) or the Vice-Chancellor may direct that the role and responsibilities of a specified person in this procedure be assumed by another University representative if required to appropriately manage a conflict of interest.

Part D - Responsibilities of Individuals

(39) Each person to whom this Procedure applies has a responsibility to:

a. apply the principles of responsible research conduct as per the Code in all aspects of their research;
b. bring instances of questionable research conduct to the attention of a Research Integrity Advisor, Senior

Manager, Ethics Integrity and Biosafety or the Designated Officer.

c. be aware that if they choose not to proceed with a complaint, the University still has an obligation to assess the nature of the complaint and whether to proceed to a preliminary assessment.
d. cooperate with the Designated Officer or a person they appoint as Assessment Officer in accordance with the Investigation Guide to conduct a preliminary assessment of a complaint about research and in the review of any alleged research misconduct.
e. contribute any evidence that may be relevant to a complaint of a potential breach of the Code to the Designated Officer or delegate or a person they appoint as Assessment Officer.

Part E - Considering a Potential Breach of the Code

(40) Any person may make a complaint about that a potential breach of the Code.

(41) For the purposes of this procedure, a complaint is a considered statement of the problem, concern or grievance about the conduct of research done under the auspices of La Trobe University.

(42) Prior to submitting a formal complaint, a person may elect to attempt resolution via informal methods at the local level. When doing so, they must ensure they follow all relevant University procedures.

(43) Any University Officer who becomes aware of informal or local complaints and their resolution must advise the Senior Manager, Ethics Integrity and Biosafety. The Senior Manager, Ethics Integrity and Biosafety will then report the specifics of the informal allegations to the Designated Officer.

(44) A person who has a concern or complaint about a potential research breach that may have occurred or is occurring is encouraged to approach a Research Integrity Advisor or Senior Manager, Ethics Integrity and Biosafety for assistance with considering options. If the person wishes to make an allegation, they must do so with the Senior Manager, Ethics Integrity and Biosafety who will then refer the matter to the Designated Officer.

(45) Outcomes of the discussion between the Research Integrity Advisor and the complainant may include:

a. not proceeding if the complaint is clearly not related to a breach of the Code;
b. proceeding under other institutional processes;
c. making a complaint about a potential breach of the Code in writing to the Designated Officer.

Part F - Protected Disclosure Act

(46) The Protected Disclosure Act 2012 (Vic) is available as an alternative complaint procedure as per the Public Interest (Whistleblower) Disclosure Policy. However, the person making an allegation should be aware that not all instances of a breach of the Code will fall within the scope of the Act. Persons who would like to make a complaint under the Act but are unsure about how to do this can contact the Independent Broad-based Anti-corruption Commission (IBAC) directly, or the Deputy Director, Risk, Audit and Insurance who is currently the University's Public Interest Disclosure Coordinator under the Public Interest (Whistleblower) Disclosure Policy.

Part G - Submitting a Complaint

(47) Information pertaining to a potential breach should be provided to the Senior Manager, Ethics Integrity and Biosafety in writing. Information should outline whether the matter was discussed with a Research Integrity Advisor, as well as indicating whether the individual wishes their identity to be protected. The complaint should:

a. identify the person (or persons) making the complaint about the conduct of research (the Complainant);
b. clearly identify each instance of the potential breach of the Code, indicating the place or places and date or

dates on which the conduct in question is alleged to have occurred;

c. state the identity of the person (Respondent) alleged to have engaged in the relevant research integrity breach;
d. identify and attach (in as much detail as possible) any supporting evidence to enable a review.

(48) Where a complainant wishes to remain anonymous as the source of the complaint, due to potential recriminations if identified. everyone involved in the processing of the complaint should, if possible, abide by these wishes to the extent possible and appropriate. I should also be explained to the complainant that:

a. there may limitations to confidentiality (where a legal action requires identification);
b. removing any information that might enable the complainant to be identified, by inference, might limit the effectiveness of the review of the complaint/s and the University's ability to effectively manage the matter;
c. procedural fairness may necessitate revealing the identity of the complainant to the respondent;
d. the University does not tolerate retribution/vilification and would take allegations of such conduct seriously.

