

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2009-001.0
Policy Title: Reporting Unanticipated Problems to the Institutional Review Board

Purpose

The purpose of this policy is to identify events that may constitute an unanticipated problem involving risk to subjects or others (unanticipated problem) that must be reported to the Institutional Review Board (IRB), the time frame within which the reporting must occur, the elements of the report, and the mechanism for filing the report.

This policy does not excuse principal investigators from their obligation to assess all adverse events and to report internal events to the sponsor of study in accordance with the sponsor's requirements.

Definitions

See policy 2011-007 for definition of:

Unanticipated Problem Involving Risk to Subjects or Others (including examples)

Policy

It is the policy of the HSPP that a Principal Investigator (PI) must report occurrences that may constitute an unanticipated problem to the IRB Office within five business days of becoming aware of the occurrence.

While an IRB Chair may determine that an event does not constitute an unanticipated problem, only the convened IRB will make the final determination as to whether an occurrence does constitute an unanticipated problem, inclusive of problems presenting no more than minimal risk. If the convened IRB determines that the occurrence does constitute an unanticipated problem, the PI must also report the occurrence at the time of continuing review or study closure, whichever is first.

The IRB will not review external adverse events (e.g. individual adverse event reports, IND safety reports, MedWatch reports, line listings of suspected unexpected serious adverse reactions (SUSARS) etc.) unless 1) the sponsor has deemed the event(s) to be an unanticipated problem that a) has been reported to the FDA and b) that requires that corrective measures be taken or 2) unless the UConn Health PI disagrees with the sponsor and believes the event is an unanticipated problem and recommends corrective actions.

The IRB will not review internal expected adverse events that are already disclosed in the informed consent form unless the PI states that the severity or frequency of the event(s) has been greater than anticipated.

Procedure

Occurrences that may constitute an unanticipated problem are reported to the IRB in one of two ways. Either the investigator self reports or an audit finding is referred to the IRB for determination.

Self Reporting:

PIs are to report to the IRB any occurrence that may be an unanticipated problem within 5 business days of becoming aware of the event. An occurrence that may constitute an unanticipated problem is to be reported even if detected after a subject withdraws from a study, after a subject has completed the study intervention, or for up to 30 days after study completion.

The PI is to complete the Problem Report Form (PRF) found within the electronic IRB submission system for reporting to the IRB. The PRF addresses all information that is required for submission. If the PI proposes a corrective action that will require a change to the protocol or study related documents, the PI must submit a request for modification form.

Upon receipt of a PRF, the Regulatory Specialist (RS) will assign an IRB Chair* of the corresponding panel to review the submission and make a determination. The Chair will be provided with the PRF Reviewer Form to use in the review process. The IRB Chair has access to the complete IRB file of the study to which the occurrence relates.

The IRB Chair may determine that the occurrence does not constitute an unanticipated problem, or may refer the occurrence to the convened board for review and determination. The Chair may also seek guidance from other individuals (e.g. someone with a specific medical expertise) in making the initial determination, providing the individual does not have a conflict with the study. In reviewing the PRF the Chair may also require the PI to take corrective actions. Any required actions will be communicated to the PI through correspondence from the RS as directed by the Chair. The Chair may determine that an occurrence is not an unanticipated problem by evaluating the reported occurrence in relation to the definition of an unanticipated problem. The determination of the Chair is documented on the PRF reviewer form.

Self-Reported Occurrences That Are Deemed Not to be Unanticipated Problems: If the Chair determines that the occurrence does not constitute an unanticipated problem, the RS will return the submission to the PI with an outcome of “Not Reportable”. For informational purposes, the determination will be presented to the convened board at the next convened meeting for which the submission deadline has not passed on the expedited and exempt agenda activity listing. Any member of the board may request that the convened board review the report and corresponding information. In such case, the determination of the convened board would stand.

Self-Reported Occurrences Referred to Convened Board: If the Chair refers the PRF to the convened board for review the RS will place the submission on the next available agenda as a discussion item. For any PRF referred to the convened board, IRB members will have access to the PRF and all documents that have been associated to the electronic study file. A primary reviewer system will be utilized and the assigned reviewers will have access to the PRF reviewer form. The Chair will also determine whether any additional supporting documentation is required and direct the RS to obtain information accordingly.

Referral of Audit Findings:

The Research Compliance Monitor (RCM) is responsible for ensuring that audit letters are reviewed by a Chair to determine whether any findings are to be referred to the Board. If so, the RCM will provide

the relevant material, the audit letter and PI responses at a minimum, to the RS for inclusion on the next available meeting agenda. Because there is not a specific submission associated with an audit report, when an audit is referred to the convened IRB, the RS will attach the audit material and the discussion item reviewer form (i.e. a pdf version of the PRF reviewer form) to the agenda such that the information is available to all members. The referring Chair will act as the primary reviewer leading the discussion at the meeting.

If the PRF or audit response is accompanied by a request for modification form, the IRB staff will list the modification and discussion item separately on the agenda. Procedures described elsewhere for the submission and review of modifications will be used for review and approval of the modification.

Actions of the IRB:

Upon initial review of a PRF or audit report, the Chair may elect to suspend the approval for the study, in whole or in part, until such time as the convened board can review the information. (Refer to procedure for imposing a study suspension).

The IRB may require corrective action including, but not limited to, a modification of the protocol or information disclosed in the informed consent document and process, that information be provided to past participants, that current participants be informed if the information may relate to their willingness to participate, re-consenting of currently enrolled subjects, more frequent continuing review, monitoring of the consent process or research project by a third party, or requiring additional education. The IRB may also consider a suspension of approval of the research; or termination of approval of the research. The IRB may seek counsel from other institutional areas (e.g. legal counsel, risk management, research compliance) in determining corrective action plans. The IRB may make recommendations regarding employment status but has no authority over an individual's employment status.

When reviewing a PRF or audit finding, any member of the IRB may request additional information from the investigator, to review the complete IRB file, or to review previous minutes relating to the study. Requests for additional information from the investigator will be done through correspondence from the IRB member or from the RS at the direction of the IRB member.

The RS will note the outcome of the discussion and determination of the IRB in the minutes. The determinations of the board, including any required corrective actions, will be communicated to the PI in a letter prepared by the RS and sent to the PI through the electronic IRB submission system. For determinations of UPs, the letter will first be routed to the Chair for sign-off.

If the IRB instructed the PI to make specific changes, the resulting request for modification may be reviewed through the expedited review process (i.e. the PI responds according to the directives provided by the IRB) or may require full board review (e.g. the responses provided by the PI do not match the directives of the IRB).

Additional Reporting From Investigators:

If the convened IRB determines that an occurrence is an unanticipated problem, the PI must also report the unanticipated problem(s) at the time of continuing review on the continuation addendum form, or at the time of study closure on the request for study closure form, whichever comes first.

*Throughout the policy/procedure, while a Chair is the default reviewer, the task may be designated to another qualified member if necessary (e.g. if a referring Chair will not be present at the next scheduled meeting).

Related Policies

2009-002 Reporting Non-Compliance to the IRB
2009-003 Imposing a Suspension or Termination of IRB Approval
2009-004 Reporting to External Agencies and Institutional Officials
2009-05.0 Monitoring of IRB Approved Studies

Basis

45 CFR 46 – Protection of Human Subjects
21 CFR 56 – Institutional Review Boards
Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events” Office for Human Research Protections (OHRP) 2007
Guidance for Clinical Investigators, Sponsors, and IRBs: Adverse Event Reporting-Improving Human Subject Protection” Food and Drug Administration (FDA), 2009

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Richard H. Simon

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Richard Simon, MD
Director Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2009-002.0
Policy Title: Reporting Non-Compliance to the Institutional Review Board (IRB)

Purpose

The purpose of this policy is to identify events that may constitute noncompliance that must be reported to the IRB, the time frame within which the reporting must occur, the elements of the report, and the mechanism for filing the report.

Definitions

See Policy 2011-007.0 for definitions of:

Non-Compliance Non-Compliance, Serious Non-Compliance, Continuing

Policy:

It is the policy of the HSPP that a Principal Investigator (PI) must report any instance of noncompliance that was within the control of the research team to the IRB within five business days of becoming aware of the occurrence.

While an IRB Chair may determine that an instance is not serious or continuing non-compliance, only the convened IRB will make the final determination as to whether an occurrence does constitute serious and/or continuing noncompliance. If the convened IRB determines that the occurrence does constitute serious and/or continuing noncompliance, the PI must also report the determination at the time of continuing review or study closure, whichever is first.

Procedure:

Occurrences that may constitute noncompliance with the approved protocol, regulations or directives of the IRB are reported to the IRB in one of two ways: either the investigator self reports or an audit finding is referred to the IRB for determination.

Self Reporting:

PIs are to report to the IRB any noncompliance with the protocol or directives of the IRB that was within the control of the research team within 5 business days of becoming aware of the event. An occurrence that may constitute noncompliance within the control of that research team is to be reported even if detected after a subject withdraws from a study, after a subject has completed the study intervention, or for up to 30 days after study completion.

The PI is to complete the Problem Report Form (PRF) found with the electronic IRB submission system for reporting to the IRB. The PRF addresses all information that is required for submission. If the PI proposes a corrective action that will require a change to the protocol or study related documents, the PI must submit a request for modification form.

Upon receipt of a PRF, the IRB Regulatory Specialist (RS) will assign an IRB Chair* of the corresponding panel to review the submission and make a determination. The Chair will be provided with the PRF reviewer form to use in the review process. The IRB Chair has access to the complete IRB file of the study to which the occurrence relates.

The IRB Chair may determine that the occurrence does not constitute serious or continuing noncompliance or may refer the occurrence to the convened board for review and determination. In reviewing the PRF the Chair may also require the PI to take corrective actions. Any required actions will be communicated to the PI through correspondence from RS as directed by the Chair. The Chair will determine whether an occurrence is not serious or continuing noncompliance by evaluating the reported occurrence in relation definitions of serious and continuing noncompliance. The determination of the Chair is documented on the PRF reviewer form.

Noncompliance that was not within the control of the research team and that does not pose any risk to subjects (e.g., a subject cancels an appointment that had been scheduled within the study window and cannot reschedule until 1 day out of study window) is to be reported at the time of continuing review or study closure, whichever comes first.

Self Reported Occurrences That Are Deemed Not to Be Serious or Continuing Non-Compliance: If the Chair determines that the occurrence does not constitute serious or continuing noncompliance, the RS will return the submission to the PI with an outcome noted of “Not Reportable”. For informational purposes the determination will be presented to the convened board at the next convened meeting for which the submission deadline has not passed on the expedited and exempt agenda activity listing. Any member of the board may request that the convened board review the report and corresponding information. In such case, the determination of the convened board would stand.

Self Reported Occurrences Referred to the Convened Board: If the Chair refers the PRF to the convened board for review, the RS will place the submission on the next available agenda as a discussion item. For any PRF referred to the convened board, IRB members will have access to the PRF and all documents that have been associated to the electronic study file. A primary reviewer system will be utilized and the assigned reviewers will have access to the PRF reviewer form. The Chair will also determine whether any additional supporting documentation is required and direct the RS accordingly.

Referral of Audit Findings:

The Research Compliance Monitor (RCM) is responsible for ensuring that audit letters are reviewed by a Chair to determine whether any findings are to be referred to the Board. If so, the RCM will provide the relevant material, the audit letter and PI responses at a minimum, to the RS for inclusion on the next available meeting agenda. Because there is not a specific submission associated with an audit report, when an audit is referred to the convened IRB, the RS will attach the audit material and the discussion item reviewer form (i.e., a pdf version of the PRF reviewer form) to the agenda such that the information is available to all members. The referring Chair will act as the primary reviewer leading the discussion at the meeting.

If the PRF or audit response is accompanied by a request for modification form, the IRB RS will list the modification and discussion item separately on the agenda. Procedures described elsewhere for the submission and review of modifications will be used for review and approval of the modification.

Actions of the IRB:

Upon initial review of a PRF or audit report, the Chair may elect to suspend the approval for the study, in whole or in part, until such time as the full board can review the information. (Refer to policy for imposing suspensions).

The IRB may require corrective action including, but not limited to, a modification of the protocol or information disclosed in the informed consent document and process, that information be provided to past participants, that current participants be informed if the information may relate to their willingness to participate, re-consenting of currently enrolled subjects, more frequent continuing review, monitoring of the consent process or research project by a third party, or requiring additional education. The IRB may seek counsel from other institutional areas (e.g., legal counsel, risk management, research compliance) in determining corrective action plans. The IRB may make recommendations regarding employment status but has no authority over an individual's employment status.

When reviewing a PRF or audit finding, any member of the IRB may request additional information from the investigator, to review the complete IRB file, or to review previous minutes relating to the study. Requests for additional information from the investigator will be made through correspondence from the IRB member or from the RS at the direction of the IRB member.

The RS will note the outcome of the discussion and determination of the IRB in the minutes. The determinations of the board, including any required corrective actions, will be communicated to the PI in a letter prepared by the RS and sent to the PI through the electronic IRB submission system. For determinations of serious and/or continuing non-compliance, the letter will first be routed the Chair for sign-off.

If the IRB instructed the PI to make specific changes, the resulting request for modification may be reviewed through the expedited review process (i.e., the PI responds according to the directives provided by the IRB) or may require full board review (e.g., the responses provided by the PI do not match the directives of the IRB).

Additional Reporting from Investigators:

If the convened IRB determines that an occurrence is serious and/or continuing noncompliance, the PI must also report this at the time of continuing review on the continuation addendum form or at the time of study closure on the request for closure form, whichever comes first.

*Throughout the policy/procedure, while a Chair is the default reviewer, the task may be designated to another qualified member if necessary (e.g., if a referring Chair will not be present at the next scheduled meeting).

Related Policies

2009-001 Reporting Unanticipated Problems to the IRB
2009-003 Imposing a Suspension or Termination of IRB Approval
2009 -004 Reporting to External Agencies and Institutional Officials
2009-05.0 Monitoring of IRB Approved Studies

Basis

45 CFR 46 – Protection of Human Subjects
21 CFR 56 – Institutional Review Boards

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Reviewed and Approved By:

Richard H. Simon

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Richard H. Simon, MD

Date

Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2009-003.0
Policy Title: Imposing and Lifting Suspensions of Institutional Review Board (IRB)
Approval or Imposing Terminations of IRB Approval

Purpose

The purpose of this policy is to identify the individuals and entities within the institution with authority for imposing and lifting suspensions of IRB approval (in whole or in part), for imposing terminations of IRB approval, and to describe the mechanism for doing so.

Definitions

See policy 2011-007.0 for definitions of:

IRB Approval Suspension Termination

Policy

It is the policy of the HSPP that the IRB Chair, convened IRB or any Administrative Officer defined in institutional policy 2002-42 may suspend IRB approval for a study (in whole or in part), inclusive of the need to do so urgently. With the exception of the Vice Chair, the authority to suspend approval for studies cannot be delegated to other individual members of the IRB. Only the IRB can reinstate approval.

The convened IRB or Administrative Officers designated in policy 2002-42 may terminate IRB approval of a study, inclusive of the need to do so urgently.

Reasons for imposing a suspension or terminations include, but are not limited to, learning that 1) research is not being conducted in accordance with the IRB's requirements, 2) the research has been associated with unexpected serious harm to participants or 3) findings from the continuing review or internal monitoring process.

Procedure

Imposing a Suspension or Termination of IRB Approval

The IRB or Administrative Officer may seek advice from other institutional areas (e.g. legal counsel, risk management, research compliance) in determining whether to impose a suspension or termination of IRB approval. In addition, when imposing a suspension or termination, the Chair, the convened IRB or Administrative Officer will give consideration to the impact that the suspension or termination may have on subject safety and/or welfare. Consideration will include, but is not limited to:

- whether participation can be stopped safely;
- whether subjects should be transferred to another physician for clinical care;
- whether subjects can be kept on study under the same PI;
- if kept on study under the same PI, whether additional monitoring is required;
- whether subjects can be kept on study under another PI.
- actions to protect the rights and welfare of currently enrolled participants.
- informing current participants of the termination or suspension.
- having any adverse events or outcomes reported to the IRB.

In the event of a suspension or termination of approval, the person/entity imposing the suspension will inform the investigator in writing. If immediate action is required, the person/representative of the entity imposing the suspension or termination may give the directive verbally to the Principal Investigator (PI) and the letter will follow. Letters to the PI are to be sent within 5 working days prior to the effective date of suspension or termination (unless PI was notified verbally). Such letters will include:

- the effective date of suspension or termination;
 - if notification was initially done verbally the letter will reference the date of verbal notification;
- the reason for the suspension or termination;
- for suspension, identification of the research activity, in whole or in part, that must stop;
- any corrective action or clarification that must occur;
- if the reason for suspension may bear on the subjects decision to continue participation, a directive that currently enrolled subjects be informed of the suspension;
- for terminations, a directive that all currently enrolled subject be informed of the termination;
- if applicable a directive of how to deal with any currently enrolled subjects; and
- a direction to the PI regarding to whom to submit responses.

The person/entity imposing the suspension or termination will send a copy of the letter to:

- the applicable Administrative Officers identified in policy 2002-42; and
- the applicable IRB Chair and Vice Chair
- the IRB Regulatory Specialists (RS)

Letters issued by the IRB will be prepared by the IRB RS; reviewed, approved and signed by the IRB Chair; and sent to the PI by the IRB staff through the electronic system. If imposed by another Administrative Officer identified in Policy 2002-42, that individual is responsible for the preparation and sending of the letter, including notification to the IRB. The IRB RS will include any notice of suspension or termination on the next meeting agenda for presentation to and review by the convened board. The IRB RS will update the Study Status field within the electronic submission system to reflect Suspension or Termination accordingly.

The investigator is to direct a written response to the person/entity who imposed the suspension/termination and copy the other individuals noted on the initial suspension/termination letter.

If an activity for which a suspension or termination has been imposed must continue, e.g., a research related treatment because it is in the best interest of the subject, the investigator must write a letter to the IRB Chair. The letter shall include:

- a justification as to why continuation is in the best interest of the subject;
- a request for approval for continuation of the specific activity either until the suspension is lifted or until alternate arrangements can be made for the subject;
- for terminations, confirmation that alternate arrangements are actively being sought and provide the anticipated time frame by which the arrangements should be finalized;
- confirmation that the investigator will inform subjects that the study has been suspended or terminated but that permission for the activity has been obtained;

- confirmation that the investigator will direct subjects to continue to report adverse events or unanticipated problems;
- confirmation that the investigator will continue to report all activity in accordance with policy.

Lifting a Suspension of Approval

Only the IRB can lift a suspension using either the expedited review process or review by the convened board. If someone other than the IRB imposed the suspension, that person is responsible for notifying the IRB Chair in writing when they are satisfied that all concerns that led to the suspension have been satisfied and to recommend lifting the suspension. That person must attach a copy of the responses from the PI to the letter to the IRB. The IRB Chair may use the expedited review process to lift a suspension:

- that was imposed by the Chair;
- that was imposed by an Administrative Officer, providing the documentation noted above is received; or
- that was imposed by the convened board when the board specifically delegates to the chair the authority to lift the suspension.

Otherwise, the convened IRB will determine whether to lift a suspension.

The IRB will send written notification to the PI when the suspension is lifted and will change the study status accordingly. The letter will be prepared by the IRB RS reviewed and signed by the Chair, and sent to the PI through the electronic system. The IRB staff will also send a copy of the letter lifting the suspension to the individuals identified above.

Informing the IRB of Suspensions or Termination Imposed by Other Institutional Officials

The IRB Chair is responsible for providing the IRB staff with information from other institutional officials who imposed a suspension or termination of IRB approval. The IRB RS will note the suspension/termination on the agenda of the next regularly scheduled meeting as a discussion item. The IRB RS will ensure that, at a minimum, each member to be present will receive the letter of suspension or termination. The Chair will determine what additional supporting documentation, if any, should be made available to IRB members. The IRB may require additional corrective actions as noted in the policy for “Reporting Non-Compliance to the IRB.”

Related Policies

#2009-001 Reporting Unanticipated Problems to the Institutional Review Board
 #2009-002 Reporting Non-Compliance to the Institutional Review Board
 #2009-004 Required Reporting to Institutional Official and External Agencies

Basis

45 CFR 46 – Protection of Human Subjects
 21 CFR 56 – Institutional Review Boards

Document Attributes

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Signed: Richard H. Simon
 Richard H. Simon, MD
 Director Human Subjects Protection Program

6/5/2023
 Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2009-004.0
Policy Title: Required Reporting to Institutional Officials and External Agencies

Purpose

The purpose of this policy is to identify the individual responsible for reporting instances of serious non-compliance, continuing non-compliance, unanticipated problems involving risk to subjects or others (unanticipated problems), and/or any suspension or termination of IRB approval to appropriate institutional officials (also referred to as administrative officers) and, as applicable, federal department or agency heads, the mechanism for reporting and the time frame within which such reports are to be filed.

Definitions

See policy 2011-007.0 for definitions of:

IRB Approval	Non-compliance, Continuing	Non-compliance, Serious
Suspension	Termination	
Unanticipated Problem Involving Risk to Subjects or Others		

Policy

It is the policy of the HSPP that the Director of the HSPP (DHSPP) is responsible for informing relevant institutional officials and, as applicable, external agencies of determinations of serious non-compliance, continuing non-compliance, unanticipated problems, suspensions of IRB approval (in whole or in part) and/or terminations of IRB approval.

Procedure

Suspensions of IRB approval, terminations of IRB approval, or determinations of unanticipated problems, serious non-compliance or continuing non-compliance are communicated to the DHSPP either by copy of a suspension or termination letter, and/or by copy of the IRB minutes.

As applicable, the DHSPP will report in letter format to the relevant agency (i.e. the Office for Human Research Protections, the FDA, or to any other regulatory agency with oversight due to conduct or an assurance of compliance) with copy to relevant institutional officials identified in Institutional Policy 2002-42 (Review and Approval of Research Involving Human Subjects) and the Department Chair of the PI. As applicable, the letter may also be sent to other sites involved in the research if the findings and corrective actions impact that site, and the study sponsor. HSPP staff will place a copy of the letter in the applicable study file. If the study file exists only in an electronic format, the letter will be uploaded to the electronic study file. If the study is funded by a federal agency the Office for Human Research Protections Incident Report Form will also be completed and the letter will be uploaded to that form. The incident report form may be completed by the Director or staff within the HSPP. (Form available at <https://oash.force.com/ohrpwebforms/s/incident-web-form>)

The letter may be written by the DHSPP or delegated to HSPP staff with review, approval and signature of the DHSPP. The letter will be sent by the HSPP staff by e-mail if available or US post if no e-mail is available or uploaded as an attachment to the OHRP incident report template. The letter will contain:

- the number and title of the study;

- the name of the principal investigator;
- a summary description of the problem and the cause;
- the date of occurrence;
- determinations of the IRB
- the corrective actions taken or to be taken;
- the reason for the corrective action (e.g. to remedy specific situation, to prevent subsequent occurrence, to ensure data integrity, etc.)
- and any plans for ongoing monitoring.

Reporting to federal agencies or institutional officials is not required if the agency or official is already made aware of the event through other mechanisms, such as by receiving a copy of the IRB minutes, reporting by the investigator, sponsor or another organization. If no external reporting is required (e.g. no federal funding, no FDA regulated product involved), the letter may be replaced by an email communication sent from the DHSPP or designee.

Unless there are extenuating circumstances, letters will be issued within three weeks of the IRB determination that an event constitutes an UP, serious and/or continuing non-compliance, or from when the suspension or termination is imposed. An example of an extenuating circumstance would be the requests of the IRB for a full audit of a study in which case reporting may be delayed until the audit is completed and reviewed by the convened board.

Related Policies

#2009-001 – Reporting Unanticipated Problems to the IRB
 #2009-002 – Reporting Non-compliance to the IRB
 #2009-003 – Imposing and Lifting Suspensions or Terminations

Basis

45 CFR 46 – Protection of Human Subjects
 21 CFR 56 – Institutional Review Boards

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Richard Simon

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Richard Simon, MD

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Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2009-005.0
Policy Title: Monitoring of IRB Approved Studies

Purpose

The purpose of this policy is to grant authority to the Research Compliance Monitor (RCM) within the HSPP to conduct audits of all studies approved by the Institutional Review Board (IRB), to identify the functions of the RCM, to identify the types of audits that may be conducted, and to articulate the obligations of investigators when audits, inspections or monitoring visits are conducted, including those conducted by an external body.

Definitions:

See policy 2011-007.0 for definitions of:

Non-compliance, Continuing, Termination	Non-compliance, Serious Unanticipated Problem Involving Risk to Subjects or Others	Suspension
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Policy

It is the policy of the HSPP that, approved studies (including those approved as exempt, and those approved under facilitated review) are subject to monitoring/audit by the RCM of the HSPP. The Education Specialist, Regulatory Specialists or other appropriate staff within the HSPP may provide coverage for or assistance with all aspects of the RCM function if necessary.

The functions of the RCM include, but are not limited to, ensuring that studies are being conducted in compliance with the approved protocol and supporting documents, that appropriate forms are being used, that consent is being appropriately obtained and documented, that modifications are receiving approval prior to implementation, that financial interests are being appropriately disclosed and when applicable managed, that unanticipated problems and non-compliance are being reported per policy, that data are being recorded accurately, that drug and device inventory is accurate, that study functions have been appropriately delegated, that HIPAA is appropriately addressed, and that procedures for safety monitoring and to protect privacy and confidentiality are being followed. The RCM may observe the consent process and the conduct of the research. The RCM also audits the IRB review process to ensure that the IRB has performed its duties in accordance with regulatory requirements and internal policies. The RCM may also provide educational services to study personnel.

The RCM shall have access to all information relevant to a study, including but not limited to, IRB files, clinical/medical records, research records including informed consent documents, adverse event reports, the initial protocol and amendments made to it, the clinical trial agreement, documents related to contact with subjects, all paper and electronic files, and the consent process. The RCM also has access to pharmacy or other relevant areas involved in the study in order to assess inventory control processes for compliance with regulations and policies regarding appropriate use of investigational drugs, biological products and medical devices. The types of audits that may be conducted are noted in Appendix A.

Investigators are expected to cooperate in all aspects of the audit process, including but not limited to, scheduling audit visits, providing necessary information and space for the audit to occur, and responding to audit letters. Cooperation is expected for both internal and external audits.

It is also the policy of the HSPP that results of external audits, inspections and/or monitoring visits be reported to the IRB.

Procedures

I. Procedures for Study Selection and Audit Scheduling

On a quarterly basis the RCM will post a listing of the studies to be audited within that quarter on a shared drive, accessible to IRB and HSPP staff. The list may be modified as need arises. The goal is to audit 5% of active studies each year. The RCM selects the majority of studies at random by exporting approved studies to excel and running a random selection program. However, the RCM may also give consideration to the following elements when selecting a study for audit:

- investigator originated vs. sponsored
- IND / IDE studies
- levels of risk
- results of previous audits
- directives of the IRB
- study populations
- principal investigators
- whether the CRC provides support for the study
- study topics
- study approval status (e.g. frequent lapses)
- funding sources
- initial review and approval categories
- complaints or concerns raised

In addition to the selection process above, the IRB may direct the RCM to audit a study. An IRB Chair may require an audit due to concerns found while conducting an expedited review. In such cases the Chair will correspond with the RCM. The convened board may require an audit due to concerns raised during a convened meeting. Such requirements are communicated to the RCM by distribution of the IRB minutes by the IRB RS to the RCM approximately 5 working days after the meeting, or by copying the RCM on an IRB outcome letter. The RCM will maintain a tickler file of IRB-mandated audits and will be responsible to schedule the audit visits as directed

Once a study is selected for audit, the RCM will send out an audit notification letter to the PI and study coordinator (and additional contacts as requested or appropriate) and will then work with the PI or Study Coordinator to schedule a time for the audit to occur. Exceptions to the notification policy may occur, for example, in the case of an unannounced or emergency audit.

II. Procedures for Conducting Audits

The audit will include a brief pre-audit interview with the PI and/or the study coordinator to discuss the research study and any related issues. After the interview, the RCM will review research records, the regulatory binder and other documents associated with the study. Generally, a sampling of 10% of the consent/HIPAA documents and research records are reviewed to start, with more records added should issues arise. Depending on the complexity of the research and the availability of the study team and RCM, the on-site review of these documents may occur over multiple days. Additional aspects of the

study may be reviewed at a separate time as appropriate (e.g., reviews of drug accountability and medical records). In IRB Directed audits, the review may be focused on and /or limited to specific areas of concern as indicated by the IRB.

When feasible, the RCM may conduct an exit interview (in person, by phone or email) to share preliminary findings, minor issues or suggestions.

If the audit reveals any concern that may involve imminent risk to subjects the RCM will report this immediately to the DHSPP by either phone, e-mail or a personal meeting and subsequently incorporate the finding into the final audit report. Upon receipt of this information the DHSPP may suspend study activity in whole or in part (refer to policy 2009-003 for imposing suspensions) or may require immediate corrective action to bring study conduct into compliance with the approved protocol to minimize the risk to subjects.

A. Correspondence

Within approximately ten working days of completion the RCM will generate a letter of the findings from the audit using the audit letter template. The Director (and/or designee) of the HSPP (DHSPP) will be given an opportunity to review and comment before the letter is issued. The DHSPP may require implementation of other corrective actions and may elect to discuss the recommendations of the RCM with the appropriate Chair prior to the RCM finalizing and issuing the letter.

The RCM will send the letter to the PI with copy to the DHSPP, Deputy DHSPP, study coordinator, and additional contacts as requested or appropriate. For studies under local IRB oversight, the IRB Chair and Regulatory Specialist will receive copy of the correspondence, as well. Other relevant parties may be copied as necessary (e.g., research pharmacy if a finding relates to dispensing of medications, research subject advocate for studies supported by the Clinical Research Center).

When corrective actions are required, the PI will be directed to respond in writing to the RCM within a reasonable time frame (e.g. 2 – 4 weeks) specified within the letter. Corrective actions required are limited to those that will bring the conduct of the study into compliance with the approved protocol, regulatory requirements (e.g. drug accountability for investigator held IND), or good clinical practice guidelines as recognized by the FDA or that require actions on the part of the staff, e.g. additional training requirements. The RCM may suggest changes to the protocol or study related documents. In such cases a recommendation will be made to the PI to submit a request for addendum/modification to the IRB for review and approval and the IRB will make the final determination as to whether to approve the request.

If the PI does not adequately address all issues in the initial response letter, this process of communication will be repeated.

If there are no audit findings and therefore no response is required from the PI, the initial audit letter sent by the RCM will indicate this and will also serve as the closeout letter and the Audit Response Form referenced below is not necessary,

B. Failure to Respond

If a PI does not respond to an audit letter by the due date the RCM will issue a reminder notice to the PI by e-mail and grant a short extension period (e.g. 1 – 2 weeks) by which a response to the audit is due. If necessary, a second reminder may be sent by the RCM to the PI with copy to the DHSPP, and/or a phone call may be placed by the DHSPP to the PI. An additional short extension period (e.g. one week) may be granted. If after that time the PI has not responded, the RCM will ask the DHSPP to contact the PI's Department Chair by phone or e-mail to enlist their services in soliciting a response from the PI. An additional short extension period (e.g. one week) may be granted. If the PI does not respond and the study was approved by the local IRB, the RCM will ask the IRB Chair to issue a directive to the PI to respond by a given date. If the PI does not respond to the directive of the IRB Chair, the RCM will ask the IRB RS to list the audit and the PI's failure to respond as a discussion item for the next convened IRB meeting. The failure to respond may constitute serious non-compliance. If the PI does not respond and the study was approved by an external IRB the RCM will work with the reviewing IRB to determine next steps.

If the PI fails to complete corrective actions in a timely manner, the RCM will follow the same procedures as stated above.

C. Review of Audits By Local IRB

(Note: For studies approved by an external IRB: the study team will be advised in the correspondence to inform the reviewing IRB of the audit outcome as directed in reporting policies of that IRB.)

The RCM will provide the relevant IRB chair with a copy of the audit letter, the response letter(s) from the PI and the Audit Review Form (ARF). The IRB Chair will review the audit letter and response letter and use the ARF to document whether any findings need to be brought before the convened board for review.

If a referral is made to the convened board, the RCM will send a final audit correspondence to the PI and study coordinator with copy to others (as requested and appropriate) indicating the areas of the audit designated by the Chair which require further review. The RCM will prepare the materials for review by the membership. At a minimum the material will include the audit letter and response letter(s). The RCM will provide the material to the IRB Regulatory Specialist (RS) for inclusion on the IRB agenda as a discussion item.

If review by the convened board is not required (inclusive of audits done by directive of the Chair), the Chair will indicate this on the ARF and return the form to the RCM.

If the audit was conducted at the direction of the convened board and no areas of the audit require further discussion by the convened board, the Chair will indicate this on the ARF and the RCM will inform the IRB RS to inform the Board that their directive had been followed.

D. Audit Close-Out

Once all audit findings and corrective actions have been addressed and the IRB chair has completed the ARF (when applicable), the RCM will prepare an audit close-out letter and copy those individuals on the initial audit outcome letter. If applicable, this letter may indicate that certain issues have been referred to the convened IRB for further review.

E. Filing

The RCM is responsible for filing all correspondence related to audits in the electronic IRB file. All audit correspondence will be attached as an “audit packet” with the original audit letter being the first document followed by other correspondence in date order. The audit packet should include the audit letter and, as applicable, the response from the PI, completed ARF form, and audit close out letter. For items that were referred to the convened board, the RCM will be copied on the discussion item outcome letter and include this letter in the audit packet. The audit packet will be uploaded to the electronic IRB file in iRIS under the Study Management tab, in the section Review Board Internal Documents. Investigators are responsible for keeping their own documentation of the audit with their study records.

III. Procedures for Annual Summary Review of All Internal Audits

On an annual basis the results of completed audits will be reviewed by the RCM to determine if there are consistent problem areas. If it is determined that there are consistent problem areas, the RCM will use this information to recommend to the DHSPP that policies be developed or clarified, and to work the ES to improve education of the research personnel.

IV. Procedures for External Audits, Inspections or Monitoring Reports

The PI is expected to forward to the IRB for review any audit, inspection, or monitoring report or finding issued by a regulatory agency, cooperative research group, contract research organization, the sponsor or the funding agency. If there are no findings or if the report is limited to deviations outside the control of the research team which pose no risk to subjects (e.g., subject rescheduled study visit outside of window) and no corrective actions are required, the report is to be submitted as part of the application for continuing review.

Reports which include deviations within the control of the research team /or require corrective action, are to be submitted to the IRB within 15 working days of receipt of the report. The information is to be submitted to the IRB in conjunction with the applicable IRIS form (i.e. an addendum/modification request form or problem report form) and include any corrective action plans. The PI must subsequently summarize the findings at the time of continuation.

The IRB RS will follow standard procedures for assigning the submission for review by the IRB.

V. Procedures for HIPAA Concerns

If an audit or external monitoring reveals a concern which may represent a HIPAA privacy issue, the RCM will instruct the PI and study coordinator to inform the UConn Health Privacy Officer of the issue. The PI will be instructed to include the RCM and/or IRB, as necessary in correspondence. If the concern should be of a serious nature and require immediate reporting, the RCM or IRB may contact the Privacy Officer directly and alert the PI when feasible.

VI. Procedures for IRB Actions

If necessary for subject safety, the Chair may suspend all or part of the research activity until such time as the board convenes (see policy 2009-003.0, 2009-004.0). If the Board determines there is a finding of serious or continuing non-compliance or an unanticipated problem involving risk to subjects or others, and/or suspends or terminates a study the procedures described in related policies will be followed.

VIII. Procedures for Potential Misconduct in Research

If the RCM is concerned that audit findings may rise to the level of misconduct in research the RCM will immediately bring this concern to the attention of the DHSPP. If the DHSPP concurs, the DHSPP will follow the policy for Reporting Compliance Concerns (2003-33) after which and if necessary, the UConn Health Research Domain Chief Compliance Officer or the Corporate Compliance Integrity Office will follow the policy for Review of Alleged Misconduct of Research (2003-41). Disagreement by the DHSPP does not prevent the RCM from reporting the compliance concern.

Related Content

2003-33 – Reporting Compliance Concerns (Institutional Policy)
2003-41 – Review of Alleged Misconduct of Research (Institutional Policy)
2009-001.0 – Reporting Unanticipated Problems to the IRB
2009-002.0 - Reporting Non-Compliance to the IRB
2009-003.0 - Imposing a Suspension or Termination of IRB Approval
2009-004.0 - Reporting to External Agencies and Institutional Officials
2011-007.0 – Definitions Applied to Policies
2011-023.0 – Educational Requirements

Basis

45 CFR 46
21 CFR 56

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Reviewed and Approved By:

Richard H. Simon

6/5/2023

Richard H. Simon, MD

Date

Director Human Subjects Protection Program

Appendix A Policy 2009-005.0

Types of Audits

Unannounced Audit

Unannounced audits are conducted to verify that the research is being conducted in accordance with the IRB's terms of approval, that informed consent is being obtained, that records are kept under secure conditions, and that information being provided to the IRB is accurate, e.g. number of subjects enrolled, recruitment methods etc. This type of audit will not be conducted frequently.

Scheduled / Random Audit

These audits are designed to conduct a more comprehensive examination of compliance, including reviews of patient eligibility and medical oversight and may include observation of the informed consent process and conduct of the research and reviews of drug/device accountability. The PI and study coordinator will be given at least one week notice prior to the start of the audit.

Directed Audit

Directed audits are conducted at the request of the IRB. The scope of the audit depends on the directive from the IRB. The IRB may require on-going monitoring by the RCM over a period of time until satisfied that the issue of concern has been resolved.

Consent Audit

The IRB may require that the consent process be monitored by the Research Compliance Monitor or a representative of the IRB. The purpose of this is to ensure that the study is being explained well to the subjects. Examples of when this practice may be exercised include when the investigator or individual obtaining consent is inexperienced, when the study is complex or when the study is high risk. Investigators may also request this audit to ensure that the consent process is being conducted properly.

Emergency Audit

This type of audit may be conducted when concerns for subject safety or concerns or allegations relating to non-compliance with the regulations or requirements or determinations of the IRB are brought to the attention of the IRB or DHSPP. The DHSPP may elect to accompany the RCM on such audits. Audits will occur within 2 weeks of notification of the allegation. The DHSPP will determine whether the PI is to be given any advance notice. If given, advance notice will be by phone call from the DHSPP, or RCM as directed by the DHSPP, and will not exceed 24 hours. The purpose of any advance notice is to allow the PI to arrange to be present for discussion.

Depending on the nature of the expressed concern, the RCM and / or DHSPP may choose to sequester all research related files in the HSPP for further review. The DHSPP and / or RCM will discuss the concern that caused the audit with the PI and obtain their perspective. It will also be explained to the PI that the sequestering of the research files, if it occurs, is for their own protection. The DHSPP will communicate back to the PI the findings of the audit and the

corrective action to be taken if needed. The DHSPP may refer matters to the IRB for review and determination of whether the matter constitutes serious or continuing non-compliance or an unanticipated problem involving risk to subjects or others. The DHSPP will follow through with any required reporting to internal and external officials based on the determinations of the IRB.

First-Time PI Audit

This type of audit occurs when a study is under the direction of a PI who has not previously been a PI or has never been a PI at UConn Health. The purpose of this audit is to ensure that the investigator is aware of their responsibilities and obligations as PI, familiar with HSPP policies and is giving appropriate oversight to the research. A first-time PI audit will typically be conducted within the first year of IRB approval.

Follow-up Audit

This type of audit occurs when a study has previously been audited and corrective actions were required as a result of the audit. The RCM may conduct a follow-up audit to check that corrective actions were implemented and that previously identified problems are not continuing to occur. Follow-up audits may be directed by the IRB to occur within a specific time frame following the initial audit. When warranted, these audits may occur with limited advanced notice.

IND/IDE Sponsor Pre-Approval Audit

This type of audit is conducted when a UConn Health faculty member is also the sponsor of an IND or IDE. The purpose of this audit is to ensure that the sponsor of the IND is aware of the additional obligations of the sponsor and to ensure that proper procedure will be followed for the manufacture, use, storage, and accountability of the investigational article. The pre-audit is conducted prior to submission of an IRB application that proposes to use the IND/IDE and the results of the audit become part of the application. An audit of this nature conducted by another area (e.g. Research Compliance Services) may substitute for the RCM audit.

Joint OCTR / HSPP Audit

This is a combined audit in conjunction with the Office of Clinical & Translational Research (OCTR) of UConn Health to assess compliance in the clinical research activities. The RCM will review research activities conducted under an IRB approval to ensure that proper scientific, ethical and regulatory requirements are followed. The OCTR auditors will conduct a financial compliance audit to ensure that subject billing adheres to the regulations set forth in the Medicare National Coverage Decision. While the on-site portion of the audit is conducted at the same time, the HSPP and OCTR reports will be issued separately.

Web / Recruitment Audit

The RCM may periodically review the content of the UConn Health clinical trials listing on the UConn Health web site to ensure that the information posted does not exceed that allowed per FDA guidance and HSPP/IRB policy. The RCM may also audit departmental web sites and other advertising to ensure compliance with recruitment policies. Web / Recruitment audits may be incorporated into another type of audit or done as a stand-alone audit.

Lapsed / Closed Study Audit

The RCM may conduct audits of studies which have experienced a lapse in IRB approval or were administratively closed. Such audits look to ensure that no research activity has occurred

during the lapse (with the exception of activities which received prior approval to continue). In the case where studies were administratively closed due to failure to obtain continuing approval, the RCM will seek to ensure that no research activity occurred during the lapse or since closure, and to confirm that records are retained per protocol, policy and applicable regulations. Such audits may be conducted on site or remotely.

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011 – 006.0
Policy Title: Additional Protections for Certain Populations: General Policy

Purpose

The purpose of this policy is to set forth the requirements of HSPP for review and approval by the Institutional Review Board of non-exempt studies involving population that may be vulnerable to undue influence or coercion or for which additional protections have been set forth in regulation.

Definitions

See policy 2011-007.0 for definitions of the following:

Pregnancy	Children
Fetus	Neonate
Pregnant Woman	Prisoner

Policy

Certain populations (e.g. pregnant women, fetus, neonates, prisoners, children, individuals with impaired decision making capacity, economically disadvantaged, or educationally disadvantaged,) may only be the target population for research when their inclusion in the research is justified (i.e., scientifically necessary, not for convenience). The research must be relevant to the population and not otherwise capable of being carried out with another population. Adequate procedures must be in place to minimize the risks related to harm (e.g. physical, psychological, legal, economic, societal) and to protect the rights and welfare of these subjects.

As required by policy and as applicable to the population being studied, the IRB will fulfill the additional duties required by federal regulations and/or internal policies, for initial review and continuing review, and when reviewing modifications to add one of the aforementioned populations. Once a study qualifies for continuation through expedited review (e.g. because the remaining activity in an FDA regulated study is limited to long-term follow-up or data analysis and continuing review is required by regulation, or the IRB otherwise determined and justified that continuing review is a requirement) the IRB will presume that the previous determinations made by the IRB satisfied the criteria for inclusion of that population, but the IRB reserves the right to require additional information.

For studies requiring full board review, at the time of initial review of a study proposing to include one of the aforementioned populations a member or consultant who is knowledgeable about or experienced in working with the population to be studied must review all material and provide comments (in person, via teleconference, or other means that allows for two way communication). Excluding studies for which prisoners are the intended population, giving consideration to the nature of the study, the IRB may determine on a case-by-case basis that an exception to the requirement to obtain special expertise may be made. For example, if a study is comparing two established and accepted methods of treatment special expertise may not be required.