(49) A Complainant may seek advice from a Research Integrity Advisor to construct a complaint that is complete and as thorough as possible. The Complainant is not solely responsible for providing all the necessary material to reach a conclusion, nor do they need to identify the parts of or other relevant policy, law, regulation or guideline that may have been breached.

(50) Individuals are expected to make complaints honestly. If a person makes a complaint that is frivolous, malicious or vexatious, the matter may be referred to People & Culture and disciplinary action may be instigated.

Part H - Receipt and Management of Complaints

(51) At this or any stage, the Senior Manager, Ethics Integrity and Biosafety may assess risk and recommend precautionary actions to protect humans, animals and/or the environment; La Trobe University property; funds provided by internal or external funding bodies; and/or any material that may be relevant to an investigation.

(52) Upon receipt of a complaint, the Senior Manager, Ethics Integrity and Biosafety may make discreet preliminary enquiries or seek confidential advice to establish whether the complaint:

a. relates to a potential breach, and if so, will consult with the Designated Officer to:
    i. instigate a preliminary assessment of the complaint;
    ii. notify relevant funding agencies as required by funding agreements and/or their policies.
b. relates to the ethical conduct or biosafety of research approved by an ethics committee or a biosafety committee and if so, may refer the matter to the chair of the appropriate committee in writing. In these cases:
    i. the appropriate committee will evaluate the matters raised in the complaint including making appropriate enquiries at the soonest practical time, and may implement appropriate actions to address the matter in accordance with the terms of reference for that committee;
    ii. if the committee forms the opinion that a breach of may have occurred, they should refer the complaint back to the Senior Manager, Ethics Integrity and Biosafety and provide a written report of the committee's findings to the Senior Manager, Ethics Integrity and Biosafety. The Senior Manager, Ethics Integrity and Biosafety will confer with the Designated Officer to assess whether an investigation is required.
c. relates to matters other than research integrity and if so, may refer the complaint to the appropriate department or office and inform the complainant about the status of the matter, for example if the complaint:
    i. refers to staff harassment or discrimination it will be referred to People & Culture, for consideration under the Workplace Behaviours Policy or the Enterprise Agreement;
    ii. is frivolous, vexatious or mischievous; in which case the complaint should be dismissed. If the Senior

Manager, Ethics Integrity and Biosafety forms the opinion that it is appropriate, the complainant should be referred to the relevant University disciplinary process or to the policy;

iii. contains insufficient information, and more information is required to assess the complaint, the complainant may be asked to provide further information. If the complaint has been made anonymously, the Senior Manager, Ethics Integrity and Biosafety may decide not to proceed with an investigation.

(53) Complaints involving more than one institution will be considered on a case-by-case basis, taking into consideration issues such as the lead institution, where the complaint was lodged, contractual arrangements or where the events occurred. In general, the following may apply:

a. Where the complaints appear to involve collaboration between employees of more than one organisation, the Designated Officer may agree with the other relevant organisations that a joint investigation be held. The processes for the joint investigation and inquiry shall be agreed in writing and shall substitute for the processes set out in this procedure.
b. La Trobe University will, as far as possible, cooperate when investigating complaints or allegations of a breach arising from research collaborations across institutions - sharing information and limiting duplication.
c. If the alleged breach occurred when the La Trobe University staff was a student at, or employed, by another institution, the complaint or allegation may be passed to that other institution for investigation and appropriate action.
d. In the case of an alleged or proven serious breach or research misconduct involving a La Trobe University staff also undertaking research at another institution, the Designated Officer can determine whether a La Trobe University investigation is warranted.

(54) Upon receipt of a complaint of a potential breach of or if the Designated Officer is made aware of a complaint which contains the elements specified in Clause 47, the Designated Officer:

a. will determine if the research implicated in the complaint is the reasonable responsibility of the University. If the Designated Officer comes to the view that the complaint refers to research that is the responsibility of another institution, the Designated Officer will refer the complaint to the other institution;
b. will consider whether any additional or alternative actions should be taken, such as referring complaints not related to research misconduct to other institutional processes;
c. may authorise a preliminary assessment to gather and evaluate facts and information, and assess whether the complaint, as evidenced, would constitute a breach of the Code;
d. will determine whether the complaint requires immediate suspension of any implicated or affected research project to ensure that all potential harm to humans, animals or the environment is minimised or avoided;
e. will notify the Dean of the relevant School about the matter along with any subsequent recommended remedial actions (corrective actions or procedural improvements);
f. has the authority to secure all relevant documents and evidence so that they are available if it is decided that the complaint is to be investigated.