For full board continuing reviews, and reviews of modifications that affect study design or populations; preference will be that a member or consultant with expertise review all material and provide comments (in person, via teleconference, or other means that allows for two way communication). As with initial review, giving consideration to the nature of the study, the IRB may determine on a case-by-case basis that an exception to the requirement to obtain special expertise may be made. In addition, providing there have not been substantive changes to the study or new information that significantly alters the risks of the study, the IRB may

make an exception and rely upon the determinations previously provided by the member or consultant with expertise when granting subsequent approvals.

The IRB may also require additional protections for any other group not specified in policy but determined to be vulnerable in the opinion of the IRB. Such additional protections may include, but are not limited to, the witnessing of the consent process, more frequent continuing review, or additional review by someone with a specific expertise.

The IRB reserves the right to require additional protections for research that is exempt from the federal requirements for the protection of human subjects in research.

Procedure

The Principal Investigator must identify within the IRB application any vulnerable group that is to be the focus of recruitment or that pregnant women are intended to be included in the research.

The Principal Investigator must then complete and submit the corresponding IRB form that addresses the special protections required for the specific subject population identified that will be included in the research.

The assigned reviewer(s) must review this form and determine whether the requirements have been met.

- For expedited reviews:
 - the reviewer will document the permissible category on the reviewer form
 - the reviewer will document on the reviewer form whether the additional protections have been satisfied
- For studies requiring review by the convened board:
 - the IRB Chair may use the IRB roster to identify members and/or standing consultants to assign reviewers with specific expertise
 - if necessary the Chair may seek an ad-hoc consultant if a standing consultant is not available
 - the IRB Regulatory Specialist will document in the minutes the determinations for the required findings. For continuing reviews the determination may be made by reference to the initial review.

Related Policies

2011-006.1 – Additional Protections for Certain Populations, Pregnant Women, Fetuses or Neonates
2011-006.2 – Additional Protections for Certain Populations, Prisoners
2011-006.3 – Additional Protections for Certain Populations, Children
2011-006.4 – Additional Protections for Certain Populations, Other Groups
2011-006.5 – Additional Protections for Certain Populations, Fetal Tissue Transplant
2011-009.3 – Institutional Review Board – Review by Expedited Procedures
2011-009.5 – Institutional Review Board - Review by the Convened Board
2011-009.6 – Institutional Review Board - Consultants
2011-007.0 – Definitions Applied to Policies

Basis

45 CFR 46
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Richard H. Simon

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Richard Simon, MD
Director Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-006.1
Policy Title: Additional Protections for Certain Populations: Pregnant Women, Fetuses or Neonates

Purpose

The purpose of this policy is to set forth the requirements of the HSPP for review and approval by the Institutional Review Board of non-exempt studies intending to involve pregnant women, fetuses or neonates.

Definitions

See Policy 2011-007.0 for definitions of the following:

Delivery	Pregnancy
Secretary	Fetus
Fetus, Dead	Neonate
Neonate, Nonviable	Neonate, Viable
Pregnant Woman	

Policy

The additional protections for the inclusion of pregnant women in non-exempt research apply in the following circumstances:

- The research is federally funded or supported; or
- The research involves pregnant women as the recipient of a drug, device or biologic.
 - The additional protections are not applicable when a woman becomes pregnant while enrolled in a non-federally funded or supported study, the intervention is stopped, and the remaining activity is limited to the collection of long-term follow-up data on the pregnancy,

When the protections apply, the IRB may approve research involving pregnant women, fetuses or neonates if the IRB finds that the research satisfies the conditions of all applicable sections noted below.

Pregnant Women or Fetuses:

Pregnant women or fetuses may be involved in research only if the IRB finds that:

- a. where scientifically appropriate, preclinical studies, including studies in pregnant animals, and clinical studies, including studies on pregnant women, have been conducted and provide data for assessing potential risks to pregnant woman and fetuses;
- b. the risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus; or, if there is no such prospect of benefit, the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means;
- c. any risk is the least possible for achieving the objective of the research;
- d. the woman's consent is obtained in accordance with regulations if the research holds out 1) the prospect of direct benefit to the pregnant woman, 2) the prospect of a direct benefit to both the pregnant woman and the fetus, or 3) no prospect of direct benefit for the woman nor the fetus when

- risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means;
- e. if the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accord with the informed consent provision set forth in regulation. The father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest;
 - f. each individual providing consent is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;
 - g. for children who are pregnant, assent and permission are obtained in accord with the regulations regarding children involved as subjects in research;
 - h. no inducement, monetary or otherwise, will be offered to terminate a pregnancy;
 - i. individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy; and
 - j. individuals engaged in the research will have no part in determining the viability of neonates.

Neonates of Uncertain Viability:

Neonates of uncertain viability and nonviable neonates may be involved in research if all of the following conditions are met:

- a. where scientifically appropriate, preclinical and clinical studies have been conducted and provide data for assessing potential risks to neonates.
- b. each individual providing consent is fully informed regarding the reasonably foreseeable impact of the research on the neonate.
 - For neonates of uncertain viability, the legally effective informed consent of either parent of the neonate or, if neither parent is able to consent because of unavailability, incompetence or temporary incapacity, the legally effective informed consent of the either parent's legally authorized representative is obtained in accordance with regulation, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.
 - For nonviable neonates, the legally effective informed consent of both parents of the neonate is obtained in accord with regulation. The provisions to request a waiver or alteration of consent do not apply. If either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the informed consent of one parent of a nonviable neonate will suffice. The consent of the father need not be obtained if the pregnancy resulted from rape or incest. The consent of a legally authorized representative of either or both of the parents of a nonviable neonate will not suffice.
- c. individual engaged in the research will have no part in determining the viability of a neonate.
- d. the following requirements have been met as applicable to neonates of uncertain viability.
 - until it has been ascertained whether or not a neonate is viable, a neonate may not be involved in research unless the IRB determines that 1) the research holds out the prospect of enhancing the probability of survival of the neonate to the point of viability, and 2) any risk is the least possible for achieving that objective; or 1) the purpose of the research is the development of important biomedical knowledge which cannot be obtained by other means and 2) there will be no added risk to the neonate resulting from the research;

- the legally effective informed consent of either parent of the neonate or, if neither parent is able to consent because of unavailability, incompetence or temporary incapacity, the legally effective informed consent of the either parent's legally authorized representative is obtained in accordance with regulation, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.

Nonviable Neonates:

Nonviable neonates: After delivery a nonviable neonate may not be included in research unless all of the following additional conditions are met:

- a. vital functions of the neonate will not be artificially maintained;
- b. the research will not terminate the heartbeat or respiration of the neonate;
- c. there will be no added risk to the neonate resulting from the research;
- d. the purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means; and
- e. the legally effective informed consent of both parents of the neonate is obtained in accord with subpart regulation. The provisions for a waiver or alteration of consent do not apply. However, if either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the informed consent of one parent of a nonviable neonate will suffice.
- f. The consent of the father need not be obtained if the pregnancy resulted from rape or incest. The consent of a legally authorized representative of either or both of the parents of the nonviable neonate will not suffice.

Viable Neonates:

Viable neonates: A neonate, after delivery, that has been determined to be viable may be included in research only to the extent permitted by and in accord with the requirements for the inclusion of children in research.

Placenta, Dead Fetus, Fetal Material:

Research involving, after delivery, the placenta, the dead fetus, or fetal material may be conducted only if the IRB finds that:

- a. research involving, after delivery, the placenta; the dead fetus; macerated fetal material; or cells, tissue, or organs excised from a dead fetus, shall be conducted only in accord with any applicable Federal, State or local laws and regulations regarding such activities.
- b. if information associated with material described in paragraph a is recorded for research purposes in a manner that living individuals can be identified, directly or through identifiers linked to those individuals, those individuals are research subjects and must be afforded the applicable protections of the regulation and its subparts as applicable.

Research involving pregnant women, fetuses or neonates that does not fit into one of the above categories may only be conducted if the IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problems affecting the health or welfare of pregnant women, fetuses or neonates and, for DHHS funded or supported research, after the Secretary has consulted with an expert panel and there has been opportunity for public review and comment. The required findings for such research are that the research does present the aforementioned opportunity, the research will be conducted in accord with sound ethical principles and informed consent will be obtained.

Proposed studies involving pregnant women, fetuses or neonates may qualify for exempt or expedited review when no more than minimal risk is involved. The Chair will make the final determination.

Consent of the Father:

Unavailability of the father as related to consent issues is interpreted to mean that he is either deceased or that his whereabouts are not known and cannot be determined with a reasonable amount of effort.

Procedure

See 2011 – 006.0 – Additional Protections for Certain Populations - General Policy

Related Policies

2011-006.0 – Additional Protections for Certain Populations - General Policy
2011-006.3 – Additional Protections for Certain Populations - Children
2011-007.0 – Definitions Applied to Policies
2011-008.0 – Informed Consent Forms
2011-008.3 - Assent
2011-008.5 – Informed Consent – Providing and Obtaining Informed Consent
2011-009.2 – Institutional Review Board – Exemptions
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

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21 CFR 50

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Richard H. Simon, MD

Date

Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-006.2
Policy Title: Additional Protections for Certain Populations: Prisoners

Purpose

The purpose of this policy is to set forth the requirements of the HSPP for review and approval by the Institutional Review Board of studies intending to involve prisoners as subjects.

Definitions

See Policy 2011-007.0 for definitions of the following terms:

Risk, Minimal | Risk, Minimal for Prisoners | Secretary | Prisoner

Policy

Studies intending to involve prisoners as subjects do not qualify for exemption. However, studies aimed at involving a broader subject population that only incidentally include prisoners may qualify for exemption.

For non-exempt studies intending to involve prisoners as subjects the additional protections for the inclusion of prisoners in research apply in the following circumstances:

- The research is federally funded or supported; or
- The research is intended to involve interaction or intervention with prisoners.

When the additional protections apply, except as noted below, the convened board must review all studies intending to involve prisoners as subjects.

- Federally funded studies for which the entire activity is limited to chart reviews may be reviewed and approved by the Chair and Prisoner Representative through expedited review providing there is an appropriate expedited category under which to approve the research.
- Requests for expedited approval of a modification may be reviewed by any experienced member of the IRB, providing the modification does not relate to a change in study design or procedures. For example, any IRB member may approve a change in staff or clarification of wording. For changes to study design or procedures (e.g., addition of a blood draw); review will be done by the Chair and prisoner representative; and either of them may determine review by the convened board is required.
- Once the remaining activity is limited to data analysis or long-term follow-up if continuing review is required, any experienced member of the IRB may conduct the review.
- Any experienced member of the IRB or experienced member of the IRB/HSPP support staff may review responses to contingencies for purposes of issuing the final approval to a submission.

When reviewing studies that will involve prisoners as subjects, the membership of the board will be such that the majority of members (exclusive of prisoner members) have no association with the prisons involved and at least one member will be a prisoner, or a prisoner representative.

In assessing the level of risk involved in a study the IRB will not use risks that face prisoners in the prison setting as the standard for acceptable risk and will only allow risks that are commensurate with those that would be accepted by non-prisoner volunteers.

When reviewing research intending to involve prisoners the IRB will ensure that the research is permissible under one of the following categories:

- study of the possible causes, effects, and processes of incarceration, and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;
- study of prisons as institutional structures or of prisoners as incarcerated persons, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;
- research on conditions particularly affecting prisoners as a class (e.g., vaccine trials and other research on hepatitis which is much more prevalent in prisons than elsewhere; and research on social and psychological problems such as alcoholism, drug addiction and sexual assaults). For research funded by the Department of Health and Human Services (DHHS), the study may proceed only after the Secretary has consulted with appropriate experts including experts in penology medicine and ethics, and published notice in the Federal Register of his intent to approve such research; or
- research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subject. For DHHS-funded research, in cases in which those studies require the assignment of prisoners in a manner consistent with protocols approved by the IRB to control groups which may not benefit from the research, the study may proceed only after the Secretary has consulted with appropriate experts including experts in penology medicine and ethics, and published notice in the Federal Register of his intent to approve such research.

The IRB may approve research involving prisoners if the IRB finds that the research satisfies the conditions of all applicable sections noted below:

- any possible advantages accruing to the prisoner through his or her participation in the research, when compared to the general living conditions, medical care, quality of food, amenities and opportunity for earnings in the prison, are not of such a magnitude that his or her ability to weigh the risks of the research against the value of such advantages in the limited choice environment of the prison is impaired;
- the risks involved in the research are commensurate with risks that would be accepted by non-prisoner volunteers;
- procedures for the selection of subjects within the prison are fair to all prisoners and immune from arbitrary intervention by prison authorities or prisoners. Unless the principal investigator provides to the Board justification in writing for following some other procedures, control subjects must be selected randomly from the group of available prisoners who meet the characteristics needed for that particular research project;
- the information is presented in a language which is understandable to the subject population; (note: use a 5th grade reading level as a benchmark)
- adequate assurance exists that parole boards will not take into account a prisoner's participation in the research in making decisions regarding parole, and each prisoner is clearly informed in advance that participation in the research will have no effect on his or her parole; and
- where the Board finds there may be a need for follow-up examination or care of participants after the end of their participation, adequate provision has been made for such examination or care, taking into account the varying lengths of individual prisoner's sentences, and for informing participants of this fact.

When funding is from DHHS, the institution shall certify to the Secretary, in such form and manner as the Secretary may require, that the duties of the Board under Subpart C have been fulfilled. The certification letter will be prepared by IRB staff and sent from the IRB Chair.

Unexpected Incarceration of Enrolled Subject:

If a participant becomes a prisoner while enrolled in a federally funded or supported non-exempt research study that did not intend to enroll prisoners and was not previously reviewed according to the special protections afforded to prisoners (i.e., Subpart C of 45 CFR 46), and the PI has confirmed that the participant meets the definition of a prisoner the following apply:

- Report the incarceration to the IRB on a Problem Report Form
- Include on the form plans to either terminate enrollment of the subject in the study; or to request that the IRB review the research study under Subpart C if it feasible for the participant to remain in the study.
 - Before terminating the enrollment of the incarcerated participant, the PI and IRB should consider the risks associated with terminating participation in the study.
 - If the participant cannot be terminated for health or safety reasons, review of the research under Subpart C must be obtained.
 - If some of the requirements of Subpart C cannot be met, but it is in the best interests of the participant to remain in the study, keep the participant enrolled and for DHHS supported research, inform the Office of Human Research Protections (OHRP) of the decision along with the justification.
- Alternatively, remove the participant from the study and keep the participant on the study intervention under an alternate mechanism such as compassionate use, off label use, etc.

Epidemiologic Research Involving Prisoners:

Effective June 20, 2003, the Secretary of the DHHS may also approve epidemiologic research involving prisoners as subjects under a provision allowing for a waiver of the applicability of provisions of 45 CFR 46.305(a)(1) and 46.306(a)(2). While prisoners may be included in such studies, they cannot be the only population included within the study. The epidemiologic research can present no more than minimal risk and no more than inconvenience to the prisoner-subjects. To qualify for such a waiver the epidemiologic study must meet the following criteria:

- the sole purposes are to describe the prevalence or incidence of a disease by identifying all cases, or to study potential risk factor associations for a disease, and
- for DHHS supported research, the IRB, via a letter prepared by the IRB staff and signed by the Chair, must include in the certification letter to the Office for Human Research Protections that:
 - the additional criteria, as described above, have been satisfied.
 - that the research presents no more than minimal risk and no more than inconvenience to the prisoner-subjects, and
 - prisoners are not a particular focus of the research.

Studies for which the waiver may apply include epidemiological research related to chronic disease, injuries, and environmental health.

Procedure

See policy 2011-006.0 – Additional Protections for Certain Populations: General

- review by expedited procedures is only allowed in circumstances described above.

In addition, for studies presented to the convened board the IRB chair will assign a prisoner representative as one of the primary reviewers. However, exceptions delineated in policy 2011-006.0 may apply.

For DHHS funded research, the assigned Regulatory Specialist will use the standard Prisoner Certification Template Letter to prepare the required certification letter for signature of the IRB Chair and send the letter to

the Secretary through the Office of Human Research Protections. The RS will include a statement in the standard IRB approval letter that prisoners may not be involved until such time as DHHS has provided documentation of its review and concurrence that the research is approvable.

Related Policies

2011-006.0 – Additional Protections for Certain Populations – General
2011-007.0 – Definitions
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

45 CFR 46
67 FR 62432, October 7, 2002 for Epidemiologic Waiver

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Richard H. Simon

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Richard Simon, MD
Director Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-006.3
Policy Title: Additional Protections for Certain Populations: Children

Purpose

The purpose of this policy is to set forth the requirements of the HSPP for review and approval by the Institutional Review Board of non-exempt research intending to involve children as subjects.

Definitions

See Policy 2011-007.0 for definitions of the following terms:

Assent	Guardian	Parent
Permission	Risk, Minimal	Children
Ward	Research	Clinical Investigation

Policy

For purposes of this policy the term research is to be interpreted as either research as defined by DHHS or clinical investigation as defined by the FDA.

Research proposing to involve children may qualify for exemption if the research falls into one of the federally-approved categories defined in 45 CFR 46. The only exemption also applicable to FDA regulated studies is the exemption regarding taste and food quality evaluation and consumer acceptance studies as also noted in 21 CFR 56. The exemption noted in 45 CFR 46 for research involving survey or interview procedures or observations of public behavior does not apply to research involving children unless the research involves only the observation of public behavior and the investigator(s) does not participate in the activities being observed.

The additional protections for children apply to all non-exempt research that is federally funded and non-exempt research that involves an intervention or interaction with a child regardless of funding source. Studies proposing to involve children may qualify for expedited review if the study falls into one or more of the federally-approved expedited categories published in the guidance in the Federal Register. The DHSP, in consultation with the IRB Chairs, may develop additional categories of research that are deemed minimal risk and eligible for expedited review providing the research is not federally funded or supported. The assigned IRB reviewer will make the final determination regarding approval status and categories.

When the additional protections apply, the IRB may approve research involving children if the IRB finds that the research satisfies the conditions of all applicable sections noted below.

No More than Minimal Risk:

For research not involving greater than minimal risk the IRB must find and document:

- that adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians.
 - when parental permission is to be obtained, the IRB may find that the permission of one parent or guardian is sufficient.

Greater than Minimal Risk / Prospect of Direct Benefit:

For research in which more than minimal risk to children is presented by an intervention or procedure that holds out the prospect of direct benefit for the individual subject, or by a monitoring procedure that is likely to contribute to the subjects well-being the IRB must find and document that:

- the risk is justified by the anticipated benefit to the subjects;
- the relation of the anticipated benefit to the risk is at least as favorable to the subject as that presented by available alternative approaches; and
- adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians.
 - when parental permission is to be obtained, the IRB may find that the permission of one parent or guardian is sufficient.

Use of a placebo, or routine monitoring for safety, is not considered to provide direct benefit to subjects.

Greater than Minimal Risk / No Direct Benefit:

For research involving greater than minimal risk and no prospect of direct benefit to individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition the IRB must find and document that:

- the risk represents a minor increase over minimal risk;
- the intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations;
- the intervention or procedure is likely to yield generalizable knowledge about the subject's disorder or condition which is of vital importance for the understanding or amelioration of the subject's disorder or condition; and
- adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians.
 - when parental permission is to be obtained, both parents/guardians must give their permission unless one is deceased, unknown, incompetent or not reasonably available, or unless only one parent has legal responsibility for the care and custody of the child.

Not Otherwise Approvable:

For research not otherwise approvable that presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children the IRB must find and document:

- the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children, and
- for studies funded or supported by DHHS, the Secretary, or for studies subject to FDA oversight the Commissioner, after consultations with a panel of experts in pertinent disciplines and following opportunity for public review and comment, has determined either that the research in fact satisfies one of the set of conditions described above, or the following:
 - the research presents a reasonable opportunity to further the understanding, prevention or alleviation of a serious problem affecting the health or welfare of children;
 - the research will be conducted in accordance with sound ethical principles; and

- adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians.

Assent:

The IRB must determine that adequate provisions are made for soliciting the assent of the children when in the judgment of the IRB the children are capable of providing assent. In determining whether children are capable of assenting, the IRB shall take into account the ages, maturity, and psychological state of the children involved. The judgment may be made for all children to be involved in research under a particular protocol, or for each child. When the IRB determines that assent is required, it shall also determine whether and how assent must be documented.

Assent is not a necessary condition for proceeding with the research if the IRB determines that the capability of some or all of the children is so limited that they cannot reasonably be consulted or that the intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health or well-being of the children and is available only in the context of the research. The IRB may also waive the assent requirement. Likewise, the dissent of the child, though normally respected and honored, may be overruled by the child's parents at the discretion of the IRB. In such situations the IRB will consider the present health status of the child, the child's wishes and the level of discomfort and risk to which the child will be exposed.

Permission:

In accordance with and to the extent that consent is required under regulation, the IRB shall determine that adequate provisions are in place for soliciting the permission of each child's parents or guardian.

In addition to the provisions for waiver of consent contained in DHHS regulations, if the IRB determines that a research protocol is designed for conditions or for a subject population for which parental or guardian permission is not a reasonable requirement to protect the subject (e.g., neglected or abused children) it may waive the consent requirements provided an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and provided further that the waiver is not inconsistent with Federal, state or local law. The choice of an appropriate mechanism would depend upon the nature and purpose of the activities described in the protocol, the risk and anticipated benefit to the research subjects, and their age, maturity status and condition. This is not applicable to FDA regulated studies.

Permission by parents or guardians shall be documented in accordance with and to the extent required by regulations. FDA regulated studies do not qualify for the exception to the requirement to document consent.

Wards:

Children who are wards of the state or other agency, institution, or entity can be included in research involving greater than minimal risk and no prospect of direct benefit to the individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition, or research that is not approvable under a defined regulatory category but that presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children only if the research is 1) related to their status as wards, or 2) conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.

If the research is approved, the IRB will require appointment of an advocate for each child who is a ward, in addition to any other individual acting on behalf of the child as guardian or in loco parentis.

One individual may be the advocate for more than one child. The individual acting as the advocate shall have the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except as the advocate or IRB member) with the research, the investigators, or the guardian organization

Procedure

See policy 2011-006.0 – Additional Protections for Certain Populations: General

In addition, when research is conducted outside of Connecticut, and review and approval by a local IRB or its equivalent is not required, the investigator must consult with legal counsel as to who is considered a child, and if applicable legally authorized representative or guardian, in the jurisdiction where the research is to be conducted and submit documentation of legal counsel's opinion.

The procedures outlined below are general and may be altered by the IRB depending on the nature of a specific study and the mental and physical status of the children involved.

- If the subject is 12 years of age or older, the child signs and dates an assent signature line on the consent form and a parent or guardian also signs the consent form. No separate assent statement is required.
- If the child is between 7-12 years of age, and the study is a therapeutic trial the child does not have to sign and the parents sign the consent form.
- If the child is between 7-12 years of age and the study is not a therapeutic trial, the parents or guardians sign the consent form and the subject signs an assent statement that is either included at the end of the consent form after the signature lines or as a separate document.
- If the child is less than 7 years of age, the parent or guardian signs the consent form, the subject signs nothing. No assent statement is required.

Related Policies

2011-006.0 – Additional Protections for Certain Populations - General

2011-007.0 – Definitions Applied to Policies

2011-008.0 – Informed Consent Form

2011-008.2 – Informed Consent - Waivers and Alterations

2011-008.3 – Informed Consent - Assent

2011-008.5 – Informed Consent - Providing and Obtaining Informed Consent

2011-009.2 – Institutional Review Board – Exemptions

2011-009.3 – Institutional Review Board – Expedited Reviews

2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

45 CFR 46

21 CFR 50

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Richard H. Simon

Richard Simon, MD

Director Human Subjects Protection Program

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Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-006.4
Policy Title: Additional Protections for Certain Populations: Other Vulnerable Groups

Purpose

The purpose of this policy is to set forth the requirements of the HSPP for review and approval by the Institutional Review Board of non-exempt studies intending to involve other vulnerable groups as subjects.

Definitions

See policy 2011-007.0 for definition of Decisionally Impaired

Policy

Other vulnerable groups (e.g. economically disadvantaged, educationally disadvantaged, employees, persons with an impaired ability to make decisions, students, terminally ill) may qualify for exempt status or expedited review if the research falls within one of the regulatory defined categories.

The additional protections for other vulnerable groups will apply to non-exempt research when the research calls for focused recruitment of a specific group, involves an intervention or interaction with that group, and the additional conditions noted under the group, if any, are met (for example the teacher-student or supervisor-employee dynamic.).

Economically and/or Educationally Disadvantaged

Economically disadvantaged individuals are considered vulnerable because they may be more inclined to participate due to financial incentives without regard for the risks involved in the research.

Educationally disadvantaged are considered vulnerable because they may have difficulty understanding the consent form and procedures involved in the research, thereby potentially reducing their appreciation for the risks involved in the research.

Students

Students are considered vulnerable when the focus of recruitment and when a direct relationship exists with the Principal Investigator (e.g. student – teacher). While a PI may use their own students as subjects if necessary the preference of the IRB is that the PI recruit students with whom the PI does not have a direct relationship (i.e. non-vulnerable students).

Students should not be asked to participate in any study that will interfere with their curricular activities and obligations. A student's decision to participate or not participate cannot have any bearing on grades awarded by the instructor.

If extra credit is awarded for participation in a study, other comparable means of earning the same amount of extra credit must be available to those students who choose not to participate.

Employees

Employees are considered vulnerable when the focus of recruitment and the relationship of the PI with the employees is such that it may create undue influence, e.g. supervisor-subordinate. While a PI/supervisor may use their own direct report employees as subjects if necessary, the preference of the

IRB is that the PI recruit employees with whom the PI does not have a direct relationship (i.e. non-vulnerable employees).

Employees should not be asked to participate in any study that will interfere with their job obligations. An employee's decision to participate or not participate cannot have any bearing on the employee's performance evaluation.

Decisionally Impaired

When reviewing proposals that focus on decisionally impaired subjects the IRB will make a determination as to whether the target subject population is capable of providing consent or whether a legally authorized representative must provide consent and the subject provide assent. The IRB may also require additional protections such as a witness to the consent process or requiring the PI to determine and document on an individual basis whether an individual is capable of providing consent, e.g. the IRB may require that the PI ask the subject to articulate in their own words the purpose of the study, the risks involved with the study, the benefits of the study and may request that those responses be documented. If the subject cannot answer such questions consent from a legally authorized representative must be obtained.

The IRB will use the additional protections set forth in regulation regarding the inclusion of children in research as guiding standards for the review process. Legally authorized representative will be substituted for reference to parent or guardian. The IRB may still elect to approve research that does not fall into one of the categories for research involving children.

Terminally Ill

When a study focuses on a terminally ill population, special attention will be paid to the recruitment and consent process. The IRB may require, for example, a witness to be present, a legally authorized representative to provide consent and that the subject provide assent, or that the IRB or HSPO observe the consent process.

The informed consent must clearly state that:

- there may be no benefit to the subject in terms of quality or length of life
- as an alternative, the subject has the right not to participate
- that the subject may in fact experience a decline in health status

Procedure

See policy 2011-006.0 – Additional Protections for Certain Populations: General

In addition the PI and IRB staff and reviewers use the informed consent checklist to ensure that required elements of consent have been addressed.

Related Policies

2011-006.0 - Additional Protections for Certain Populations - General

2011-006.3 – Additional Protections for Certain – Children

2011-007.0 – Definitions Applied to Policies

2011-008.3 – Informed Consent – Assent

2011-008.5 – Informed Consent – Providing and Obtaining Informed Consent

2011-009.2 – Institutional Review Board – Exemptions
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

45 CFR 46

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Director Human Subjects Protection Program

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Issuing Department: Human Subjects Protection Program
Policy Number: 2011-006.5
Policy Title: Additional Protections for Certain Populations - Fetal Tissue Transplants

Purpose

The purpose of the policy is to describe when human fetal tissue may be used in transplant research.

Definitions

See policy 2011-007.0 for definition of the following:

Fetus

Human Fetal Tissue

Policy

Human fetal tissue may be used in research involving transplant procedures regardless of whether the tissue is obtained pursuant to a spontaneous or induced abortion or pursuant to a stillbirth only if the procedures outlined below are satisfied.

All documentation related to this type of research is subject to audit and for DHHS supported research human fetal tissue may be used only if the head of the agency or other entity conducting the research certifies to the Secretary that the statements described below will be available for audit by the Secretary.

Procedure

The woman providing the tissue must provide a written signed statement declaring that:

- the woman donates the fetal tissue for use in the research,
- the donation is made without any restriction regarding the identity of the individuals who may be the recipients of transplantations of the tissue; and
- the woman has not been informed of the identity of any such individuals.

The attending physician with respect to obtaining the tissue from the woman involved must provide a written signed statement declaring that:

- in the case of tissue obtained pursuant to an induced abortion
 - the consent of the woman for the abortion was obtained prior to requesting or obtaining consent for a donation of the tissue for use in such research;
 - no alteration of the timing, method, or procedures used to terminate the pregnancy was made solely for the purposes of obtaining the tissue; and
 - the abortion was performed in accordance with applicable State law
- the tissue has been donated by the woman accordance with the above section; and
- full disclosure has been provided to the woman with regard to
 - the physician's interest, if any, in the research to be conducted with the tissue and
 - any known medical risks to the woman or risks to her privacy that might be associated with the donation of the tissue and that are in addition to risks of such type that are associated with the woman's medical care.

The individual with the principal responsibility for conducting the research involved must provide a written, signed statement declaring that they:

- are aware that
 - the tissue is human fetal tissue,
 - the tissue may have been obtained pursuant to a spontaneous or induced abortion or pursuant to a still birth and
 - the tissue was donated for research purposes.
- have provided such information to other individuals with responsibilities regarding the research;
- will require, prior to obtaining the consent of an individual to be a recipient of a transplantation of the tissue, written acknowledgment of receipt of such information by such recipient; and
- have had no part in any decisions as to the timing, method, or procedures used to terminate the pregnancy made solely for the purposes of the research.

Related Content

2011-007.0 – Definitions Applied to Policies

Basis

Public Law 103-43; June 10, 1993 <https://www.hhs.gov/ohrp/regulations-and-policy/guidance/public-law-103-43/index.html>

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Issuing Department: Human Subjects Protection Program
Policy Number: 2011-007.0
Policy Title: Definitions Applied to Policies

Purpose

The purpose of this policy is to set forth one document that defines various terms used within other policies issued by the Human Subjects Protection Program. This will reduce redundancy of defining a term in multiple policies and help to ensure consistency in terminology throughout all policies.

Definitions

Administer: The direct application of a drug or device to the body of a patient or research subject by injection, inhalation, ingestion or any other means.

Administrative Review: As related to DoD-supported research, a review of a research protocol and supporting documents (e.g., safety review, scientific review, IRB minutes) which ensures the institution engaged in the research involving human subjects has met the requirements of all applicable regulations and policies. This is NOT an IRB review.

Adverse Event: Any untoward medical occurrence that presents during the course of a clinical investigation that might be caused by either the condition under study or by the research intervention. Adverse events are categorized into those that are expected (predictable) and those that are unexpected (unpredictable). Adverse events include but are not limited to, adverse reactions to drugs, biologics, radioisotope labeled drugs, and medical devices. An adverse event is considered an unanticipated problem involving risk to subjects or others only when the event is unexpected (see definition below), related or possibly related to the research intervention (see definition below), and places the subjects or others at greater risk of harm than was previously recognized.

Adverse Event – Expected: An event that is anticipated on the basis of prior experience with the drug/device under investigation or with related drugs; an event identified in the Investigator's Brochure and/or study drug labels for post marketing studies; an event that is likely due to the underlying condition of the patient being studied; or an event attributed to the patient population being studied. Such events do not require reporting to the IRB (unless the nature, severity or frequency of the events is different/greater than previously anticipated) but may require reporting to the sponsor based on terms of the clinical trial agreement and /or protocol.

Adverse Event - External: The research participant signed an informed consent form from another institution. These events do not require reporting to the IRB unless the sponsor specifically states that the event is an unanticipated problem that has been reported to the FDA and for which a corrective measure has been implemented by the sponsor.

Adverse Event - Internal: The subject signed a University of Connecticut Health Center informed consent document. Principal investigators should assess all internal adverse events, document their assessment of the event, and report accordingly to the IRB (i.e., if the event is unexpected and related or possibly related to the research intervention and may place subjects are greater risk than previously recognized).

Adverse Event – Life Threatening: Any adverse drug experience that places the patient/subject, in the view of the investigator, at immediate risk of death from the reaction as it occurred (21CFR 312.32).

Adverse Event – Non-serious: Any undesirable symptom or occurrence a subject experience during participation in a clinical trial that does not meet the serious criteria.

Adverse Event, Related: An internal event is related to the research procedures if in the opinion of the principal investigator, it was more likely than not to be caused by the research procedures. The sponsor will make the determination of relatedness for external events.

Adverse Event – Serious: those events that meet at least one of the following criteria:

- Death
- Life-threatening
- Hospitalization/prolongation of existing hospitalization
- Congenital anomaly/birth defect
- Persistent or significant disability/incapacity
- An important medical event that, based upon appropriate medical judgment, requires medical or surgical intervention to prevent one of the outcomes listed above.

A non-serious adverse event is any undesirable symptom or occurrence a subject experiences during participation in a clinical trial that does not meet the criteria for serious.

Adverse Event – Unexpected: Any untoward medical occurrence not listed in the protocol and the informed consent document and not anticipated on the basis of prior experience with the intervention under investigation or with related interventions; an event that cannot be attributed to the underlying condition of the patient being studied or to the patient population; or expected events with frequency and/or severity exceeding what was anticipated.

Agent: An individual performing institutionally designated activities or exercising institutionally delegated authority or responsibility.

Assent: An affirmative agreement to participate in research (e.g., clinical investigation) used with those who are not competent or not of legal age to provide informed consent. Failure to object may not be construed as assent. Assent must be accompanied by consent of a parent or legally authorized representative.

Authorization Agreement: the agreement that documents respective authorities, roles, responsibilities, and communication between an institution/organization providing the ethical review (i.e., IRB review) and a participating site relying on that IRB review (NIH NOT-OD-16-094)

Benign Behavioral Intervention: A behavioral intervention which involves the performance of a cognitive, intellectual, educational or behavioral task or the manipulation of the participant's sensory, social or emotional environment, which is:

- brief in duration (e.g., no more than a few hours in a single day)
- harmless
- painless

- not physically invasive
- not likely to have a significant adverse lasting impact on participants
- no reason for the investigator to think participants will find the intervention offensive or embarrassing

Examples may include, subjects playing an online game, solving puzzles under various noise conditions, deciding how to allocate a nominal amount of received cash between themselves and someone else, rating personal preferences for and reactions to daily activities, foods, or other stimuli, either on an individual basis or in interaction with another participant or a research staff person .

Case Report: Per NCI dictionary of cancer terms, a detailed report of the diagnosis, treatment, and follow-up of an individual patient. Case reports also contain some demographic information about the patient (for example, age, gender, ethnic origin). At UConn Health, this definition applies across all clinical disciplines, and single case report does not require prospective review by the IRB.

Case Series: Per NCI dictionary of cancer terms, a group or series of case reports involving patients who were given similar treatment. Reports of case series usually contain detailed information about the individual patients. This includes demographic information (for example, age, gender, ethnic origin) and information on diagnosis, treatment, response to treatment, and follow-up after treatment. At UConn Health, this definition applies across all clinical disciplines and any summary of four or more cases requires prospective review by the IRB.

Causality/Attribution: Both expected and unexpected adverse events are further subdivided by causality into those attributable to the condition or patient population under study and those attributable to the research intervention. Attribution for internal adverse events is the responsibility of the PI. As a disclaimer, assignment of an unexpected adverse event to the research intervention does not necessarily imply agreement as to the cause by the manufacturers, suppliers or the FDA.

Certification: The official notification by the institution to the supporting Federal department or agency component, in accordance with the requirements of 45 CFR 46 Part A, that a research project or activity involving human subjects has been reviewed and approved by an IRB in accordance with an approved assurance.

Children: Persons who have not attained the legal age for consent to treatments or procedures involved in the research/clinical investigations, under the applicable law of the jurisdiction in which the research/clinical investigations will be conducted. When research is conducted in Connecticut, persons who meet this definition are all individuals under 18 years of age with the following exceptions:

1. Individuals between 16 and 18 years of age adjudicated as emancipated by a probate court
2. All individuals under 18 years of age, if the research procedures are limited to:
 - HIV testing, counseling, and treatment
 - Outpatient mental health services
 - Testing or treatment for sexually transmitted diseases
 - Treatment or rehabilitation for alcohol or drug dependence
 - Abortion counseling and treatment
3. All individuals between 16 and 18 years of age, if the research procedures are limited to:
 - Inpatient mental health services

4. All individuals between 17 and 18 years of age, if the research procedures are limited to donation of blood or any component thereof and to the withdrawal of blood in conjunction with any voluntary blood donation program.

When research is conducted outside of Connecticut, and review and approval by a local IRB or its equivalent is not required, the investigator must consult with legal counsel regarding the definition of child in the jurisdiction.

Classified Information: Information that has been determined pursuant to Executive Order 13526 or any predecessor order to require protection against unauthorized disclosure and is marked to indicate its classified status when in documentary form.

Classified Research: Research where the protocol or other information required by the IRB for review and oversight or required or provided by the research subjects includes classified information.

Clinical Investigation (21 CFR 312): Any experiment (i.e., any use of a drug except for the use of a marketed drug in the course of medical practice) in which a drug is administered or dispensed to, or used involving, one or more human subjects.

Clinical Investigation (FDA): Any experiment that involves a test article and **one or more** human subjects and that is either 1) subject to requirements for prior submission to the FDA under §505(i) or §520(g); or 2) not subject to the requirements for prior submission to the FDA under those sections but the results of which are intended to be submitted later to, or held for inspection by, the FDA as part of an application for a research or marketing permit. The term does not include experiments that are subject to the provisions of 21 CFR 58, Good Laboratory Practice Regulations, regarding non-clinical laboratory studies. The terms research, clinical research, clinical study, study, and clinical investigation are synonymous for purposes of FDA regulations. (21 CFR 50.3(c), 21 CFR 56.102 (c))

Clinical Trial: A research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of the interventions on biomedical or behavioral health-related outcomes.

Coercion: The act of bringing about a decision or action by force or threat.

Co-Investigator: Individual working on an approved research project under the direction of the Principal Investigator. Co-investigators are appointed to a study by the PI and must be approved by the IRB. Co-investigator is considered synonymous with sub-investigator.

Conflict of Interest: In conducting or reviewing human subject research, a conflict of interest is defined as a situation in which an individual (or someone in their immediate family) has a significant financial, professional or personal, interest in the approval or outcome of a study and the interest could affect decisions related to the design, conduct or reporting of the research; or the review of the research.

Decisionally Impaired: Having a severe psychiatric disorder (e.g., psychosis, neurosis, personality or behavior disorders), an organic impairment (e.g., dementia) or a developmental disorder (e.g., mental retardation) that affects cognitive or emotional functions to the extent that capacity for judgment and reasoning is significantly diminished. Others, including persons under the influence of or dependent on

drugs or alcohol, those suffering from degenerative diseases affecting the brain, terminally ill patients, and persons with severely disabling physical handicaps may also be compromised in the ability to make decisions in their best interest.

Delivery: Complete separation of the fetus from the woman by expulsion or extraction or any other means.

Department or Agency Head: The head of any Federal department or agency, for example the Secretary of Health and Human Services, and any other officer or employee of any Federal department or agency to whom the authority provided by 45 CFR 46 to the department or agency head has been delegated.

Detainee: Any person captured, detained, held, or otherwise under the control of DoD personnel (military, civilian, or contractor employee). It does not include persons being held primarily for law enforcement purposes, except where the United States is the occupying power. A detainee may also include the following categories: Retained Persons, Enemy Combatant; Lawful Enemy Combatant, Unlawful Enemy Combatant, Enemy Prisoner of War, Retained Person, Civilian Internee (refer to DoD Directive 2310.0E for detailed definition of each category of detainee.)

Department of Defense (DoD) Personnel: DoD civilian employees and members of the military services.

Device: Instruments, apparatus and contrivances, including their components, parts and accessories, intended (a) for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans or other animals, or (b) to affect the structure or any function of the body of humans or other animals (excluding contact lenses)

Device, Custom: A device 1) necessarily deviates from devices generally available or from an applicable performance standard or premarket approval requirement in order to comply with the order of an individual physician or dentist; 2) is not generally available to, or generally used by, other physicians or dentists; 3) is not generally available in finished form for purchase or for dispensing upon prescription; 4) is not offered for commercial distribution through labeling or advertising; and 5) is intended for use by an individual patient named in the order of a physician or dentist, and is to be made in a specific form for that patient, or is intended to meet the special needs of the physician or dentist in the course of professional practice.

Device, Investigational: A device, including a transitional device, which is the object of an investigation.

Device, Investigational Exemption (IDE): An IDE allows the investigational device to be used in a [clinical study](#) in order to collect safety and effectiveness data required to support a Premarket Approval (PMA) application or a Premarket Notification [510(k)] submission. All clinical evaluations of investigational devices, unless exempt, must have an approved IDE before the study is initiated. Clinical evaluation of devices that have not been cleared for marketing requires:

- An IDE approved by an institutional review board (IRB). If the study involves a significant risk device, the IDE must also be approved by FDA

- Informed consent from all patients
- Labeling for investigational use only
- Monitoring of the study and
- Required records and reports

An approved IDE permits a device to be shipped lawfully for the purpose of conducting investigations of the device without complying with other requirements of the Food, Drug, and Cosmetic Act that would apply to devices in commercial distribution. Sponsors need not submit a PMA or Premarket Notification, register their establishment, or list the device while the device is under investigation. Sponsors of IDE's are also exempt from the Quality System (QS) Regulation except for the requirements for design control.

A sponsor of a significant risk device study must submit a complete IDE application to FDA. There are no preprinted forms for an IDE application; however, an IDE application must include certain required information. The sponsor must demonstrate in the application that there is reason to believe that the risks to human subjects from the proposed investigation are outweighed by the anticipated benefits to subjects and the importance of the knowledge to be gained, that the investigation is scientifically sound, and that there is reason to believe that the device as proposed for use will be effective.

Device, Significant Risk (SR): A device that presents a potential for serious risk to the health, safety, or welfare of a subject and 1) is intended as an implant, or 2) is used in supporting or sustaining human life, or 3) is of substantial importance in diagnosing, curing, mitigating or treating a disease, or otherwise prevents impairment of human health, or 4) otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

Device, Transitional: A device subject to section 520(l) of the FD&C Act and which FDA previously regulated as a new drug or an antibiotic drug before May 28, 1976

Device, Non-Significant Risk (NSR): A NSR device is one that does not meet the definition of a SR device.