Part I - Preliminary Assessment

(55) If the Designated Officer determines a complaint relates to a potential breach of the Code, they will assign a suitable Assessment Officer as outlined in Section C to conduct a Preliminary Assessment.

(56) The purpose of the preliminary assessment is to gather and evaluate facts and information pertinent to the complaint submitted, to assess whether investigation as a potential breach of the Code is warranted.

(57) Any investigation of the role of a supervisor under the Research - Higher Degree Student Misconduct Procedure will meet the requirements of a Preliminary Assessment and the Misconduct Officer under that Procedure will take the

actions assigned to the Assessment Officer in this Research Misconduct Procedure with respect to the role of the supervisor.

(58) A Preliminary Assessment Checklist is provided as Attachment 1 of the Investigation Guide.

(59) As part of the preliminary assessment the Assessment Officer will:

a. formulate and record a framework for the preliminary assessment, clarifying its objectives and setting limits on its scope and determine the standard of proof to be applied;
b. consider any requirements of relevant legislation, the Code of Conduct and the University's guidelines, policies, procedures and workplace agreements;
c. review the evidence available in respect of the complaint and may seek information from the complainant, and/or relevant others, including drawing on expertise from other sources, such as staffs from the same or aligned disciplines, especially where the complaint relates to specific disciplinary expertise;
d. collect, catalogue and secure facts and information relevant to the complaint;
e. ensure that appropriate records are prepared and retained, with the support of Ethics, Integrity and Biosafety, ensuring confidentiality of the assessment and related materials;
f. take all appropriate steps required for determining the validity or veracity of any of the matters raised by the complaint or about the person or persons who are the subject of a complaint relating to potential research misconduct;
g. endeavour to complete the Preliminary Assessment within forty (40) working days from the date of the complaint;
h. ensure that the records created and retained would enable any person authorised to review the records to follow the procedures adopted by the investigator(s).

(60) If the Assessment Officer considers it necessary to clarify the facts and/or information with the respondent, they will provide sufficient detail for the respondent to understand the nature of the complaint and provide an opportunity to respond in writing.

(61) In some cases, the Assessment Officer may need to meet with the complainant and/or respondent. In these cases, they are entitled to be accompanied to any meeting by an individual support person. The support person is limited to providing personal support, not legal representation, and they are not to participate in content, advocate or attempt to influence outcomes. Where a support person has legal qualifications, they may attend but must act in a non-legal capacity.

(62) All support persons will be required to disclose potential conflicts of interest or affiliations prior to the meeting.

(63) The support person only participates in the meeting at the discretion of the Assessment Officer if their participation is required to ensure procedural fairness.

(64) For the purposes of the Preliminary Assessment the Assessment Officer(s) may also:

a. Seek advice on any technical matters from an appropriate person either within or outside the University, provided that the person has no conflict of interest or bias;
b. Recommend that legal advice be sought, as appropriate to the complaint;
c. Recommend if any of the complaints not related to research should be referred to another department or authority.

(65) If at any time during the process of a preliminary assessment, the Assessment Officer forms the opinion that there is evidence of potential research misconduct, or that there is a risk of serious reputational risk to the University, the matter must be referred to the Designated Officer as soon as practicable.

(66) The Assessment Officer is to provide a written report detailing the preliminary assessment to the Designated Officer in a timely manner. This should include:

a. a summary of the process that was undertaken;
b. an inventory of the facts and information that was gathered and its relationship to the potential breach of the Code;
c. an evaluation of facts and information about how the potential breach relates to the principles and responsibilities of the Code and/or institutional processes;
d. recommendations for further action.

(67) The respondent's acceptance of responsibility for a breach, or the resignation of a respondent from the University, is not necessarily an end point. Further assessment or an investigation may still be required to fully establish the facts and to identify appropriate corrective actions for systemic matters.

Part J - Preliminary Assessment Outcomes

(68) The preliminary assessment report will be considered by the Designated Officer who prepares a recommendation for the Responsible Executive Officer, on the basis of the facts, complexity and information presented, whether the matter should be:

a. dismissed;
b. clear finding and/or respondent acceptance of a breach of the Code or research misconduct subject to local resolution with or without corrective action;
c. referred to other institutional processes;
d. referred for Investigation

(69) Upon receipt of the recommendations/advice of the Designated Officer, the Responsible Executive Officer may endorse the recommendation or request additional information.