Device, Unanticipated Adverse Device Effect: Any serious adverse effect on health or safety or any life-threatening problem or death caused by , or associated with , a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that related to the rights, safety or welfare of subjects. (21 CFR 812)

Disclosure: The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information. (45 CFR 164)

Dispense: Those acts of processing a drug or device for delivery or for administration for a patient pursuant to a prescription consisting of : (a) comparing the direction on the label with the direction on the prescription to determine accuracy; (b) the selection of the drug or device from stock to fill the prescription; (c) the counting, measuring, compounding or preparation of the drug or device; (d) the placing of the drug or device in the proper container; (e) the affixing of the label to the container and; (f) the addition to a written prescription of any required notations. Dispensing does not include the acts of

delivering a drug or device to a patient or of administering the drug or device to the patient. (CT Chapter 400j)

Emancipated Child (Emancipated Minor): A legal status conferred upon persons who have not yet attained the age of legal competency as defined by state law, but who are entitled to treatment as if they had by virtue of assuming adult responsibilities, such as self-support, marriage, or procreation. In CT, must be adjudicated by the court.

Emergency Use: The use of a test article on a human subject in a life-threatening situation in which no standard acceptable treatment is available, and in which there is not sufficient time to obtain prior IRB approval.

Exempt: A project that does constitute human subject research but that also falls within one or more of the federally recognized categories that allow for the project to be excused from satisfying regulatory requirements for approval regarding human subject protections. The IRB reserves the right to impose additional requirements on exempt research.

Experimental Subject: The Department of Defense defines “Research Involving a Human Being as an Experimental Subject” as an activity, for research purposes, where there is an intervention or interaction with a human being for the primary purpose of obtaining data regarding the effect of the intervention or interaction (32CFR.210.102 (f) reference (c)). Examples of interventions or interactions include, but are not limited to, a physical procedure, a drug, a manipulation of the subject or subject’s environment, the withholding of an intervention that would have been undertaken if not for the research purpose.

External Agencies: Government entities that provide funding and/or have oversight interest in approved research studies, including the Office for Human Research Protections, Food and Drug Administration and other agencies as applicable to specific studies.

Family Member: Any one of the following legally competent persons: spouse; parent; child (including adopted child); brother, sister, and spouse of brothers and sisters; and any individual related by blood or affinity whose close association with the subject is the equivalent of a family relationship.

Family Member, Immediate: As related to conflict of interest, the investigator’s or IRB member’s spouse, or dependent children.

Federal Department or Agency: Refers to a federal department or agency (the department or agency itself rather than its bureaus, offices or divisions) that takes appropriate administrative action to make 45 CFR 46 Part A applicable to the research involving human subjects it conducts, supports, or otherwise regulates (e.g., the U.S. Department of Health and Human Services, the U.S. Department of Defense, or the Central Intelligence Agency).

Federalwide Assurance: An agreement between an institution and the Department of Health and Human Services (HHS) through which an institution commits to HHS that it will comply with the requirements in the HHS Protection of Human Subjects regulations at 45 CFR part 46.

Fetus: The product of conception from implantation until delivery.

Fetus, dead: A fetus that exhibits neither heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, nor pulsation of the umbilical cord.

Financial Interest Related to the Research: A financial interest in the sponsor, product or service being tested.

Generalizable Knowledge: Information resulting from a systematic investigation that has at least one of the following characteristics:

- it is intended to be disseminated to a broader external audience by means such as professional publication and/or formal presentation
- it may be applicable to circumstances other than those under which the systematic investigation was conducted.

Guardian: Per the common rule a guardian is an individual who is authorized under applicable State or local law to consent on behalf of a child to general medical care. Per FDA regulations a guardian is an individual who is authorized under applicable State or local law to consent on behalf of a child to general medical care when general medical care includes participation in research; or an individual who is authorized to consent on behalf of a child to participation in research.

When research is conducted in Connecticut, the persons who meet the definition of guardian are court-appointed guardians with the authority to consent to major medical, psychiatric or surgical treatment. When research is conducted outside of Connecticut, and review and approval by a local IRB or its equivalent is not required, the investigator must consult with legal counsel as to who can serve as the guardian and submit documentation of legal counsel's opinion.

Health Care Representative: Per Connecticut General Statutes § 19a-570(5) the individual appointed by a declarant pursuant to an appointment of health care representative for the purpose of making health care decisions on behalf of the declarant.

Human Fetal Tissue: Tissue or cells obtained from a dead human embryo or fetus after a spontaneous or induced abortion, or after a stillbirth.

Human Subject (pre-2018 Common Rule): A living individual about whom an investigator (whether professional or student) conducting research obtains (1) data through intervention or interaction with the individual or (2) identifiable private information.

Human Subject (2018 Revised Common Rule): A living individual about whom an investigator (whether professional or student) conducting research (i) obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or (ii) obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens.

Human Subject (per FDA): An individual who is or becomes a participant in research, either as a recipient of the test article or as a control. A subject may be either a healthy human or a patient. For research involving medical devices a human subject is also an individual on whose specimen an

investigational device is used. When medical device research involves in vitro diagnostics and unidentified tissue specimens, the FDA defines the unidentified tissue specimens as human subjects.

Human Subject Research: Any activity that encompasses the definition of human subject and research as set forth by OHRP or human subject and clinical investigation as set forth by the FDA.

Humanitarian Device Exemption: To obtain approval for a humanitarian use device (HUD), a humanitarian device exemption (HDE) application is submitted to FDA. An HDE is similar in both form and content to a premarket approval (PMA) application but is exempt from the effectiveness requirements of a PMA. An HDE application is not required to contain the results of scientifically valid clinical investigations demonstrating that the device is effective for its intended purpose. The application, however, must contain sufficient information for FDA to determine that the device does not pose an unreasonable or significant risk of illness or injury, and that the probable benefit to health outweighs the risk of injury or illness from its use, taking into account the probable risks and benefits of currently available devices or alternative forms of treatment. Additionally, the applicant must demonstrate that no comparable devices are available to treat or diagnose the disease or condition, and that they could not otherwise bring the device to market. An approved HDE authorizes marketing of the HUD.

Humanitarian Use Device: A marketed medical device that is intended to benefit patients in the treatment and diagnosis of diseases or conditions that affect or are manifested in fewer than 8,000 individuals in the United States per year. The designation of a device as an HUD is made by the FDA under a category of approval known as Humanitarian Device Exemption (HDE). An investigator or a sponsor may submit a request for HUD designation to the FDA. To receive the determination as an HUD, the device must be expected to benefit fewer than 8,000 people in the US per year and no comparable device, other than another HUD approved under the HDE regulation or a device being studied under an approved Investigational Device Exemption is available to treat or diagnose the condition.

Identifiable Biospecimen: A biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen.

Identifiable Private Information: private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information.

Illiterate: Having little or no education; *especially* unable to read or write

Immediate Family: Spouse, domestic partner, child/stepchild, who stands to gain financially by the employee's decisions. Interest related to the research means an interest in the sponsor of the research or a product or service being tested. For example, if an investigator conducts a non-sponsored study on drug X and the investigator owns stock in the manufacturer of drug X, that interest is considered an interest related to the research.

Immediately Life-threatening Disease or Condition (21 CFR 312.300): A stage of a disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment.

Implant: A device that is placed into a surgically or naturally formed cavity of the human body if it is intended to remain there for a period of 30 days or more. FDA may, in order to protect public health, determine that devices placed in subjects for shorter periods are also “implants” for purposes of 21 CFR 812.

IND (21 CFR 312): Investigational new drug application; often synonymous with “Notice of Claimed Investigational Exemption for a New Drug.”

Individually Identifiable Health Information: Information that is a subset of health information, including demographic information collected from an individual, and is created or received by a health care provider, health plan, employer or health care clearinghouse and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present, or future payment of the provision of health care to an individual, and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. (45 CFR 164)

Informed Consent Process: A process that occurs between a potential subject (or their legally authorized representative) and a knowledgeable and authorized member of the research team that provides the prospective research subject (or the subject’s legally authorized representative) with information pertaining to the research study and sufficient opportunity to consider whether or not to participate.

Informed Consent Form: The IRB approved form used to document the essence of the discussion between the individual obtaining consent and the potential subject or the subject’s legally authorized representative.

Institution: Any public or private entity, or department or agency (including federal, state, and other agencies).

Institutional Officials: Include the individuals identified in Policy 2002-42, Review and Approval of Research Involving Human Subjects.

Institutional Review Board (IRB): A board established, operating and functioning in accordance with regulatory criteria (e.g., at 45 CFR 46 and 21 CFR 56) and formally designated by an institution to review research involving human subjects.

IRB Approval: The determination of the IRB that the research has been reviewed and may be conducted at an institution within the constraints set forth by the IRB and by other institutional and federal requirements.

IRB Reliance Agreement: See Authorization Agreement

Interaction: Includes communication or interpersonal contact between an investigator and a research participant.

Intervention: Both physical procedures by which data (e.g., information or biospecimens) are gathered (e.g., venipunctures) and manipulations of the subject or the subject's environment that are performed for research purposes.

Investigation (21 CFR 812): A clinical investigation or research involving one or more subjects to determine the safety or effectiveness of a device.

Investigational Device: An investigational device is a medical device which is the subject of a clinical study designed to evaluate the effectiveness and/or safety of the device.

Investigational New Drug (21 CFR 312): A new drug or biological drug that is used in a clinical investigation. The term also includes a biological product that is used in vitro for diagnostic purposes. Synonymous with investigational drug.

Investigator (21 CFR 312.305(c)(1)): As related to an expanded access use a licensed physician under whose immediate direction an investigational drug is administered or dispensed for an expanded access use.

Investigator (21 CFR 812): An individual who actually conducts a clinical investigation, i.e., under whose immediate direction the test article is administered or dispensed to, or used involving, a subject, or, in the event of an investigation conducted by a team of individual, is the responsible leader of that team.

Legally Authorized Representative: Under DHHS and FDA regulations an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research.

When research is conducted in Connecticut, the persons who meet the definition of a legally authorized representative are a child's parent(s), court-appointed conservators or guardians, individuals designated as having power of attorney for health care, or individuals designated as health care representatives. Absent one of the prior designations, when research is conducted in Connecticut, the persons who meet the definition of a legally authorized representative are those defined in institutional policy 2012-05 titled Legal Representative for Health Care Decisions.

When research is conducted outside of Connecticut, and review and approval by a local IRB or its equivalent is not required, the investigator must consult with legal counsel as to who can serve as the legally authorized representative and submit documentation of legal counsel's opinion.

Life Threatening: As related to emergency use policies, encompasses both life-threatening and severely debilitating conditions. Life threatening means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria for life-threatening do not require the condition to be immediately life-threatening or to immediately result in death. Rather, the subjects must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.

Member, Affiliated: An employee or agent of U. of CT Health Center (or a member of that person's immediate family) is considered affiliated. Affiliated members also include: individuals who are part-time employees; current students; members of any governing panel or board of the institution; paid or unpaid consultants; healthcare providers holding credentials to practice at the institution; and volunteers working at the institution on business unrelated to the IRB.

Member, Experienced: An IRB member who has completed the required training and attended at least 6 IRB meetings.

Member, Non-affiliated: An individual that has no affiliation with the organization registering the IRB (i.e., UCHC), other than as an IRB member, is considered unaffiliated. Unaffiliated members may include people whose only association with the institution is that of a patient, subject, or former student at that institution.

Member, Non-Scientific: A member whose training, background, and occupation **would incline** them to view research activities from a standpoint **outside of** any biomedical or behavioral scientific discipline should be considered a nonscientist.

Member, Scientific – A member whose training, background, and occupation **would incline** them to view scientific activities from the standpoint of someone within a behavioral or biomedical research discipline.

Modification, Minor: A minor modification to previously approved research is a change that may be reviewed and approved using the expedited process. Modifications are considered minor changes when they are of an administrative nature, do not substantially change the design of the study, do not pose information pertaining to greater than minimal risks to subjects, and/ or fall into a category or categories of research that could be reviewed using the expedited procedure.

Modification, Full Board: Changes to an approved study that will increase the level of risk to which a subject is exposed or are substantial changes to the procedures or design of a protocol and/or informed consent form as it was previously approved.

Multi-site Study: Study in which multiple sites use the same protocol to conduct non-exempt human subjects research. (NIH NOT-OD-16-094)

Neonate: A newborn.

Neonate, nonviable: A neonate after delivery that, although living, is not viable.

Neonate, viable: Being able, after delivery, to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration.

Noncompliance: Any action that is taken or occurs that is not in accordance with an IRB approved study, IRB policies or regulations or represents failure to follow the requirements and/or determinations of the IRB. Noncompliance may be minor (e.g., a participant is one day late for visit due to family emergency and there is no impact on the safety of the participant due to the late visit, or a study

coordinator schedules a follow-up visit 2 days outside of the study window and there is no impact on the safety of the subject) or it may be considered serious or continuing. Noncompliance is sometimes referred to as a protocol deviation.

Noncompliance, Continuing: Noncompliance that reflects a pattern of noncompliance that if allowed to continue is likely to increase the risks to subjects, adversely affect the rights and/or welfare of subjects, or affect the scientific integrity of the study. It may involve the same mistake being made repeatedly within one study or across studies (e.g., a co-investigator on two of the PI's approved studies fails to document subject consent) or the same mistake being made after a corrective plan has been issued to the investigator for previous findings of noncompliance. The convened IRB will make the final determination as to whether the noncompliance is continuing. For DoD supported research continuing noncompliance is inclusive of the following: a) a pattern of noncompliance that suggests the likelihood that, without intervention, instances of noncompliance will recur; b) a repeated unwillingness to comply with DoD Instruction 3216.02 or a persistent lack of knowledge of how to comply with this Instruction.

Noncompliance, Serious: Noncompliance that creates increased risks to subjects, adversely affects the rights and/or welfare of the subjects or affects the scientific integrity of a study. Willful violations of IRB policies and /or Federal regulations including those pertaining to obtaining informed consent, reporting of unanticipated problems, and disclosure to subjects of risks associated with a study are also considered serious noncompliance. The convened IRB will make the final determination as to whether the noncompliance is serious. For DoD supported research serious noncompliance is inclusive of the following: a) failure of a person, group, or institution to act in accordance with DOD Instruction 3216.02 and its references such that the failure could adversely affect the rights, safety, or welfare of a human subject; place a human subject at increased risk of harm; cause harm to a human subject; affect a human subject's willingness to participate in research; or damage or compromise the scientific integrity of research.

Noninvasive: When applied to a diagnostic device or procedure, means one that does not by design or intention: 1) penetrate or pierce the skin or mucous membranes of the body, the ocular cavity, or the urethra or 2) enter the ear beyond the external auditory canal, the nose beyond the nares, the mouth beyond the pharynx, the anal canal beyond the rectum, or the vagina beyond the cervical os. For purposes of 21 CFR 812, blood sampling that involves simple venipuncture is considered noninvasive, and the use of surplus samples of body fluids or tissues that are left over from samples taken for non-investigational purposes is also considered noninvasive.

Parent: A child's biological or adoptive parent.

Participating Site: In a multi-center study a domestic entity that will rely on the single IRB (sIRB) to carry out the sites IRB review of human subjects research for the multi-site study. (NIH NOT-OD-16-094)

Permission: The agreement of parent(s) or guardian to the participation of their child or ward in research/clinical investigation.

Pharmacy and Therapeutics Committee: The committee charged with overseeing and managing medication formulary, medication errors, adverse drug events and medication protocols.

Pregnancy: The period of time from implantation until delivery.

Pregnant Woman: A woman shall be assumed pregnant if she exhibits any of the pertinent presumptive signs of pregnancy, such as missed menses, until the results of a pregnancy test are negative or until delivery.

Principal Investigator: An individual who the IRB determines is qualified to conduct a research project and who assumes primary responsibility for the ethical, scientific and administrative aspects of the proposed project and project staff.

Prisoner: Any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures which provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing.

Prisoner of War: A prisoner of war (POW, PoW, PW, P/W, WP, PsW, enemy prisoner of war (EPW) or "Missing-Captured") is a person, whether [combatant](#) or [non-combatant](#), who is held in custody by an enemy power during or immediately after an [armed conflict](#). This includes any person captured, detained, held, or otherwise under the control of Department of Defense (DoD) personnel (military and civilian, or contractor employee) except DoD personnel held for law enforcement purposes.

Privacy Certificate: Regulations at 28 CFR 22 require all applicants for National Institute of Justice (NIJ) support to submit a Privacy Certificate as a condition of approval of a grant application or contract proposal that contains a research or statistical component under which personally identifiable information will be collected. However, NIJ by policy requires the Certificate for all proposals regardless of whether the project involves the collection of identified data. In cases where no personally identifiable information will be collected, the Privacy Certificate should contain a statement to this effect. The Privacy Certificate is the applicant's assurance that they understand their responsibilities to protect the confidentiality of research and statistical information and has developed specific procedures to ensure that this information is only used or revealed in accordance with 42 USC 3789 and 28 CFR 22 which provide that research and statistical information identifiable to a private person is immune from legal process and may only be used or revealed for research purposes.

Private Information: Includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e., the identity of the subject or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.

Protected Health Information: Individually identifiable health information.

Protocol – Protocol is inclusive of all documents, processes and procedures associated with the study that have been presented to the IRB for approval (e.g., the IRB application, consent form, recruitment material, protocol, amendments etc.).

Public Health Authority: An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, an Indian tribe, or a foreign government, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractor or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

Quorum: A majority of IRB committee members present at a meeting (in person or via teleconference), including a non-scientific IRB member.

Registry: A registry is used in research for the collection and maintenance of information on individuals who have a similar condition and who will consent to being contacted regarding participation in future studies.

Repository: A repository is used in research for the collection and storage of identifiable specimens. By participating in the repository, the subject's consent to be contacted for possible participation in future studies that make use of identifiable samples.

Research: A systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. The following activities are deemed not to be research under the 2018 revised Common Rule:

- (1) Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.
- (2) Public health surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. Such activities are limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance (including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products.) Such activities include those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters).
- (3) Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes.
- (4) Authorized operational activities (as determined by each federal agency) in support of intelligence, homeland security, defense, or other national security missions.

Research, Engaged In: An institution becomes "engaged" in human subjects research when its employees or agents (i) intervene or interact with living individuals for research purposes or (ii) obtain individually identifiable private information for research purposes [\[45 CFR 46.102\(d\),\(f\)\]](#). An institution is automatically considered to be "engaged" in human subjects research whenever it receives

a direct DHHS award to support such research. In such cases, the awardee institution bears ultimate responsibility for protecting human subjects under the award. The institution may also be considered 'engaged in research' if it (or its employees, staff, or agents) has a key role in designing the research, conducting the research, analyzing and interpreting the results, or gaining informed consent from human subjects.(SACHRP 7/20/2022).

Research Involving a Human Being as an Experimental Subject: See Experimental Subject

Risk, Minimal: The probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

For DoD supported research, the definition of minimal risk in 32 CFR 219 does not include the inherent occupational risks that certain subjects face in their everyday life, such as those encountered by service members, law enforcement or first responders while on duty; or resulting from or associated with high-risk behaviors or pursuits.

The phrase "ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests" shall not be interpreted to include the inherent risks certain categories of human subjects face in their everyday life. For example, the risks imposed in research involving human subjects focused on a special populations should not be evaluated against the inherent risks encountered in their work environment (e.g., emergency responder, pilot, soldier in a combat zone) or having a medical condition (e.g., frequent medical tests or constant pain).

Risk, Minimal for Prisoners: The probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental or psychological examination of healthy persons.

Secretary: The Secretary of Health and Human Services and any other officer or employee of the Department of Health and Human Services to whom authority has been delegated.

Serious Disease or Condition (21 CFR 312.300): A disease or condition associated with morbidity that has substantial impact on day-to-day functioning. Short lived and self-limiting morbidity will usually not be sufficient, but the morbidity need not be irreversible, provided it is persistent or recurrent. Whether a disease or condition is serious is a matter of clinical judgment, based on its impact on such factors as survival, day -to-day functioning, or the likelihood that the disease, if left untreated, will progress from a less severe condition to a more serious one.

Service Members: Individuals appointed, enlisted, or inducted for military service under the authority of the Department of Defense. The Military Services are the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, and the Reserve Components, which includes the Army and the Air National Guards of the U.S. Members of the Reserve Components are included when in a duty status.

Severely Debilitating: Means diseases or conditions that cause major irreversible morbidity. Examples of severely debilitating conditions include blindness, loss of arm, leg hand or foot, loss of hearing, paralysis or stroke.

Significant Financial Interest: As defined in Institutional Policy 2006-01

Single IRB (sIRB): The selected IRB of record that conducts the ethical review for participating sites of the multi-site study. (NIH NOT-OD-16-094)

Sponsor: A person or other entity that takes responsibility for and initiates a clinical investigation, or that funds extramural research. The sponsor does not actually conduct the investigation unless the sponsor is a sponsor-investigator.

Sponsor (21 CFR 312.305(c)(2)): As related to expanded access, an individual or entity that submits an expanded access IND or protocol.

Sponsor-Investigator: An individual who both initiates and actually conducts, alone or with others, a clinical investigation, i.e., under whose immediate direction the test article is administered or dispensed to, or used involving, a subject.

Sponsor-Investigator (21 CFR 312.305(c)(3)): As related to expanded access, a licensed physician under whose immediate direction an investigational drug is administered or dispensed, and who submits an IND for expanded access use.

Sub-investigator: See Co-investigator

Suspension: A temporary hold on any or all research activity associated with a study, or a permanent stop to some portion of a previously approved research activity placed by the IRB or other institutional official. For example, a hold placed on additional recruitment pending clarification of an adverse event would be considered a suspension of approval. Suspended protocols remain open and require continuing review.

Systematic Investigation: A formal scientific inquiry characterized by all of the following:

- the formulation of a hypothesis or experimental question
- the requirement of adherence to a predefined plan for the data collection and analysis
- the performance of data analysis to evaluate the hypothesis or experimental question
- the results of the inquiry are intended to be replicable.

Terminal Condition: The final stage of an incurable or irreversible medical condition which, without the administration of a life support system, will result in death within a relatively short time, in the opinion of the attending physician (CT General Statute §19a-570(3)).

Terminally Ill: A person who is deteriorating from a life-threatening disease or condition for which no effective standard treatment exists.

Termination: A permanent withdrawal of study approval by the IRB or institutional official that requires all study related activity to cease. It does not include a sponsor's decision to stop a study.

Test Article: Any drug for human use, biological product for human use, medical device for human use, human food additive, color additive, electronic product or any other article subject to regulation under the FDA or Public Health Service Act.

Therapeutic Intent: The research physician's intent to provide some benefit to improving a subject's condition (e.g., prolongation of life, shrinkage of tumor, or improved quality of life, even though cure or dramatic improvement cannot necessarily be affected.)

Treatment: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to the patient; or the referral of a patient for health care from one health care provider to another. (45 CFR 164)

Treatment Relationship, Direct: A treatment relationship between an individual and a health care provider that is not an indirect treatment relationship. (45 CFR 164)

Treatment Relationship, Indirect: A relationship between an individual and a health care provider in which: (1) the health care provider delivers health care to the individual based on the orders of another health care provider; and (2) the health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual. (45 CFR 164)

Unanticipated Problem Involving Risk to Subjects or Others (UP): Any unforeseen occurrence that involves risk to the subject or others (e.g., family member of subject, member of the research team, community at large etc.) that is related to or is possibly related to either a research intervention or interaction, or the conduct of the study in general. This definition is inclusive of unexpected, serious adverse events that are, or that may be, related to the research intervention. This definition is inclusive of expected, adverse events for which the overall profile of frequency and/or severity has been greater than expected. The convened IRB will make the final determination as to whether an instance represents a UP.

Examples of unanticipated problems involving risk include, but are not limited to, an accidental or unintentional change to the IRB-approved protocol (e.g., administering the wrong dose of a drug, the delay or contamination of a drug shipment that will impact the timing of a treatment trial etc.), a complaint from a subject that indicates an unanticipated risk (e.g., loss of employment due to inadvertent disclosure of confidential data such as drug use etc.), unexpected changes to the risk/benefit profile of the study (e.g., based on literature, safety reports, interim results or other findings), unforeseen events involving the research team (e.g., the loss of a laptop computer with identifiable subject information, sudden unavailability of the PI and/or co-investigator etc.); unexpected internal serious adverse events that in the opinion of the PI may be related to the study intervention; unexpected external serious adverse events that the sponsor has deemed to be an unanticipated problem, or any change to the protocol taken without prior IRB review to eliminate apparent immediate hazard to a research subject when the immediate hazard is, in the opinion of the PI, related to the study.

Undue Influence: Occurs when a person in a fiduciary capacity or in a position of authority misuses their trust or power in order to unfairly induce a party to enter into an agreement (e.g., sign an informed consent form) or to unfairly influence the decision-making process (e.g., senior faculty member pressuring junior member to sway IRB vote for approval of a study).

Use: With respect to individually identifiable health information the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

Ward: A person (usually a minor) who has a guardian appointed by the court to care for and take responsibility for that person. A governmental agency may take temporary custody of a minor for their protection and care if the child is suffering from parental neglect or abuse or has been in trouble with the law. Such a child is a "ward of the court" (if the custody is court-ordered) or a "ward of the state."

Written or in writing (per 2018 Common Rule): Refers to writing on a tangible medium (e.g., paper) or in an electronic format.

Procedure

This document is to be referenced for all official definitions of terms used within policies issued by the Human Subjects Protection Program.

Related Policies

Policies issued by the Human Subjects Protection Program

Basis

45 CFR 46 – Protection of Human Subjects
21 CFR 50 – Protection of Human Subjects
21 CFR 56 – Institutional Review Boards
45 CFR 164 – Privacy of Individually Identifiable Health Information
DOD Directive 3216.02
CT Statutes
Accreditation Standards
SACHRP Recommendation to HHS July 20, 2022

Document Attributes

Date Effective: 9/30/2025

Replaced Version: 11/20/2023

Reviewed and Approved By:

Shemetra Owens

**Shemetra Owens CIP, CIM
Associate Director, Human Subjects Protection Program**

9/26/2025

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-008.0
Policy Title: Informed Consent Forms

Purpose

The purpose of this policy is to describe the elements of an informed consent form and when those elements apply.

Definitions

See policy 2011-007.0 for definitions of the following term:

Informed Consent Form

Policy

For purposes of this policy the term subject is inclusive of the subject or the subject's legally authorized representative. UConn Health has not adopted the broad consent provision in the 2018 Common Rule therefore this policy is exclusive of the elements for broad consent.

While the applicable regulatory criteria for consent will be used as the general premise for all consent forms, when the research is not federally funded or supported, nor subject to FDA oversight, the IRB may exercise judgement as to whether the elements noted below are required. In all cases the consent form must provide sufficient detail for the potential subject to make an informed decision.

The Institutional Review Board (IRB) may require additional elements of consent and may require an informed consent form and/or information sheet for exempt research. The Principal Investigator (PI) or designee is required to use the most recently approved and stamped version of the consent form when obtaining consent.

Consent forms for studies that involve clinical procedures should be placed in the medical/dental record and this should be disclosed within the consent document.

Unless otherwise waived or altered by the IRB, the following table presents the requirements of consent for federally funded or supported (FFS) research, and the requirements for FDA regulated research. Elements noted with a ⁺ are elements in the revised version of 45 CFR 46. These elements are required for FFS research initially approved after the effective date of the revised Common Rule regulation (1/21/2019) or for FFS research approved prior to the effective date of the revised Common Rule which transitioned to review under the revised Common Rule. Unless consent has been completely waived, the elements noted with an * cannot be omitted or altered for FFS research approved in accordance with the 2018 Common Rule regulation.

FDA	FFS	ELEMENT
X	X	Before involving a human subject in research an investigator shall obtain the legally effective informed consent of the subject. *
X	X	Informed consent will be sought only under circumstances that provide the prospective subject sufficient opportunity to discuss and consider participation and that minimize the possibility of coercion or undue influence.*

X	X	The information that is given to the subject shall be in a language understandable to the subject,* (preferably the subjects' native language).
X	X	Exculpatory language which releases or appears to release the institution, sponsor or investigator from liability or which makes or appears to make a subject waive any legal rights cannot be included in the ICF *
	X	The prospective subject must be provided with the information that a reasonable person would want to have in order to make an informed decision about whether to participate, and an opportunity to discuss that information ⁺ *
	X	Informed consent as a whole must present information in sufficient detail relating to the research, and must be organized and presented in a way that does not merely provide lists of isolated facts, but rather facilitates the prospective subject's understanding of the reasons why one might or might not want to participate. ⁺ *
	X	The ICF must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject in understanding the reasons why one might or might not want to participate in the research. This part of the informed consent must be organized and presented in a way that facilitates comprehension. ⁺ *
X	X	a statement that the study involves research
X	X	an explanation of the purpose of the research
X	X	the expected duration of the subject's participation
X	X	a description of the procedures to be followed
X	X	identification of any procedures which are experimental
X	X	a description of any reasonably foreseeable risks or discomforts to the subject
X	X	a description of any benefits to the subject or to others which may reasonably be expected from the research
X	X	a disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject
X	X	a statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained
X		for studies involving the use of drugs, devices or biologics (marketed or investigational), a statement that indicates that the FDA and sponsor may inspect records
X	X	for applicable clinical trials subject to FDA regulation and/or funded by NIH the following required statement: "A description of this clinical trial will be available on http://www.ClinicalTrials.gov , as required by U.S. Law. This web site will not include information that can identify you. At most, the web site will include a summary of the results. You can search this web site at any time."
X	X	for studies above minimal risk, an explanation as to whether any compensation is available if injury occurs, and, if so, what it consists of, or where further information may be obtained,
X	X	for studies above minimal risk, an explanation as to whether any medical treatment is available if injury occurs and, if so, what it consists of, or where further information may be obtained
X	X	an explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subjects

X	X	a statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.
	X	one of the following statements about any research that involves the collection of identifiable private information or identifiable biospecimens: ⁺ ○ a statement that identifiers might be removed from the identifiable private information or identifiable biospecimens and that, after such removal, the information or biospecimens could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject if this might be a possibility; or ○ a statement that the subjects information or biospecimens collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.
X	X	a signature line for the subject (note the IRB also requires that the subject date the form, the electronic signature of the subject may be acceptable).
And as applicable		
X	X	a statement that the particular treatment or procedure may involve risk to the subject (or to the embryo or fetus, if the subject is or may become pregnant) which are currently unforeseeable (required when the study involves the use of investigational, drugs, devices or biologics, or drugs for which post marketing safety/efficacy data are being collected or when there are insufficient data on how a marketed drug impacts embryos or fetuses and subjects are or may become pregnant)
X	X	anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent (required when the investigator may remove a subject from a trial due to medical /safety issues, subjects inability to continue to provide informed consent, subject's non-compliance with the direction of the investigator, or other situations when the investigator may determine it is in the best interest of the subject to withdraw him/her from the trial)
X	X	any additional costs to the subject that may result from participation in the research (required if the subject will incur any permanent or temporary out-of-pocket expense related to participation in the trial, e.g. for procedures, drugs, research related injury etc.)
X	X	the consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject (required if the subject's decision to withdraw will raise safety concerns, e.g. withdrawal from medications that should be tapered rather than abrupt)
X	X	a statement that significant new findings developed during the course of the research which may relate to the subject's willingness to continue participation will be provided to the subject (required for treatment trials or trials of moderate or more risk)
X	X	a statement indicating the approximate number of subjects involved in the study
	X	A statement that the subject's biospecimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit ⁺
	X	A statement regarding whether clinically relevant research results, including the individual research results, will be disclosed to subjects, and if so, under what conditions ⁺

	X	For research involving biospecimens, whether the research will (if known) or might include whole genome sequencing (i.e. sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen). ⁺
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As applicable to the research the following additional elements may also pertain:

- Local requirements as noted on the informed consent checklist, inclusive of the signature and date of the person obtaining consent.
- Requirements imposed by a funding agency (e.g. refer National Institute of Justice consent checklist addendum).

For genetic research,

- disclosure that a family member may become aware of the information related to the study and subject, and/or that the subjects may become aware of information about themselves or family members that they would preferred not to have known.
 - Consent from the subject for disclosure of relevant information to relatives when the release of that information may improve the prognosis of the relatives will be sought. However, the subject must be made aware of the possibility of such a disclosure without consent. Disclosure that breaks confidentiality may occur if there is a treatment that will help the prognosis of the family member(s). To break confidentiality the following conditions outlined by the President's Commission (1983) must be satisfied:
 - reasonable efforts to obtain voluntary consent for disclosure have failed;
 - there is a high probability that harm will occur from withholding the information and that the disclosure will avert that harm; and
 - the harm that would likely occur would be serious.
 - only the information needed for diagnosis and treatment is disclosed.
- a statement that the action of the subjects may place them risk (e.g. if they self-disclose to their employer)
- a detailed description of what information will be presented to subjects including:
 - what type of information will be provided to them or others,
 - who will provide the information,
 - how the information will be communicated,
 - at what point in the study it will be provided,
 - whether interim findings will be disclosed or not,
 - the reliability of the information being provided, and
 - what information will not be provided to them.
- if study information is intended to be shared with subjects, the consent form must include an option whereby subjects retain the choice of being told or not being told that information. An exception to the right not to know may occur when treatment could improve the prognosis. The PI must explain to the subject within the consent form whether the right not to know will be honored in such a circumstance.
- if the study is likely to yield unexpected or unrelated findings the consent must:
 - state that findings that do not affect the health of the subject or health of family members, for example issues of maternity or paternity, will not to be disclosed.
 - Either provide subjects with an option of receiving or declining to receive information on unexpected and/or unrelated findings that are health-related, or

- Inform the subject that such information will be disclosed.
- information regarding genetic counseling by qualified genetic counselors if a study may reveal important genetic information, e.g., being a carrier for an illness that has not yet manifested. At whose expense the counseling is provided must also be disclosed. The PI must also inform participants of existing support groups.

Posting of Clinical Trial Consent Forms:

For each federally funded or supported clinical trial one IRB-approved informed consent form used to enroll subjects must be posted by the awardee of the Federal department or agency component conducting the trial on a publicly available Federal website that acts as a repository for such informed consent forms. The informed consent form must be posted after the clinical trial is closed to recruitment, and no later than 60 days after the last study visit by any subject, as required by the protocol. Principal investigators are responsible for working with the funding agency to address this requirement.

Electronic Informed Consent (eIC) Documents

If e-consent is proposed within a study the applicable regulatory elements must be included and the investigator must provide the IRB with all material (e.g. the consent form, videos, web-based presentations, supplemental materials) that will be presented to the subject as part of the e-consent form. This is inclusive of supplemental material that may be accessed by hyperlinks so that the IRB can evaluate the content of that hyperlink to determine if it is accurate and appropriate, and of questions that may be used to gauge a subject's level of comprehension. When an e-consent form is proposed subjects must still be provided the option of reviewing and signing a paper-based consent form.

A written copy of the consent form is to be provided to the subject.

Procedure

The PI and the IRB staff will use the informed consent checklist(s) to ensure that the regulatory and local elements of consent are included in the informed consent. The PI may also use the IRB consent form template, which addresses the regulatory and local requirements, to develop the study specific consent.

The PI submits the completed informed consent checklist(s) and the consent form to the IRB for review. Screening and review procedures discussed in the policies for expedited review and full board review are used.

Upon approval of the ICF by the IRB, IRB staff will at a minimum record the date of IRB approval on the consent form and return it to the PI with other routine approval paperwork.

Related Policies

2011-007.0 – Definitions Applied to Policies
 2011-008.1 – Informed Consent – Process
 2011-008.2 – Informed Consent – Waivers and Alterations
 2011-008.5 – Informed Consent – Providing and Obtaining Informed Consent
 2011-009.3– Review by Expedited Procedures
 2011-009.5 – Review by Convened Board

2011-013.0 – Translation Policy

2014-028.0 – National Institute of Justice Additional Requirements

Basis

45 CFR 46

21 CFR 50

Document Attributes

Date Created:

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Reviewed and Approved By:

Richard H. Simon

3/16/2023

Richard Simon, MD

Director, Human Subjects Protection Program

Date:

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-008.1
Policy Title: Informed Consent Process

Purpose

The purpose of this policy is to describe the informed consent process and provide examples of acceptable methods for obtaining informed consent as well as examples of activities that may occur without informed consent of the subject or a waiver of the requirement to obtain consent.

Definitions

See policy 2011-007.0 for definitions of the following terms:

Coercion	Informed Consent Process	Informed Consent Form
Legally Authorized Representative	Undue Influence	

Policy

For purposes of this policy the term subject is inclusive of the subject or the subject's legally authorized representative when applicable and the term investigator is inclusive of the principal investigator, co-investigator, study coordinator, consentor or data manager.

The IRB may approve a research proposal in which an investigator will obtain information or biospecimens for the purpose of screening, recruitment or determining the eligibility of prospective subjects without the informed consent of the prospective subject (and without the need for waivers or alterations), if either of the following conditions is met:

- The investigator will obtain information related to screening, recruiting or determining eligibility through oral or written communication with the prospective subject.
- The investigator will obtain identifiable private information or identifiable biospecimens for the purpose of screening, recruiting or determining eligibility by accessing records or stored identifiable biospecimens.
 - In order to access records or specimens for such purposes, there must be an established relationship between the investigator and the individuals whose records /specimens will be reviewed.
 - The investigator may delegate the review to designated UConn Health research staff.
 - Appropriate measures must be in place to protect the confidentiality of the data being utilized.

When obtaining information or biospecimens for the purpose of screening, recruitment or determining the eligibility of prospective subjects without the informed consent of the prospective subject, the protocol and/or supporting research documents must address plans to protect the confidentiality of the information/specimen during this process.

Unless waived by the Institutional Review Board (IRB), the IRB-approved informed consent process must be conducted with a potential subject prior to any involvement of the subject in non-exempt research to ensure that the subject has an appreciation for the study (e.g., understanding of the purpose, risks, benefits) in which they may enroll. The process of consent should continue throughout the study,

for example by explaining each visit as it occurs and ensuring the subject is still willing to participate, or by providing new information to subjects as it is learned to ensure they are still willing to participate.

Consent can be sought only under circumstances that provide the prospective subject sufficient opportunity to consider whether or not to participate and to ask and obtain answers to questions, and that minimize the possibility of coercion or undue influence. The consent process must also be conducted in a setting that affords sufficient privacy to the potential subject and the information that is given to the subject shall be in language understandable to the subject. As necessary, the Principal Investigator (PI) must address other special provisions required by the subject, e.g., hearing impaired individuals may want a sign language interpreter present or individuals with dyslexia may prefer to have the document read to them.

Exculpatory language which releases or appears to release the institution, sponsor or investigator from liability or which makes or appears to make subjects waive any legal rights cannot under any circumstance be included in the informed consent process.

Individuals conducting the consent process must have in depth knowledge of the research protocol and the ability to answer questions that may be posed by the potential subject. The individual obtaining consent is required to have completed education in the protection of human subjects in research.

Unless documentation of consent has been waived by the IRB, the informed consent process is documented by use of an IRB approved informed consent form. Documentation of the initial informed consent process may be supplemented by notes in a research chart that indicate on-going discussions with the subject at subsequent study visits.

Consenting a subject, is a process that should occur in person whenever feasible. When it is not feasible, the IRB may approve other methods of consent such as e-consent, or consent by phone or videoconference. The IRB may require a consent process for exempt research. The IRB may impose additional protections as part of the consent process. For example, the IRB may require observation of the consent process, the use of the consent feedback form, the use of a consent process checklist, a witness to the consent process or videotaping the consent process.

With the exception of the short form consent process, obtaining consent from illiterate subjects, and obtaining consent by phone/fax, the consent process generally does not have to be witnessed but the IRB may require this. When an individual is signing the form as a witness they must indicate whether they are a witness to the signature only or a witness to the entire consent process. The IRB reserves the right determine who may serve as the witness.

Subjects in long-term follow-up must be informed of outcome data and safety related information. The PI will determine the mechanism of communication, giving consideration to the subject's underlying conditions, available support systems and the nature of the information being conveyed. They do not have to be re-consented regarding changes to the protocol if they are no longer in the active phase of the study.

Techniques that may be used in the consent process included but are not limited to, the following:

Observation: The consent process may be observed by the Research Compliance Monitor or other representative of the HSPP or IRB. The observation will be done to ensure compliance with regulations and policy, for quality improvement and/or for educational purposes. Verbal consent of the subject may be sought prior to the observation.

Waiting Period Requirement: The IRB may require a waiting period between the time that a study is explained to a potential subject and the time that consent is sought from the potential subject or representative. Situations when this option may be exercised include, but are not limited to, studies that involve vulnerable populations or studies that are of high-risk.

Staged Consent Process: The IRB may require a staged consent process whereby consent is obtained at various points in the study to ensure that the subject is still willing and / or still able to provide consent. Situations when this option may be exercised include, but are not limited to, studies that involve vulnerable populations, for example populations with diminishing capacity, or studies that are of high-risk.

Summary of Information: The IRB may require that an individual obtaining consent also ask the subject to provide a summary of the study after the initial discussion occurs as a means of evaluating their level of understanding of the study. The IRB may require that the individual obtaining consent ask the subject to explain in their own words the purpose of the study, the risks involved, the potential benefits, the alternatives available etc. and may require that the responses be documented. If the potential subject is unable to demonstrate an understanding of the study, either consent from a legally authorized representative must be obtained or the subject may not be enrolled into the study. The IRB may provide the questions to be used to solicit feedback or may require the PI to develop the questions and submit them to the IRB for review/approval.

Procedure

General:

Details of the informed consent methods and documentation must be described to and approved by the IRB. When submitting an application to the IRB, the PI must respond to questions within the IRB application regarding the process for obtaining and documenting initial and on-going consent from subjects, including the names of the individuals authorized to obtain consent and identification of who will be providing consent (i.e., subject or legally authorized representative). Once the consent materials are approved, the investigator must obtain prospective IRB approval for any subsequent modifications to the study-related information, whether electronic or in hard copy.

Unless waived by the IRB, the process of consent will be documented on an IRB approved consent form to be signed and dated by the subject (or legally authorized representative) and the person obtaining consent.

- For embryo donation both the egg and sperm donor must sign the consent form.
- The person obtaining consent must provide the subject (or the subject's legally authorized representative) with a copy of the signed and dated document, including any relevant addendums, appendices, attachments etc.
- An emancipated subject must provide proof of emancipated status. The person obtaining consent must attach this proof to the informed consent form.

- A legally authorized representative, other than a parent of a minor child or next of kin, must provide proof of such status. The person obtaining consent must attach this proof to the informed consent form. When the LAR is next of kin the affirmation of the LAR will be accepted and it is recommended that a note be made to file.

Standard screening and review procedures are used as described in the procedures for Expedited and Full Board reviews.

Consent by Phone / Fax

Procedure 1:

- the potential subject must be given a copy of the approved, IRB-stamped consent document (either by mail, fax or e-mail of scanned document) prior to the phone conversation and with enough time allowed to read the document prior to the conversation;
- the PI ensures the individual obtaining consent is approved by the IRB to consent and has sufficient knowledge of the study to conduct the conversation and to answer any questions;
- a witness must be present for the entire conversation;
- the subject must be informed that the witness is present and consent to the witness listening to the entire conversation (via speaker or extension phone);
- the consent conversation includes an in-depth review of the consent document allowing sufficient time for questions to be asked and answered;
- the subject must be instructed that if they agree to participate, they must return the signed and dated consent document (either by mail, fax or e-mail of scanned signed document); and
- the individual obtaining consent and the witness must sign, and date the IRB approved consent document upon completion of the phone conversation;
- the two forms are joined together upon receipt
- research can begin after the forms are joined; or

Procedure 2:

- the investigator requests a waiver of the requirement to document consent at the time of initial application or via a request for modification using the form to request such a waiver;
- an IRB approved script incorporating the elements of consent is presented over the phone to the subject;
- the IRB may require that the investigator provide subjects with a copy of the script (via mail, e-mail or fax) regarding the research.

Consent by Videoconference (e.g., WebEx, Zoom)

- the potential subject must be given a copy of the approved, IRB-stamped consent document (either by mail, fax or e-mail of scanned document) prior to the consent conversation and with enough time allowed to read the document prior to the conversation;
- the PI ensures the individual obtaining consent is approved by the IRB to consent and has sufficient knowledge of the study to conduct the conversation and answer any questions
- the consent conversation includes an in-depth review of the consent document allowing sufficient time for questions to be asked and answered
- when documenting consent on the paper consent form:
 - the subject must be instructed that if they agree to participate they must return the signed and dated consent document (either by mail, fax or e-mail of scanned signed document);

- the individual obtaining consent must sign, and date the IRB approved consent document during the videoconference;
- the two forms are joined together upon receipt
- research can begin after the signed forms are joined.
- when documenting consent electronically:
 - the subject must be instructed that if they agree to participate, they will electronically sign and date the consent document and return it by e-mail or through the electronic platform being used (e.g., RedCap, Qualtrics) to the study team for consentor signature.
 - the individual obtaining consent will apply their signature and date to the consent document signed by the subject;
 - when the consent document is fully-signed and a copy has been provided to the participant, the research can begin.
- a copy of the informed consent signed and dated by both the person providing consent and the consentor must be provided to the person signing the form.

Electronic Documentation of Consent

The IRB may approve an electronic method to capture the signature of the subject or the subject's LAR when written informed documentation of consent is required (i.e., documentation of consent has not been waived). When proposing to use electronic methods to document consent, the PI is responsible to ensure electronic signatures are legally valid within the jurisdiction where the research is to be conducted. For FDA-Regulated research, the PI is responsible to ensure documentation of consent is compliant with regulations at 21 CFR part 11 and 21 CFR part 50 and to provide the IRB with confirmation that the electronic systems used to obtain consent and electronic signature meet the relevant regulatory requirements in 21 CFR part 11.

The subject/LAR must be instructed that if they agree to participate they will electronically sign and date the consent document and return it by e-mail or through the electronic platform being used (e.g., RedCap, Qualtrics) to the study team for the individual conducting the consent meeting (consenter) to sign. The consentor will apply their signature and date to the consent document signed by the subject. After the consent document is fully-signed by the subject and consentor, a copy of the signed informed consent will be provided to the person signing the form and the research can begin.

Electronic Informed Consent (eIC) Process *(When Consent is not Witnessed by Study Personnel)*

The investigator should discuss plans for using eIC with the IRB before finalizing development of the eIC to ensure that the IRB agrees that such a format may be used for obtaining informed consent for the applicable research. When eIC is proposed subjects must still be provided the option of the consent process occurring in person and/or using a paper-based consent form. For FDA-Regulated research, the PI is responsible to ensure consent procedures and documentation are compliant with regulations at 21 CFR part 11 and 21 CFR part 50. The PI must provide the IRB confirmation that the electronic systems used to obtain consent and electronic signature meet the relevant regulatory requirements in 21 CFR part 11.

Date Effective: 6/9/2023

Replaced Version: 5/11/2020

Reviewed and Approved By:

Richard H. Simon

6/8/2023

Richard Simon, MD

Date

Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-008.2
Policy Title: Informed Consent – Waivers and Alterations

Purpose

The purpose of this policy is to set forth the requirements that must be met to allow the Institutional Review Board (IRB) to grant a waiver or alteration of the requirement(s) for obtaining informed consent or for granting a waiver of the requirement to document consent. This policy is not inclusive of the provisions set forth for emergency use of a test article or for planned emergency research for which separate policies exist. For purposes of this policy the term research and clinical investigation are considered synonymous.

Definitions

See policy 2011-007.0 for definition of:

Informed Consent Form
Legally Authorized Representative

Informed Consent Process

Policy

UConn Health does not utilize the provision of broad consent. Therefore, the regulatory requirements related to waivers or alterations of elements of broad consent are not applicable to this policy. When the research is not federally funded/supported nor subject to FDA regulations the IRB will utilize the criteria for waiver/alterations set forth in 45 CFR 46 as guiding criteria but may exercise judgement in determining whether to grant the waiver/alteration. The IRB may also impose criteria in addition to that defined in regulation in determining whether to grant a waiver/alteration. In this policy the term subject is inclusive of the subject or the subjects legally authorized representative.

Waiver of Consent: The IRB may approve a waiver of the requirement to obtain consent if it finds and documents that the criteria noted in Option 1 or Option 2 below have been met. Option 1 is not applicable to research subject to FDA regulations.

Alteration of Consent: Except as described in the section titled Limitation of Alterations, the IRB may approve a consent form that alters some or all of the elements of consent that are allowed to be altered, or that omits some of the elements of consent that may be omitted if it finds and documents that the criteria noted in Option 1 or Option 2 below have been met. Option 1 is not applicable to research subject to FDA regulations.

- Option1: Waiver or alteration of consent in research involving public benefit and service programs conducted or subject to the approval of state or local officials.
 - the research or demonstration project is conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or otherwise examine one or more of the following items:
 - public benefit of service programs; or
 - procedures for obtaining benefits or services under those programs; or
 - possible changes in or alternatives to those programs or procedures; or
 - possible changes in methods or levels of payment for benefits or services under those programs; and
 - the research could not practicably be carried out without the alteration or waiver;

- Option 2: General waiver or alteration of consent
 - the research involves no more than minimal risk to subjects;
 - the research could not practicably be carried out without the alteration or waiver;
 - if the research involves using identifiable private information (IPI) or identifiable biospecimens (IB), the research could not practicably be carried out without using such IPI or IB⁺ ;
 - the waiver or alteration will not adversely affect the rights and welfare of the subjects; and
 - whenever appropriate subjects or legally authorized representatives will be provided with additional pertinent information after participation, for example when the research required the use of deception.

Limitation of Alterations: For federally-funded or supported research, unless consent is completely waived, the following elements of consent may not be omitted or altered:

- Before involving a human subject in research an investigator shall obtain the legally effective informed consent of the subject.
- Informed consent will be sought only under circumstances that provide the prospective subject sufficient opportunity to discuss and consider participation and that minimize the possibility of coercion or undue influence.
- The information that is given to the subject shall be in a language understandable to the subject.
- Exculpatory language which releases or appears to release the institution, sponsor or investigator from liability, or which makes or appears to make a subject waive any legal rights cannot be included in the ICF.
- The prospective subject must be provided with the information that a reasonable person would want to have in order to make an informed decision about whether to participate, and an opportunity to discuss that information.
- Informed consent as a whole must present information in sufficient detail relating to the research, and must be organized and presented in a way that does not merely provide lists of isolated facts, but rather facilitates the prospective subject's understanding of the reasons why one might or might not want to participate.
- The informed consent must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject in understanding the reasons why one might or might not want to participate in the research. This part of the informed consent must be organized and presented in a way that facilitates comprehension.

The assigned reviewer will make the final determination as to whether or not to approve the request for an expedited study and the Board will make the determination for full board studies.

Waiver of Documentation of Consent: In the situations outlined below, the IRB may still require that the consent process occur but waive the requirement to obtain documentation of consent. In order to do so the IRB must find that the criteria noted in Option 1, Option 2 or Option 3 have been met. Option 2 is also applicable to research subject to FDA regulations.

- Option 1:
 - the only record linking the subject and the research would be the informed consent form and the principal risk would be potential harm resulting from a breach of confidentiality (each subject must be asked whether the subject wants documentation linking the subject with the research and the subject's wishes will govern), **or**
- Option 2:
 - the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context, **or**
- Option 3:
 - if the subjects are members of a distinct cultural group or community in which signing forms is not the norm, that the research presents no more than minimal risk of harm to subjects and provided there is an appropriate alternative mechanism for documenting that informed consent was obtained. The IRB will evaluate alternative mechanisms on a case-by-case basis based on information put forth by the PI.
 - Option 3 is currently applicable only to non-exempt research that is not subject to FDA oversight. If regulations are implemented that extend this provision to FDA regulated research, UConn Health will also extend this provision.

If the requirement of documentation is waived, the IRB may require that the investigator provide the subject with a written summary of the research and if so the IRB must review and approve that summary. The PI may request, and the IRB may approve, that a consent form also serve as the written summary.

To Waive Documentation of the Consent Process for Screening, Recruiting, and Determining Eligibility

- The investigator will obtain information through oral or written communication with the prospective subject or legally authorized representative, or
- The investigator will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable biospecimens.
- The research is not regulated by the US FDA.

To Waive Documentation of the Consent Process – Confidentiality

- The oral or written information provided to subjects includes all required and appropriate additional elements of consent disclosure.
- The research is not regulated by the US FDA.

To Waive Documentation of the Consent Process: Consent normally not required outside the research context

- The research presents no more than minimal risk of harm to participants.
- The research involves no procedures for which written documentation of the consent process is normally required outside of the research context.
- The oral or written information provided to subjects includes all required and appropriate additional elements of consent disclosure.

To Waive of Documentation of the Consent Process: Distinct Cultural Groups

- The subjects or legally authorized representatives are members of a distinct cultural group or community in which signing consent documents is not the norm.
- There is an appropriate alternative mechanism for documenting that informed consent was obtained.
- The oral or written information provided to subjects includes all required and appropriate additional elements of consent disclosure.
- The research is not regulated by the US FDA.

+ the element is applicable to federally funded or supported research for which the waiver/alteration is still necessary and for which the review has transitioned to meet the requirements of the 2018 revised Common Rule regulation. This may require investigators to submit a request for modification to update the previously approved waiver form.

Procedure

Research Conducted by or Subject to State or Local Government Officials: To request this method of waiver or alteration the investigator must complete and submit the form titled “Request for Waiver or Alteration of Consent for Projects Conducted by or Subject to the Approval of State or Local Government Officials.”

Request to Waive Consent: The investigator must complete and submit the form titled “Request for Full or Partial Waiver of Informed Consent.”

Request to Alter Consent: The investigator must complete and submit the form titled “Request to Alter Elements of Consent.”

Request to Waive Documentation: If not addressed within the IRB application, the investigator must complete and submit the form titled “Request for Waiver of the Requirement to Document the Consent of Subjects.”

Each form noted above addresses the regulatory criteria for approval. For each type of request the reviewer will determine if the criteria for approval are met, granting approval only when all criteria have been satisfied.

Standard screening and review procedures apply as noted in the policies for expedited and convened board review. For expedited research, the assigned reviewer will make the final determination as to whether or not to approve the request for an expedited study and document approval on the reviewer form.

For studies requiring review by the convened board the IRB Regulatory Specialist will document justifications in the minutes. Determinations made by the convened board will supersede the opinion documented by the individual reviewer on the reviewer form.

Related Policies

2011-007.0 – Definitions Applied to Policies

2011-008.0 – Informed Consent – Forms

2011-009.3 – Institutional Review Board – Expedited Reviews

2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

45 CFR 46

21 CFR 56

21 CFR 50

FDA- Institutional Review Board Waiver or Alteration of Informed Consent for Minimal Risk Clinical Investigations 12/21/2023

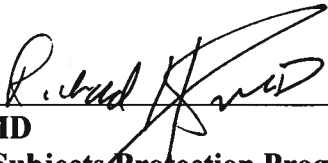
Document Attributes

Date Effective: 1/22/2024

Replaced Version: 11/20/23

Reviewed and Approved By:

Richard H. Simon



22 Jan 24

Richard Simon, MD

Date

Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-008.3
Policy Title: Informed Consent - Assent

Purpose

The purpose of this policy is to set forth information about obtaining assent from individuals who are either not of age to provide consent or who do not have the capacity to provide consent.

Definitions

See 2011-007.0 for definitions of the following:

Assent	Informed Consent	Legally Authorized Representative	Parent
Permission	Vulnerable Populations - Children		

Policy

Adequate provisions should be made for soliciting the independent, non-coerced assent from children or decisionally impaired persons who are capable of a knowledgeable agreement. In cases where assent is obtained from a child or decisionally impaired subject, permission must also be obtained from parents or legally authorized representatives.

If the person from whom assent is sought refuses, the person should not be enrolled, even if the parents or legally authorized representatives give permission. The Institutional Review Board (IRB) may make an exception to this in studies related to life-threatening illnesses when eligible subjects may benefit from research treatment protocols. Alternatively, if the person from whom assent is sought agrees to participate, the person may not be enrolled if the parents or legally authorized representatives do not give permission. In rare circumstances, depending on the nature of the study and the age and circumstances of the child or impaired adult, the IRB may waive the requirement for permission from parents or legally authorized representatives.

Policy 2011-006.3 addresses in detail issues of assent from children and permission from parents.

The provisions for obtaining the assent of an adult with impaired decision making ability are based on provisions set forth in regulations for obtaining assent of a child. The IRB shall determine that adequate provisions are made for soliciting the assent of the decisionally impaired individual, when in the judgment of the IRB the individuals are capable of providing assent. In determining whether the individuals are capable of assenting, the IRB shall take into account the maturity and psychological state of the individual involved. This judgment may be made for all individuals to be involved in research under a particular protocol, or for each individual, as the IRB deems appropriate. If the IRB determines that the capability of some or all of the individuals is so limited that they cannot reasonably be consulted or that the intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health or well-being of the individual and is available only in the context of the research, the assent of the individual is not a necessary condition for proceeding with the research. Even where the IRB determines that the subjects are capable of assenting the IRB may still waive the assent requirement under circumstance in which consent may be waived in accord with 45 CFR 46. For FDA regulated studies, assent may be waived in accordance with 50.55

Procedure

The Principal Investigator (PI) describes within the IRB application the plans for obtaining assent and permission and, as applicable, provides the informed consent form and the separate assent statement.

The standard screening and review procedures for expedited and convened board review apply.

The IRB reviewer evaluates and approves the plan for obtaining assent and permission and as applicable the related documents. The IRB may require changes to the proposed plan / document prior to granting approval.

Related Policies

2011-006.3 – Additional Protections – Children
2011-007.0 – Definitions Applied to Policies
2011-008.0 – Informed Consent – Forms
2011-008.1 – Informed Consent - Process
2011-008.2 – Informed Consent – Waivers and Alterations
2011-008.5 – Informed Consent – Obtaining and Providing Informed Consent
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by the Convened Board

Basis

21 CFR 50
45 CFR 46

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Reviewed and Approved By:

Signed Richard H. Simon

1

May 2017

Richard Simon, MD
Director Human Subjects Protection Office

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-008.4
Policy Title: Informed Consent – Short Form

Purpose

The purpose of this policy is to identify when the short form consent process may be used.

Definitions

See 2011-007.0 for definitions of the following:

Informed Consent Form | Informed Consent Process | Legally Authorized Representative

Policy

At times investigators may unexpectedly encounter a potential subject who does not speak/understand English. In such a situation, or other situations deemed appropriate by the Institutional Review Board (IRB), it may be acceptable to use the short form consent process. This process also applies to FDA regulated studies.

To allow the use of the short form of consent documentation, the IRB shall determine:

- The short form consent document states that the basic and appropriate additional elements of disclosure have been presented orally to the subject or the subject's legally authorized representative, including required disclosures when the research involves private identifiable information or identifiable biospecimens.
- A written summary embodies the basic and required additional elements of disclosure.

The IRB must receive the foreign language version(s) of the short form informed consent form. For studies initially reviewed by the full board, expedited review of the translated document is acceptable only if the English language version of the informed consent document has already been approved.

The IRB makes the final determination as to whether to require a complete written informed consent form or to accept an oral presentation of consent with the summary documents.

Per Federal regulation, a witness to the oral presentation will be required if a short form written consent has been approved for oral presentation to the subject.

Procedure

The person obtaining consent from the subject or the subject's legally authorized representative (LAR) conducts an oral presentation of the informed consent information in conjunction with providing

- an IRB approved short form consent document written in a language understandable to the subject/LAR stating that the elements of informed consent have been presented orally, and
- for federally supported research a statement that the key information required by 45 CFR 46.116(a)(5)(i) was presented first to the subject, before other information, if any, was provided.
- an IRB approved written summary of what is presented orally to the subject/LAR (an approved informed consent form may serve as the written summary).

A witness who is fluent in English and the language of the subject/LAR must be present throughout the oral presentation.

At the time of consent:

- the subject /LAR signs and dates the short form
- the witness shall sign and date both the short form and a copy of the summary,
- the person obtaining consent shall sign and date a copy of the summary.
- the person obtaining consent provides the subject/LAR with copies of the short form document and the summary.

Related Policies

2011-008.1 – Informed Consent - Process

2011-008.5 – Informed Consent – Providing and Obtaining

Basis

45 CFR 46

21 CFR 50

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Richard H. Simon

11/01/23

Richard H. Simon, MD

Date

Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-008.5
Policy Title: Providing and Obtaining Informed Consent

Purpose:

The purpose of this policy is to describe who may give and obtain informed consent.

Definitions:

See policy 2011-007.0 for definitions of the following terms:

Assent	Healthcare Representative	Informed Consent Process
Informed Consent Form	Legally Authorized Representative	

Policy:

Obtaining Consent: The individual who obtains consent from a research subject or the subject's legally authorized representative (LAR) must have an in-depth knowledge of the study such that they can adequately explain the study to the potential participant and answer questions posed by the potential participant.

The Institutional Review Board (IRB) requires that subjects/LARs be re-consented if there have been developments that may affect a willingness to continue to participate. Re-consenting a subject/LAR will serve to demonstrate that they have been informed of the additional information and that they willingly consent to continued participation.

Children who are actively participating in a study when they reach the age of majority are to be re-consented at the next regularly scheduled visit.

If procedural changes are made to the informed consent form and those changes are not pertinent to an individual subject there is no need to re-consent. For example if a procedure is added to the first visit and some subjects have already progressed beyond that phase of the study they do not have to be re-consented. A revision to a consent form to bring it into compliance with regulatory changes would also be considered a procedural change that does not require re-consent.

The IRB may require that an individual obtaining consent also seek feedback from the potential subject as a means of evaluating their level of understanding of the study.

If there are administrative changes to a consent document, e.g. in terms of contact names or numbers, subjects still actively enrolled may be re-consented but it is not a requirement. However, the PI must ensure that the subjects are provided with the revised information by letter, post-card or some other means approved by the IRB.

With the exceptions of the short form consent process and the process for consenting illiterate subjects, the consent process generally does not have to be witnessed. However the IRB may require this. When an individual is signing the form as a witness they must indicate whether they are a witness to the signature only, or a witness to the entire consent process. Use of the short form and consenting of illiterate subjects require the witness be present for the entire process. The IRB may determine who may serve as the witness.

Providing Consent: With the few exceptions noted below, consent must be obtained from individuals of at least 18 years of age who are competent to give informed consent. Such individuals are considered to have decision-making capacity if (1) they have not been declared incompetent by a court and (2) they are generally capable of understanding the consequences of alternatives, weighing the alternatives by the degree to which they promote their desire, and choosing and acting accordingly.

- Emancipated individuals between the ages of 16 - 18 may provide consent to participate in research activities. An emancipated individual does not meet the federal definition of child and therefore subpart D is not applicable.
- In the specific circumstances individuals under the age of 18 may provide consent to participate in research without demonstrating emancipated status when the research is limited to the categories noted below. In such circumstances the individuals are not considered children and therefore subpart D is not applicable.
 - All individuals under 18 years of age, if the research procedures are limited to:
 - HIV testing, counseling, and treatment
 - Outpatient mental health services
 - Testing or treatment for sexually transmitted diseases
 - Treatment or rehabilitation for alcohol or drug dependence
 - Abortion counseling and treatment
 - All individuals between 16 and 18 years of age, if the research procedures are limited to:
 - Inpatient mental health services
 - All individuals between 17 and 18 years of age, if the research procedures are limited to donation of blood or any component thereof and to the withdrawal of blood in conjunction with any voluntary blood donation program.

If an adult with an intellectual disability has not been declared incompetent, the Principal Investigator (PI) must decide if the subject is capable of understanding the elements of informed consent. The IRB may direct that a family member or other representative co-sign as a witness. If the investigator determines the subject is not capable of providing consent, a legally authorized representative (e.g. guardian) must be appointed and must provide consent before the subject can be enrolled.

Consent from Illiterate Subjects: At the onset of the consent process the PI or designated individual authorized to obtain consent must ask the subject if any special provisions are required by them for the consent process, including having the consent document read to them. A witness to the process is required when obtaining consent from illiterate subjects. An illiterate subject may make their mark on the consent form to indicate a willingness to participate. A video or audio tape of the process is recommended but the subject must consent to the taping and that consent must be on the tape. If taped, a copy of the tape must be provided to the subject and a copy must be retained with the study records.

Consent from Legally Authorized Representatives: When a potential subject is unable to provide consent because of impaired competency, consent must be obtained from a legally authorized representative of the subject. Documentation of this status must be obtained except when the LAR is the parent of a participant who has not yet reached the age of majority, or attests to being the next of kin. One exception to the next of kin provision is that adults with intellectual disabilities who have been declared incompetent must have an appointed legal guardian provide consent to participate in research. The natural parents of the adult are not authorized to give permission unless they have been appointed legal guardian(s).

When research is conducted in Connecticut, the persons who meet the definition of a legally authorized representative are a child's parent(s), court-appointed conservators or guardians, individuals designated as having power of attorney for health care, individuals designated as health care representatives, or next-of-kin for adults who have not been declared incompetent due to an intellectual disability as defined in institutional policy 2012-05 titled Legal Representative for Health Care Decisions. When research is conducted outside of Connecticut, and review and approval by a local IRB or its equivalent is not required, the investigator must consult with legal counsel as to who can serve as the legally authorized representative and submit documentation of legal counsel's opinion.

Procedure:

When submitting an application to the IRB, the principal investigator must respond to questions within the IRB application regarding the process for obtaining initial and on-going consent from subjects/LARs.

The principal investigator will designate on the IRB application the names of individuals authorized to obtain consent and also indicate whether the subject or legally authorized representative will be providing consent.

Standard screening and review procedures described in policies for expedited and convened board review apply.

The PI will demonstrate any necessary re-consenting of a subject in one or more of the following ways:

- Obtaining the signature of the subject on a revised IRB-approved consent form at the next regularly scheduled visit
 - If the consent document has not yet been approved by the IRB at the time of the visit a qualified member of the research team must provide a verbal explanation of the information to the subject and document the explanation in the research or medical record as appropriate to the study.
 - The subject is to sign the revised consent document at the next available opportunity.
- If the new information warrants immediate contact (e.g. the principal investigator learns that a drug is causing life threatening adverse events), the PI will determine the best way to communicate the information to the subjects in the study and may do so prior to approval of the revised consent form. Consideration must be given to the subject's underlying condition, available support systems, and the nature of the information being conveyed.
 - The PI must document the contact with the subjects, inform the IRB of the contact, and if the subjects choose to continue, obtain their signature on the revised consent form at the next available opportunity.
- Obtaining the signature of subject who has reached the age of 18 on the approved consent form at the next regularly scheduled visit

Related Content

2011-007.0 – Definitions Applied to Policies

2011-008.0 – Informed Consent -Forms

2011-008.1 – Informed Consent – Process

2011-009.3 – Institutional Review Board – Expedited Review

2011-009.5 – Institutional Review Board – Review by the Convened Board

Basis

45 CFR 46.

21 CFR 50

Document Attributes:

Date Effective: 6/5/2023

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Reviewed and Approved By:

Richard H. Simon

6/5/2023

Richard H. Simon, MD
Director Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-009.0
Policy Title: Institutional Review Board (IRB) - Membership

Purpose

The purpose of this policy is to set forth 1) the requirements and process to constitute an IRB and 2) the expectations and obligations of IRB members.

Definitions

See policy 2011-007 for definitions of the following terms:

Member – Experienced		Member – Nonscientific		Member – Nonaffiliated
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Policy

Membership: It is the policy of the HSPP that the membership of the IRB shall be constituted in accordance with the following regulatory criteria.

- each IRB panel shall have at least five members with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the institution;
- the membership shall be sufficiently qualified through the experience and expertise of its members (e.g., professional competence), and the diversity of its members, including race, gender and cultural backgrounds and sensitivity to such issues as community attitudes,
- the membership shall be able to ascertain the acceptability of proposed research in terms of institutional commitments (e.g., including policies and resources) and regulations, applicable law, and standards of professional conduct and practice.
- the membership shall consist of at least one member whose primary concerns are in scientific areas; at least one member whose primary concerns are in nonscientific areas, at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution, and a member who represents the perspective of research participants (one member may fulfill more than one role);
- if a panel regularly reviews research involving a subject population that may be vulnerable (e.g., children, prisoners, individuals with impaired decision-making capacity, economically or educationally disadvantaged who may be vulnerable to coercion or undue influence), consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with that population
- when reviewing studies involving prisoners
 - a majority of the board (exclusive of prisoner members) shall have no association with the prison(s) involved, apart from their membership on the board
 - at least one voting member shall be a prisoner, or a prisoner representative with appropriate background and experience to serve in that capacity, except that where a particular research project is reviewed by more than one board only on board need satisfy this requirement. The prisoner representative may be listed as an alternative member who becomes a voting member when needed.

The Director of the HSPP (DHSP) appoints the members, including Chairs and Vice Chairs. Appointments are for an open-ended period.

The Chair will have at least 2 years of previous IRB experience, have a scientific background, be familiar with clinical research and have demonstrated an ability to work in committee. The Vice Chair must have at least one year of previous IRB experience, and have a scientific background. Consideration will be given to length of time on the IRB, thoroughness of reviews and attendance at meetings when selecting a Chair and Vice Chair.

Once appointed to a panel; a member of one panel may alternate for a member of another panel. The DHSPP may also appoint a specific, designated alternate IRB member as deemed necessary and appropriate, for example by appointing a designated alternate for the prisoner representative and that alternate is not a member of any other panel. An alternate member will have an area of expertise similar to the member for whom they serve as the alternate. Alternate members will be called upon as needed. Alternate members will have sufficient time for review of material prior to meetings and will receive the same material for review that the regular IRB member would have received.

Members of the IRB are either employees of the University of Connecticut Health Center or acting in a volunteer capacity in which case they are considered to be an agent of UConn Health. When acting in the capacity of either employee or agent, and in accordance with IRB standard operating procedures, members are indemnified (for actions not willful, wanton or malicious) by the State of Connecticut.

Individuals from within the Office of Research Administration and Finance will not be appointed as voting members. Individuals who are responsible for business development are prohibited from serving as members or ex-officio members and from carrying out day-to-day operations of the review process.

The membership of the IRB is registered with the Office for Human Research Protections (OHRP).

Member Responsibilities: The responsibilities of all IRB members include attending regularly scheduled meetings once per month, thoroughly reviewing all material to which they are assigned as a primary reviewer, being prepared to present and discuss the material at the meeting, reviewing and having a familiarity with all other material to be presented at the convened meeting such that they can participate in the discussion of all studies, possessing an understanding of the principles of the Belmont Report and regulations pertaining to human subject protections, applying those principles and regulations to the review process, reviewing IRB minutes, and providing input/feedback on new policies that relate to the IRB. No member may participate in any of the IRB's review of a study in which the member has a conflicting interest, except to provide information requested by the IRB. Therefore, members are responsible for excusing themselves from the deliberation and vote on any study for which they have a conflict of interest, inclusive of reviews of exempt studies, any expedited review activity, and any full board review activity. The IRB may invite individuals with competence in a special area to assist in the review of issues that require expertise beyond or in addition to that available on the IRB. Such individuals do not have voting rights.

Additional Responsibilities of Chair: Chairpersons are generally the party responsible for reviewing and approving new expedited applications and making the final determination of the appropriate approval categories, assigning reviewers for full board reviews (new applications, continuing reviews, modifications, and discussion items which are inclusive of non-compliance and unanticipated problems), running the convened IRB meetings (keeping conversation on topic, soliciting motions for vote, ensuring all members have opportunity to express opinions/comments), giving final approval to new studies that had been approved with contingencies, and serving as a resource to investigators and IRB members.

Due to the absence or unavailability of the Chair the Vice Chair is authorized to perform all functions of the Chair. The Chair may also delegate some or all duties to another member of the IRB who is considered an experienced member.

Performance of Members: Each year the IRB Chairs will be asked to evaluate the performance of IRB members. Elements taken into consideration will include attendance, number of studies reviewed (new and continuing), the ability to apply ethical principles to the review process, the thoroughness and clarity of presentations, and contributions to discussions. Likewise, each year the members will be asked to evaluate the Chairs. The DHSPP will receive and review the forms and address any issues identified if necessary.

A member not fulfilling their obligations may be asked to step down by the DHSPP or the signatory official for the institution.

The operating budgets of the HSPP and IRB cover expenses associated with continuing education of members. For members who are also UConn Health faculty, service on the IRB is recognized by the faculty promotions committee, as well as in the annual faculty evaluations.

Procedure

Appointment of Members: On an as needed basis as determined by the DHSPP and/or IRB Chairs, the DHSPP will appoint new members. Designated IRB staff will set up an orientation meeting with the potential new member, the Chair, and the DHSPP to discuss the issue of being appointed to the IRB. If interested in serving on the IRB and acceptable to the Chair, the DHSPP will issue the official appointment letter.

Designated staff within the HSPP will:

- maintain a membership roster for each IRB panel
- when required (e.g., prior to 1/19/2018) register the IRB panel(s) with the OHRP through the on-line registration system when required (e.g. prior to 1/19/2018) report changes in IRB membership to OHRP through the on-line registration system and as applicable, indicate on the roster the identity of the member or class of members for whom a designated alternate may serve.

Performance of Members: Within a reasonable time (e.g. two months) after the end of a fiscal year, designated staff within the HSPP will distribute performance evaluation forms to the IRB Chairs and members for completion within approximately a two week period. The period to be evaluated will be July 1 – June 30. Completed forms are returned to the HSPP staff person and a copy is presented to the person being reviewed. The original evaluations are given to the DHSPP for reviews and, if necessary, action. After review, designated staff files the evaluations in the IRB membership booklet.

Related Policies

2011-006.2 – Vulnerable Populations: Prisoners

2011-009.4 – Institutional Review Board – Convened Meeting Operations

Basis

45 CFR 46

21 CFR 56

Document Attributes

Effective Date: 9/30/2025

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Reviewed and Approved By:

Shemetra Owens

9/29/2025

Shemetra Owens, CIP, CIM

Date

Associate Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-009.1
Policy Title: Institutional Review Board (IRB) – Submission of Materials

Purpose

The purpose of this policy is to describe when review and approval by the IRB is required because of the institution's engagement in research activities.

Definitions

See policy 2011-007.0 for definitions of the following terms:

Clinical Investigation
Research

Generalizable Knowledge
Systematic Investigation

Human Subject

Policy

Principal Investigators (PIs) must submit material to the IRB for review and approval **prior** to initiating any research activity that meets either the DHHS definition of research involving human subjects or the FDA definition of clinical investigation involving human subjects. Ancillary reviews that are also required to secure final approval from the IRB are built into the IRB submission process as noted on the submission checklists for initial and continuing review. The checklists may be revised as necessary.

PIs may request a specific type of review but the Chair* makes the final determination of the type of review required and if applicable the appropriate approval category.

When continuing review is a requirement, PIs must submit material to request continuing review and approval for non-exempt human subject research prior to the end of the day through which approval is valid. For studies requiring review by the convened board, submissions must be received by posted deadlines. For expedited continuations PIs should submit 30 days prior to the expiration date. Continuing review is also required for studies that have been suspended, in whole or in part.

IRB approval must also be obtained **prior** to implementing modification to previously approved research, except when necessary to eliminate apparent immediate hazards to subjects. For addendums / modifications issued by sponsors, inclusive of cooperative groups, the PI must submit the material for review by the IRB within 90 days of receipt.

An investigator must make a submission to the IRB for review and approval of human subject research projects when:

- UConn Health employees, students, or agents intervene with living individuals by performing invasive or non-invasive procedures for research purposes;
- UConn Health employees, students or agents intervene with living individuals by manipulating the environment for research purposes;
- UConn Health employees, students or agents interact with living individuals for research purposes;
- UConn Health employees, students or agents obtain the informed consent of human subjects for the research
- UConn Health employees, students or agents obtain, receive, or possess identifiable private information or identifiable biospecimens for research purposes;

- UConn Health employees, students or agents obtain, receive, or possess private information that is individually identifiable for the purposes of maintaining statistical centers for multi-site collaborative research;
- UConn Health employees, students or agents maintain operations center or coordinating centers for multi-site collaborative research; or
- UConn Health receives an award through a grant, contract, or cooperative agreement directly from HHS for non-exempt human subject research, even where all activities involving human subjects are carried out by employees or agents of another institution. award to conduct human subject research.
- UConn Health employees, students or agents release individually identifiable private information, or permit investigators to obtain individually identifiable private information, without the subjects explicit written permission;

The PI is responsible for submitting complete forms and required supporting documentation.

The IRB staff and/or reviewer reserve the right to return any submission that is incomplete or that contains out-dated forms.

*Reference to Chair throughout this document means Chair, Vice Chair, or designated experienced IRB member.

Procedure

General Submissions:

The PI completes and submits the relevant form and supporting documentation as indicated on the applicable checklist or instructional document.

The IRB staff and reviewers will follow standard procedures for assigning submissions, conducting reviews and for communicating outcomes to the PI according the exempt, expedited or full board requirements.

Immediate Changes to Secure Subject Safety:

- When changes are necessary to eliminate apparent immediate hazards to the subjects the changes may be implemented prior to approval but must be reported by the PI to the IRB using the problem report form, and when applicable to the FDA, within 5 business days.
- The problem report form is to be accompanied by any other document affected by or related to the change that was instituted.
- The convened IRB will determine whether the change was consistent with ensuring the subject's continued welfare and will also determine whether the event requires reporting as an unanticipated problem, or serious or continuing non-compliance if the change is found to be inconsistent with ensuring the welfare of the subject.

Related Policies

2009-001.0 - Reporting Unanticipated Problems to the Institutional Review Board

2011-009.2 – Institutional Review Board - Exemptions

2011-009.3 – Institutional Review Board – Expedited Reviews

2011-009.5 – Institutional Review Board - Review by Convened Board

Basis

45 CFR 46.103(4)

21 CFR 56.108(a)

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Reviewed and Approved By:

Signed Richard H. Simon

1 May 2017

Richard Simon, MD
Director Human Subjects Protection Office

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-009.2
Policy Title: Institutional Review Board (IRB) - Exemptions

Purpose

The purpose of this policy is to describe circumstances under which an exemption from regulations may be granted, and who may grant said exemption.

Definitions

See policy 2011-007.0 for definition of Exempt.

Policy

Unless otherwise noted, regardless of funding source, the categories of research for which an exemption may be granted are those that have been published in the Human Subject Protection regulation, 45 CFR 46. UConn Health will not use any provision for broad consent. The exemption category regarding research and demonstration projects that are conducted or supported by a federal department or agency, or otherwise subject to the approval of department or agency heads and that are designed to study, evaluate, improve or otherwise examine public benefit or service programs pertains only to studies sponsored or funded by the Department of Health and Human Services. Research subject to FDA regulations only qualifies for the exemption regarding Taste and Food quality evaluations. The exemption category regarding secondary research use of identifiable private information (IPI) when that use is regulated under 45 CFR parts 160 and 164, subparts A and E pertains only to use of information (not biospecimens) when the data remain protected under HIPAA (e.g., principal investigator's home institution is UConn Health and the IPI is not shared outside UConn Health or accessed by non-UConn Health personnel). Additional categories may be developed and published by the institution for non-federally funded minimal risk research.

Investigators cannot make the determination as to whether a research project is exempt. Such determination must be made by a representative of the Human Subjects Protection Program (e.g., an IRB Regulatory Specialist (RS), IRB member, Research Compliance Monitor, Educational Specialist). However, if an exemption category specifically requires IRB review as a criterion for the exemption, the exemption must be granted by an IRB member. When review by the IRB is required by the exemption category, the research is subject to policies pertaining to suspension/termination of approval. Investigators must obtain exempt determinations prior to the start of the research. The reviewer may require expedited approval or review and approval by the convened board but may not disapprove the project. When requiring expedited or full board review, justification for doing so is to be provided.

In the event of changes to the regulatory categories of research that may be exempt, an exemption made prior to such change will continue to be recognized as a valid exemption made according to the federal categories of exemption in place at the time the exemption was granted.

The exemptions defined in regulations may be applied to research involving pregnant women, fetuses or neonates if the conditions of the exemption are met.

The exemptions defined in regulations do not apply to research involving prisoners, except for non-federally funded / supported research aimed at involving a broader subject population that only incidentally includes prisoners if the conditions of the exemption are met. If the federal regulations are

implemented to allow for this incidental inclusion of prisoners in federally funded/support exempt research UConn Health will also permit this.

The exemptions defined in regulations may be applied to research involving children if the conditions of the exemption are met with the following exclusion.

- For research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview process or observation of public behavior (including visual or auditory recording) children may only be involved when the activity is limited to involving educational tests or the observation of public behavior when the investigators do not participate in the activities being observed.

The reviewer may require a consent process or other protections for exempt research.

All studies approved as exempt are presented for informational purposes on the agenda of the next regularly scheduled meeting of the appropriate panel for which the submission deadline has not passed.

Research which is deemed exempt is not subject to continuing review requirements, even when the criteria for granting the exemption required some level of IRB review. For administrative purposes of maintaining databases and files the HSPP staff will assign an expiration date to exempt research. The expiration date will be the anticipated completion date of the project put forth in the application, or one year from the date the exempt determination is made; whichever is longer. While the exemption is active the research is subject to the Research Compliance Monitoring Program. When the expiration date passes, unless otherwise requested by the PI, the IRB will administratively close the exemption which will remove it from the pool of studies subject to audit. This closure does not invalidate the exemption (e.g., the research may continue as planned). For exemptions granted prior to the implementation of this practice the IRB staff may periodically contact the Principal Investigators (PIs) of exempt studies to determine if the study is still active and obtain expected completion dates in order to implement the same practice.

Procedure

A PI requests exempt status for a research study by indicating within the material provided to the IRB the exemption category that s/he believes is applicable to the study. The PI must also provide all of the other material requested on the IRB application checklist as applicable to the study.

Designated IRB staff will assign requests for exemptions to a RS.* The RS may elect to perform a general screening function prior to performing a formal review. During the screening and/or formal review process, the RS may request that the PI provide additional documents, clarifications, or make corrections before granting the exemption. Such requests for information will be made through the electronic submission system by returning the submission for corrections if requested during the general screening process; or by returning the submission for responses if requested after the formal review is done.

- If corrections are requested as part of a screening process, the review process is set to Returned for Corrections, the study status is set to Initial Screening
- If responses are requested after the formal review, the review process is set to exempt, and the submission outcome is set to Approved Contingent.

The process may repeat if the investigator does not provide adequate responses.

Once all requested additional information is received the RS may grant the exemption. When determining whether to grant the exemption, the RS will review the application and all of the material required for submission for exempt studies as noted in the submission checklist.

The RS documents the final determinations by completing the reviewer form and the form becomes part of the IRB study file.

- If the RS determines the study does not qualify for exemption:
 - the RS will inform the PI by returning the submission with the electronic submission with contingency that directs that study to be resubmitted requesting either expedited or full board review with inclusion of required documents (e.g., consent forms).
- If the RS determines the study qualifies for exemption:
 - the RS will issue to the PI the standard exempt approval letter;
 - the RS will apply the electronic approval stamp to the relevant documents as indicated on the application for exemption checklist;
 - for administrative purposes the RS will assign an expiration date to the exempt research. The expiration date will be either the expected completion date of the research or one year from the date the exempt determination is made, whichever is longer. The expiration date is not stamped on documents.
 - the RS will add the exemption approval to the informational agenda of the next regulatory scheduled board meeting for which the submission deadline has not passed.
 - Any member of the board may request full board review of a study previously deemed exempt. The board will vote and if the vote is in favor of full board review, the Chair will contact the PI, or direct the RS to do so, to withdraw the approval until full board review is conducted. Notification will be sent through the electronic submission system correspondence or through email. This is not considered a suspension or termination of approval that is reportable to institutional officials or agency heads.

While the RS is authorized to grant exemptions, this does not preclude the RS from assigning the task to an IRB member. In such cases the RS may perform a screening function before assigning the task for review by a member. The RS may ask for corrections as noted above. Upon receipt of all responses, the RS would assign the reviewer. Any concerns expressed by the reviewer would be returned to the RS, who in turn would communicate the concerns to the PI as noted in order to obtain the responses. Upon receipt of responses, either the RS or the previously assigned reviewer can then make the determination as to whether the exemption may be granted.

* Note, if there is a regulatory requirement that the IRB review an exemption for purposes of ensuring provisions for privacy/confidentiality are appropriate, the RS must also be a member of the IRB, and if not, the RS will assign the review to an IRB member. While the RS is the default reviewer for making exempt determinations, for exemptions that do not require IRB review, other staff within the HSPP may also be assigned the review.

Related Policies

2009-005.0 - Monitoring of IRB Approved Studies

2011-008.1 - Informed Consent – Process

2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

45 CFR 46
21 CFR 56

Document Attributes

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Reviewed and Approved By:

Richard H. Simon

6/8/2023

Richard Simon, MD

Date

Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-009.3
Policy Title: Institutional Review Board (IRB) – Expedited Reviews

Purpose

The purpose of this policy is to describe circumstances under which an IRB reviewer may determine that a human subject research study qualifies for initial or continuing approval under one or more of the federally recognized expedited categories, or one or more expedited categories that may be developed by the institution for non-federally funded non-FDA regulated minimal risk research. This policy also sets forth circumstances when modifications to a previously approved study may be reviewed by the expedited procedure.

Definitions

See policy 2011-007.0 for the definitions of the following terms:

Member, experienced	Modification, Minor	Suspension
Termination	Test Article	-Prisoner

Policy

Regardless of funding source, the categories of research for which expedited review may be used for initial and/or continuing review are those that have been published in the Federal Register. The institution may also develop and publish categories of research for which expedited review may apply for non-federally funded or non-FDA regulated minimal risk research. The expedited categories for continuing review of research previously approved by the convened IRB are not applicable to initial reviews, and UConn Health does not utilize the provision that expedited continuing review may occur for a study previously reviewed by the convened board where no subjects have been enrolled and no additional risks have been identified.

FDA regulated research that involves the use of investigational articles cannot be approved through the expedited review process unless the remaining activity for the study is limited to long-term follow-up or data analysis.

For all types of submissions (e.g., initial, continuation, modifications), unless otherwise specified by the IRB, responses to contingences for approval may be reviewed by any experienced member of the IRB or experienced IRB/HSPP support staff for purposes of issuing the final approval.

For all expedited submissions, the reviewer may approve an expedited project, require modifications to secure approval, or refer the submission to the full board for review. The reviewer may not deny approval.

Initial Review by Expedited Procedures:

Under an expedited review procedure, the initial review may be carried out by the IRB Chair or by one or more experienced reviewers designated by the Chair from among members of the IRB. In efforts to minimize the time to approval by reducing the number of times a submission is returned to the study team for correction, the screening function and formal review process may be incorporated into a primary reviewer system whereby the officially assigned reviewer and IRB staff person* review the

submission concurrently. If the study does not clearly meet the criteria for expedited review, it will be assigned for full board review. If continuing review is required (e.g., FDA regulated research), projects will be approved for no more than 365 days. If continuing review is not required, projects will be approved for either the expected duration of the project, or one year from the date of final approval, whichever is longer.