(70) Where, after considering the report, the Designated Officer forms the view that an investigation is required, they will refer the complaint together with the preliminary assessment report to the Responsible Executive Officer.

(71) If the complaint has no basis in fact (for example, due to a misunderstanding or because the complaint is frivolous or vexatious), then efforts, if required, must be made to restore the reputation of any affected parties.

(72) If a complaint is considered to have been made in bad faith or is vexatious, efforts to address this with the complainant should be taken under appropriate institutional processes for disciplinary action.

(73) Where it has been determined the matter can be resolved locally with or without corrective actions, the Designated Officer will direct the relevant parties to resolve the matter. This might include cases where a potential breach is assessed as being related to research administration processes, or a matter involving planned authorship ascription which may be rectified at a local level.

(74) The Responsible Executive Officer may consult with Designated Officer, People & Culture or the Office of the General Counsel when considering the most appropriate response to the referral.

(75) If the Responsible Executive Officer determines to establish an investigation into the complaint:

a. the parties to the complaint will be notified of this course of action;
b. appropriate arrangements will be made to secure all relevant documents and evidence relating to the complaint;

c. the Responsible Executive Officer will consider the need to notify other relevant parties of the existence of complaints, and appropriate actions be taken;
d. the Responsible Executive Officer should consider the risk to the University, others associated with the research, and any reporting obligations (including to the ARC or NHMRC);
e. the Responsible Executive Officer may notify and consult with the Chief People Officer, of the course of action to be taken and, if appropriate, provide any necessary information to that office;
f. the Responsible Executive Officer or their delegate may consider briefing the Marketing Unit so that they are informed in the event of a media inquiry.

(76) Where the Designated Officer considers the report of the Assessment Officer and forms the view that a matter does not relate to research integrity or is better managed by another institutional process, they have the delegation to direct the Senior Manager, Ethics Integrity and Biosafety to refer appropriately.

(77) The outcome of the preliminary assessment will be provided to the parties in a timely manner where appropriate.

(78) Following preliminary assessment, the respondent will be given reasonable opportunity to be heard and/or be given not less than ten (10) working days to make written submissions, in relation to the complaints.

(79) An admission by the respondent of a breach of the Code should not be an end point. It may still be necessary to investigate and identify appropriate corrective actions, any other parties that may be complicit and/or any other necessary steps to ensure understanding and closure.

(80) Where a respondent leaves the institution following a complaint, the institution has a continuing obligation to address the complaint.

Part K - Preparing for the Investigation

(81) When a preliminary assessment outcome finds that a complaint meets the threshold of a potential breach of the Code or research misconduct and is referred for investigation, the Responsible Executive Officer will authorise an investigation under the Code and this Procedure by a formally constituted Investigation Panel (Panel).

(82) For the purposes of this Procedure, a complaint relative to a potential breach of the Code or research misconduct that has been referred for or is under investigation (post preliminary assessment) is referred to as an allegation.

(83) The purpose of an investigation is to make findings of facts to enable the Responsible Executive Officer to make a final determination on whether a breach of the Code or research misconduct has occurred, the extent of the breach, and the appropriate next actions.

(84) The Panel will examine the facts and information from the preliminary assessment and gather and evaluate additional evidence if required. Investigations will be conducted ensuring procedural fairness.

(85) The Responsible Executive Officer and Designated Officer will determine the appropriate size and composition of the Panel including the panel chair and develop the relevant terms of reference, seeking legal or other advice on matters of process as appropriate.

(86) The terms of reference for the Panel will include details of the responsibilities and obligations of Panel members, and the scope of the investigation.

(87) The terms of reference will sanction the Panel to investigate and report on the facts surrounding the relevant allegation and report to the Responsible Executive Officer on the facts relating to the allegation, any mitigating circumstances, and/or systemic issues revealed during the investigation or raised by the respondent in their response.

(88) The Panel is to make a finding/s of fact in relation to the allegation to determine if there has been a failure to

comply with the Code and associated standards or policies governing the conduct of research by University staff. The Panel will also be expected to report on mitigating factors and may recommend appropriate corrective actions.