Expedited Review of Modifications, Problem Reports and Responses to Contingencies:

Under an expedited review procedure, the review of modifications may be carried out by the IRB Chair or by one or more experienced reviewers designated by the Chair from among members of the IRB.

For expedited review of modifications to studies involving prisoners, refer to HSPP policy 2011-006.2.

Any member of the IRB may review and approve administrative modifications.

An IRB Chair or Vice Chair will review Problem Reports Forms to determine if the reported issue needs to be referred to the full board, or if it is a minor issue that does not represent serious or continuing non-compliance or an unanticipated problem involving risk to subjects or others.

The reviewer will determine whether a request for modification meets the definition of minor modification to previously approved research and therefore the eligibility criteria for expedited review. Studies involving vulnerable populations may request approval of modification through the expedited process. A request for modification through the expedited review and approval process cannot include procedures whose inclusion would make the research ineligible for initial review using the expedited procedures (e.g., addition of an investigational drug). If the modification does not meet the criteria for expedited review, the modification will be referred to the full board.

Study closures are most often reviewed as expedited modifications. Requests for closure should be submitted upon premature completion of the study, at the time the next continuation application is due or within 30 days after the completion of all study activity involving the use of private identifiable information or biospecimens, whichever comes first.

Continuing Review by Expedited Procedures:

The IRB is permitted, but not required, to eliminate the requirement for continuing review of research originally approved through expedited review, when:

- Research meets one or more expedited review categories.
- Research has progressed to the point that it involves only one or both of the following:
 - Data analysis, including analysis of identifiable private information or identifiable biospecimens, or
 - Accessing follow-up clinical data from procedures that subjects would undergo as part of clinical care.

Continuing review is currently required on at least an annual basis for FDA regulated research. Should the FDA regulation be revised to adopt a policy whereby expedited continuing approval is not required, UConn Health will apply this same standard to such research.

Unless specifically required otherwise by the IRB continuing review is not required for the following:

- non-FDA regulated and non-federally funded/supported studies that were initially approved under an expedited category;
- non-FDA regulated and non-federally funded/supported studies or that now qualify for expedited status (e.g., remaining activity is limited to blood draws within expedited limits),
 - investigators should submit an expedited request for modification to the IRB to request eligibility for expedited status when a study reaches the point where the remaining activity is limited to activity that would qualify for expedited review.

When continuing review is required, unless otherwise noted, the approval period for studies approved through expedited review will be for one year from the date the final content review is completed. This may sometimes result in a shorter review cycle if there are administrative issues that must be addressed before final IRB approval is released. Content review is inclusive of reviewing responses to contingencies for approval when such contingencies require a change to a study related document. In such cases the content review is considered completed when the required changes to study related documents have been approved (e.g., change to protocol or change to consent as contingency for approval). For example, if a study were reviewed on October 7, 2016 and the IRB required a change to a consent and that an investigator complete required training before approval could be granted, if the revised consent was reviewed and approved on October 8, but the investigator did not complete required training until October 10, 2016, the final approval date would be October 10, but the review cycle would be based on the date the content review was completed so the study would be valid through October 7, 2017. Anniversary dates are not retained for expedited studies. Approval is valid through the expiration date (also known as the valid through date) noted in the approval letter. For example an expedited study given final IRB approval (either initially or for continuing review) on October 8, 2016 would be approved as valid through October 7, 2017, meaning that research is approved to be conducted on October 7, 2017, but will no longer be approved on October 8, 2017 and may not be conducted on or after that date without final continuing approval by the IRB. Continuing review and final approval for expedited studies must be obtained prior to the end of the day through which IRB approval is granted in order to avoid a lapse in approval

When continuing review of minimal risk research is not required, the PI should provide an annual update to the IRB on the study status within 30 days of the anniversary date of initial approval. The PI may provide the update using the annual check-in form (e.g., via RedCap or HSPP website) or via email message detailing the information requested on the check-in form (e.g., changes in funding, any problems, concerns or complaints events of concern or complaints). The assigned regulatory specialist or IRB staff will review the update and follow-up with the PI regarding any concerns identified in the responses. The completed form and any follow-up correspondence will be filed in the IRB file.

Reviewer Form:

The expedited reviewer form must be completed by the reviewer to document that the criteria for approval have been met. The reviewer form becomes part of the IRB study record. If the reviewer determines that continuing review is required for a study that meets expedited criteria that would not otherwise require continuing review the reviewer should document the reason for the requirement.

Agenda Listing:

For informational purposes, all submissions approved through the expedited review process are presented on the agenda of the next regularly scheduled meeting of the original reviewing panel for which the submission deadline has not passed. Any member may request that a submission approved through expedited review require full board review. The board will vote and a majority vote of the members present will decide the issue. Decisions made at full board meeting will supersede any decisions made through the expedited review process. Should the full board vote to deny approval previously granted, the withdrawal of approval is considered a termination of approval.

*The IRB staff person may also be an IRB member but is not required to be.

Procedure

Submission by PI:

A Principal Investigator (PI) may request expedited review and approval of a research study by indicating the level of review requested within the electronic submission form (e.g., the application, request for continuing, or request for modification form). The PI must also provide all of the other material requested on the IRB application checklist as applicable to the study.

Assignment to Regulatory Specialist*:

The IRB Administrator or designee will assign expedited submissions to a Regulatory Specialist (RS).

- For new studies, the RS assignment is generally determined by alternating the assignment of new submissions among the RS for each panel.
- For previously approved research, preference will be to assign the submission to the RS of the Panel that granted the initial approval, however assignment of submissions may be alternated among the RSs to more evenly distribute assignments.

*The RS may also be a member of the IRB.

Screening:

The RS will screen all submission for completeness and may request that the PI provide additional documents, clarifications, or make corrections. Such requests for information will be made through the electronic submission system by setting the study status to initial screening, assigning a review process of returned for corrections, and checking the submission complete box. The RS will screen response and may repeat this process if necessary. In efforts to reduce processing time, this screening function may be incorporated into the formal review process. The RS will determine whether to use a separate screening function (e.g., several documents are missing from the submission such that a thorough review cannot be completed), or to incorporate the screening function into the formal review process by using a primary reviewer system or forwarding concerns to the reviewer.

Assignment for Review:

Once a submission is determined to be of sufficient quality for review, the RS will assign the reviewer(s) per policy. The assigned reviewer will receive an automatic notification of the assignment.

Conducting the Review:

All reviewers will be provided with all of the material relevant to the submission as well as the corresponding reviewer form. The reviewer form addresses the regulatory criteria for approval and the reviewer must document on the form that the criteria are met.

For initial and continuing review the expedited reviewer form requires the reviewer to document:

- the research is not classified
- the research is not greater than minimal risk
- risks are reasonable in relation to potential benefits
- subject selection is equitable
- informed consent has been appropriately addressed
- plans for protection of privacy and confidentiality of data are adequate
- that if identification of the subjects and/or their responses reasonably place them at risk of criminal or civil liability or could be damaging to the subjects' financial standing, employability, insurability, or reputation, or be stigmatizing, there are reasonable and appropriate protections that will be implemented so that risk related to invasion of privacy and breach of confidentiality are no greater than minimal
- adequate resources are available
- the approval category

If applicable, for initial review, the reviewer will document on the reviewer form the permissible categories for vulnerable populations and that the required findings for the population to be included in the research have been met. If applicable, the reviewer will document on the reviewer form that criteria for waivers or alterations of consent, or waivers of documentation of consent have been met. The signature statement when documenting approval for continuation, when continuing review is a requirement, affirms that the reviewer has determined such protections continue to be met.

Reviewers also have access to historical data if necessary to supplement the review.

The review of an annual update addendum (for studies not requiring continuing review) may be conducted by a member of the IRB, the IRB Chair or IRB staff. Should the submission indicate any issues or noncompliance which may represent a risk to subjects or others have occurred, the submission will be assigned to the IRB Chair for review.

Communication Back to PI:

After review of the material the reviewer may approve the submission or request revisions before granting approval.

- The RS is automatically notified by the system once the reviewer completes the assignment
- If revisions are required,
 - the RS returns the submission to the PI with the noted contingencies by setting the submission status to Approved Contingent and checking the submission complete box. An expected date for response to contingencies may be included.
 - In efforts to minimize time to approval and the number of times a submission is returned for correction/responses, the RS may revise the documents as necessary. In such an event the contingency for approval would be that the PI review and accept the changes made by the IRB. If not accepted the PI would indicate why and the review process would repeat.
 - the RS will screen the responses. If response are not sufficient the process of returning the submission to the PI for response would repeat. If responses are sufficient, the RS will reassign the submission for review. At this point the

- review of responses may be assigned to any member of the IRB or HSPP/IRB staff as an experienced IRB member has already conducted the initial review.
- If approved, as applicable
 - the RS will enter the approval period for the study
 - if continuing review is required a due date for continuation will be entered
 - will set the submission status, and if applicable study status, to approved
 - will generate and send the final approval letter using the applicable standard template
 - will stamp relevant documents with the IRB electronic stamp
 - will return the submission to the PI by checking the submission complete box

Referral to Full Board:

If the reviewer determines the submission does not qualify for expedited review, or if the reviewer and the investigator cannot agree on the modifications required for approval, the submission will be referred to the convened IRB for review. The expedited reviewer cannot deny approval. The PI will be informed automatically through the electronic submission history tracking that the submission has been placed on a full board agenda.

Informing the Board of Expedited Activity:

After approval has been granted by the reviewer, the RS will add the expedited approval to the informational agenda of the next regularly scheduled board meeting for of the initial reviewer's panel for which the submission deadline has not passed.

- Any member may request that a submission approved through expedited review require full board review. The board will vote and a majority vote of the members present will decide the issue.
 - If the vote is in favor of full board review the Chair will contact the PI, or direct the RS to do so, to withdraw the approval until full board review is conducted. Notification will be done through the study correspondence tab in the electronic system. This is not considered a suspension or termination of approval that is reportable to institutional officials or agency heads.
 - Should the full board vote to negate approval previously granted the withdrawal (i.e., denial) of approval is considered a termination of approval.
 - The RS will inform the Director of the HSPP (DHSPP) and HSPP Manager of this decision by copy of the minutes, and
 - The DHSPP will report to institutional officials and, as applicable, regulatory agencies.
 - Letter may be prepared for signature by RS or HSPP Manager
 - The PI will be informed by letter prepared by the RS and signed by the IRB Chair. This letter will also instruct the investigator to inform any previously enrolled subjects of the change in approval status.

Related Policies

2009-003 – Imposing and Lifting Suspensions of IRB Approval or Imposing Terminations of IRB Approval

2009-004 – Required Reporting to Institutional Officials and External Agencies

2009-005 – Monitoring of IRB Approved Studies

2011-006.2 – Vulnerable Populations – Prisoners
2011-007.0 – Definitions Applied to Policies
2011-009.5 – Institutional Review Board – Review by Convened Board
2011-009.10 – Institutional Review Board – More Frequent Review

Basis

45 CFR 46

21 CFR 56

Guidance Document: Categories of Research that may be reviewed by the IRB through an expedited Review Procedure (<http://www.hhs.gov/ohrp/policy/expedited98.html>)

Document Attributes

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Reviewed and Approved By:

Shemetra Owens

6/10/2025

Shemetra Owens, CIP, CIM

Date

Assoc Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-009.4
Policy Title: Institutional Review Board – Convened Meeting Operations

Purpose

The purpose of this policy is to describe the particulars of a convened board meeting. This policy is not inclusive of the policy/procedure used to conduct individual reviews at a convened board meeting.

Definitions

See policy 2011-007.0 for definition of the following terms:

Member, Non-scientific		Quorum
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Policy

It is the policy of the HSPP to post on the web the meeting schedule and submission deadlines for IRB panels that meet on a regular basis. Adjustments to the meeting schedule may be made because of holidays or other issues. Material requiring review by the convened board must be submitted by the published submission deadlines to provide sufficient time for screening and review prior to the meeting date. If a study is deferred at a convened meeting, the investigator is granted a one-week extension on the submission deadline for the meeting to be held in the following month.

The panel conducting the review is determined by the submission date of the application with the following exception:

- all studies that require full board review that propose to involve prisoners are reviewed by a panel that has a prisoner representative as a member

A Chair may refer initial review of a study to another panel due to conflict of interest issues; due to more appropriate expertise lying on the other panel; or other reason deemed appropriate by the Chair (e.g. volume of submissions).

A majority of the members, including one non-scientific member, must be present to establish quorum to convene a meeting. If a required member (e.g., non-scientific) leaves the room, and no other persons with that role are present; quorum is lost even if over half of the membership is present. The IRB cannot take any action until quorum is restored.

While federal regulations do not require it, the practice of the IRBs that meet monthly is that a non-affiliated member and a member who represents the interest of participants be present for at least 9 out of 12 meetings. One member may fulfill all three roles (i.e., non-scientific, non-affiliated, and participant representative). Members may be considered present via video or teleconferencing that allow for two way communication. The IRB Regulatory Specialist (RS) documents attendance in the minutes which can then be used for tracking.

The convened meetings will be conducted in a location that allows access to current and historical IRB records (electronic files via internet connections). When reviewing electronic submissions, the agenda item (inclusive of supporting documents) being discussed will be projected to a screen in the meeting room or shared on the screen in the videoconference. Members may also choose to follow along on

individual laptops, but this is not required. In all cases, the reviewer form provided to the primary reviewers addresses the regulatory criteria for approval. This form is available to all members at any time from the web and also for projection at the meeting.

After initial review a study remains under the oversight of the panel to which it was initially presented. Another panel may take action on a study under a different panel's oversight only in rare circumstances, e.g., to prevent a lapse in approval that is not due to the investigators failure to request continuation. One panel cannot approve a study that the other panel has denied or deferred.

Under unusual circumstances the Chair of any panel may call an emergency meeting of their own panel, e.g., due to audit findings that indicate subjects are at risk. However, such a meeting cannot be called due to the negligence of the investigator to submit material on time.

IRB meetings are not public meetings. Guests, including principal investigators, may attend an IRB meeting only at the invitation of the Chair. Principal investigators who are present will be excused prior to deliberation and voting. Principal investigators may elect to be available by phone during the meeting to be called upon to provide clarifications should that need arise.

Voting by Members

Each full board agenda item will be individually reviewed and voted on by the members present, inclusive of Chair and Vice Chair. If a member abstains from voting that abstention will be noted and counted as a vote of no. The abstaining member's presence will count towards quorum.

A member cannot review or vote on a study, (whether it is for initial review, continuing review, a request for modification, or any other action such as a vote regarding unanticipated problems or non-compliance) if: 1) the member or immediate family member is involved with the conduct of the study, 2) the member or immediate family member has any financial conflict of interest with the study. Members who cannot vote on a specific study may provide information to and/or answer questions from the committee but cannot be present for the deliberations and voting and cannot count towards quorum for that particular vote.

At the conclusion of discussion for an agenda item, the Chair will call for a motion. A majority vote of the members present will be required to carry a motion. In general, the vote will be taken by a show of hands and the RS will record the motion and the number for, against and abstaining in the minutes. The Chair reserves the right to use an alternate method of voting, such as by ballot, or voice if it is deemed necessary.

Procedure

Meeting Schedule: On an annual basis, designated IRB staff will prepare and post the meeting schedule and submission deadlines to the web. An IRB staff person will send an e-mail message to announce any adjustments to the published meeting schedule.

Emergency Meetings: A designated IRB staff person will be responsible for coordinating an emergency meeting. If material is not already distributed to members from the previous meeting, or if it is not available through electronic means, the IRB RS will distribute material as soon as possible to allow for sufficient time for the review. The material to be distributed will depend on the nature of the issue being

discussed. For example, if the PI disagrees with the contingencies previously imposed by the convened board and risks to subjects is involved, the board may review the original approved contingent letter, the response of the principal investigator and the applicable associated documents such as the consent form, the protocol or survey tools. The investigator may be asked to attend the meeting to address questions or provide additional information or clarification.

General Meeting Procedures: The Chair will call the meeting to order when a quorum is reached. The Chair will perform the following functions, as indicated on the agenda: 1) remind members that they cannot partake in the review/vote of any study with which they have a conflict, 2) call for comments regarding exempt and expedited activity that is presented for informational purposes, and 3) ensure appropriate expertise is available for the review (written comments may be acceptable).

The IRB RS will ensure that a quorum is maintained throughout the convened meeting. The IRB RS will use the IRB roster to track attendance at the meeting to ensure that a quorum has been met and is maintained. If quorum is lost, the IRB cannot continue deliberations or voting until quorum is restored.

The IRB RS will obtain a signed confidentiality statement from guests (e.g., consultants), other than principal investigators who are present to provide information for a specific study.

Minutes: The IRB RS will take minutes at each meeting and finalize them using a template that reflects:

- that a quorum was met and maintained throughout the meeting,
- the start and stop time of the meeting,
- members, staff and any guests present at the meeting,
- identification of members fulfilling the non-scientific role, non-affiliated role, and prisoner advocate role,
- notation of when a member leaves or joins a meeting,
- summary and findings of each project discussed (new studies, continuing review, requests for modifications),
- IRB number, principal investigator, project title,
- the risk/benefit assessment,
- findings of the Board (basis for contingencies for approval or reasons for denial of approval),
- details of the vote reflecting number voting in favor, number opposed and number abstaining along with the name of who abstained,
- by study, the name of any IRB member with a conflict of interest who left the room for deliberations and voting, including notation that reason was due to conflict,
- the review interval required,
- rationale for conducting continuing review on research that otherwise would not require continuing review.

When applicable the IRB RS will also ensure that the minutes reflect:

- attendance of any member who is serving as an alternate and the identity of the member for whom they are the alternate
- the approval category for the inclusion of population requiring additional protections (e.g. children, prisoners),
- protocol specific information for how criteria for vulnerable populations or fetal transplantation are satisfied,

- information justifying an alteration to or waiver of informed consent,
- information justifying a waiver of consent for planned emergency research
- the requirements that were met to grant a waiver of the requirement to document consent,
- the rationale for a determination of significant risk or non-significant risk for device studies,
- review and approval of data safety monitoring plans/boards,
- discussion and determination regarding unanticipated problems involving risk to subject or others
- discussion and determination regarding serious or continuing non-compliance
- discussion and determination of any suspension or termination of IRB approval
- a summary of controverted issues and the resolution of those issues,
- other discussion items and the motion and vote of those discussions
- a justification of any deletion or substantive modification of information concerning risks or alternative procedures contained in the DHHS-approved sample informed consent document.

At each meeting the Chair will ensure that appropriate expertise is available for the reviews. The Chair will also ask for a motion to approve the minutes of the previous meeting. The IRB RS will send the approved IRB minutes by e-mail to the Institutional Official designated on the FWA and Director of the Human Subjects Protection Program and other parties with legitimate interest as needed / requested (e.g. Research Compliance).

Related Policies

2011-006.0 – Vulnerable Populations: General Policy
 2011-007.0 – Definitions Applied to Policies
 2011-009.5 – IRB Convened Review

Basis

45 CFR 46
 21 CFR 56

Document Attributes:

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Reviewed and Approved By:

Richard H. Simon, MD

Richard H. Simon, MD
 Director Human Subjects Protection Program

11/01/23

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-009.5
Policy Title: Institutional Review Board (IRB) – Review by Convened Board

Purpose

The purpose of this policy is to describe when and how the IRB members conduct reviews (initial, continuing, and modifications) in preparation for and at a convened meeting.

Definitions

See policy 2011-007.0 for definition of:

Risk, Minimal		Test Article
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Policy

Proposed research that does not qualify for either exempt status or expedited review will be sent to the convened board for review. If the board determines that the study is minimal risk and continuing review is a requirement, continuing review may be done through expedited review providing that 1) there have been no changes or developments that indicate an increase in risks to subjects, 2) prisoners are not involved as subjects (excluding studies for which activity is limited to chart reviews) and 3) the study does not involve the use of an investigational test article.

A primary reviewer system will be used for all types of reviews conducted by the board. The reviewer form used by the primary reviewers to conduct reviews of studies incorporates the regulatory criteria for approval and specific points for consideration under each criterion. This is an unofficial document that guides the review process. Determinations made at a convened meeting will be documented in the meeting minutes and supersede the comments of the individual reviewer on the reviewer form.

For initial review of studies subject to FDA oversight one reviewer will be an M.D. (for drug or device studies) or a Pharm.D. (drug studies).

For initial submissions, continuing submissions and submissions of requests for modifications, all members of the IRB are provided with and review sufficient information about the proposed research (or change in the proposed research) to determine that the research fulfills the regulatory criteria for approval. At least one member will be provided with and review the Investigators Brochure, when one exists. For initial submission at least one member is provided and reviews the DHHS approved sample consent (when one exists); the complete DHHS-approved protocol (when one exists) and any relevant grant application.

For continuing review submissions, all members are provided with the submission materials for review prior to the convened meeting. Any member of the IRB (or consultant) may request to see additional information, including the IRB file and previous minutes related to the study. When modifications are requested as part of a continuing review submission, all members have access to previously approved documents and the newly proposed documents in order to compare versions and review changes, such as the current consent document and any newly proposed consent document.

When there are contingencies that must be addressed before final approval can be granted, the Regulatory Specialist (RS)* may review the responses and grant the final approval. This does not preclude the RS from assigning the review to the Chair or other experienced IRB member.

*The RS does not have to be a member of the IRB in order to review such responses. Experienced staff of the HSPP/IRB may also conduct the review of response material and issue the approval if the RS is unavailable.

Procedure

Screening

A designated RS will screen the submission for completeness and, during this screening process, may request through communications in the electronic system that the PI provide additional documents or clarifications.

Once all requested additional information is received, the submission will be eligible for review and approval and the RS will place the submission on the agenda for the next regularly scheduled IRB meeting.

Assigning Reviewers

At least two primary reviewers are assigned to each submission. The RS may make the preliminary assignments but the Chair will make the final determination of assignments. The RS / Chair will ensure one scientific and one experienced member is assigned to each study, ensuring that at least one of the primary reviewers has the appropriate scholarly and scientific expertise.

Primary Reviewers

Members will have at least 5 days for review of the material prior to the meeting date. The assigned reviewers will be notified of assignments by e-mail notifications generated from the electronic submission system.

A primary reviewer system will be used for initial and continuing review and review of modifications. The two primary reviewers will receive and review all material requested on the initial/continuing application checklist, or the instructions for requesting a modification, as applicable to the study, including the complete protocol and any protocol modifications previously approved by the IRB. Reviewers may elect to contact the Principal Investigator (PI), either directly or through the IRB office, to seek clarification or additional information prior to the convened meeting.

All other IRB members will have access to the same documentation as the primary reviewers, and at a minimum will be expected to review the relevant IRB form (e.g. application, request for modification, addendum to application for continuation), the consent form and other relevant material (e.g. recruitment material, survey tools etc.) such that they can participate fully in the discussion, deliberation and voting.

At the convened meeting the primary reviewers will present a summary of the study, noting any concerns with specific items in the submission. Discussion and voting will follow. A majority vote of the members present will decide the motion.

If one or both of the primary reviewers are absent the review will be deferred unless the Chair or another member or consultant has also conducted an in-depth review of the study and has the appropriate expertise, or the absent reviewers have provided a detailed written summary of the review such that the Chair determines there is sufficient information available to conduct the review.

The RS will document the determinations of the convened board in the minutes. The RS will send the minutes of the meeting to the membership for review and comment. The RS may also send the minutes to other parties with a legitimate interest as needed / requested (e.g. Research Compliance).

Communications

Decisions of the convened IRB will be communicated to the PI in writing through the electronic submission system. This correspondence, and related documents, will be sent to the PI by the RS after the minutes of the meeting have been provided to the IRB panel and the members have had 48 hours to respond with any comments/corrections. Official communication from the RS to the PI is to be sent within approximately 10 working days after the meeting date.

- For submissions that have been approved as submitted the RS will send to the PI the standard approval letter accompanied by other study related documents.
- For submissions that are approved contingent upon minor modification or confirmation of IRB assumptions, the standard approved contingent letter, along with a list of contingencies, will be prepared and sent by the RS. The IRB Chair, or RS, will review* responsive material. If issues have not been satisfactorily addressed the communication cycle will repeat. If the Chair or RS and the investigator disagree on the adequacy of a response, the material will be placed on the agenda for the next convened meeting for which the submission deadline has not passed. Once the Chair or RS determines that all contingencies are addressed, the RS will then send to the investigator the standard approval letter, accompanied by other study related documents.
- If there is a contingent issue that the PI must address to secure continuing approval, the RS may inform the PI informally via phone or e-mail the day after the meeting to allow sufficient response time to prevent a lapse in the continuing approval of a study. The PI will be informed that the official communication will be forthcoming after the minutes have been reviewed by the membership.
- For studies that are deferred the standard deferral letter, with a listing of contingencies, will be prepared and sent by the RS. This letter will explain the reason for the deferral. Responses to deferred protocols will be reviewed at subsequent meetings following the same procedures for the type of review. For example, if a study is deferred on initial review, the response will be handled as an initial review being reviewed by the convened board. When possible the same primary reviewers will be assigned.
- For studies that are disapproved a letter will be prepared by the RS and signed by the Chair. The letter will describe the reasons for the disapproval and how the investigator may respond. Refer to the section regarding Investigator Appeals for more details.

***While the RS or Chair are the default reviewers, response material may be reviewed by any member of the IRB or experienced staff of the IRB/HSPP.**

Related Policies

2011-007.0 – Definitions Applied to Policies
2011-009.4 – Institutional Review Board - Convened Meeting Operations
2011-009.7 – Institutional Review Board – Assignment of Status Codes
2011-009.8 – Institutional Review Board – Appeals Process
2011-009.10 – Institutional Review Board – More Frequent Review

Basis

45 CFR 46
21 CFR 56
OHRP - Guidance on IRB Approval of Research with Conditions (11/10/2010)

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Reviewed and Approved By:

Richard H. Simon

11/01/23

Richard H. Simon, MD
Director Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-009.6
Policy Title: Institutional Review Board (IRB) - Consultants

Purpose

The purpose of this policy is to describe when and how the IRB may implement the use of a consultant to aid in the review of a research protocol.

Definitions

See policy 2011-007.0 for definition of the following term:

Conflict of Interest Financial Interest Related to the Research Immediate Family Member

Policy

As related to vulnerable populations, the IRB will follow policy 2011-006.0 regarding use of consultants. The IRB may also enlist the help of a consultant who is not a member of the IRB as it deems necessary. Such consultants will be called upon when, in the opinion of the IRB, someone with a specific expertise is needed to conduct a thorough review of a study or to address specific questions related to a study.

In all cases, consultants may not have a conflict with the research being reviewed (regardless of the type of review (initial, continuation, modification, non-compliance, unanticipated problem, etc.) or level of review (full board, expedited, exempt)). Conflict of interest for a consultant is defined in the same manner as a conflict of interest for an IRB member and investigator.

No UConn Health employee will be paid for conducting a review. Consultants will have full access to the IRB file for the specific study being reviewed, including access to previous minutes.

Procedure

Need for Consultant:

For vulnerable populations policy 2011-009.6 is followed. Otherwise, the Chair may determine that a consultant is required at the time of initially assigning reviewers, an assigned reviewer may make a request to the Chair that a consultant be called upon, or the IRB may come to this conclusion at a meeting. An assigned reviewer may also elect to contact a consultant during the course of conducting a review, e.g. by calling a colleague with known expertise.

Identifying Consultant:

If the Director of the HSPP has not appointed a standing consultant (e.g. to review studies involving particular vulnerable groups such as children or of a particular design such as Community Based Participatory Research) and the IRB membership does not have the required expertise, the IRB Chair will seek a consultant from within the institution or neighboring facilities and ask the individual to perform the review as a courtesy to the IRB.

If an individual cannot be identified from within the institution or neighboring facility an external consultant will be sought. The operating budget of the IRB or HSPP will pay for such consultation if payment is required.

Conflicts of Interest:

Standing consultants are informed at the time of appointment that they cannot have a conflict with any study for which their services are sought. They are reminded of this when being assigned to a review through the reviewer form which states that no conflict may exist. When using an ad-hoc consultant the Chair or reviewer will determine that no conflict exists in the course of communication with the consultant and confirm orally that such determination was made at the convened meeting.

Participation of Consultant:

The IRB Regulatory Specialist will provide the consultant with the same material that a primary reviewer receives. The consultant will be invited to attend the convened meeting at which the review will occur to participate in the discussion and make recommendations. The Chair will excuse the consultant prior to deliberations and voting. As noted in policy 2011-006.0, when expertise of a consultant is required for vulnerable populations; the consultant must be present for the initial review of the research. When consultation is called upon for issues related to research design, if the consultant cannot attend the meeting, but can provide a written summary of recommendations; the Chair may determine on a case-by-case basis whether to proceed with the review at the meeting based on the written recommendation.

The IRB RS will note participation of a consultant in the minutes of the IRB meeting.

Related Policies

2011-006.0 – Vulnerable Populations – General Policy
2011-007.0 – Definitions Applied to Policies
2011-012.0 – Conflict of Interest – Research Personnel
2011-012.1 - Conflict of Interest – IRB members

Basis

45 CFR 46
21 CFR 56

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Reviewed and Approved By:

Signed Richard H. Simon

1 May 2017

Richard H. Simon, MD
Director Human Subjects Protection Office

Date:

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-009.7
Policy Title: Institutional Review Board (IRB) – Assignment of Status Codes

Purpose

The purpose of this policy is to set forth the status codes that the IRB may assign to a study and to define when each code would be used.

Definitions

See policy 2011-007.0 for definition of the following terms:

IRB Approval | Noncompliance | Noncompliance, Continuing | Noncompliance, Serious
Unanticipated Problem Involving Risk to Subjects or Others

Policy

The IRB will assign the applicable status codes to each submission and study that it reviews. As described below, the code may reflect the status of the study overall, or the status of a particular submission associated with the study (e.g., a request for modification).

Administrative Hold

This post-approval status is assigned to studies when an investigator voluntarily places some or all research activities temporarily on hold. The PI must notify the IRB in writing of intent to lift the hold and await notification from the IRB prior to resuming any activities subject to the hold. The IRB will not initiate an Administrative Hold on behalf of an investigator, and this status code is not used to reflect a suspension of approval (in part or in full) imposed by the IRB or other administrative official. Study expiration dates and applicable requirements for continuing review are not impacted by an Administrative Hold.

Approved

This status code is assigned when a study is given final IRB approval through the expedited or convened board review process. Final approval means that any contingencies initially identified have been addressed. This code is also used to reflect approval of requests for continuations and requests for study addendum/ modifications. Other institutional officials cannot approve research if it has not been approved by the IRB.

Closure by PI

This status code is assigned by the IRB Regulatory Specialist when an investigator has submitted a request for closure of a study and the IRB (UConn Health or external IRB in the case of reliance) grants the request.

Contingent Approval

This status code is assigned after formal review by the IRB when minor modifications or confirmation of assumptions are required before final IRB approval will be given. The modifications required for approval must be directives to the investigators and not require the judgment of the IRB to determine if the criteria for approval have been satisfied. This code may also be used to reflect the review outcome for submissions for requests for continuation and modifications and facilitated reviews.

Deferred

This status code is assigned when the board has reviewed a study at a convened meeting and has significant concerns with the protocol, consent document or other relevant material, or requires substantive clarifications on issues that relate to the regulatory criteria for approval. The principal investigator must respond to each concern in writing and resubmit for review by the same IRB panel. This status may also be assigned to requests for continuation and modifications.

Determined Not Human Subjects

This status code is assigned when the IRB determines that a submission for which IRB approval has been sought does not meet the definition of research involving human subjects or a clinical investigation involving human subjects.

Disapproved

This status code is assigned when the board reviews a study and determines that one or more of the regulatory criteria for approval has not been met and in the board's opinion cannot be satisfied. This status code may also be used for requests for continuations and modifications. This status code can only be assigned by the convened board.

Facilitated Review Accepted/ Declined

The accepted or declined status code is assigned to indicate whether the UConn Health IRB has agreed to rely upon an external IRB for a study. The review may be accepted contingently if the UConn Health IRB requires minor modifications prior to agreeing to defer oversight to an external IRB.

Inactive / Administratively Closed

This status code is assigned by the IRB Administrator to reflect that a study has been administratively closed by the IRB due to failure to request continuing review or to respond to contingencies for continuing approval in a timely manner. The investigator will be notified of studies closed by the IRB. Administrative closures by the IRB are not reportable events. The HSPP staff will assign this status code to exempt research after the anticipated completion date has passed.

Lapsed

This status code is administratively assigned to a study by the IRB submission system, iRIS, when a study has not received final approval for continuation, or final approval to extend the expected completion date of the study when continuing is not required, prior to the expiration of the current approval period. The status will also be automatically assigned to exempt research for which the expected completion date has passed.

Non-Reportable Event

This status code may be assigned by an expedited reviewer or the convened board to reflect the determination that an event described within an IRB submission, e.g. an issue described on a problem report form, does not constitute serious noncompliance, continuing noncompliance or an unanticipated problem involving risk to subjects or others.

Pending

This status code is assigned by the IRB submission system, iRIS, to new study submissions when material has been received for review but the review has not yet occurred.

Reportable Event

This status code may be assigned by the convened board to reflect the determination that an event described within the IRB submission, e.g. an issue described on a problem report form or in an audit letter, does constitute serious noncompliance, continuing noncompliance and/or an unanticipated problem involving risk to subjects or others. The specific type of event that the issue represents will be noted in the IRB meeting minutes.

Suspension

This status code is assigned to reflect the imposition of a temporary hold on any or all research activity associated with a study, or a permanent stop to some portion of a previously approved research activity. This code may be assigned by the Chair, the convened board or other institutional official designated in the policy for imposing suspensions. Suspension may ultimately result in termination if the investigator cannot adequately address the concerns of the IRB or other institutional officials.

Tabled

This status code is used in the IRB minutes only when a submission is not reviewed at the meeting for which it was originally scheduled, for example, due to a loss of a quorum. This status code may also be used for requests for continuation and modification.

Termination

This status code is assigned to reflect a permanent withdrawal of study approval that requires all study related activity to cease. This code may be assigned by the convened IRB or other institutional official designated in the suspension policy for reasons such as noncompliance or the occurrence of serious or unexpected risks to subjects.

Withdrawn – Never Approved

This code will be administratively assigned by the IRB staff to submissions and/or studies seeking approval upon communication from an investigator that final approval will not be sought or the PI does not respond to pre-review corrections or contingencies for approval in a reasonable timeframe (e.g., within six months).

Procedure

For submissions reviewed by the convened board, the IRB Regulatory Specialist (RS) will enter the status code assigned by the board into the electronic data base.

For expedited and exempt submissions the RS will enter the status code in the electronic system based on documentation received from the reviewer.

The status code assigned will be communicated from the IRB to the investigator in writing using the standard IRB outcome letter.

For suspensions or terminations imposed by other institutional officials the IRB RS will change the status code in the system upon receipt of documentation from the individual imposing the action.

To exercise the option for an administrative hold, the PI must notify the IRB within 5 business days using an Addendum or Problem Report form in the IRB electronic submission system. The notification will include the rationale for the Administrative Hold and any relevant supporting documents and indicate what specific activities are being placed on hold (e.g., recruitment, screening/enrollment, interactions/interventions with subjects, collection/analysis of identifiable information) and whether the administrative hold will impact the rights and welfare of subjects. The PI must continue to report

noncompliance or unanticipated problems to the IRB per policy during an administrative hold and the study expiration date remains in effect. The investigator must notify the IRB, through a modification via the IRB electronic system, of the intent to resume the research activities on hold when the issues which led to the PI initiated Administrative Hold have been resolved. The PI must await notification from the IRB before resuming the research activities subject to the hold.

Related Content

2009-001 - Reporting Unanticipated Problems to the Institutional Review Board
2009-002 - Reporting Noncompliance to the Institutional Review Board
2009-003 - Imposing and Lifting Suspensions of IRB Approval or Imposing Terminations of IRB Approval
2011-007.0 – Definitions Applied to Policies
2011-009.2 – Institutional Review Board - Exemptions
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by the Convened Board

Basis

45 CFR 46
21 CFR 56

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Shemetra Owens

9/26/2025

Shemetra Owens, CIP, CIM
Assoc. Director Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-009.8
Policy Title: Institutional Review Board (IRB) – Appeals Process

Purpose

The purpose of this policy is to identify circumstances when a Principal Investigator (PI) may appeal decisions made by the IRB.

Definitions

See policy 2011-007.0 for definitions of:

IRB Approval		Suspension		Termination
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Policy

In the event that an application is disapproved, suspended or terminated by the IRB the principal investigator may appeal the decision in writing to the convened IRB. The investigator may also appeal contingencies required by the convened IRB to secure approval or other determinations made by the board. The PI will have 90 days from the date of the convened meeting at which the IRB decision was made to file an appeal. The PI may file a subsequent appeal (within 90 days of the appeal meeting date) only if additional information is available to supplement the initial appeal.

An appeal can only be made to the panel that has oversight of the study.

Procedure

Appeal of IRB Decision to Deny Approval, Suspend or Terminate a Study

If electing to appeal the IRB's decision to deny approval or suspend or terminate a study, the PI will submit a written appeal that includes information that supports the PI's position.

Designated IRB Regulatory Specialist (RS) will place the appeal on the meeting agenda and distribute the material to IRB members. The Chair will designate primary reviewers to lead the discussion, with preference of using the same reviewers who conducted the review that resulted in the disapproval, suspension or termination.

The Chair may elect to convene a special meeting to process the appeal or to place it on the agenda for the next regularly scheduled meeting.

- At the discretion of the Chair, the PI may be invited to attend the meeting at which the appeal will be processed;
- If attending, the PI will present their case and may engage in discussion with the IRB to provide additional information;
- The Chair will excuse the PI prior to deliberations and voting.

The PI will be informed in writing of the final decision of the IRB. The letter will be prepared by the RS for signature (wet-ink or electronic) by the Chair.

The PI may file a second appeal within 90 days of the initial appeal meeting if additional information is available to support the PI's position. The procedure noted above is followed.

Appeal of Contingencies or Other Determinations:

The initial appeal will be filed through a written correspondence from the PI to the IRB Chair explaining why the contingency imposed by the IRB, or the determination made by the IRB, is not appropriate.

If the appeal is related to a contingency for approval the Chair may elect to do one of the following:

- agree with the investigator and grant approval providing the contingency does not affect the regulatory criteria for approval (i.e., minimization of risk, reasonableness of risk in relation to benefits, equitable selection of subjects, the process or required elements of consent, adequate provisions for monitoring data to ensure subject safety, adequate provisions for privacy and confidentiality of data, protection of vulnerable subjects);
- disagree with the investigator and still require that the contingency be addressed, or
- refer the matter back to a convened board meeting for review, e.g., if the Chair and investigator cannot come to agreement and/or the contingency is directly related to a regulatory criterion for approval.

Designated IRB staff will communicate the decision of the IRB Chair in writing to the PI. If referral to the convened board is made, the procedure noted in the first section will be followed.

If the appeal relates to a determination made by the IRB (e.g., that an issue represents serious non-compliance,) the appeal will be reviewed by the convened board and the procedures noted above will be followed.

Related Policies

2009-003 – Imposing and Lifting Suspensions of IRB Approval or Imposing Terminations of IRB Approval

2011-007.0 – Definitions Applied to Policies

2011-009.5 – Institutional Review Board – Review by Convened Board

2011-009.7 – Institutional Review Board – Assignment of Status Codes

2011-009.12 – Institutional Review Board – Criteria for Approval

Basis

45 CFR 46

21 CFR 56

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Richard H. Simon

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Richard Simon, MD

Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-009.9
Policy Title: Institutional Review Board (IRB) - Verification of No Material Changes

Purpose

The purpose of this policy is to describe situations for which verification from sources other than an investigator may be required to ensure that no material changes have occurred since previous IRB review and to describe the process for obtaining such verification.

Definitions

See policy 2011-007.0 for definition of the following terms:

Conflict of Interest Suspension Termination

Policy

The IRB will require independent verification from sources other than the Principal Investigator (PI) that no material changes (i.e. changes that are both relevant and consequential) have occurred since previous IRB review in the following situations:

- When there is inconsistency in the information presented by the PI to the IRB and those inconsistencies cannot be easily resolved.
- When the IRB questions the ability or the willingness of the PI to provide accurate information.
- When concerns have been raised, through continuing review or from other sources, that material changes have been implemented without IRB approval.
- Other circumstances for which the IRB deems independent verification is needed.

In most cases a Research Compliance Monitor (RCM) from within the HSPP will conduct the verification. The RCM has complete access to all research data and may observe the research and consent process.

The IRB may require that a consultant with particular expertise review the research activity. Such consultants will not have a conflict of interest in the research.

Procedure

The IRB Chair, an assigned reviewer through the IRB Chair, or the convened board may request that the RCM or a consultant review the relevant research documents or observe the conduct of the research and / or consent process to verify the accuracy of the information presented to the IRB and to ensure that no material changes have been instituted without IRB approval.

- The request may be made prior to the IRB meeting or requested at the IRB meeting and documented in the minutes.
 - If requested at or prior to the meeting, approval or contingent approval may still be granted pending outcome of the review (e.g. approved contingent upon confirmation of accuracy).
- If a consultant is to be called upon, the IRB Chair may determine who will act as the consultant and will confirm that no conflicts exist.

- The individual performing the verification will provide the IRB Chair with a written summary of the verification.
 - If after evaluation it is established that there may have been material changes made, the IRB Chair will direct the IRB Regulatory Specialist (RS) to place the item on the agenda for the next convened board meeting for further review and discussion and determination as to whether the findings constitutes serious or continuing non-compliance or an unanticipated problem involving risk to subjects or others.
 - the IRB may require corrective actions such as imposing a suspension or termination of approval, requiring additional education, review of policies or other mechanisms to prevent subsequent occurrences.
 - The RS will communicate the determination of the board back to the PI through the correspondence section of the study file in the electronic submission system.
 - The RS will also upload and attach a copy of the evaluation report and the outcome letter to the "Review Board Internal Documents" section of the study file within the electronic system.
 - If after evaluation it is established that there have been no material changes made, the Chair will review and sign off on the report and the issue will be considered resolved.
 - The Chair will forward the report to the RS for processing.
 - The RS will communicate to the PI through the correspondence section of the study file in the electronic submission system that the issues has been resolved.
 - The RS will also upload and attach a copy of the evaluation report and the outcome letter to the "Review Board Internal Documents" section of the study file within the electronic system.
 - For informational purposes, the RS will include the outcome on the agenda of the next board meeting for which the submission deadline has not passed.

Related Policies

2009-003 – Imposing and Lifting Suspensions of IRB Approval or Imposing Terminations of IRB Approval
 2009-004.0 - Required Reporting to Institutional Officials and External Agencies
 2009-005.0 – Monitoring of IRB Approved Studies
 2011-007.0 – Definitions Applied to Policies
 2011-009.6 – Institutional Review Board – Consultants

Basis

45 CFR 46
 21 CFR 56

Document Attributes

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Reviewed and Approved By: Richard H. Simon **Date:** 1 May 2017
Richard H. Simon, MD
Director Human Subjects Protection Office

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-009.10
Policy Title: Institutional Review Board – More Frequent Review

Purpose

The purpose of this policy is to set forth circumstances under which the IRB may require continuing review more frequent than annually.