(89) A sample checklist for the Panel terms of reference is at Appendix 2 of the Investigation Guide.

(90) A range of factors should be considered when determining the size and composition of the Panel, including:

a. the potential consequences for those involved;
b. the seniority of those involved;
c. the need for members to be free from conflicts of interest or bias;
d. appropriate level of experience, skills, knowledge or expertise in the relevant discipline or research approach or in the responsible conduct of research;
e. the need to maintain public confidence in research.

(91) Panel members may be drawn from La Trobe University staff or may be external to the University. In more serious cases, such as alleged falsification of data, the panel must include an external member. The respondent will be advised of the Panel's composition and then has an opportunity to raise any concerns, which will be considered by the Responsible Executive Officer prior to formally appointing the Panel members in writing.

(92) Panel members will be provided with written appointments, be required to sign a confidentially agreement, and, in the case of external members, provided assurance and conditions of indemnity.

(93) Once a Panel is established, it should be provided with all relevant information and documentation.

(94) The Senior Manager, Ethics Integrity and Biosafety will ensure appropriate resources and secretariat support to the Panel. Ethics, Integrity and Biosafety will maintain the record of evidence.

Part L - Conduct of the Investigation

(95) The conduct of the Investigation will follow the Investigation requirements outlined in the Investigation Guide.

(96) As part of the investigation, the respondent should be provided with an opportunity to respond to the allegation and relevant evidence, and to provide additional evidence upon which the Panel may rely. If the respondent chooses not to respond or fails to appear before the Panel where and when requested, the investigation continues in their absence. The complainant may also be given the opportunity to see relevant evidence used in the investigation (e.g., if they are directly affected by the investigation).

a. All investigations will be proportional, fair, impartial, transparent and timely whilst maintaining appropriate confidentiality.
b. The Panel Chair may meet with any of the parties to the allegation to discuss the investigation process.
c. The Panel will convene in a timely fashion to evaluate all available information and to develop an investigation plan.
d. Secretariat support will be provided for the Panel by Ethics, Integrity and Biosafety who will maintain the record of evidence.
e. Where the Panel is of the view that a party may be unable to represent themselves adequately due to the complexity of the matter, the Panel may take extra steps to ensure a fair investigation. This may include allowing extra time for parties to consider matters or encouraging a greater reliance on written evidence.
f. In general, the respondent or complainant is entitled to be accompanied by a support person to any meeting with the Panel. The support person is limited to providing personal support, not legal representation, and they are not to participate in content, advocate or attempt to influence outcomes. Where a support person has legal qualifications, they may attend but must act in a non-legal capacity. However, there may be times when a

respondent and/or complainant requires a higher level of involvement from the support person and the Panel will consider this on a case-by-case basis.

g. All support persons will be required to disclose potential conflicts of interest or affiliations prior to the meeting.
h. The Panel will gather and evaluate the evidence to determine whether 'on the balance of probabilities' the respondent has breached the Code. To do this, the Panel:
    i. will assess the evidence and consider if more may be required;
    ii. may request expert advice to assist the investigation;
    iii. will arrive at findings of fact about the allegation;
    iv. will consider the seriousness of any breach;
    v. will provide a report into its findings of fact consistent with its terms of reference;
    vi. will provide in its report an assessment of any mitigating circumstances;
    vii. may provide in its report an assessment of any systemic issues identified during the investigation;
    viii. may make recommendations for corrective actions where appropriate.
i. If, at any time during an investigation, the Panel discovers that the potential extent of the allegations is more serious or deviates from that which was originally thought, it must provide an interim report to the Responsible Executive Officer. The Responsible Executive Officer may amend the terms of reference for the current Panel or may choose to terminate the current investigation and establish a new panel with a different composition or size.

(97) With the support of the Senior Manager, Ethics Integrity and Biosafety, the Panel will develop an investigation plan (described in Appendix 3 of the Investigation Guide).

(98) All those asked to give evidence are to be provided with relevant, and if necessary, de-identified information in accordance with details outlined in the Investigation Guide and as relevant to the matter.

(99) The Panel is to determine whether, having regard to evidence and on the balance of probabilities, the respondent has breached the Code.