Definitions

See policy 2011-007.0 for definitions of:

Noncompliance, Serious | Noncompliance, Continuing | IRB Approval

Policy

The IRB may require that continuing review occur more often than annually in the following circumstances:

- The research involves the use of procedures that have not been studied in humans.
- The research is expected to result in a high frequency of morbidity or mortality.
- The investigator has a history of serious or continuing non-compliance that the IRB believes necessitates closer monitoring.
- Any other situation in which the IRB believes that more frequent continuing review is warranted.
- If none of the above applies and the research is undergoing initial review by the convened IRB, the review interval noted on Appendix A will apply unless specifically stated otherwise at a meeting. If the IRB approves research with conditions, the date of approval is the date the conditions were determined to be met. A similar review interval will be implemented for any additional IRB panels established. For studies requiring continuing review by the convened board the IRB will maintain the anniversary date by which continuing review must occur providing the PI requests continuing review at the designated meeting.
- If none of the above applies and the research is undergoing continuing review by the convened IRB after the research approval has lapsed, if approval is re-instated, the study will be approved through the original valid through date. For example, if a study valid through June 10, 2011 did not undergo continuing review on May 16, 2011, but rather obtained continuing review and approval on June 20, 2011, there would be a lapse in approval from June 11th through June 19th during which all research related activity must stop (unless otherwise approved by the IRB due to it being in the best interest of subjects). Once review and approval by the IRB was granted, the study would be assigned an approval period of June 20, 2011 – June 10, 2012 with continuing review required at the meeting convened in May 2012, the 11th month of the cycle.
- A request for continuation requiring review by the convened board that is submitted early will be placed on the agenda of the next regularly scheduled IRB meeting. If reviewed early, the approval period by which subsequent continuing review must occur will be adjusted accordingly such that it occurs within one year of the convened meeting date. For example, a study that was scheduled to be reviewed at the September 26, 2011 meeting is submitted early and the PI requests review at the August 22, 2011 meeting. The PI addresses contingencies and final approval is granted on August 30, 2011. The approval period will be from August 30, 2011 – August 14, 2012, with continuing review occurring at the July 2012 meeting.

- Requests for initial or continuing review for expedited studies will be processed as received. Anniversary dates are not maintained for expedited reviews. If continuing expedited review is required, the review interval may be shorter than 365 days when there are administrative issues (e.g., completion of training) that remain outstanding after the reviewer has completed the final review. For example, if the Chair reviews the contents of a submission on April 1st and has no concerns with the study, but training for one investigator is not completed until April 15th; the date of final IRB approval will be April 15th but the study, which requires continuing review, will only be valid through March 31st of the following year.
- If a study is reviewed by another panel as opposed to the panel to which it was originally assigned, e.g., to prevent a lapse in approval that is not due to the investigator's failure to request continuation but due to loss of quorum at a previous IRB meeting, the original review cycle will be retained, i.e., it will be based off of the assigned panels review cycle.

Each year the IRB staff will publish submission deadlines for studies requiring review by the convened board.

Procedure

Full Board:

The primary reviewers of a study will suggest the review interval for a study at a convened IRB meeting as prompted by the IRB reviewer sheet.

The majority vote of those members present will determine the review cycles.

Designated IRB staff will document the review cycle in the IRB minutes and in the electronic IRB system.

Designated IRB staff will use the information in the system to generate the correspondence to the investigator (e.g., the standard approval letter) that reflects the approval interval.

Expedited:

The expedited reviewer will complete and date the reviewer form. When the reviewer has no concerns with the content of the submission, and if there are no administrative issues to be addressed, this date will reflect the date of final IRB approval and the IRB staff will enter it into the IRB system with a review cycle of 365 days from this date, unless otherwise stipulated by the reviewer.

If there are administrative issues (i.e., issues not affecting content) that must be addressed, such administrative issues do not require additional review by the assigned reviewer. Designated IRB staff will track when the issues are addressed and use that date as the date of final IRB approval. The review cycle however will be based on the date that the reviewer completed the review of the content; i.e. the review cycle may be shorter than 365 days.

Designated IRB staff will use the information in the system to generate the correspondence to the investigator (e.g., the standard approval letter) that reflects the approval interval.

Related Policies

2011-007.0 – Definitions Applied to Policies
2011-009.4 – Institutional Review Board – Convened meeting Operations
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

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Richard H. Simon

07/20/2023

Richard H. Simon, MD

Date

Director, Human Subjects Protection Program

Appendix A
IRB Initial Approval Intervals Based on Final Approval Date

Panel 1			Panel 2		
Initial Final Approval Date Range	Valid Through Date	Continuing Review Meeting Date	Initial Final Approval Date Range	Valid Through Date	Continuing Review Meeting Date
Jan 26 – Feb 25	25 th Jan	1 st Mon. Jan.	Jan 11 – Feb 10	10 th Jan	3 rd Mon. Dec.
Feb 26 – Mar 25	25 th Feb	1 st Mon. Feb.	Feb 11 – Mar 10	10 th Feb	3 rd Mon. Jan.
Mar 26 – Apr 25	25 th Mar	1 st Mon. Mar.	Mar 11 – Apr 10	10 th Mar	3 rd Mon. Feb.
Apr 26 – May 25	25 th Apr	1 st Mon. Apr.	Apr 11 – May 10	10 th Apr	3 rd Mon. Mar.
May 26 – Jun 25	25 th May	1 st Mon. May	May 11 – Jun 10	10 th May	3 rd Mon. Apr.
Jun 26 – Jul 25	25 th Jun	1 st Mon. Jun.	Jun 11 – Jul 10	10 th Jun	3 rd Mon. May.
Jul 26 – Aug 25	25 th Jul	1 st Mon. Jul.	Jul 11 – Aug 10	10 th Jul	3 rd Mon. Jun.
Aug 26 – Sep 25	25 th Aug	1 st Mon. Aug.	Aug 11 – Sep 10	10 th Aug	3 rd Mon. Jul.
Sep 26 – Oct 25	25 th Sep	1 st Mon. Sep.	Sep 11 – Oct 10	10 th Sep	3 rd Mon. Aug.
Oct 26 – Nov 25	25 th Oct	1 st Mon. Oct.	Oct 11 – Nov 10	10 th Oct	3 rd Mon. Sep.
Nov 26 – Dec 25	25 th Nov	1 st Mon. Nov.	Nov 11 – Dec 10	10 th Nov	3 rd Mon. Oct.
Dec 26 – Jan 25	26 th Dec	1 st Mon. Dec.	Dec 11 – Jan 10	10 th Dec	3 rd Mon. Nov.

Initial Full Board Approval will always be granted by Chair / administrative review & approval of contingencies may be assigned for continuing review and/or review of modifications

Emergency Panel – First continuing review will be based on schedule above depending on which Chair convened the meeting

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-009.11
Policy Title: Institutional Review Board – Studies Conducted in Foreign Locations

Purpose

The purpose of this policy is to ensure that subjects who enroll in studies conducted in foreign locations are provided with equivalent protections.

Definitions

Policy

Research conducted by UConn Health investigators in foreign countries remains under UConn Health purview and guidelines. While some adjustments may be made to some requirements to respect cultural differences, standards for ethical conduct are not relaxed. In addition, if identifiable protected health information is brought back to UConn Health, HIPAA must be addressed.

Research projects must have been approved by the local equivalent of an IRB before the UConn Health IRB will grant final approval. Where there is no equivalent board or group, investigators may rely on local experts or community leaders to provide approval. There must also be detailed plans in place for local monitoring of studies that pose more than minimal risk to subjects. If the IRB is not satisfied with the review of local experts and/or the plans for monitoring there is the possibility that the study will not be approved. Such determinations would be made by the convened board.

Researchers must describe what, if any, knowledge or experience they possess regarding the language and culture of the country in which the research is to be conducted.

The IRB may seek guidance from the Office for Human Research Protection (OHRP) to determine whether procedures described by a foreign institution afford protections that are at least equivalent to U.S. regulations and may be substituted for the US regulations. If OHRP finds the foreign guidelines are found to be equivalent to U.S. regulations, the investigator is permitted to substitute those foreign procedures.

Studies conducted in foreign locations are also subject to audit by the Research Compliance Monitor (RCM). The RCM may require the investigator to provide copies of or access to all research related records such that the audit may occur. Only in extreme extenuating circumstances would the RCM visit a foreign location. Investigators continue to be obligated to report issues of noncompliance and unanticipated problems to the IRB and to provide participants with a mechanism for expressing complaints or concerns.

Procedure

When preparing a submission to the IRB the PI is directed to:

- provide documentation of local approval,
- provide documentation of the authority and expertise of the individual or group who granted approval,
- provide plans for local monitoring for studies involving more than minimal risk,

- describe their knowledge of language and culture of the location where the research will be conducted.

The IRB staff screen the submission and the IRB reviews the study in accordance with policies and procedures for conducting IRB reviews, including requirements for consent and translation of documents.

Complaints, concerns and reports of noncompliance and/or unanticipated problems involving risk will be reviewed by the IRB in accordance with existing policies.

The IRB will communicate and coordinate with the local IRB or ethics board as needed when appropriate.

Related Policies

2009-001.0 – Reporting Unanticipated Problems to the IRB
 2009-002.0 – Reporting Non-Compliance to the IRB
 2009-005.0 – Monitoring of IRB Approved Studies
 2011-009.2 – Institutional Review Board – Exemptions
 2011-009.3 – Institutional Review Board – Expedited Reviews
 2011-009.5 – Institutional Review Board – Review by Convened Board
 2011-018.0 – Complaints, Concerns, Suggestions

Basis

45 CFR 46

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Richard H. Simon

11/01/23

Richard Simon, MD
Director Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-009.12
Policy Title: Institutional Review Board (IRB) - Criteria for Approval

Purpose

The purpose of this policy is to set forth the criteria that the IRB must ensure are satisfied prior to granting IRB approval to an investigator to conduct a non-exempt research protocol, and, if applicable by regulation to set forth criteria that must be met when limited IRB review is utilized for exempt research.

Definitions

See policy 2011-007.0 for definition of IRB Approval

Policy

Regardless of funding source, in order for the IRB to grant approval to a non-exempt research study the IRB must find that the following criteria are met at the time of initial approval and sustained through continuing review as it is required and requests for modifications/addendums.

- Risks to subjects are minimized: (i) by using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.
- Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result. In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research). The IRB should not consider possible long-range effects of applying knowledge gained in the research (for example, the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.
- Selection of subjects is equitable. In making this assessment the IRB should take into account the purposes of the research and the setting in which the research will be conducted. The IRB should be particularly cognizant of the special problems of research that involves a category of subjects who are vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons and subjects afforded additional protections such as pregnant women.
- Informed consent will be sought from each prospective subject or the subject's legally authorized representative, or appropriately waived or altered, in accordance with, and to the extent required by applicable regulations or by policy when the research is not otherwise subject to regulation.
- Informed consent will be appropriately documented, or documentation appropriately waived, in accordance with, and to the extent required by applicable regulations or by policy when the research is not otherwise subject to regulation.
- When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects.

- At its discretion, the IRB may require that a monitoring plan be in place for minimal risk studies and studies presenting a slight increase over minimal risk.
- At its discretion, the IRB may require that a data safety monitoring board (DSMB) or independent monitor be in place for studies above minimal risk. The DSMB or independent monitor may be internal or constituted by the sponsor. In determining whether an internal board or independent monitor is required the IRB will take into consideration such things as the length of the study, the number of subjects to be enrolled in the study, overall subject exposure and other mechanisms for monitoring already in place, e.g., adverse event reporting requirements, access to information from safety divisions etc.
- Issues that should be addressed within the area of data safety monitoring include the frequency of the monitoring, who will conduct the monitoring, what data will be monitored, how the data will be interpreted and analyzed, what actions will be taken upon the occurrence of specific events or end points, and how communication from the DSMB to the IRB will occur.
- When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.
 - Privacy refers to the individual. Therefore the PI must ensure that as applicable the consent process and study activities are conducted in a setting that affords sufficient privacy to the subject. Confidentiality refers to the data related to the subject. Confidentiality encompasses the secure storage of electronic and paper files and biological samples.
- When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, economically or educationally disadvantaged persons, or students, or have special protections afforded to them, such as pregnant women and neonates, additional safeguards have been included in the study to protect the rights and welfare of these subjects.

For certain exemptions, as per regulation, the IRB will conduct a limited IRB review. The IRB shall make the determinations required by the applicable exemption category such as ensuring that there are adequate provisions in place to protect the privacy of subjects and to maintain the confidentiality of data. UConn Health will not utilize federal exemption categories regarding broad consent.

Procedure

The Principal Investigator (PI) must complete the IRB application, inclusive of supporting documents such as the appendices, consent form, data safety monitoring plan, etc., and in so doing address the regulatory criteria for approval.

The standard screening and review procedures used for exempt, expedited and convened board review apply.

Designated IRB staff will prepare the appropriate letter to communicate the determinations of the IRB to the investigator.

The Research Compliance Monitor verifies in audit that the regulatory criteria for approval continue to be satisfied, e.g., that the plans to protect privacy and confidentiality, as submitted to the IRB, are in fact being followed.

Related Policies

2009-005.0 – Monitoring of IRB Approved Studies
2011-006.0 – Vulnerable Populations – General
2011-007.0 – Definitions Applied to Policies
2011-008.0 – Informed Consent – Forms
2011-008.1 – Informed Consent – Process
2011-008.2 – Informed Consent – Waivers and Alterations
2011-008.5 – Informed Consent – Providing and Obtaining Informed Consent
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by Convened Board
2011-009.7 – Institutional Review Board – Assignment of Status Codes

Basis

45 CFR 46.111
21 CFR 56.111

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Richard H. Simon

6/8/2023

Richard H. Simon, MD

Date

Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-009.13
Policy Title: Institutional Review Board – Lapse in IRB Approval

Purpose

The purpose of this policy is to describe what occurs when a Principal Investigator does not maintain IRB approval.

Definitions

See policy 2011-007.0 for definition of:

IRB Approval		Suspension		Termination
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Policy

For non-exempt research the Principal Investigator (PI) retains the responsibility for ensuring that IRB approval is maintained.

When continuing review is required the PI is responsible for submitting requests for continuation. If continuing review is not required (e.g., the research is expedited research that does not require continuing review) but the expected completion date of the research is approaching (i.e. the expiration date of the research) the PI is responsible for submitting a request to the IRB to extend the expected completion date. If a PI does not obtain final continuing approval from the IRB, or approval from the IRB for an extension of the expected completion date for the research, by the end of day through which approval is valid, a lapse in approval will occur (e.g., research valid through 2/1/2018 could not be conducted on 2/2/2018). With one exception as described below, once a lapse in non-exempt research occurs all research related activity, including analysis of identifiable data, must stop until such time as final approval for continuation, or an extension of the expected completion date, is granted.

For studies requiring full board review, if review does not occur by the next convened meeting and the PI has not expressed an intention to obtain continuing approval, the study is administratively closed by the IRB. For studies for which continuing approval is sought, the IRB will retain the anniversary date by which continuing review must occur (i.e., the review interval will be more frequent than annually).

For studies requiring expedited continuing review (e.g. if specifically imposed by the IRB, or if required by regulation), if review has not been obtained within a reasonable time frame (e.g. 30 days after the expiration date), and the PI has not expressed an intention to obtain continuing approval, the study is administratively closed by the IRB staff. For studies for which continuing approval is ultimately obtained the approval interval will be for 364 days from the date of approval unless specified otherwise by the reviewer. Anniversary dates are not maintained for expedited continuing reviews.

For expedited research that does not require continuing approval or for exempt research, if a request for modification to extend the expected completion date of the research is not received within a reasonable time frame (e.g., 30 days after the expiration date) the study will be administratively closed by the IRB. For exempt research neither the lapse in approval nor the administrative closure invalidate the exemption (i.e., the exempt research may continue).

If a request for continuation is approved contingent, and a PI does not respond to contingencies for approval for continuation within a reasonable time frame after a lapse (e.g. 30 days), the IRB may administratively close the study.

An administrative study closure is not considered a suspension or termination that is reportable to institutional officials or agency heads.

The exception to conducting activity in non-exempt research during a lapse is if continuation of an activity is required due to it being in the best interest of the subject. In such cases the PI must submit a written request to continue the activity to the Chair explaining why the activity is in the best interest of the subject, and obtain the approval from the Chair prior to continuing the activity. The IRB Chair reserves the right to grant or deny permission to continue an activity.

Procedure

Notification of Lapse:

When continuing review is a requirement, the electronic IRB system will generate automatic reminder notifications to the PI to request continuing review. When continuing review is not a requirement designated staff in the IRB will run a monthly report to identify the studies for which the expected completion date is nearing and will contact the PI via email or IRIS correspondence with a reminder to either request an extension of the anticipated completion date or close the study.

If approval for continuation or a modification to extend the expected completion date is not obtained prior to the expiration of the current approval period, the system will automatically change the study status to Lapsed and generate a Lapse In Approval Notification. The Regulatory Specialist will verify that the PI was included as a recipient of the Lapse Notification, and if not will forward the message to the PI through Outlook as well as through Study Correspondence.

Permission to Continue Activity:

If during the lapsed period for non-exempt research the PI needs to continue an activity due to it being in the best interest of the subject the PI must submit a written request for permission for continuation of specific activity(ies), explaining why the continuation of the activity is in the best interest of the subject; and confirming that approval for continuation is actively being sought.

The IRB Chair will decide whether to grant approval for such requests and designated Regulatory Specialist will communicate the decision back to the PI.

The preferred method of communication for this to occur is for the PI to submit a request for addendum/modification in IRIS and attach the form titled "Permission to Treat During a Lapse." If the PI communicates outside of IRIS (e.g., by e-mail with attached memo) the Regulatory Specialist will ensure that communications are uploaded to the Study Management, Review Board Internal Documents section of IRIS and the PI is responsible for keeping documentation of the correspondence with the study file.

Tracking Lapse Status:

Designated IRB staff will use the system generated lapsed status to track studies and determine whether continuing approval or a request to extend the expected completion date has been requested/obtained. For studies for which approval for continuation is not sought (i.e., by the next convened board meeting for studies requiring full board review, or within a reasonable time frame (e.g., 30 days) after expiration for expedited studies), or a request to extend the expected completion date has not been received within a reasonable time frame (e.g., 30 days), IRB staff will administratively close the study and send a written notification to the Principal Investigator of the administrative closure. For lapsed studies for which a response to contingencies has not been received within a reasonable time frame (e.g., 30 days) the Regulatory Specialist may administratively close the study and send written notification to the PI. Prior to closure the RS will issue a final request for responses by email to the PI and study contacts and the PI will be given a reasonable period within which to respond (e.g., one or two weeks).

Related Policies

2011-007.0 – Definitions Applied to Policies
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by Convened Board
2011-009.10 – Institutional Review Board – More Frequent Review

Basis

45 CFR 46
21 CFR 56

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Richard H. Simon

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Richard H. Simon, MD

Date

Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-009.14
Policy Title: Institutional Review Board - Human Subject Research Determinations

Purpose

The purpose of this policy is to describe the authority and role of the HSPP / IRB as related projects that do not involve human subjects and / or that do not involve research.

Definitions

See policy 2011-007.0 for definitions of the following terms:

Clinical Investigation (FDA)	Human Subject	IRB Approval
Non-compliance, Serious	Research	

Policy

The authority of the HSPP and IRB does not extend to projects that do not involve human subjects or to projects that involve humans but do not constitute research.

If a UConn Health faculty member, employee or student is considering a project that involves human interactions, human materials and / or human data that they do not believe constitutes research involving human subjects, they are **strongly** encouraged to complete the Human Subject Research Determination Form. Individuals may use this form to self-determine that the project does not constitute human subject research. The same form may also be used to seek a formal determination from the HSPP/IRB. If a formal determination is sought, a representative of the HSPP/IRB (e.g. Regulatory Specialist, Research Compliance Monitor, Educational Specialist, IRB Program Support Staff or member of the IRB) will review the information and will make an official determination.

Any project determined to be human subject research, including exempt research, must be reviewed and approved by the IRB prior to implementation. If such projects are undertaken without IRB review because the investigator believed the project did not constitute human subject research, but it is later deemed as such, the convened IRB will review the scenario and may determine that conducting the project without IRB approval constitutes serious non-compliance.

Example scenarios of when it is strongly encouraged that an individual complete the determination form prior to starting a project include, but are not limited to quality improvement projects, classroom projects, program evaluations and surveillance activities, case reports, research on decedents.

If a project does not constitute research involving human subjects, individuals may still be obligated to comply with other relevant regulations. For example, for research on decedents, investigators must comply with HIPAA (Refer to policy 2011-014.0).

Procedure

The IRB Administrator or designee will log receipt of such forms and forward them to a representative of the HSPP/IRB for review and determination. While it is expected that the RS will make the majority of such determinations, other representatives of the HSPP/IRB may also make such determinations.

However, if a waiver of HIPAA is required, the determination is to be made by a member of the IRB who will also approve the HIPAA waiver.

The assigned reviewer will review the applicable form and document their final determination as to whether a project constitutes human subject research.

- The reviewer may request additional information if necessary.
- If the reviewer determines the project does not constitute human subject research the HSPP / IRB will have no further involvement.
- If the reviewer determines the project does constitute human subject research, the investigator will be instructed that a complete IRB application will be required.

In all cases, the reviewer will email the outcome of the review to the individual who filed the form.

The review and determination process should be completed within approximately 10 days of receipt.

Related Content

2011-007.0 – Definitions Applied to Policy

2011-014.0 - HIPAA

Basis

Office For Human Research Protections (OHRP) Frequently Asked Questions on Quality Improvement

<http://answers.hhs.gov/ohrp/categories/1569>

OHRP Decision Chart - <http://www.hhs.gov/ohrp/policy/checklists/decisioncharts.html#c1>

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Richard H. Simon, MD

Date

Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-009.15.a
Policy Title: Institutional Review Board –Reliance on UConn Health as IRB of Record

Purpose

The purpose of this policy is to set for the mechanism by which the UConn Health IRB may elect to act as the IRB for another institution.

Definitions

See policy 2011-007 for definition of Institutional Review Board

Policy

The UConn Health IRB may agree to act as the IRB of Record for another institution. In such cases the UConn Health IRB will hold the same rights, authority and responsibility as the IRB for the other institution, should one exist.

Before a UConn Health employee, student, or agent can begin a research activity that engages another institution in research, that institution must have accepted UConn Health as the IRB of Record.

When acting as the IRB for another institution:

- Standard UConn Health submission requirements pertain
- At the time of initial approval, personnel from the other institution must provide proof of training in human subject protections completed within the past three years and as applicable make disclosures regarding significant financial interests in the research.
 - The UConn Health IRB reserves the right to require additional training of those personnel.
 - The UConn Health IRB reserves the right to add requirements to manage a conflict should one exist.

In all cases for which UConn Health agrees to act as the IRB of Record for another institution, a written IRB Reliance Agreement must be in place between the institutions that outlines the expectations and responsibilities each party will undertake to ensure compliance with the requirements of the Common Rule. For study specific agreements related to minimal risk research the template provided by the Office for Human Research Protections (OHRP) may be utilized. Otherwise, the agreement should address the applicable points denoted in the IRB Reliance Agreement Checklist.

Procedures

Execution of Written Agreements:

A designated IRB Regulatory Specialist (RS) within the HSPP will oversee processing of IRB Reliance Agreements that are study specific. The UConn Health or SMART IRB template agreement may serve as the basis for such agreements. The RS will ensure that the following occurs:

- Signatures from appropriate officials at each institution are obtained.
 - At UConn Health the Director of the HSPP is the individual designated to sign such agreements however other individuals who have the authority to commit the institution to

a binding agreement (e.g., the Associate Vice President for Research Integrity and Compliance) may sign if the Director is unavailable.

- Final approval for a study is not released until the agreement has been fully executed.
- Details of the agreement are logged on the IRB Reliance tracking log on the shared HSPP drive
- A copy of the agreement is uploaded to the electronic file
- A copy of the agreement is placed in the IRB Reliance Agreements binder.

The HSPP Manager will oversee the processing of blanket IRB Reliance Agreements, ensuring that signatures from appropriate officials at each institution have been obtained and that a copy is placed in the IRB Reliance Agreements binder.

Requesting that UConn Health Act as the IRB of Record

The following are general procedures for requesting that UConn Health act as the IRB of Record. The procedures may have to be adjusted to accommodate unique circumstances surrounding an IRB submission.

Principal Investigators are encouraged to contact an IRB RS to inquire about the possibility of UConn Health acting as the IRB of record prior to submitting a request.

- The RS will advise the PI as to whether a blanket agreement already exists, the relying institution(s) is(are) part of the SMART IRB Initiative, or whether a study specific agreement would likely be accepted.

When a research study involves collaboration with another institution that may rely upon the UConn Health IRB, the Principal Investigator is to identify that institution in the IRB application and describe the role that the institution will have in the research (e.g., enrollment of subjects, data analysis, performance of procedures etc.). The PI is also to indicate in the application that UConn Health is the requested IRB of record.

Obtaining approval at UConn Health indicates UConn Health's willingness to act as the IRB of Record. The PI must also obtain confirmation from the other institution's IRB that it will accept UConn Health as the IRB of Record. The PI will have to comply with requirements of that IRB when making this request (e.g., the other institution may agree to accept UConn Health forms or may require that the PI complete their forms).

The IRB of the other institution will conduct a review and determine whether to accept UConn Health as the IRB of Record or to require an independent review by their IRB.

- If the other IRB requests changes prior to accepting UConn Health as the IRB of record the PI must submit a request for modification to the UConn Health IRB to address the changes requested from the other IRB. Once the modification is approved it would then be provided to the other IRB for final determination of acceptance.
- If UConn Health is accepted as the IRB of record, the other IRB should issue a statement to that effect to the UConn Health IRB and the PI.
 - From this point forward, the PI will only deal with the UConn Health IRB and the UConn Health IRB will keep the other IRB apprised of continuing reviews, modifications, other

- events related to the study (e.g., unanticipated problems, serious or continuing non-compliance, and lapses in study approval).
- The UConn Health IRB RS is responsible for ensuring that a letter that indicates the institution for which UConn Health is acting as the IRB of record is incorporated into the IRB number as described in the document titled “Coding Scheme for IRB Reliance.”

The project cannot start at the other site until UConn Health has approved the project **and** the other IRB has provided documentation that they have accepted UConn Health as the IRB of record.

If independent IRB review is required, the PI must also follow directions/requirements of the other institutions IRB and continue to fulfill requirements of both IRBs independently.

Once the research is approved, the addition of an investigative site may be considered a minor modification when the new site will follow the currently approved protocol. Requests to add research sites which will follow a new or different protocol will require review as a separate study or protocol.

Related Policies

2011-009.1 – Institutional Review Board – Submission of Materials
 2011-009.15.b – Institutional Review Board – Reliance on External IRB
 2011-023.0 0 - Educational Requirements

Basis

45 CFR 46.114

Document Attributes

Date Effective: 11/20/23

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Reviewed and Approved By:

Richard H. Simon

11/1/2023

**Richard H. Simon, MD
 Director, Human Subjects Protection Program**

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-009.15.b
Policy Title: Institutional Review Board –Reliance on External IRB

Purpose

The purpose of this policy is to set forth the mechanism by which the UConn Health IRB may elect to rely upon an external IRB.

Definitions

See policy 2011-007 for definition of Institutional Review Board

Policy

The UConn Health IRB may elect, or may be required, to rely on an external IRB for initial and continuing review and approval of a study. For non-exempt research, in order to do so a written IRB Reliance Agreement must be in place between the relying and reviewing IRB. The agreement must be signed by individuals from each institution with the authority to enter such agreements and must outline the expectations and responsibilities each party will undertake to ensure compliance with the requirements of the Common Rule. When the UConn Health IRB elects to rely on an external IRB the external IRB is referred to as the IRB of Record and it holds the same rights, authority and responsibility as the IRB of UConn Health. The IRB may also need to concur with an external IRB that a project meets criteria for exemption.

When an external IRB is to be utilized, in addition to obtaining the approval of that IRB, before any research activity that engages UConn Health begins, the UConn Health investigator must obtain an official determination from the UConn Health IRB that oversight for the study will be deferred to the external IRB, or that UConn Health IRB concurs that the research meets criteria for exemption. After the initial determination is made, changes to UConn Health study personnel after initial approval will continue to be processed through the local IRB as an administrative change.

When determining whether to rely on an external IRB when the research is conducted at UConn Health, a member of the UConn Health IRB Office will conduct a facilitated review of the study. The facilitated review is done to ensure that that local issues such as training and ancillary approvals have been addressed and that there are no other local issues of concern. The reviewer may require changes prior to agreeing to accept the external IRB as the IRB of Record. This may require that investigators submit a request for modification to the IRB of Record. For research approved by the Hartford Hospital, CCMC or Trinity Health IRB through either expedited review, or deemed to be exempt, when that research engages UConn Health students, residents or fellows, the UConn Health IRB may elect to accept the approval letter of the other site as notification and not require a formal submission in the iRIS system. The HSPP Director/designee, may elect to accept this process for other minimal risk research on a case-by-case basis. The UConn Health IRB reserve the right to require the formal facilitated review process be used.

Facilitated reviews may be conducted by an IRB Chair or designated IRB member, or by IRB support staff as this is an administrative review function not a formal IRB review. Unless prevented by a regulatory mandate for single IRB review, the UConn Health IRB reserves the right to require local review in any circumstance it deems appropriate. If an IRB support person has reviewed the submission and believes local review should be required, consultation with an IRB member will occur before making a final determination. If local review is required, the investigator will be informed and instructed to follow standard submission requirements.

Procedures

The following are general procedures for relying upon an external IRB. The procedures may have to be adjusted to accommodate unique circumstances surrounding an IRB submission and/or requirements of the external IRB.

Requesting Reliance on an External IRB for a New Study (inclusive of UConn Health being added as a new site to an industry sponsored clinical trial or NIH multi-center trial)

The investigator should first consult with staff in the IRB to determine if an IRB Reliance Agreement for the requested IRB of Record is in place.

- If an agreement is not in place a new agreement will be required.
 - The IRB staff (for a study specific agreement) or the HSPP manager (for an umbrella agreement) may need to begin/coordinate discussions with the external IRB to facilitate the establishment of an IRB Reliance Agreement.
 - For minimal risk, non-industry sponsored research, or for research in which the involvement of UConn Health personnel is limited to activity that may qualify for expedited review, the OHRP template may suffice.
 - For other research, the checklist list for elements of an IRB Reliance Agreements will be utilized to ensure the agreement contains all necessary elements.
 - The agreement may be based upon the UConn Health template, or the external site's template, but must address the applicable points denoted in the IRB Reliance Agreement Checklist.
 - The Director of the HSPP at UConn Health is the individual designated to sign such agreements on behalf of UConn Health. In the absence of the Director, others with appropriate signing authority (e.g., the Associate Vice President for Research Integrity and Compliance) may sign.

The investigator is to submit an application to the UConn Health IRB requesting facilitated review. This request may occur prior to, in conjunction with, or after the review by the IRB of Record. If submitted prior to the IRB of Record granting final approval UConn Health may grant a contingent acceptance until all required documents are submitted. The normal process for responding to contingencies is followed. As applicable, at a minimum the protocol, consent form, HIPAA authorization and approval letter from the IRB of Record that also shows the expiration date of approval should be attached to the UConn Health facilitated application. It is strongly encouraged that the application form from the reviewing IRB site be attached as well. Additional requirements pertain to industry sponsored multi-center research and NIH multi-center research.

- for studies that are not industry-sponsored and not NIH multi-center studies (e.g., student research projects, or collaborative research projects involving UConn Health and a nearby facility) the application submission checklist can be used as a guide to determine what additional material to submit. While all elements may not be required for facilitated reviews, the IRB reserves the right to request such material.
 - For research conducted by students, residents and fellows for which IRB Reliance is requested, since the request for facilitated review is an administrative process the student, resident or fellow may submit the facilitated application noting themselves as PI providing that the actual PI of the study is identified in the material being provided.
 - An exception may be made to the need for submission of an application for minimal risk research that engages students, residents or fellows at HH or CCMC that was deemed exempt or approved through expedited review. In such a case the IRB may elect to use the approval letter issued from the other facility to create

the study record in iRIS on behalf of the student, resident or fellow. If done, the IRB person creating the entry will notify the UConn Health personnel engaged in the research and the reviewing IRB that this was done. The IRB reserves the right to require the submission of the application and study documents approved by the other site or original approval letter to ensure the research is minimal risk.

- for industry sponsored trials or NIH multi-center trials to which UConn Health is being added as a site, the facilitated submission checklist for industry sponsored studies is the applicable checklist to use.
 - The site PI and all key personnel must be designated and sign-off on the submission.
- if a new study-specific IRB Reliance Agreement is being executed, the RS will be responsible for ensuring execution of the document as described in policy 2011-015.a and attaching the document to the study file.

Upon receipt of the material designated IRB staff will assign an IRB number to the submission that reflects that reliance upon an external IRB has been requested as described in the document titled “Coding Scheme for IRB Reliance” and assign the submission to a designated IRB staff person for screening. After screening is complete the submission will be assigned for formal review to an IRB Chair, IRB member, or IRB staff. The IRB reliance agreement will be used as a guide in determining the extent of screening activities. For example, if the agreement stipulates that the relying institution is responsible for verification of training of its personnel, the assigned IRB staff will include that function in the screening process.

- If changes are required prior to acceptance of the external IRB, assigned IRB staff will communicate this to the PI and the routine process for responding to the IRB will be followed.
 - If necessary, the PI will have to submit a modification request to the requested IRB of record to secure approval of the changes.
- If subjects are to be enrolled at UConn Health, the consent form and HIPAA Authorization form are to contain applicable UConn Health language.

The assigned reviewer will make the determination as to whether to accept the external IRB as the IRB of Record. If the determination is made to accept the external IRB as the IRB of Record, the IRB staff assigned to screen the submission will inform the PI and the IRB of Record in writing using the standard template outcome notification letter and verify that the IRB study number indicates which institution is the IRB of record as detailed in the “Coding Scheme for IRB Reliance” document, revising the number if necessary. If a determination is made that local IRB review is required, the IRB staff assigned to screen the submission will inform the PI in writing and revise the IRB number to remove reference to the external IRB.

For a study specific reliance agreement IRB staff assigned to screen the submission is to enter the details of the study and the IRB of record on the HSPP IRB Reliance tracking log.

If the determination is made to accept the external IRB as the IRB of Record, from that point forward, with the exception of reporting changes in study personnel, the investigator only deals with the IRB of Record for the review of continuations, modifications, unanticipated problems and non-compliance.

Requesting Reliance on an External IRB to Add UConn Health as Collaborating Site to an Existing Study

If UConn Health personnel are being added as collaborators to a previously approved study at another facility (e.g., a neighboring facility that provides research opportunities to UConn Health students), and that study did not previously engage UConn Health in the research, in addition to the steps of ensuring that an IRB Reliance Agreement is established, the following steps should be taken:

- A request for modification should first be submitted to the IRB of the other institution to add the UConn Health personnel.
 - The modification should make it clear that a request will be made to UConn Health for reliance upon the other institution as the IRB of Record.
- Once approval has been obtained, an application is to be made in the iRIS system at UConn Health to request facilitated review. The application should include, but not necessarily be limited to; the approved modification, a copy of the currently approved protocol and, as applicable, consent form and HPA form. The documentation should also include the date through which the study is approved.
- The UConn Health IRB will conduct the review as noted above.
 - UConn Health personnel being added must be in compliance with UConn Health human subject training requirements.
 - UConn Health personnel must also submit the SFI project disclosure form if applicable.
 - UConn Health personnel cannot engage in the research until the review process at UConn Health has been completed.
- An IRB staff member will assign a study number as noted above.

Requesting Reliance on an IRB that is not AAHRPP Accredited

When the IRB of Record is not AAHRPP-accredited, the UConn Health IRB will:

- Require assurance from the non-accredited IRB that it will conduct its review in accordance with ethical standards, applicable laws and regulations and that it will report any regulatory violations or investigations of the reviewing IRB by regulatory agencies, such as OHRP, the FDA or regulatory agencies in other countries (e.g., through use of UConn Health IRB Authorization Agreement).
- Request results of any audits/inspections of the IRB by regulatory agencies (e.g., OHRP, FDA).
- For **greater than minimal risk** research, the assigned RS or IRB staff will obtain relevant policies and procedures of the reviewing IRB and a copy of the relevant portion of the minutes of the meeting where the study was reviewed to ensure the review and approval of the study is consistent with applicable ethical standards and regulations.

The UConn Health IRB, when allowable, may elect to forgo reliance on a non-accredited IRB or require additional steps to ensure adherence to applicable ethical standards and regulatory requirements.

Changes in Personnel after UConn Health has Deferred Oversight to an External IRB

When deferring IRB oversight, changes to study personnel must be approved by the IRB of Record in accordance with that IRB's policies and procedures. Changes to UConn Health study personnel are also to be processed through the local IRB as a request for an administrative change through the iRIS system.

Related Policies

2011-009.1 - Institutional Review Board (IRB) – Submission of Materials

2011-009.15.a – IRB Reliance – UConn Health as the IRB of Record

2011-023.0 0 - Educational Requirements

Basis

45 CFR 46.114

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Reviewed and Approved By:

Richard H. Simon

11/01/2023

Richard H. Simon, MD
Director, Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-009.16
Policy Title: Institutional Review Board - Undue Influence

Purpose

The purpose of this policy is to affirm that the Institutional Review Board will operate in an environment free from undue influence.

Definitions

See Policy 2011-007.0 for the following definitions:

Undue Influence		Suspension		Termination
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Policy

The IRB must operate in an environment free from undue influence so that it may independently conduct objective and thorough reviews of research protocols.

[Note: The issue of undue influence as related to the protection of research subjects is addressed in the IRB submission and review process. Investigators are required to disclose plans to eliminate / minimize these factors in the IRB application process and the IRB considers this plan in the review process.]

Procedure

Any member of the IRB or IRB staff who believes that undue influence is being brought to bear on him/her or any other member of the IRB must report the concern to the Director of the Human Subjects Protection Program (DHSP). If the DHSP is the individual creating the undue influence, the report is to be filed with the individual to whom the DHSP reports.

- Reporting may occur through the Chair of the IRB to the DHSP or directly to the DHSP.
- The person reporting the concern should provide the name(s) of the individual(s) who may be creating the undue influence, the name(s) of who may be being influenced, and a summary of the situation, e.g. junior faculty member being pressured to vote for approval of a senior faculty member's study.
- The person reporting the concern may choose the method of communication.

Once aware of the concern, the DHSP will contact the individual alleged to be creating the undue influence to discuss the issue.

- If after the discussion the issue is not resolved and the DHSP believes it necessary s/he may exercise the authority to conduct an audit of the study that is associated with the issue, suspend or terminate studies previously approved for the individual allegedly creating the influence or coercion, or suspend that individual's involvement in studies for which s/he is not the principal investigator.
- If an allegation is substantiated and the effort to influence was done knowingly and willfully, the DHSP shall report the instance to the immediate supervisor of the individual creating the undue influence and to the Signatory Official. The DHSP may also take other appropriate actions based on the findings, including recommending disciplinary action, including termination of employment.

Related Policies

2009-003 – Imposing and Lifting Suspensions of IRB Approval or Imposing Terminations of IRB Approval

2009-005 – Monitoring of IRB Approved Studies

Basis

Accreditation Standard Element I.1.C

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Richard H. Simon

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Richard Simon, MD
Director Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-011.0
Policy Title: Research Personnel

Purpose

The purpose of this policy is to identify who may act as a Principal Investigator for research studies and to describe expectations and obligations of research personnel.

Definitions

See policy 2011-007.0 for definition of:

Principal Investigator		Co-Investigator
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Policy

Principal Investigators:

In the majority of cases only paid faculty of UConn Health, or University of Connecticut in Storrs or branch campuses qualify to serve as principal investigators on IRB applications for studies conducted at UConn Health.

- Only one person may be designated as the principal investigator.
- Students, fellows or other trainees may be designated as co-investigators but not principal investigators.

There are two exceptions to the paid faculty requirement as related to student research. For student projects conducted in the course of curricular activities, an individual with a clinical faculty appointment at UConn Health (i.e., non-pay faculty appointment) may act as PI for the student. UConn Health may accept a Hartford Hospital, CT Children's Medical Center, or St. Francis Medical Center employee as the Principal Investigator based on the affiliation agreement between UConn Health and these institutions to provide educational opportunities to our students. This also applies to any other site with which UConn Health develops or has such an agreement. UConn Health reserves the right to require that a UConn Health faculty member serve as PI for student projects.

Other requests for someone other than a paid faculty member to serve as PI will be reviewed on a case-by-case basis by the Director of the HSPP. The non-paid faculty fundamental criterion will be the strength of the accountability of the proposed PI to the institution. For other individuals, consideration will also be given to qualifications including degrees, licensure and prior research experience; the nature of the proposed study, and the individual's position and level of authority of that position.

Research Personnel:

The IRB may require that the research team include an individual holding a medical or dental degree, or an individual having some other specified expertise as a means for ensuring subject protections. The research team should also consist of at least one co-investigator who could fulfill the role of the principal investigator in the event of extended absence of the current principal investigator, e.g., due to sabbatical leave, medical leave or change in employment.

HSPP and IRB Expectations of Investigators and Research Personnel:

Principal Investigator: The HSPP and IRB hold the principal investigator responsible for the overall management of an approved study. Management of the study encompasses the ethical, technical, administrative and fiscal elements of a project. The principal investigator may delegate certain tasks but retains ultimate responsibility and accountability. As applicable to the research elements for which the principal investigator is responsible include, but are not limited to:

- ensuring that any research personnel intervening or interacting with UConn Health patients are affiliated with UConn Health
- ensuring that any research personnel intervening or interacting with UConn Health patients have completed required institutional training
- ensuring that patients are only approached about potential participation in research by someone with an existing treatment relationship with the patient
- understanding and applying relevant professional standards to the conduct of the study
- initiating the research team to the study and their respective roles and responsibilities
- supervising all study personnel and ensuring that all personnel abide by the ethical principles of respect for persons, beneficence and justice as outlined in the Belmont Report,
- communicating with and supervising study personnel to ensure they are knowledgeable of, and conducting the study in accordance with, the approved protocol (including approved modifications),
- protecting the rights and welfare of subjects,
- reporting any real or potential conflicts of interest of the PI or any study personnel and compliance with conflict of interest policies and management plans,
- reporting any changes in UConn Health affiliation for key study personnel to the IRB (e.g., PI or Co-I move to another institution but remain on study team),
- communicating with subjects, e.g., obtaining consent, informing subject of new information that may affect their willingness to continue to participate in the study, responding to complaints or requests for information
- ensuring protected health information is only used/disclosed in compliance with HIPAA
- ensuring the confidentiality and security of research records and data as described to the IRB
- overseeing the budget and expenditures related to the study
- ensuring that adequate resources are available, including staff, equipment, supplies, bed space, storage space etc., to conduct the study at UConn Health and any other performance site for which the principal investigator is responsible,
- keeping the IRB informed of all funding sources of the study
- ensuring accurate billing of research related activities (e.g., subjects should not be billed for expenses covered by the sponsor, there should be no charges assessed to insurance carriers for procedures or treatments covered by the sponsor),
- disclosing information pertaining to adverse events including frequency of occurrences, severity of occurrences and duration of occurrences,
- requesting approval from the IRB for, and notifying the sponsor of, modifications to an approved study prior to implementation, e.g., requesting changes in the study personnel, in the consent form, or in the approved protocol,
- requesting continuation of an approved study by specified deadlines,
- maintaining and retaining research records and informed consent documents,
- cooperating in all aspects of internal or external audits and inspections,
- providing the IRB with audit or inspection reports or findings issued by regulatory agencies, cooperative research groups, contract research organizations, the sponsor or the funding agency
- when applicable, the investigator's plans to communicate with representatives of the community from which individuals will be recruited about community concerns, values and expectations
- when applicable, maintaining accurate records on the receipt, use and disposition of excess drugs/devices, and
- conducting the study in compliance with internal policies and applicable regulations and IRB approvals

All Study Personnel (including PI and co-investigators): The HSPP and IRB hold all study personnel responsible for meeting certain obligations. These obligations include, but are not limited to:

- having completed relevant training required by the institution
- having knowledge of the ethics and regulations governing the protection of human subjects,
- being familiar with and following the reporting requirements regarding noncompliance and unanticipated problems,
- documenting contact with subjects, e.g., obtaining informed consent or informing them of changes that may affect their willingness to continue participating,
- complying with applicable HSPP and IRB policies and procedures,
- knowing the appropriate use of an investigational intervention (drug or device) as described in the protocol, investigator brochures, product information/drug labeling, and various other available sources such as newsletters, safety alerts, or communications from sponsors,
- providing a thorough explanation of the study in lay terms to the subject during the consent process, and
- providing a subject the opportunity to ask questions and have them answered.