(100) If the Panel finds during the investigation that the scope and/or the terms of reference are too limiting, it should refer the matter to the Responsible Executive Officer. The Responsible Executive Officer may decide to amend the scope of the investigation and the terms of reference. Should this occur, the respondent and relevant others are to be advised, and the respondent given the opportunity, to respond to any new material arising from the increased scope.

Part M - Outcome of Investigation

(101) On completion of the investigation, the Panel will prepare a draft written investigation report. The draft report should be detailed, accurate and cogent, and fully address the terms of reference.

(102) The Senior Manager, Ethics Integrity and Biosafety will ensure secretariat support to assist in the preparation of the draft report.

(103) The draft report should contain findings of fact, detailed information on any mitigating factors identified as contributing factors or system issues detected and any recommendations (see Appendix 4 of the Investigation Guide for a sample checklist for the report of the investigation findings).

(104) If the panel did not come to a consensus, dissenting view(s) should be detailed in the report.

(105) The draft report will be provided to the respondent and, in some circumstances the complainant, if they will be affected by the outcome for comments relating to the facts or evidence.

(106) Following the panel's consideration of the comments by the respondent or complainant and any further

information, the panel will finalise its report and recommendations including any amendments or corrections. The final report and recommendations will be provided to the Responsible Executive Officer.

(107) The Responsible Executive Officer will review the Panel's final report and recommendations to determine whether a breach of the Code has occurred; the seriousness of the breach and whether the breach constituted research misconduct; and the institutions' response regarding the extent of the breach and remedial actions.

(108) An Investigation should seek to be completed within six months from the date of a decision to complete an investigation.

(109) Where the Responsible Executive Officer accepts that a major breach of the Code has occurred, the Responsible Executive Officer decides the institution's response, considering the extent of the breach and whether other institutions should be advised.

(110) In the case of staff appointed under the Honorary Appointments Policy or by contract, La Trobe will follow established internal processes relating to these appointments and may consider seeking legal or other expert advice in relation to the management of these appointments with other institutions.

(111) Following the outcome of an Investigation, a copy of the decision of the Responsible Executive Officer must be promptly provided in confidence to the person against whom the allegation was made (i.e. the Respondent) and to the person making the allegation, as appropriate.

(112) The Responsible Executive Officer will inform all relevant parties of the Investigation findings and the actions taken by the University. Relevant parties will be those that have a legitimate 'need to know' and, depending on the circumstance, may include affected staff, research collaborators including those at other institutions, all funding organisations, journal editors, and professional registration bodies. The public record, including publications, will need to be corrected if research misconduct has affected the research findings and their dissemination.

(113) The findings of an independent, external Investigation may be made available to the public. Public statements may be made as appropriate as determined by the Responsible Executive Officer.

(114) Appropriate actions must also be taken when the allegations of misconduct are demonstrated toe unfounded. The following will need to be considered:

a. if the allegation has no basis in fact, then efforts must be taken to restore the reputations of those alleged to have engaged in improper conduct.
b. if an allegation is considered to have been frivolous or vexatious, action to address this with the complainant should be taken under appropriate institutional processes, including consideration of the way such communication is carried out. Support for both the respondent and complainant must be considered.

Part N - Requesting a Review of the Investigation Outcome

(115) The Complainant (if directly affected by the outcome) and Respondent have 10 working days from the date on which they are informed of the outcome of an Investigation, or 10 working days from the date on which they become aware of new and relevant information, to lodge a request to reopen the Investigation or lodge an appeal in writing to the Responsible Executive Officer.

(116) Appealing or reopening an Investigation may be appropriate where new and relevant information not available to the Panel becomes known, to correct errors or injustice, or where there is a perceived denial of Procedural Fairness. However, an Investigative process will not be reopened to simply try to achieve a different outcome. For example, a conflict of interest could invalidate a process and require that it be redone without conflict. However, this would not be the case if the conflict of interest was considered, addressed and managed appropriately.

(117) In the event that the Responsible Executive Officer determines that there are grounds for reopening or accepting an appeal of the outcome of an Investigation, the matter will be referred to a higher authority, such as an independent adjudicator or Panel comprised of a larger number of members or having greater experience / expertise, more rigorous processes, or greater resources.

(118) In accordance with the principles of Procedural Fairness, Respondents will be given as much warning of the decision to reopen or accept an appeal of the outcome.

(119) Given that confirmed Breaches can lead to serious penalties, Respondents who are the subject of such findings may also have an entitlement to appeal to the courts.

(120) A person against whom action has been taken by the Responsible Executive Officer pursuant to this Procedure or the person who has made the allegation may have a right to make a request for further review by the Australian Research Integrity Committee.

(121) The Australian Research Integrity Committee (ARIC), a jointly established body by the National Health and Medical Research Council (NHMRC) and the Australian Research Council (ARC), provides a review system of institutional processes responding to allegations of breaches of the Code for institutions that are in receipt of funding from the NHMRC or the ARC. More information about ARIC and how to request a review from ARIC is available on the NHMRC website

Part O - Internal and External Reporting

(122) Reporting outcomes of major breach of the Code requires:

a. Written documentation of the preliminary assessment, investigations, outcome and justification and reports on actions provided to the Senior Manager, Ethics Integrity and Biosafety, to be included in the Breach Register;
b. The Responsible Executive Officer or nominee will inform all relevant parties of the decision and outcome. Relevant parties may include but are not limited to affected staff, research collaborators including those at other institutions, all funding organisations, journal editors, ethics committees and professional registration bodies.
c. The Senior Manager, Ethics Integrity and Biosafety will submit quarterly reports to the Research and Graduate Studies Committee on the occurrence and nature of allegations and any actions to address the underlying causes and will regularly report to the Risk and Compliance Office.

(123) Suspected breaches of the Code must be reported to the relevant institution and/or authority as per the requirement of the Code of Conduct and the relevant legislations and guidelines:

a. Where applicable, under the Australian Privacy Act 1988 (Cth) the University is required to notify the Office of the Australian Information Commissioner (OAIC) when a data breach is likely to result in serious harm to individuals whose personal information is involved in the breach.
b. The University must inform the Australian Research Council (ARC) on the outcomes of a preliminary assessment of a suspected research integrity breach related to ARC funded research as per the ARC Research Integrity Policy.
c. Allegation or finding of a breach of the Code should be reported to the NHMRC according to the NHMRC Research Integrity and Misconduct Policy (2019) if the University determines such disclosure is necessary to fulfil obligations under the NHMRC Funding Agreement, the Code or other funding/cooperative agreement.

Section 7 - Definitions

(124) For the purpose of this Procedure:

a. Balance of probabilities: The civil standard of proof which requires that on the weight of evidence it is more probable than not that a breach has occurred.
b. Corrective actions: These include actions to correct a specific breach, improve research conduct more generally, or modification of administrative processes.
c. Evidence: Any document (hard copy or electronic, including e-mail, images and data), information, tangible item (for example, biological samples) or testimony offered or obtained that may be considered during the process of managing and investigating a potential breach of the Code.
d. Local resolution: Corrective actions may be undertaken within a School of Department in response to a complaint or after a preliminary assessment as deemed appropriate.
e. Precautionary action/s: An action initiated to mitigate risks (actual, perceived or potential) at any time during the management of a complaint, allegation or investigation of a potential breach.
f. Remedial actions: Actions initiated by La Trobe University in response to a finding of a breach or research misconduct. These include corrective actions (deemed necessary to rectify the research record or research output, address staff behaviour or improve systemic processes) and/or any other actions directed by the Responsible Executive Officer. Research output: Any record that communicates or makes available the findings of research. A research output may be in any form (hardcopy, electronic, creative work or other) of academic or public communication of the research from any stage of the research process (e.g. including but not limited to a professional blog, web-based publications, books, performances, book chapters, Higher Degree Research thesis chapters, conference papers, reports, datasets or journal articles) when done under in association with or under the auspices of La Trobe University.
g. An employee as defined in the La Trobe University Act 2009 and employed in a full-time or part-time role; appointed under the Honorary Appointments Policy; or via contract (paid or unpaid) who conducts or assists with the conduct of research at or on behalf of La Trobe.

Section 8 - Authority and Associated Information

(125) This Policy is made under the La Trobe University Act 2009.

Status and Details

Status	Current
Effective Date	4th December 2025
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Responsible Manager - Policy	Alistair Duncan Executive Director, Research Office
Enquiries Contact	Ethics, Integrity and Biosafety