Procedure

Requesting Approval for PI who is not UConn Health/UConn Paid Faculty (exclusive of clinical non-pay faculty for student projects)

- The intended PI must submit written requests for an exception to the Director of the HSPP and the request must include:
 - for non-pay faculty positions
 - a description of the level and nature of involvement they have with UConn Health,
 - how that involvement relates to the mission of UConn Health, and
 - to what data they are requesting access.
 - and the points noted below for other non-faculty positions.
 - For other individuals who are paid employees who do not hold faculty appointments
 - a summary of qualifications to conduct the study (degrees, licensure, prior research experience),
 - a brief description of the nature of the proposed study,
 - position held and level of authority of that position to provide oversight for the study (e.g., to spend funds if needed, to supervise and direct study team etc.)
- The Chair of the department in which the research will be conducted must also submit a letter to the DHSPS supporting the request and accepting administrative responsibility for the proposed appointment as PI.
- The DHSPS will inform the PI, department chair and the IRB Office, via copy of the memo noting the approval, if such a request is approved.
- If not from UConn Health, the individual seeking appointment as the PI also completes the Individual Investigators Form, obtains applicable signatures, and submits the form with the IRB application material.

Research Personnel:

- The PI self identifies on the IRB application form.
- The PI identifies within the IRB application other study personnel including co-investigators, study coordinators and persons/positions authorized to obtain consent.
- The IRB staff screen this information and members review this information to ensure necessary expertise is present.
 - If not, the IRB imposes a contingency to obtain necessary expertise.

Expectations:

The HSPP and IRB ensures that research personnel are fulfilling expectations through the continuing review process, through reports from the research compliance monitoring program, and through receipt of participant feedback forms.

Related Policies

2009-001 – Reporting Unanticipated Problems to the Institutional Review Board
2009-002 – Reporting Non-Compliance to the Institutional Review Board
2009-005.0 – Monitoring of IRB Approved Studies
2011-008.1 – Informed Consent – Process
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 - Institutional Review Board –Review by Convened Board

Basis

Accreditation Element III.2.B

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Richard H. Simon

6/8/2023

Richard Simon, MD

Date

Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-012.0
Policy Title: Financial Conflict of Interest – Research Personnel

Purpose

The purpose of this policy is to set forth requirements that must be followed by research personnel involved in human subject research for financial disclosures and, if applicable, for following a conflict of interest management plan.

Definitions

See policy 2011-007.0 for definitions of:

Human Subject	Immediate Family Member
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See Institutional Policy 2006-01 for definitions of:

Financial Conflict of Interest	Investigator	Significant Financial Interest (SFI)
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See Guidance Document for Policy 2006-01 for elaboration of the following terms:

Conduct	Design	Investigator
Reporting		

Policy

It is the policy of the HSPP that investigators, study coordinators, data managers and persons authorized to obtain consent (i.e. key personnel) disclose whether a SFI (as defined in Policy 2006-01) in the sponsor, product, service, and/or technology being researched exists. Disclosures are to be solicited from and made by key personnel when initial approval is sought, when continuing approval is sought, or when key personnel are added to a study.

Records of disclosures are to be kept with the study documents (e.g., with the regulatory binder). If a SFI is disclosed, the IRB Project-Specific Disclosure of SFI Form must be completed and routed to a designated person who supports the Financial Conflict of Interest Committee (FCIC) for review and sign-off. The signed form is then included in the submission to the IRB, along with any management plan that may have been developed. The form will list only the individual(s) who disclosed a SFI related to the project (e.g., a SFI in the sponsor, product, service, and/or technology).

When a SFI is disclosed, and it constitutes a Financial Conflict of Interest (FCOI), the FCIC develops a management plan if one is not already in place from the annual disclosure process. If a determination is/has been made by that committee that the SFI does not constitute a FCOI, a management plan is not required.

In all cases, the decisions of the committee are shared with the IRB and the IRB makes the final determination as to whether the conflict can be managed sufficiently to allow for approval of the research. The IRB may add to, but not remove from, the management plan developed by the FCIC. Restrictions that might be imposed by the IRB to manage a conflict of interest to prevent it from adversely affecting the rights and welfare of subjects and/or integrity of the data, include, but are not limited to:

1. Witnessing of the consent process;
2. Monitoring of the research by independent reviewers;
3. Modification of the research plan;
4. Disqualification of the PI or other research personnel from participation in all or a portion of the activities affected by the conflict (e.g. restricted from obtaining consent or analyzing data);
5. Divestiture of significant financial interests, or;
6. Severance of relationships that create the conflict.

Sanctions: Failure of an investigator to comply with the requirements of disclosure and/or a management plan may be considered serious and/or continuing noncompliance by the IRB and may also lead to sanctions identified in Institutional Policy for Individual Financial Conflicts of Interest in Research (2006-01).

Procedure

Principal Investigators, or their designee, will be responsible for obtaining information about SFIs related to a specific project from the investigators, coordinators, data managers, and persons authorized to obtain consent (i.e. key personnel). The information is to be retained with the study records (e.g., in the regulatory binder). For any individual who does disclose a SFI, the name(s) will be recorded on the IRB Project-Specific Disclosure of SFI form. This form will be submitted to the staff person who supports the Financial Conflicts of Interest Committee who will sign and date and return the form, and if applicable the management plan, to the PI or designee.

The signed form, and if applicable management plans, are then included as part of the IRB submission packet. If there is no SFI disclosed by any of the key personnel, the Project-Specific Disclosure Form is not required to be part of the IRB submission.

The IRB* reserves the right to impose management strategies in addition to those outlined by the FCIC.

- If a management plan has not been developed prior to the IRB meeting date
 - the IRB may defer the review until the plan has been developed or a determination has been made by the FCIC that the SFI does not constitute a conflict; or
 - the IRB may develop the initial plan, requiring at a minimum disclosure in the consent form and during the consent process.
 - upon receipt of the determination from the FCIC, if a management plan is required and it differs from what was required by the IRB, the PI will be required to follow both plans. If there is a conflict between the plans, the PI must submit a request for modification to the previously imposed IRB requirements. The Chair may elect to refer the FCIC's determination to the next convened board meeting for review.
 - The Chair will determine on a case-by-case basis whether the investigator may continue with the research or whether to restrict their involvement until the plan is reviewed by the convened board. Such restriction is not considered a suspension of study approval.

When plans are available at the meeting, the IRB will consider the disclosures and the measures in place to manage, reduce or eliminate the conflict. The IRB is responsible for taking the appropriate action(s), e.g.:

1. Reviewing the nature of the conflict and the management plan developed by the FCIC.
2. Determining whether the FCIC plan is sufficient to properly oversee and manage the conflict(s), or whether additional management strategies are required, taking into consideration the possible remedies as outlined in the policy section above.
3. Determining whether the conflict can be sufficiently managed to ensure protection of subjects is not affected and to allow for approval of the research.

*When the research qualifies for exempt status or expedited review, the assigned reviewer assumes the responsibility.

Related Policies

2006-001 – Individual Conflict of Interest in Research – University Policy

Basis

The U. S. Public Health Service (PHS) Objectivity in Research
The National Institutes of Health (NIH) Office of Extramural Research: Conflict of Interest
The National Science Foundation (NSF) Investigator Financial Disclosure Policy
The Food and Drug Administration (FDA) Guidance for Clinical Investigators on COI Disclosure

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Richard H. Simon

6/5/2023

Richard H. Simon, MD
Director Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-012.1
Policy Title: Conflict of Interest – IRB members

Purpose

The purpose of this policy is to set forth requirements that must be followed for disclosing and managing a conflict of interest in human subject research for IRB members.

Definitions

See policy 2011-007 for definitions of:

Human Subject		Financial Interest Related to Research		Immediate Family Member
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See Institutional Policy 2006-01 for definitions of:

Financial Conflict of Interest		Investigator		Significant Financial Interest (SFI)
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See Guidance Document for Policy 2006-01 for elaboration of the following terms:

Conduct		Design		Investigator
Reporting				

Policy

On an annual basis IRB members will be asked to disclose known significant financial interests (SFIs) and board or executive relationships that may relate to their review of research. Annual disclosures will be used to aid in proper assignment of reviewers to studies (e.g. an IRB member who owns a significant amount of stock in a pharmaceutical company will not be assigned to review research sponsored by that company). An IRB member may also not participate in the review of research for which they or an immediate family member have any involvement in the design, conduct or reporting of the research. This policy pertains to all levels of review (i.e. full board, expedited, exempt) and all types of reviews (e.g. initial, continuing, modification, unanticipated problems, non-compliance). Reminders will be incorporated on all IRB reviewer sheets and announced at the IRB meeting.

An IRB member may also not participate in the review of research for which the member believes he or she cannot objectively review the research.

- A subordinate / supervisor relationship, or someone's departmental or center affiliation with a project, does not necessarily create a conflict of interest. The IRB member is expected to exercise their judgment and is encouraged to solicit advice from the IRB and / or the Director of the HSPP, to determine whether or not to review / vote on a study.

Procedure

Near the beginning of each fiscal year the IRB Administrator will send an email to the IRB membership to solicit information about Significant Financial Interests and board or executive relationships.

- the IRB Administrator will record such disclosures on excel tracking file titled IRBCommitteesyy-yy (fiscal years inserted for yy-yy)
- the Regulatory Specialists (RS) may refer to excel file when making preliminary reviewer assignments to make sure that no member is assigned to review a study for which they have a known conflict.
 - the IRB chair gives final approval to reviewer assignments

- If erroneously assigned as a reviewer for a study in which the member has a conflict, the member is responsible for contacting the IRB Office so that the Chair may assign another reviewer.

At the beginning of each meeting the Chair will remind members to recuse themselves from the review of any study with which a conflict exists, regardless of the type of review (e.g. initial review, continuing review, modification review, discussion item).

- IRB members will determine if a conflict exists by reviewing the agenda which notes study personnel and study sponsors.

If a conflict is disclosed, when the study is reviewed the member with the conflict may provide information requested by the IRB but is required to leave the meeting for the deliberation and voting and does not count towards quorum. The RS will document any such recusals in the minutes.

This policy also pertains to reviews conducted through the expedited process and for exempt determinations. The reviewer of such studies is responsible for identifying conflicts and excusing him/herself from the review of any study in which they have a conflict. If necessary, the review will be reassigned to a qualified member of the IRB.

Related Content

2006-001 – Conflict of Interest in Research – University Policy

2009-003.0 – Imposing and Lifting Suspension of IRB Approval or Imposing Terminations of IRB Approval

2011-009.2 - Exemptions

2011-009.3 - Review by Expedited Procedures

2011-009.5 - Review by Convened Board

2011-009.6 – Institutional Review Board - Consultants

Basis

45 CFR 46.107(e)

21 CFR 56.107(e)

The U. S. Public Health Service (PHS) Objectivity in Research

The National Institutes of Health (NIH) Office of Extramural Research: Conflict of Interest

The National Science Foundation (NSF) Investigator Financial Disclosure Policy

The Food and Drug Administration (FDA) Guidance for Clinical Investigators on COI Disclosure

Document Attributes:

Effective Date: 6/5/2023

Replaced Version: 8/17/2017

Reviewed and Approved By:

Richard H. Simon

Richard Simon, MD

Director Human Subjects Protection Program

6/5/2023

Date:

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-013.0
Policy Title: Translation Policy

Purpose

The purpose of this policy is to set forth acceptable means for translating documents and using translators for the consent process when non-English speaking subjects are expected to enroll in a research study.

Definitions

See policy 2011-007.0 for definitions of
Informed Consent Process | Informed Consent Form

Policy

When non-English speaking subjects are expected to enroll in a study, study related documents (e.g. the informed consent form, the HIPAA authorization, survey tools etc.) must be presented in a language understandable to the subject. Documents may be translated by a professional service or back-translated.

The informed consent process must also be conducted in a language understandable to the subject and may therefore require the use of a translator. The translator may be a family member or friend of the subject, an employee of the institution or may be hired by the principal investigator.

The PI is responsible for covering the cost of the translation. The cost of the translation will not be incurred by the subjects.

An investigator may elect to obtain approval of the English language version of documents first and then proceed with the translation of the documents, subsequently obtaining approval for those documents with a request for modification to the study.

Procedure

When documents are translated by a professional translation service, the service must attest to the accuracy of the translation and the principal investigator submits the attestation with the translated documents.

When documents are back-translated into English the following procedures are followed:

- the English version of the document is translated into the foreign language and the investigators provides the following documents to the IRB;
 - the original English version(s)
 - the translated document(s), and
 - the name and credentials of the individual who did the translation
- another individual who has not seen the English version of the document translates the foreign language document back into English and the investigator provides the following documents to the IRB;
 - the back-translated English document

- the name and credentials of the individual who did the translation
- a signed statement from the individual who did the translation that s/he has not seen the original English version of the form;
- the investigators submits the forms noted above concurrently to the IRB for review;
- the IRB reviewer compares both English versions of the documents
- if the IRB reviewer determines the translation is accurate the foreign language document will be approved for use.

Related Policies

2011-008.0 – Informed Consent – Forms
 2011-008.1 – Informed Consent - Process
 2011-008.4 - Informed Consent - Short Form

Basis

45 CFR 46.116
 21 CFR 50.20

Document Attribute

Date Created: 8/17/2017

Replaced Version: 7/8/2011

Reviewed and Approved By:

Richard H. Simon

17 August 2017

Date: _____

 Richard Simon, MD
 Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-014.0
Policy Title: Health Insurance Portability and Accountability Act (HIPAA) in Research

Purpose

The purpose of this policy is to set forth the requirements for compliance with the HIPAA regulation as related to human subject research.

Definitions

See policy 2011-007.0 for definitions of:

Disclosure		Protected Health Information		Use
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Policy

Unless grandfathered by the transition provisions, as of April 14, 2003 all studies that include protected health information (PHI) of subjects must be compliant with the HIPAA regulation. The IRB panels and will act as the Privacy Board for UCHC research studies. Throughout this policy reference to Chair is inclusive of the Chair or other experienced member of the IRB.

Compliance with HIPAA may be achieved by one of the following methods.

Authorization to Use and Disclose Protected Health Information: It is expected that the majority of studies enrolling subjects will seek an Authorization to Use and Disclose Protected Health Information from the subject. Such authorization must be obtained prior to the use and / or disclosure of protected health information.

Unless exceptions are granted by the IRB (e.g. UConn Health involvement in a study is limited to data analysis and collaborating site is obtaining authorization) the authorization is a document apart from the informed consent document. Use of the approved template available from the HSPP/IRB web site is strongly encouraged; and the IRB reserves the right to mandate use of this template. The completed form must be submitted to the IRB for review and approval as part of the initial application and at the time of continuing review.

A valid authorization must contain all of the following elements:

- a specific and meaningful description of the information to be used and / or disclosed;
- the name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
- the name or other specific identification of the person (s), or class of persons, to whom the covered entity may make the requested user or disclosure;
- a description of each purpose of the requested use or disclosure;
- an expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure (statements such as “end of the research study,” “none,” or similar language is sufficient for a research authorization) (Note: if an expiration date is not included the authorization must be retained permanently.);
- signature of the individual and date (if signed by a representative, a description of such representative’s authority to act for the individual must also be provided).
-

Statements addressing the following elements must also be included:

- that the individual has the right to revoke the authorization in writing (provide name and address of whom to send the notice of revocation) except that the researcher may continue to use and disclose information that had already been collected and acted upon pursuant to the authorization and prior to the revocation;
- that non-research clinical treatment will not be conditioned upon signing a research authorization;
- that enrollment in the research study will be conditioned upon signing the authorization; and
- that information disclosed under the authorization could potentially be re-disclosed by the recipient and may no longer be protected under HIPAA.

The authorization must be written in plain language.

In addition, individuals must acknowledge receipt of information on the privacy practices of UConn Health. Individuals may receive information pertaining to privacy practices at the time of providing authorization for research, or during clinical visits that occurred prior to providing authorization.

Use of De-Identified Data: If information is de-identified it is not considered protected health information and the HIPAA regulation does not apply. The investigator is required to sign and submit to the IRB a form certifying the use of de-identified data. The form is available from the HSPP/IRB web site. In order to meet the criteria of being de-identified the 18 identifiers defined within the HIPAA regulations and noted below cannot be included in a data set.

Information that is considered to be an identifier includes the following:

- name
- phone number
- fax number
- social security number
- account number
- certification/license Number
- device identifiers and serial numbers
- i.p. addresses
- photographic images
- geographic subdivisions smaller than a state
- all elements of date, except year (except that ages over 89 must be reported in aggregate)
- e-mail address
- medical record numbers
- health plan beneficiary numbers
- vehicle identifiers and serial numbers
- web u.r.l.s
- biometric identifiers
- any other unique identifying number, characteristic or code

A code may be assigned by someone other than the investigator to de-identified data that allows it to be re-identified if necessary. The code cannot be derived from any identifiable piece of information or combination of pieces of identifiable information. The key to the code cannot be accessible to the investigator or research personnel using the de-identified data.

There are three mechanisms by which an investigator may certify de-identification:

Creation of De-identified Data: A member of UConn Health may use identifiable information to create a de-identified data set. The principal investigator and, if different, individual(s) creating the de-identified data set must certify that no identifiable protected health information is recorded, that no link can be made back to the individual, and that any information seen in the course of creating the data set will be kept confidential.

Use and / or Disclosure of De-identified Data: The investigator may certify that no identifiers are used, reviewed or recorded during the course of the study.

Statistical De-identification: An individual with appropriate statistical and scientific knowledge may certify that the information is not identifiable. The analysis must be done on each identifier that is included in the data set. It must be determined that the risk is very small that the information could be used, alone or in combination with other available information, by the intended recipient to identify an individual who is the subject of the information. In conjunction with the Certification of De-Identification submitted to the IRB the principal investigator must provide documentation from the statistician that includes the date of the analysis, the methods(s) used, the results obtained, a statement that the likelihood of re-identification is very small, and the name, credentials, signature of the statistician and the date of signature.

Limited Date Set/Data Use Agreement: If an authorization or waiver are not applicable, if indirect identifiers must be kept within a limited data set (LDS) in order to perform the research study and the information is to be disclosed outside of UConn Health, the principal investigator must enter into a Data Use Agreement (DUA) with the data recipient. A DUA may also be utilized when UConn Health is the recipient of a LDS. Only after the agreement has been executed can the limited data set be used/disclosed.

At UConn Health, for research related activities, LDS/DUAs are executed by either the Office of Clinical and Translation Research (OCTR), the Office of Sponsored Programs (ORSP), or the Office of Privacy and Protection Management (OPPM). The investigator must submit the details of the information to be contained within the limited data set to OCTR/ORSP/OPPM for review and approval in conjunction with the Data Use Agreement. The elements of the LDS may be defined within the DUA. When the activity constitutes human subject research the executed LDS/DUA is to be submitted as part of the IRB submission. The IRB may grant contingent approval while the LDS/DUA is in the process of being executed.

The data contained within the limited data set must be the minimum necessary to conduct the research project.

The indirect identifiers that may be included in a limited data set include town, city, state and zip code, and dates directly related to an individual, including birth date, admission date, discharge date and date of death. The limited data set may not include any other identifier listed under method 2 that is related to the individual, the individual's relatives, employers, or household members.

Use of Information as Preparatory to Research: Investigators seeking to review charts or other sources of information that contain PHI to determine the feasibility of a study must first get approval from the IRB. The investigator must submit a form to the IRB to request permission for the review, to confirm that the review is necessary to prepare a research protocol, to certify that no protected health information will be removed from the institution, and to certify that the information to be reviewed is necessary for

the research purpose. The review may begin only after the IRB Chair, acting as a member of the HIPAA privacy board, approves the request.

The preparatory to research allowance will only be approved for determining the feasibility of conducting a study. It may not be used to contact subjects for recruitment purposes.

Only the minimum PHI necessary to determine the feasibility of the study may be used.

The owner of the data that the investigator is seeking to review may require the investigator to provide proof that the IRB has approved the request as preparatory to research.

Use of Information on Decedents: Investigators seeking to review chart information on deceased individuals must submit a form to the IRB to request permission to conduct the review. The investigator must certify that the PHI is necessary to conduct a research project and is being sought solely for research on the decedents (not living relatives of the decedent), and to certify that the information to be reviewed is necessary for the research purpose. The initial review may begin only after the IRB Chair, acting as a member of the HIPAA privacy board, authorizes the request. Such studies are not considered human subject research and are not subject to continuing review or audit. The review is conducted to ensure that adequate procedures are in place to ensure confidentiality.

The IRB may require proof of death of the study subjects.

Only the minimum PHI necessary to conduct the study may be used.

The owner of the data that the investigator is seeking to review may require the investigator to provide proof that the IRB has approved the request to perform research on decedent information.

The IRB which also acts as the privacy board must review such activities to ensure that the privacy rights of the deceased and / or the family of the deceased are protected. Such activities are not subject to continuing review or audit. The Chair may authorize such requests.

6. Waiver/Alteration of Authorization to Use and Disclose PHI: Under certain circumstances it is possible to conduct research using protected health information without an authorization. The principal investigator must submit a request for waiver of authorization to the IRB for review and approval. To approve the waiver the following elements must be satisfied:

- the use and / or disclosure of PHI involves no more than a minimal risk to the privacy of individuals;
- the research could not practicably be conducted without the waiver; and
- the research could not practicably be conducted without access to and the use of the PHI.

To ensure that risks to privacy are minimized the principal investigator must address:

- plans to protect identifiers from improper use and disclosure;
- plans to destroy the identifiers at the earliest opportunity consistent with the conduct of the research (unless justification for retaining the identifiers or such retention is otherwise required by law); and
- assurance that the PHI will not be reused or disclosed, except as required by law for authorized oversight of the project.

The IRB shall maintain the following documentation about the waiver, which may be captured by evidence of review within an electronic IRB submission system:

- identification of the responsible IRB panel or Chair or reviewing member
- the signature of the Chair or reviewing member
- the date on which the waiver was approved
- that the criteria to approve the waiver have been satisfied
- the type of review conducted on the waiver (full board vs. expedited)

Waivers may be granted for a portion of a study. This is referred to as a partial waiver.

The required elements of an authorization may also be altered using the waiver process identified above.

Only the minimum necessary PHI to conduct the study may be sought by the investigator. An accounting of any disclosures must be maintained for any PHI disclosed under a valid waiver or partial waiver.

Procedure:

The principal investigator completes and submits the relevant HIPAA form(s) as part of an IRB application.

The reviewer reviews and approves the document as part of the submission, requiring changes to secure approval if necessary.

Related Content

2009-011.3 – Institutional Review Board – Expedited Reviews

2009-011.5 – Institutional Review Board – Review by Convened Board

Basis

45 CFR 164

Document Attributes:

Date Created: 10/29/2019

Replaced Version: 6/16/2017 which was signed 6/20/2017

Reviewed and Approved By:

Richard Simon

29 October 2019

Date: _____

Richard Simon, MD

Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-015.0
Policy Title: Recruitment and Payment

Purpose

The purpose of this policy is to set forth requirements regarding recruitment of subjects into research studies.

Definitions

See policy 2011-007.0 for definitions of:

Informed Consent Form	IRB Approval	Private Information
Treatment Relationship, Direct	Treating Relationship, Indirect	

Policy

Recruitment of subjects into a study may not begin prior to final IRB approval by the UConn Health IRB, or official acceptance of another IRB as the IRB of record.

UConn Health as Reviewing IRB: The IRB must approve all recruitment methods and material prior to use. Payments to investigators and research staff that are tied to the rate or timing of enrollment (i.e., bonus payments) are designed to accelerate recruitment and are prohibited. Likewise, payment or receipt of a finder's fee for the referral and ultimate enrollment of subjects into a study are prohibited. For example, investigators may not award a treating physician with a financial payment or other incentive for referring a subject to the investigators study. Likewise, investigators may not accept payment or other incentives for referring a subject to another study.

It is however acceptable for the sponsor to pay the institution for the reasonable costs associated with subject enrollment (e.g., research induced procedures, administrative time to manage subjects etc.). Any such arrangements must be delineated in a Clinical Trial Agreement or similar contractual arrangement.

The Principal Investigator is responsible for ensuring that recruitment methods are accurately described in the IRB submission. The content of recruitment materials and the method for communicating it cannot contain misleading language or tactics that create undue influence or coercion. The IRB will evaluate proposed recruitment methods and materials as part of the standard IRB review process. The recruitment process must also be compliant with the Health Insurance Portability and Accountability Act (HIPAA) which regulates how identifiable health information can be used and disclosed in connection with research.

Subjects are considered enrolled at the time of signing a consent form. If a separate consent form is used for the initial screening phase of the study, subjects must be informed that they may be withdrawn if it is determined that they do not meet inclusion criteria. The principal investigator is to report subjects who signed a screening consent but did not meet the inclusion criteria as withdrawals from the study at the time of continuation.

Principal investigators are responsible for tracking the ethnicity or race of subjects who are recruited into studies. Investigators should ask subjects to self-identify at the time of consent. When continuing

review is required, at the time of continuation the investigator will be asked to provide this information as part of an overall summary report of enrolled subjects.

Recruitment of Health Center Patients: For any research proposing an interaction or intervention with UConn Health patients, inclusive of research meeting criteria for exemption, the Human Subjects Protection Program (HSPP) at UConn Health must have an opportunity to review the research and determine whether the activity is appropriate. In order for the activity to be deemed appropriate the patient must first be approached about the research by someone with an existing treatment relationship with the patient and any member of the study team that will interact or intervene with the patient must have an affiliation with UConn Health (e.g. faculty appointment, employee, student, intern, volunteer); and if the Principal Investigator is not a paid UConn Health faculty member, there must be a paid faculty member from UConn Health as co-investigator. The Director of the HSPP may grant an exception to the requirement of a paid UConn Health faculty member as co-investigator on a case-by-case basis. The Principal Investigator of the research is responsible for ensuring that the required affiliations are in place and that all training required by UConn Health (e.g., HIPAA, blood borne pathogen, annual compliance) has been completed.

The review by the HSPP may be done by the IRB or the Director of the HSPP.

This does not preclude UConn Health personnel from simply providing patients with information about studies that the patient may then elect to pursue at their own discretion.

Recruitment on Site without Engagement: If UConn Health is simply a recruitment site (e.g., recruitment table set up in cafeteria) but not engaged in the conduct of the research; approval should be obtained from the Director of the Human Subject Protection Program for the recruitment activity to occur. The Director may delegate the decision to Department Chairs or other appropriate personnel. Permission is not required for advertising in UConn Health broadcast (e.g., Lifeline) messages.

Advertisements: Advertisements should contain only limited information that still provides enough information to the prospective subject to determine their interest and potential eligibility. Visual effects that may create undue influence cannot be used, e.g., placing the word PAID in all capital letters while the rest of the ad is in lower case.

Generally, the elements of any advertisement to recruit subjects should be limited to the elements noted below.

- the name of the principal investigator;
- the department conducting the study;
- the title of the study;
- an accurate description of the condition under study and/or the research purpose e.g. if a placebo is to be used in a drug study, the advertisement should describe the study as a comparison of the drug to the placebo; if investigational products are to be used they must be identified as such and not represented as new treatments;
- in summary form, the eligibility criteria that will be used to admit subjects into the study;
- a straightforward and truthful description of the benefits, if any, to the subject from participating in the study;

- if applicable, a statement that compensation is available or a statement of how much compensation is available and how it will be paid, e.g., “Participants may receive up to \$100 paid in equal installments over 4 visits”
- the amount / length of time or other commitment required of the subjects;
- the location of the research and contact information for obtaining additional information;

The IRB recommends inserting the following reference points on approved advertisements:

- the IRB number, and
- the date the ad was approved.

Advertisements **cannot** incorporate elements that:

- state or imply a certainty of favorable outcome or other benefit beyond what is in the informed consent form;
- make claims that the drug, device or biologic is safe or effective for the purpose under investigation;
- make claims that the drug, device or biologic is known to be equivalent or superior to any other drug, device or biologic;
- use terms such as new treatment, new medication or new drug without identifying it as investigational;
- promise free medical treatment when the actuality is that subjects will not be charged for partaking in the study.
- appear to release the institution, sponsor, or investigator from liability

If the study involves the use of FDA regulated products (drugs or devices) no claims can be made, either explicitly or implicitly, that the drug or device is safe or effective for the purposes under investigation, or that the drug or device is in any way equivalent or superior to any other drug or device. Such representation would not only be misleading to subjects but would also be a violation of the FDA's regulations concerning the promotion of investigational drugs and of investigational devices.

Advertisement may be reviewed through the expedited review process if the content of the ad can be easily compared to the informed consent form. The IRB reserves the right to require full board review of any recruitment material.

The IRB must review and approve the final taped version of any radio or television advertisement. Contingent approval for the ad may be granted based on the script but the final product must be submitted for additional review and approval to ensure consistency with the language / tone presented in the script. The final approval of taped ads may be granted through the expedited review process.

Web Postings: IRB review and approval is not required for listings of clinical trials on the internet providing that the listing is limited to providing only basic trial information as listed below. Information pertaining to compensation cannot be listed without IRB review and approval.

- PI name;
- IRB number;
- study title;
- study purpose;
- protocol summary;
- basic eligibility criteria;

- study location;
- contact information

Payment or Incentives Related to Subjects: It is acceptable to offer financial payments or other types of incentives, e.g., gift certificates, to research subjects for participation in a study. However, the value of the payment or incentive(s) cannot create undue inducement for subjects to enroll. Furthermore, the payment structure should not be such that a subject cannot withdraw from a study without forfeiting the entire payment. There are no federal regulations that determine what is an acceptable payment or payment structure and it is therefore judged on a case-by-case basis taking into consideration:

- the types and numbers of procedures to be involved
- the time commitment involved
- the expenses incurred by the subject
- the anticipated discomfort or inconvenience
- the level of risk of the study
- the type of populations likely to be enrolled
- the option of using a tiered approach in which subjects receive payment at various stages of the study.

The principal investigator is responsible for ensuring that funds are available to make the payments as presented within the informed consent document. Payment to subjects who withdraw from a study may be held until such time as the payment would have been made had the subject not withdrawn, unless holding the payment will create an undue inconvenience to the subject or a coercive practice. For example, it may be acceptable to hold payment until the end of the study if the study is only a few weeks long, or to hold payment until the first disbursement would have been made if there is only a few weeks difference between the date the subject withdrew and the date the payment was scheduled to be made. The wishes of the subject should be honored when possible. Compensation offered to potential subjects may not include a coupon for discounts on the purchase price of the product once it is approved for marketing.

Financial Reporting Obligations: The confidentiality of a subject must be respected throughout their participation in a study. However, in order to make a payment by check payable to the subject certain information may be required to be recorded on financial records and forwarded to accounts payable for compliance with state and federal requirements for income reporting. The subject may choose to decline receiving payment if they do not want the information reported outside of the study, or checks may be issued to cash if the services of the Clinical Research Center are utilized or permission is obtained from Research Administration and Finance.

The subject should also be informed that 1) if cumulative payments to a subject within a year add up to \$600 or more a Form 1099 will be issued by UConn Health and the income will be reported to the IRS.

Procedure

Recruitment –

To request permission to use UConn Health as a recruitment site when UConn Health is not engaged in the conduct of the research (for example, when posting recruitment flyers or setting up a recruitment table set in a common area), external researchers must complete a Request to Use UConn Health as a Recruitment Site form (available on the HSPP website). The completed form and IRB-approved

recruitment materials are submitted to the HSPP via email (irb@uchc.edu) to obtain approval from the DHSP. Request forms will be reviewed by the DHSP and approvals communicated back to the requestor via email within approximately 10 business days.

Payment - General:

The Office of Clinical and Translational Research is responsible for negotiation of the Clinical Trial Agreement which may allow for the reasonable costs associated with subject enrollment.

The IRB application informs study personnel that bonus payments and finders fees are not acceptable.

The IRB application process solicits information about recruitment populations and plans and the reviewer will use the reviewer form provided by IRB staff as a prompt to consider the method of recruitment, recruitment materials, and payments to subjects for enrollment during the IRB review process.

To request approval of an exception to the requirement that paid faculty member be appointed as co-investigator when UConn Health patients are being recruited, send communication to the Director of the HSPP indicating who from UConn Health would be appointed as the co-investigator, describing the individual's position at UConn Health and the relationship of the position to the patients. If granted, include this approved exception as part of the IRB submission packet.

Checks Payable to Subjects:

The subject should be informed by the person obtaining consent of the following:

- that information will be sent to Accounts Payable, e.g., name, social security or taxpayer identification number, mailing address, and amount paid to the subject.
 - subjects should be given the opportunity to decline payment
- the obligation to report to the IRS earnings from participation in research studies that exceed \$599 in a calendar year.

Checks Made Payable to Cash:

Check may only be payable to cash if the services of the Clinical Research Center are utilized, or permission is obtained from Research Administration and Finance. The subject should be informed by the person obtaining consent of the following:

- that the check must either be picked up in person and that identification must be presented at that time, or the check must be sent through certified mail
- that should the check be lost or stolen another check will not be issued
- of the obligation to report to the IRS earnings from participation in research studies that exceed \$599 in a calendar year.

The department must maintain an internal log of the check number, date of issue and to whom it was issued.

Other Incentives:

The subject should be informed by the person obtaining consent about any implications regarding other types of incentives, e.g., that lost gift cards will not be replaced etc.

The department must also track distribution and inventory control of such items.

Related Content

2011-009.2 – Institutional Review Board - Exemptions
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by Convened Board
2011-011.0 – Research Personnel

Basis

21 CFR 50 & 56
45 CFR 46
45 CFR 164
21 CFR 312
21 CFR 812
Guidance on Institutional Review Board Review of Clinical Trial Websites at
<http://www.hhs.gov/ohrp/policy/clinicaltrials.html>

Document Attributes:

Date Effective: 6/9/2023

Replaced Version: 2/14/2020

Reviewed and Approved By:

Richard H. Simon

6/8/2023

Richard H. Simon, MD
Director, Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-016.0
Policy Title: Scientific Review

Purpose

The purpose of this policy is to set forth the requirements regarding the scientific review of protocols involving human subjects.

Definitions

See policy 2011-007.0 for definition of the following terms:

Human Subject		IRB Approval		Conflict of Interest
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Policy

The Institutional Review Board (IRB) requires formal scientific review of studies that require review by the convened board. If scientific review has not already been conducted (e.g., NIH, FDA, CRC, funding foundation, etc.), the Scientific Review Committee (SRC) of the HSPP will conduct the review. The SRC is advisory to the IRB and as such the IRB may agree or disagree with the recommendations of the SRC. The IRB reserves the right to require additional review by the SRC even if another review has already been conducted.

Final IRB approval may only be granted after the scientific review is completed and the results of such have been provided to the IRB for consideration. While preference is for the convened board to see the review, contingent approval may be granted based upon receiving a recommendation for approval, or contingent approval from the SRC. If the SRC recommends deferral because substantive changes to the study are recommended, the study, along with the recommendations of the SRC, will be referred back to the convened board. The Chair always reserves the right to refer a study back to the convened board after receipt of the results from the SRC.

The HSPP's SRC will be comprised of at least 3 members appointed by the Director of the HSPP for an open-ended term. One member will be designated as Chair. The SRC will strive to complete its review during the week prior to each convened IRB meeting, as necessary. In most cases the SRC Chair will obtain input from at least 2 primary reviewers. However, if necessitated by scheduling conflicts or other unforeseen circumstances, one member of the SRC may conduct the review. The SRC may call upon individuals with specific areas of expertise on an as needed basis for consultation. No member of the SRC or consultant may participate in the review of a study in which s/he has a conflict; including a financial interest in the sponsor, or a professional or personal interest in the study. If needed, the IRB may call upon an external scientific advisory committee to conduct the review (e.g., a scientific review committee within another department at UConn Health).

In evaluating a study, the SRC will consider:

- clarity of the research question
- appropriateness and efficiency of design
- rigor and feasibility of methods
- qualifications and expertise of the research team
- scholarship and pertinence of background material and rationale

- adequacy of sample size and relevance of controls
- and the validity of the statistical analysis plan.

In addition, the SRC may desire to comment on the proposal's scientific relevance or compelling ethical or patient safety issues. The SRC may also provide additional information to be conveyed to the investigator for educational value.

For studies reviewed via the expedited or exempt process, the assigned reviewer will also give consideration to these factors and will only grant approval to those studies determined to have scientific merit.

Procedure

The Principal Investigator (PI) will be informed by the application instructions when scientific review by the SRC will be required and will indicate that such a request is being made within the application material provided to the IRB.

Upon receipt of the material the IRB Regulatory Specialist will forward the material to the Chair of the SRC. The Chair of the SRC will in turn assign the reviewers from among the SRC membership, noting a date by which their review is due.

The Chair of the SRC will then send a summary of the findings of the SRC for each study evaluated directly to the IRB Regulatory Specialist by e-mail, or through upload to an electronic system, prior to the convened meeting date.⁺

The IRB Regulatory Specialist will distribute the results of the SRC review to the IRB members by e-mail or by notification to log into the electronic system prior to the meeting.

Based on the results of the scientific review the IRB may approve the study, require the investigator to make changes prior to approval and/or exercise the right to disapprove a study.

- If there are concerns related to the scientific merit of the study, the PI will be informed of the findings by the standard letter (e.g., approved contingent letter, deferral letter) prepared by the IRB.

The PI will be required to respond in writing to the IRB to address those concerns identified and further review will occur as necessitated by the approval decision (e.g., by the Chair for contingent approvals, by the board for deferrals).

⁺review by the IRB may continue if for some reason the summary from the SRC is not received in time – however only contingent approval based upon a positive report from the SRC may be granted. If the report from the SRC recommends deferral of approval, the study is referred back to the convened board.

Related Policies

2011-009.5 – Review by Convened Board

Basis

45 CFR 46.111
21 CFR 56.111

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Richard H. Simon

6/8/2023

Richard H. Simon, MD

Date

Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-017.0
Policy Title: Statistical, Operational or Coordinating Center

Purpose

The purpose of this policy is to outline obligations of investigators and the Institutional Review Board when this institution is acting as a statistical, an operations or a coordinating center for a multi-site clinical trial.

Definitions

See policy 2011-007.0 for the definition of the following term:

Clinical Trial

Policy

If personnel at this institution lead an operational, statistical or coordinating center for a multi-site clinical trial, this institution is engaged in research. If activities of personnel at this institution in the conduct of the trial involve no interaction or intervention with subjects, and the principal risk associated with activities is limited to the potential harm resulting from a breach of confidentiality, the IRB need not review each collaborative protocol. However, the IRB must find and document that the operations, statistical or coordinating center has sufficient mechanisms in place to ensure that:

- management, data analysis, and data safety and monitoring systems are adequate;
- sample protocols and informed consent documents are developed and distributed to each collaborating institution;
- each collaborating institution holds an approved assurance(when federally funded/supported);
- each protocol is reviewed and approved by the IRB at the collaborating institution prior to the enrollment of subjects;
- any substantive modification by the collaborating institution of sample consent information related to risk or alternative procedures is appropriately justified; and
- informed consent is obtained from each subject or an approved waiver of consent is in place; and
- the privacy of subjects and the confidentiality of data are adequately maintained

Procedure

The investigator must complete and submit the form applicable to UConn Health acting as the statistical, operational or coordinating center as part the IRB submission packet. The form address the key points noted above.

Designated IRB staff will provide the IRB reviewer with the reviewer checklist that prompts for consideration of whether the responses provided by the PI are sufficient.

- IRB will take action as necessary if responses are not adequate

Related Policies

2011-009.3 – Institutional Review Board – Expedited Reviews

2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

Guidance on Engagement of Institutions in Human Subject Research -
<http://www.hhs.gov/ohrp/policy/engage08.html>

Document Attributes

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Date: _____

Richard Simon, MD
Director Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-018.0
Policy Title: Complaints, Concerns, Suggestions

Purpose

The purpose of this policy is to set forth the position of the HSPP for receiving and processing complaints, concerns or suggestions. This policy does not encompass filing allegations of research misconduct for which a separate institutional policy exists.

Definitions

See policy 2011-007.0 for definitions of the following terms:

Human Subject | Research

Policy

Research participants, research personnel or others, may file complaints, concerns or suggestions with the HSPP that relate to their involvement in or the conduct of a human subject research study.

Research personnel may also file complaints, concerns or suggestions about the HSPP (inclusive of the IRB) operating practices and policies.

To encourage study participants to provide feedback about their participation as a research subject, including complaints, concerns or suggestions, participants should be provided with the Participant Feedback Form at the time of giving written consent. This form will also be made available to subjects by other means such as web postings.

Procedure

Complaints, Concerns, Suggestions: The individual filing the complaint, concern or suggestion may choose the initial means of communication. Communications should be directed to the following individuals in the order noted below, moving forward if not satisfied with the resolution provided:

- staff within the HSPP (e.g. the IRB Regulatory Specialist for a specific panel, the IRB Chair of a specific meeting etc.)
- the Director of the HSPP (DHSPP)
- the individual to whom the DHSPP reports.
 - The DHSPP, or individual to whom the DHSPP reports, may recommend or require that the HSPP implement corrective action to address the reported issue. However, no requirements can be made that would change or influence a decision of the IRB.

The person receiving the complaint/concern/suggestion will gather relevant information from the filer.

- Individuals will be asked to submit their comments in writing (e-mail is acceptable) but this is not required.
- the template titled Complaint/Concern/Suggestions Intake Form may be used to facilitate this process
- The person receiving the complaint will attempt to resolve the issue through communication with the filer and, if necessary, other relevant parties such as investigators or study coordinators.

- If unable to resolve the issue, the individual receiving the complaint will forward a summary of the issue to the next appropriate individual as noted above for further action.
 - The Chair or DHSPP (providing s/he does not influence the decision of the IRB) may require the investigator or IRB staff to take corrective action to resolve the issue, may contact the filer and/or the PI of the relevant project for additional information, or may request that the RCM perform an audit.
 - If any corrective action requires a change to previously approved documents the IRB Chair will instruct, or direct the IRB staff to instruct, the investigator in writing to submit a request for modification form that addresses the corrective action.
 - The Chair or DHSPP may issue a letter (e-mail) to the filer outlining the actions taken, or that no action was taken.
 - The Chair or DHSPP will also evaluate the nature of the complaint/concern to determine if it should be reviewed by the full board for possible determination as a reportable event (i.e., an unanticipated problem involving risk to subjects or others or serious or continuing non-compliance). Referral to the IRB may be held until such time as the results of audit findings and/or responses from the PI are available for review.

As noted above, the recipient may refer the complaint/concern to a higher authority if unable to resolve the situation on their own.

For suggestions, the individual who received the suggestion will bring it to the attention of the DHSPP or designee. The person who received the suggestion will inform the individual who made the suggestion of the outcome regarding implementation of the suggestion through email, by phone or by an announced change in policy / procedure.

Participant Feedback: Within the informed consent process and document, the person obtaining consent must inform subjects that they may contact the IRB if they have complaints, concerns or suggestions about their participation in a research study. The phone number of the IRB must be provided. The participant should also be provided with the Participant Feedback Form which s/he can elect to complete and which solicits suggestions from participants.

On approximately a bi-weekly basis a designated staff member within the HSPP will process the Participant feedback forms that have been received.

- Depending on the nature of the information provided the staff person may share comments with principal investigator and/or research staff,
- Staff person will acknowledge receipt of the form to the participant using the standard template acknowledgement letter unless the subject filed anonymously,
- For any form that expresses a concern or complaint the staff person may request that an IRB Chair review the form to determine if any additional action is needed.
 - The IRB Chair will review the form and, depending on the nature of its content, may refer it to the convened board for review as a potential unanticipated problem, serious non-compliance or continuing non-compliance
 - The IRB may request that an audit of the study occur, and/or
 - The IRB may require changes to the protocol or consent to address the concern.

The Director of the HSPP will also review all forms and, if necessary, take appropriate action.

Tracking: The HSPP/IRB will maintain a central log of complaints, concerns, suggestions and participant feedback forms that have been received by subjects and research personnel. The staff member receiving the information is responsible for logging the information and follow-up activity, or delegating this activity to the IRB Regulatory Specialist whose panel has oversight of the study. The log will contain the date of receipt and as applicable, the principal investigator involved, the subject's name, the nature of the complaint, concern or suggestion and the outcome. The information on the log will be evaluated by the Director of the HSPP as part of the annual evaluation of the HSPP to determine if any additional actions, e.g. change in policies, are required to adequately address the identified issues.

Subject complaints received by research personnel are also reported as part of the annual continuing review process. In this manner the IRB is informed of complaints that were resolved without the involvement of the IRB or HSPP.

The same process will be followed regardless of whether the study was reviewed through the expedited review process, by the full board or determined to be exempt.

Related Policies

2009-001 – Reporting Unanticipated Problems to the Institutional Review Board
2009-002 – Reporting Non-compliance to the Institutional Review Board
2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board – Review by the Convened Board

Basis

Guidance on IRB Continuing Review of Research at
<http://www.hhs.gov/ohrp/policy/continuingreview2010.html>

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Richard Simon, MD

Director, Human Subjects Protection Office

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-019.0
Policy Title: Research Registries and Repositories

Purpose

The purpose of this policy is to outline the general framework for obtaining approval from the Institutional Review Board for a research registry and/or repository (often referred to as a bank).

Definitions

See policy 2011-007.0 for definitions of the following terms:

Individually Identifiable Health Information | IRB Approval | Registry | Repository

Policy

Clinical Care Data: Information that is collected and stored in clinical registries/repositories in the course of clinical care and for clinical purposes does not require IRB approval. De-identified information/samples may be released for research by an individual authorized to have clinical access to the information, e.g. a treating physician or clinical data manager, when this person is not involved in the research project making use of the information/sample. The information / samples may be coded such that the authorized individual granting the release can link the information back to the individual but the recipient cannot. The code cannot be comprised of any identifiable information and the recipient cannot at any time know the mechanism for creating the code. Furthermore individually identifiable health information / samples within the clinical registry/repository may not be used for research purposes without first obtaining IRB approval.

Research Data: IRB approval must be obtained for the creation of a research registry or repository. IRB approval must also be sought for each subsequent research project that will make use of the individually identifiable health information in the registry or repository prior to any research being implemented.

An individual or individuals must be designated as the data manager for a registry/repository. Only those designated as the Principal Investigator (PI) and/or data manager will be allowed to release identifiable registry data on individuals for purposes of recruiting those registry participants into other IRB approved studies.

The PI or data manager of the registry/repository may de-identify information for release to researchers, and the researchers do not have to have IRB approval to receive the de-identified data. The data may be coded such that the PI or manager can link the information back to the individual but the recipient cannot. The code cannot be comprised of any identifiable information. The researchers cannot at any time know the mechanism for creating the code or how to link the code to the individual and, unless procedures for the registry/repository are in place that prevent the release of this information, must sign a statement to that effect (e.g. that they do not know and will not ask for the key to the code or how the code is derived). In this scenario the PI cannot be a part of the research team receiving the de-identified information unless specific approval by the IRB of a human subject research determination form has been obtained. In order to grant such approval the IRB must determine that adequate measures are in

place to keep the data de-identified to the PI. If the IRB cannot make this determination, the PI must submit a complete IRB application.

If data or samples will be stored at an external site, e.g. become the property of the sponsor, the IRB may require that a copy of that site's policies for confidentiality and use of the samples be submitted for review.

Research registries / repositories may be approved through expedited review if one of the expedited categories is applicable. The IRB reserves the right to require review by the convened board.

Procedure

To obtain IRB approval for a research registry / repository the PI completes the IRB application for such and submits it along with corresponding documents as noted on the application submission checklist to the IRB for review and approval.

The IRB follows its routine practice for conducting reviews.

Related Policies

2011-009.3 – Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board - Review by Convened Board
2011-009.12 – Institutional Review Board – Criteria for Approval

Basis

45 CFR 46.111
OHRP Guidance on Biological Materials and Data available at
<http://www.hhs.gov/ohrp/policy/biodata/index.html>

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Richard Simon

3/25/2022

Richard Simon, MD
Director Human Subjects Protection Program

Date:

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-020.0
Policy Title: Humanitarian Use Device

Purpose

The purpose of this policy is to set forth requirements for review, approval and use of a Humanitarian Use Device.

Definitions

See Policy 2011-007.0 for the definitions of:

Humanitarian Device Exemption	Humanitarian Use Device	Informed Consent
IRB Approval	Legally Authorized Representative	

Policy

A clinician must obtain review and approval by the convened Institutional Review Board (IRB) prior to use of a Humanitarian Use Device (HUD). The IRB approval will be for use in accordance with the FDA approved indication. However the IRB reserves the right to impose additional limitations on the scope of the FDA approved use of the device. For example, the IRB may limit use to a specific medical specialty.

The Board may determine that continuing review may be conducted by the expedited review process. However, if expedited continuing review is requested the Chair reserves the right to require full board review.

The clinician must submit a consent form that is specific to the use of the HUD, apart from the clinical consent form. The clinician must use the HUD consent form in addition to the clinical consent form when obtaining consent.

An HUD may be used in an emergency situation to save the life or protect the physical well being of a patient when there is not time to obtain prospective IRB review and approval. The clinician must obtain authorization from the Humanitarian Device Exemption holder for emergency use and if possible concurrence from the IRB Chair an independent physician and consent of the patient or the patient's legally authorized representative. The emergency use must be reported to the HDE holder and IRB within 5 days. The HDE holder is then obligated to submit the report as an amendment to the HDE. The reporting of an emergency use to the IRB is in addition to any hospital requirements for reporting emergency use.

Procedure

Standard Use:

The clinician must submit to the IRB the material listed on the HUD application form for initial and continuing review.

- The clinician must request continuing review for use of the HUD at least annually.

The IRB will conduct the initial and continuing review of the material using a primary reviewer system, or if after initial review the use of the HUD is eligible for expedited review, in accordance with expedited review procedures.

- For full board reviews, the IRB Regulatory Specialist will document the review in the IRB minutes.
- For expedited reviews, the board will be informed of the activity at the next regularly scheduled meeting for which the submission deadline has not passed.

The IRB staff will send the notification letter (e.g. approval letter, deferral letter) to the clinician.

- The approval letter sent to the clinician by the IRB staff will indicate the date by which continuing review must occur.
- The material that must be submitted for continuing review is noted on the HUD request for continuation form.

Once approved for use, the clinician must use the HUD consent form in addition to the clinical consent form when obtaining consent.

Emergency Use Procedures:

When there is not time to obtain prospective IRB approval, the clinician must obtain authorization from the HDE holder for emergency use. In addition to the authorization from the HDE holder, the physician should obtain, if possible:

- the IRB Chair's concurrence
- the informed consent from the patient or their legally authorized representative
- an independent assessment by an uninvolved physician.

Within 5 business days after the use the physician must submit a follow-up report on the patient's condition and information regarding the patient protection measures taken to the HDE holder and to the IRB.

Related Policies

2011-007.0 – Definitions Applied to Policy

2011-009.3 – Institutional Review Board – Expedited Review

2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

21 CFR 814 Sub-part H

Document Attributes

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Richard H. Simon, MD

Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-021.0
Policy Title: Investigational Device Studies

Purpose:

The purpose of this policy is 1) to set forth circumstances under which a Principal Investigator (PI) is not required to obtain an investigational device exemption (IDE) and 2) to set forth the requirements that PIs, sponsors and Institutional Review Boards (IRB) must fulfill when conducting studies that are conducted under an IDE [including studies evaluating modifications or new intended uses of legally marketed devices].

Definitions:

See policy 2011-007.0 for definitions of the following terms:

Device		Device, Custom		Device, Non-significant Risk		Device, Significant Risk
Device, Investigational Device Exemption		Device, Unanticipated Adverse Device Effect				

Policy:

When research is conducted to determine the safety or effectiveness of a device, one of the following will apply:

- the device has an IDE issued by the FDA,
- the device fulfills the requirements for an abbreviated IDE, or
- the device fulfills one of the IDE exemption categories described below.

The sponsor of the device will make the initial determination of whether the device presents a significant (SR) or non-significant risk (NSR). NSR devices are not necessarily minimal risk studies.

For SR studies, the FDA must approve an investigational device exemption (IDE) application submitted by the sponsor and the IRB must approve the study before it may commence. SR devices studies require review by the convened IRB.

Unless otherwise notified NSR devices are considered to have an approved IDE if the sponsor fulfills the abbreviated requirements set forth below. NSR studies are exempt from FDA approval but must receive IRB approval prior to commencing. NSR studies generally will require full board review but may qualify for expedited review procedure if the study falls within a designated approvable category and is minimal risk.

An approved IDE allows a device to be shipped for investigational use without complying with other requirements of the Food, Drug, and Cosmetic Act, including Premarket Approval (PMA), Premarket Notification [510(k)], establishment registration, and listing. Sponsors are exempt from Quality System (QS) requirements except for design controls.

NSR device studies may not require submission to the FDA providing they comply with the abbreviated requirements of the regulations as follows:

- The device is not a banned device
- The sponsor labels the device in accordance with the following criteria

- the investigational device or its immediate package shall bear a label with the following information: the name and place of business of the manufacturer, packer, or distributor, the quantity of contents, if appropriate, and the following statement: “CAUTION –Investigational device. Limited by Federal (or United States) law to investigational use.” The label or other labeling shall describe all relevant contraindications, hazards, adverse effects, interfering substances or devices, warnings, and precautions.
- The labeling of an investigational device shall not bear any statement that is false or misleading in any particular and shall not represent that the device is safe or effective for the purpose for which it is being investigated.
- The sponsor obtains IRB approval of the investigation after presenting the reviewing IRB with a brief explanation of why the device is not a significant risk device, and maintains such approval.
- The sponsor ensures that each investigator participating in an investigation of the device obtains from each subject under the investigator’s care, informed consent and documents it, unless documentation is waived.
- The sponsor complies with the requirements for monitoring investigations as follows:
 - a sponsor who discovers that an investigator is not complying with the signed investigators agreement, the investigational plan, applicable regulatory requirements, or other applicable FDA regulations, or any conditions of approval imposed by the reviewing IRB or FDA shall promptly either secure compliance, or discontinue shipments of the device to the investigator and terminate the investigator’s participation in the investigation. A sponsor shall also require such an investigator to dispose of or return the device, unless this action would jeopardize the rights, safety or welfare of a subject.
 - a sponsor shall immediately conduct an evaluation of any unanticipated adverse device effect
 - a sponsor who determines that an unanticipated adverse device effect presents an unreasonable risk to subjects shall terminate all investigations or parts of investigations presenting that risk as soon as possible. Termination shall occur not later than 5 working days after the sponsor makes this determination and not later than 15 working days after the sponsor first received notice of the effect.
 - a sponsor may not resume a terminated study without IRB and FDA approval
- The sponsor maintains the required records as follows:
 - the name and intended use of the device and the objectives of the investigation
 - a brief explanation of why the device is not a significant risk device
 - the name and address of each investigator
 - the name and address of each reviewing IRB
 - a statement of the extent to which the good manufacturing practice regulation will be followed in manufacturing the device
 - any other information required by the FDA
 - records concerning adverse device effects (whether anticipated or unanticipated) and complaints
- The sponsor makes the required reports as follows;
 - Unanticipated adverse device effects. A sponsor who conducts an evaluation of an unanticipated adverse device effect shall report the results of such evaluation to FDA and to all reviewing IRBs and participating investigators within 10 working days after the sponsor first receives notice of the effect. Thereafter the sponsor shall submit such additional reports concerning the effect as FDA requests.

- Withdrawal of IRB approval. A sponsor shall notify FDA and all reviewing IRBs and participating investigators of any withdrawal of approval of an investigation or a part of an investigation by a reviewing IRB within 5 working days after receipt of the withdrawal of approval.
- Withdrawal of FDA approval. A sponsor shall notify all reviewing IRBs and participating investigators of any withdrawal of FDA approval of the investigation, and shall do so within 5 working days after receipt of notice of the withdrawal of approval.
- Progress reports. At regular intervals, and at least yearly, a sponsor shall submit progress reports to all reviewing IRBs. In the case of a significant risk device, a sponsor shall also submit progress reports to FDA. A sponsor of a treatment IDE shall submit semi-annual progress reports to all reviewing IRB's and FDA and annual reports.
- Recall and device disposition. A sponsor shall notify FDA and all reviewing IRBs of any request that an investigator return, repair, or otherwise dispose of any units of a device. Such notice shall occur within 30 working days after the request is made and shall state why the request was made.
- Final report. In the case of a significant risk device, the sponsor shall notify FDA within 30 working days of the completion or termination of the investigation and shall submit a final report to FDA and all reviewing the IRBs and participating investigators within 6 months after completion or termination. In the case of a device that is not a significant risk device, the sponsor shall submit a final report to all reviewing IRBs within 6 months after termination or completion.
- Informed consent. A sponsor shall submit to FDA a copy of any report by an investigator of use of a device without obtaining informed consent, within 5 working days of receipt of notice of such use.
- Significant risk device determinations. If an IRB determines that a device is a significant risk device, and the sponsor had proposed that the IRB consider the device not to be a significant risk device, the sponsor shall submit to FDA a report of the IRB's determination within 5 working days after the sponsor first learns of the IRB's determination.
- Other. A sponsor shall, upon request by a reviewing IRB or FDA, provide accurate, complete, and current information about any aspect of the investigation.
- The sponsor ensures that participating investigators maintain the required records
 - Documents evidencing informed consent and, for any use of a device by the investigator without informed consent, any written concurrence of a licensed physician and a brief description of the circumstances justifying the failure to obtain informed consent. The case history for each individual shall document that informed consent was obtained prior to participation in the study.
- The sponsor ensures that participating investigators makes the required reports;
 - Unanticipated adverse device effects. An investigator shall submit to the sponsor and to the reviewing IRB a report of any unanticipated adverse device effect occurring during an investigation as soon as possible, but in no event later than 10 working days after the investigator first learns of the effect.
 - Withdrawal of IRB approval. An investigator shall report to the sponsor, within 5 working days, a withdrawal of approval by the reviewing IRB of the investigator's part of an investigation.

- Informed consent. If an investigator uses a device without obtaining informed consent, the investigator shall report such use to the sponsor and the reviewing IRB within 5 working days after the use occurs
- Other. An investigator shall, upon request by a reviewing IRB or FDA, provide accurate, complete, and current information about any aspect of the investigation.
- The sponsor complies with the prohibitions against promotion and other practices.
 - a sponsor, investigator, or any person acting for or on behalf of a sponsor or investigator shall not;
 - promote or test market an investigational device, until after FDA has approved the device for commercial distribution
 - commercialize an investigational device by charging the subjects or investigators for a device a price larger than that necessary to recover costs of manufacture, research, development, and handling.
 - unduly prolong an investigation if data developed by the investigation indicate in the case of a class III device that premarket approval cannot be justified or in the case of a class II device that it will not comply with an applicable performance standard or an amendment to that standard, the sponsor shall promptly terminate the investigation.
 - represent that an investigational device is safe or effective for the purpose for which it is being investigated

The sponsor must collect and maintain financial disclosure information from each investigator and provide it to the FDA or IRB upon request.

In the event that a UConn Health PI is also the sponsor of the IDE, the PI must make arrangements with a Research Compliance Monitor to request a pre-audit of the facilities and to review the additional obligations that the PI assumes when also acting as the sponsor. The audit must occur prior to the submission of the IRB application and the results of the audit must be submitted with the IRB application.

Exemptions from the Requirements of Part 812:

The following types of investigational device studies are exempt from the requirements of Part 812:

- A device, other than a transitional device, in commercial distribution immediately before May 28, 1976 when used or investigated in accordance with the indications in labeling in effect at that time.
- A device, other than a transitional device, introduced into commercial distribution on or after May 28, 1976, that FDA has determined to be substantially equivalent to a device in commercial distribution immediately before May 28, 1976, and that is used or investigated in accordance with the indications in the labeling FDA reviewed under subpart E of part 807 in determining substantial equivalence.
- A diagnostic device is exempt if the sponsor complies with applicable regulatory requirements and the testing meets all of the following criteria::
 - Is noninvasive
 - Does not require an invasive sampling procedure that presents significant risk.
 - Does not by design or intention introduce energy into a subject.
 - Is not used as a diagnostic procedure without confirmation of the diagnosis by another, medically established diagnostic product or procedure

- A device undergoing consumer preference testing, testing of a modification, or testing of a combination of two or more devices in commercial distribution if the testing is not for the purpose of determining safety or effectiveness and does not put subjects at risk.
- A device intended solely for veterinary use.
- A device shipped solely for research on or with laboratory animals and labeled in accordance with regulatory requirements
- A custom device, unless the device is being used to determine safety or effectiveness for commercial distribution.
- A humanitarian use device (HUD/HDE) or expanded access (treatment use) protocol is not covered by this policy; see policy 2011-020 for applicable requirements.

Assessment of Risk

The sponsor makes the initial determination of SR or NSR for the device. However, the IRB will make the final determination for NSR devices. If the IRB disagrees with the sponsor and designates the device as SR, the sponsor will be required to submit to the FDA for an IDE. The study will not be approved by the IRB until the IDE is obtained. The investigator will be informed of the IRB's determination in writing and the investigator must inform the sponsor.

In assessing the risk level of a device the IRB will consider information such as a description of the device and its proposed use, nature of the harm that may result from the use of the device or from procedures required for use of the device, e.g. surgical implants, reports of prior investigations conducted with the device, the proposed investigational plan, a description of subject selection criteria and monitoring procedures. The Sponsor must provide the IRB with a brief explanation of why the device is not a significant risk device. The sponsor must provide the IRB with the FDA's assessment of the device's risk if such an assessment has been made. The IRB may also choose to consult with the FDA.

A clinical study may be exempt from the regulation if the study involves the investigation of a lawfully marketed device.

Investigator Obligations:

The PI of a device study must:

- obtain appropriate approvals (IRB, FDA) prior to obtaining consent and enrolling any subjects;
- maintain control of the device under investigation;
- conduct the study in compliance with the signed agreement with the sponsor, the investigational plan, applicable regulations and policies;
- protect the rights, safety and welfare of subjects under the investigator's care;
- make financial disclosures to the sponsor;
- supervise the device use, the device shall be used only with subjects under the investigator's supervision;
- supply the device to only authorized individuals;
- upon completion or termination of a clinical investigation, or the investigator's part of an investigation, or at the sponsor's request, return to the sponsor any remaining supply of the device or otherwise dispose of the device as the sponsor directs;
- permit authorized persons (e.g. HSPP / IRB staff, FDA staff) to inspect and copy records relating to the investigation;

- if authorized, permit authorized persons (e.g. HSPP / IRB staff, FDA staff) to enter and inspect any establishment where devices are held (manufactured, processed, packed, installed, used, or implanted, or where records of results from use of devices are kept);
- maintain adequate records including:
 - correspondence with another investigator, an IRB, the sponsor, a monitor, or the FDA;
 - records of receipt, use or disposition of a device that relate to the type and quantity of the device, the dates of its receipt, and the batch number or code mark, the names of all persons who received, used, or disposed of each device, why and how many units of the device have been returned to the sponsor, repaired, or otherwise disposed of;
 - each subject's case history and exposure to the device (include the case report forms and supporting data including, for example, the signed and dated consent forms, medical records including progress notes, adverse event reports);
 - the protocol and records of any deviations from the protocol; and
 - any other records required by the FDA or IRB or relevant to the study;
- submit reports of unanticipated adverse device effects to the IRB in accordance with the Adverse Event reporting policy and to the sponsor as soon as possible but within 10 days of becoming aware of the event;
- submit a report to the sponsor within 5 days of any withdrawal of IRB approval;
- submit progress reports to the IRB, sponsor, and monitor at least annually.

PIs are to retain records for 2 years after the latter of either the date on which the investigation is terminated or completed, or the date that the records are no longer required for purposes of supporting a pre-market approval application or a notice of completion of a product development protocol. Transfer of custody of the records to another person/entity willing to accept responsibility for them may occur but requires that the investigator inform the FDA within 10 days of the transfer.

Names of subjects need not be disclosed unless there is reason to suspect that adequate informed consent was not obtained, or that reports required to be submitted by the investigator to the sponsor or to the IRB have not been submitted or are incomplete, inaccurate, false or misleading.

Procedure

The PI will provide the required information about the device as part of the IRB application process.

- When the PI is also the sponsor of the IDE, the PI will be responsible for arranging a meeting with the Research Compliance Monitor and providing proof that the PI is prepared to meet the additional obligations of the sponsor, as directed to do so in the application checklist

The IRB will conduct its review according to standard practice, evaluating the information provided using the reviewer checklists as a tool in the review process.

Related Policies

2009-005.0 - Monitoring of IRB Approved Studies

2011-007.0 – Definitions Applied to Policies

2011-009.3 – Institutional Review Board – Expedited Reviews

2011-009.5 – Institutional Review Board – Review by Convened Board Full

Basis

21 CFR 50

21 CFR 56.109(c).

21 CFR 812
21 CFR 820.30
21 CFR 54

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Shemetra Owens

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Shemetra Owens, CIP, CIM

Date

Associate Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-021.1
Policy Title: Investigational Device –Single Emergency Use

Purpose

The purpose of this policy is to set forth the requirements that Principal Investigators (PI), sponsors and Institutional Review Boards (IRB) must fulfill when using investigational devices in a therapeutic manner in an unplanned emergency situation.

Definitions

See policy 2011-007.0 for definitions of the following terms:

Device, Investigational Legally Authorized Representative	Emergency Use	Immediate Life-threatening Disease
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Policy

Treatment use of an investigational device includes the use of a device for diagnostic purposes. An individual treated through emergency use is considered a research subject as defined in Food and Drug Administration (FDA) regulations, but may not be considered a research subject as defined in Department of Health and Human Services regulations unless IRB approval is obtained prior to the use.

In order to use a test article for emergency treatment without prior IRB approval, and when there is not time to obtain such approval, each of the following conditions must exist:

- the patient is faced with an immediate life-threatening condition or disease ;
- no generally acceptable alternative for treating the patient is available; and
- because of the immediate need to use the device, there is no time to use existing procedures to get FDA approval for the use.

The physician must determine whether these criteria have been met, assess the potential for benefits from the unapproved use of the device, and have substantial reason to believe that benefits will exist. The physician may not conclude that an "emergency" exists in advance of the time when treatment may be needed based solely on the expectation that IDE approval procedures may require more time than is available. In the event that an investigational device is to be used in this situation the device developer should notify the Center for Devices and Radiological Health (CDRH), Program Operation Staff by telephone (301-796-5640) immediately after shipment is made. Nights and weekends contact the FDA Office of Emergency Operations (HFA-615)301-443-1240

The physician must follow as many subject protection procedures as possible including:

- obtaining an independent assessment by an uninvolved physician;
- obtaining informed consent from the patient or a legal representative;
- notifying institutional officials as specified by institutional policies;
- notifying the Institutional Review Board (IRB); and
- obtaining authorization from the IDE holder, if an approved IDE for the device exists.

If possible, a prospective review from the IRB Chair determining the single emergency use complies with the FDA regulations allowing an exemption from the requirement of IRB review should be sought.

Subsequent emergency use of the device should not occur unless the physician or another person obtains approval of an IDE for the device and its use. If an IDE application for subsequent use has been filed with FDA and FDA disapproves the IDE application, the device may not be used even if the circumstances constituting an emergency exist.

Consent: Consent will be obtained in accordance with FDA regulations, unless the circumstances meet the exception to the requirement for consent in FDA regulations.

Unless exemption criteria are met, informed consent will be sought from each prospective participant or the participant's legally authorized representative, in accordance with and to the extent required by 21 CFR 50 and consent will be documented in accordance with and to the extent required by 21 CFR 50.27.

Criteria for exceptions are as follows: both the investigator and a physician who is not otherwise participating in the clinical investigation certify in writing all of the following:

- the subject is confronted by a life-threatening situation necessitating the use of the test article,
- informed consent cannot be obtained because of an inability to communicate with, or obtain legally effective consent from, the subject,
- time is not sufficient to obtain consent from the subject's legally authorized representative, and
- no alternative method of approved or generally recognized therapy is available that provides an equal or greater likelihood of saving the subject's life.

If, in the investigator's opinion, immediate use of the test article is required to preserve the subject's life, and if time is not sufficient to obtain an independent physician's determination that the four conditions above regarding consent have been met, the clinical investigator should make the determination and, within 5 working days after the use of the article, have the determination reviewed and evaluated in writing by a physician who is not participating in the clinical investigation. The treating clinician must notify the IRB within 5 working days after the use of the test article.

Procedure

If possible (i.e. time permits), the PI is to request a prospective review from the IRB Chair to determine that the single emergency use complies with the FDA regulations allowing an exemption from the requirement of IRB review. The material submitted to the Chair from the PI is to include:

- assurance from the prescribing person that the use is NOT part of a project that is currently awaiting IRB approval;
- that the use of the device is to treat/diagnose a patient with a seriously debilitating or immediate life-threatening condition or disease
- assurance that there is no generally acceptable alternative for treating/diagnosing the subject available
- a written statement explaining the rationale for the use of the investigational device(e.g. reason to believe there will be benefit from use of the device); and

- a copy of the consent form that will be used

After an unapproved device is used in an emergency, the physician must:

- report to the IRB Chair within five days and otherwise comply with provisions of the IRB regulations;
- evaluate the likelihood of a similar need for the device occurring again, and if future use is likely, immediately initiate efforts to obtain IRB approval and an approved IDE for the device's subsequent use; and
- if an IDE for the use does exist, notify the sponsor of the emergency use, or if an IDE does not exist, notify FDA of the emergency use (Center for Devices and Radiological Health Program Operation Staff 301-594-1190) and provide FDA with a written summary of the conditions constituting the emergency, subject protection measures, and results.

If consent cannot be obtained prior to the emergency use both the investigator and a physician who is not otherwise participating in the clinical investigation must certify in writing to the IRB Chair that the four conditions for not obtaining consent noted above in the policy section have been satisfied. If, in the investigator's opinion, immediate use of the test article is required to preserve the subject's life, and if time is not sufficient to obtain an independent physician's determination that the four conditions above have been met, the clinical investigator should make the determination and, within 5 working days after the use of the article, have the determination reviewed and evaluated in writing by a physician who is not participating in the clinical investigation and submit the material to the IRB Chair.

After review, the IRB Chair will submit a letter to the prescribing clinician, indicating that the clinician has complied with the internal policy and FDA regulations regarding the emergency treatment use of an investigational device. Designated IRB staff will also place a copy of the letter in the IRB Office files for emergency use.

- If in the course of conducting a retrospective review the Chair determines that the investigator was not compliant with policy and regulations, the matter will be considered an instance serious non-compliance. The Chair will inform the investigator and the Director of the HSPO via letter and the Director will follow through with reporting to institutional officials and external agencies.

Related Policies

2009-002 – Reporting Non-compliance to the IRB

2009-004 – Reporting Non-compliance to Institutional Officials and External Agencies

2011-007.0 – Definitions Applied to Policy

2011-008.5 – Informed Consent – Obtaining and Providing

Basis

21 CFR 812

FDA Information Sheet Guidance for IRBs, Clinical Investigators, and Sponsors: Frequently Asked Questions About Medical Devices (available at

<http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM127067.pdf>)

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Date

Associate Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-022.0
Policy Title: Study Drug - General

Purpose

The purpose of this policy is to set forth requirements for labeling, dispensing storing and maintaining inventory control of research drugs.

Definitions

See policy 2011-007.0 for definition of the following terms:

Dispense		Investigational New Drug
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Policy

Labeling: All study drug labels must indicate:

- the name, address and phone number of the dispensing area;
- the subject's name or identifying number;
- the name of the prescribing physician;
- the date of issue;
- the drug name and strength or study acronym; and
- directions for use.
- Labels for investigational drugs must also incorporate the following statements: "Caution: New Drug – Limited by Federal law to investigational use."

Dispensing and transfer of drug: There must be an order from the physician (a standing order would be acceptable) if someone other than the physician is delivering study drugs to subjects. Per CT Law only pharmacists and those with prescribing authority may dispense drugs other than over-the-counter drugs. Qualified study staff may then deliver (i.e., hand over) the prescribed and dispensed drug to the subject. The Director of Pharmacy may delegate the ability to approve of dispensing plans to other pharmacy staff.

Storage and Inventory: Investigational new drugs for inpatient use must be stored in the John Dempsey Hospital Pharmacy. Investigational new drugs for outpatient use may be stored in the pharmacy or by the investigator. The Director of Pharmacy must approve of the plans for storage and inventory control of research drug not stored within the Pharmacy. The Director of Pharmacy may delegate the ability to approve of storage and inventory plans to other pharmacy staff.

Procedure

The PI must disclose within the IRB submission the plans for dispensing of research drug and approval from Pharmacy for such plans must be provided.

The PI must disclose within the IRB application the plans for storage and inventory of research drugs and approval from Pharmacy must be provided.

As part of the sign-off statement within the IRIS system the Principal Investigator acknowledges their responsibility by confirming that s/he has read the Responsibility of Investigators Regarding Control and Use of Investigational Drug information.

Drug labeling and storage and physicians orders will be verified as part of the Research Compliance Monitoring Program.

Related Policies

2009-005.0 - Monitoring IRB Approved Studies

2011-007.0 – Definitions Applied to Policies

Basis

21 CFR 312

CT Statute – Chapter 400j Pharmacy

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Richard H. Simon

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Richard H. Simon, MD
Director Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-022.1
Policy Title: Investigational Drug Studies

Purpose

The purpose of this policy is to describe the obligation of investigators, sponsors and the Institutional Review Board when conducting or reviewing studies involving the use of investigational new drugs.

Definitions

See policy 2011-007.0 for definitions of the following terms:

Clinical Investigation | Investigational New Drug

Policy

Unless criteria for an exemption are met, clinical investigations in which a drug is administered to human subjects must be conducted under an IND as required in 21 CFR part 312 when research involves the use of a drug other than the use of a marketed drug in the course of medical practice.

The IND goes into effect 30 days after the FDA receives the IND, unless the sponsor receives earlier notice from the FDA.

Investigators will be responsible for conducting the investigation in accordance with the signed investigator statement, the investigational plan, and applicable regulations and policies; and for protecting the rights, safety and welfare of subjects in their care. Investigators are also responsible for the following:

- controlling of drugs under investigation;
- administering the drug only to subjects under the investigator's personal supervision or under the supervision of a co-investigator responsible to the investigator;
- supplying the drug only to persons authorized to receive it;
- maintaining adequate records for the disposition of the drug (dates, quantity, and use by subjects);
- returning unused supplies to the sponsor or otherwise providing for the disposition in accordance with the direction of the sponsor;
- maintaining adequate and accurate case histories on each individual receiving the drug or employed as a control (all observations and other data pertinent to the investigation including case report forms and supporting data, e.g. signed and dated consent forms, medical records including progress notes, hospital charts and nurses notes);
- retaining records for 2 years after either the date a marketing application is approved for the drug for the indication under investigation, or, if no application is to be filed or if the application is not approved, until 2 years after the investigation is discontinued and FDA is notified;
- submitting progress reports and safety reports to the sponsor and IRB;
- providing financial disclosures to the sponsor and the IRB;
- storing drugs properly and securely;

- obtaining IRB and FDA review and approval prior to initiating the research (including the consent process); and
- permitting authorized individuals (HSPP or IRB staff, FDA staff) to have access to and to copy relevant records.

The names of subjects do not have to be disclosed unless the records of particular individuals require a more detailed study of the cases, or unless there is reason to believe that the records do not represent actual case studies, or do not represent actual results obtained.

In the event that a UConn Health PI is also the sponsor of the IND, the PI must make arrangements with a Research Compliance Monitor to schedule a pre-approval-audit to ensure that procedures are in place to fulfill the additional obligations of the sponsor.

Exemptions: The IRB may determine that a clinical investigation of a lawfully marketed drug(s) is exempt from the investigational new drug regulation if all of the following conditions apply:

- the investigation is not intended to be reported to the FDA as a well-controlled study in support of a new indication for use nor intended to be used to support any other significant change in the labeling for the drug;
- if the drug is lawfully marketed as a prescription drug product, the investigation is not intended to support a significant change in the advertising for the product;
- the investigation does not involve a route of administration or dosage level or use in a patient population or other factor that significantly increases the risk (or decreases the acceptability of the risk) associated with the use of the drug product;
- the investigation is conducted in accordance with the requirements of institutional review and informed consent as set forth in FDA regulations
- the investigation is conducted in compliance with requirements regarding the promotion and charging for investigational drugs.

A clinical investigation involving use of a placebo is exempt if the investigation does not otherwise require submission of an IND.

A clinical investigation involving an in vitro diagnostic biological product (blood grouping serum; reagent red blood cells; and anti-human globulin) is exempt if it is intended to be used in a diagnostic procedure that confirms the diagnosis made by another, medically established, diagnostic product or procedure and it is shipped in compliance with the requirements set forth in regulations.

Procedure

In the course of preparing a submission to the IRB the Principal Investigator must respond to a series of questions regarding the need for an IND.

- If an IND is required the PI must include the submission material proof that the FDA has granted the IND.
- If the IRB has questions as to whether an exemption can be granted the IRB may require the PI to provide proof that the FDA has determined that the use of the drug qualifies for exemption.

The IRB conducts its review according to standard practice.

When the PI is also the sponsor of the IND, the PI must arrange for an audit with a Research Compliance Monitor prior to the submission of the IRB application and the results of the audit must be submitted with the IRB application.

Related Policies

2009-005 – Monitoring of IRB Approved Studies

2011-007.0 – Definitions Applied to Policies

2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

21 CFR 312

21 CFR 50

21 CFR 56

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Date

Associate Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-022.2
Policy Title: Investigational Drug/Biologic - Expanded Access for Treatment Use, Including Single Emergency Use

Purpose

The purpose of this policy is to set for the requirements that investigators, sponsors, Institutional Review Boards and the FDA must fulfill when an investigational new drug or biologic is to be used in a therapeutic manner.

Definitions

See policy 2011-007.0 for definitions of the following terms:

Emergency Use	Investigational New Drug	Immediately Life Threatening
Noncompliance, Serious	Test Article	Seriously Debilitating
Serious Disease or Condition	Investigator	Sponsor

Policy

FDA regulations permit expanded access to an investigational drug or biologic for treatment use, including emergency treatment for an individual patient, providing certain criteria, submission requirements, and safeguards are met before beginning treatment.

In all cases of expanded access use, investigators must be aware of their obligations; including, but not limited to, the obligation to obtain IRB review and informed consent when possible.

Per 21 CFR 312.305(a), for all expanded access requests sufficient information must be provided to the FDA such that the FDA can determine that:

- The patient or patients to be treated have a serious or immediately life-threatening disease or condition, and there is no comparable or satisfactory alternative therapy to diagnose, monitor, or treat the disease or condition;
- The potential patient benefit justifies the potential risks of the treatment use and those potential risks are not unreasonable in the context of the disease or condition to be treated; and
- Providing the investigational drug for the requested use will not interfere with the initiation, conduct, or completion of clinical investigations that could support marketing approval of the expanded access use or otherwise compromise the potential development of the expanded access use.

Per 21 CFR 312.305(b) an expanded access submission is required for each type of expanded access request. The submission may be a new IND or a protocol amendment to an existing IND. Information required for a submission may be supplied by referring to pertinent information contained in an existing IND if the sponsor of the existing IND grants the physician a right of reference to the IND. If the physician obtains permission to reference the existing IND, the holder of the IND (typically the manufacturer) should provide the physician with a letter of authorization (LOA) to refer to that IND and that LOA would be included in the submission to the FDA.

All expanded access submissions must include the points noted below. For individual patient expanded access requests (emergency or non-emergency) an appropriately completed and signed Form FDA 3926 is

recommended in place of the Form FDA 1571 and will be considered by the FDA to comply with the submission requirements.

- A cover sheet (i.e. Form FDA 3926 for Individual Patient Expanded Access or Form 1571 for other types of Expanded Access Requests);
- The rationale for the intended use of the drug, including a list of available therapeutic options that would ordinarily be tried before resorting to the investigational drug or an explanation of why the use of the investigational drug is preferable to the use of available therapeutic options;
- The criteria for patient selection or, for an individual patient, a description of the patient's disease or condition, including recent medical history and previous treatments of the disease or condition;
- The method of administration of the drug, dose, and duration of therapy;
- A description of the facility where the drug will be manufactured;
- Chemistry, manufacturing, and controls information adequate to ensure the proper identification, quality, purity, and strength of the investigational drug;
- Pharmacology and toxicology information adequate to conclude that the drug is reasonably safe at the dose and duration proposed for expanded access use (ordinarily, information that would be adequate to permit clinical testing of the drug in a population of the size expected to be treated); and
- A description of clinical procedures, laboratory tests, or other monitoring necessary to evaluate the effects of the drug and minimize its risks.

The expanded access submission and its mailing cover must be plainly marked "EXPANDED ACCESS SUBMISSION." The type of expanded access request must be delineated in the applicable box on Form FDA 1571.

In all cases of expanded access, an investigator (i.e. a licensed physician under whose immediate direction an investigational drug is administered or dispensed for an expanded access use) must comply with the responsibilities for investigators set forth in 21 CFR 312 subpart D to the extent they are applicable to the expanded access use. Investigators are responsible for reporting adverse drug events to the sponsor, and, with the possible exceptions for emergency use noted below, ensuring that informed consent requirements are met and that IRB review of the expanded access use is obtained prior to use of the investigational agent. Investigators are also responsible for maintaining accurate case histories and drug disposition records and retaining records.

In all cases of expanded access, the sponsor (i.e. the individual or entity that submits an expanded access IND or protocol) must comply with the responsibilities for sponsors set forth in subpart D to the extent they are applicable to the expanded access use. Sponsors are responsible for submitting IND safety reports and annual reports (when the IND or protocol continues for 1 year or longer) to FDA, ensuring that licensed physicians are qualified to administer the investigational drug for the expanded access use, providing licensed physicians with the information needed to minimize the risk and maximize the potential benefits of the investigational drug (the investigator's brochure must be provided if one exists for the drug), maintaining an effective IND for the expanded access use, and maintaining adequate drug disposition records and retaining records.

A licensed physician under whose immediate direction an investigational drug is administered or dispensed, and who submits an IND for expanded access use under this subpart is considered a *sponsor-investigator*, and must comply with the responsibilities for sponsors and investigators set forth in subpart D to the extent they are applicable to the expanded access use as described above.

With the exception of expanded access for emergency use, an expanded access IND goes into effect 30 days after the FDA receives the IND or on earlier notification by FDA that the expanded access use may begin. Per 21 CFR 312.42, the FDA may place any expanded access IND or protocol on clinical hold.

Additional requirements for each specific type of Expanded Access request are as follows:

Expanded Access - Single Patient (SP), Including Emergency Use (21 CFR 312.310)

SP Additional Criteria: FDA may permit an investigational drug to be used for the treatment of an individual patient by a licensed physician. The criteria noted above per 21 CFR 312.305(a) must be met and the following additional determinations must be made:

- The physician must determine that the probable risk to the person from the investigational drug is not greater than the probable risk from the disease or condition; and
- FDA must determine that the patient cannot obtain the drug under another IND or protocol

SP Submission Requirements: The submission requirements noted above per 21 CFR 312.305(b) apply. FDA will accept completion of Form FDA 3926.

- If the drug is the subject of an existing IND, the expanded access submission may be made by the sponsor or by a licensed physician.
- A sponsor may satisfy the submission requirements by amending its existing IND to include a protocol for individual patient expanded access.
- A licensed physician may satisfy the submission requirements by obtaining from the sponsor permission for FDA to refer to any information in the IND that would be needed to support the expanded access request (right of reference) and by providing any other required information not contained in the IND (usually only the information specific to the individual patient).

SP Safeguards: Treatment is generally limited to a single course of therapy for a specified duration unless FDA expressly authorizes multiple courses or chronic therapy. At the conclusion of treatment, the licensed physician or sponsor must provide FDA with a written summary of the results of the expanded access use, including adverse effects. The FDA may require sponsors to monitor an individual patient expanded access use if the use is for an extended duration. When a significant number of similar individual patient expanded access requests have been submitted, FDA may ask the sponsor to submit an IND or protocol for the use under 312.315 or 312.320.

SP Emergency Use Procedures. An individual treated through emergency use is considered a research subject as defined in FDA regulations. An individual treated through emergency use is not considered a research subject under DHHS regulations unless IRB approval of an emergency use protocol was obtained prior to the use.

Emergency Use requires authorization from the FDA. If there is an emergency that requires the patient to be treated before a written submission can be made, FDA may authorize the expanded access use to begin without a written submission. The FDA reviewing official may authorize the emergency use by telephone. Emergency expanded access use may be requested by telephone, facsimile, or other means of electronic communications. See Appendix A for FDA Contact Information. Expanded access use under the emergency procedures may begin when the use is authorized by the FDA reviewing official.

The licensed physician or sponsor must explain how the expanded access use will meet the requirements of 312.305 and 312.310 and must agree to submit an expanded access submission within 15 working days of FDA's authorization of the use.

Informed consent of the subject shall be obtained unless, per 21 CFR 50.23: the investigator and a physician who is not otherwise participating in the intervention certify in writing that all of the criteria noted below are met.

- the subject is confronted by a life-threatening or severely debilitating situation necessitating the use of the test article;
- informed consent cannot be obtained because of an inability to communicate with, or obtain legally effective consent from, the subject;
- time is not sufficient to obtain consent from the subject's legal representative;
- no alternative method of approved or generally recognized therapy is available that provides an equal or greater likelihood of saving the subject's life.

If immediate use of the test article is, in the investigator's opinion, required to preserve the life of the subject, and time is not sufficient to obtain the independent determination noted above in advance of using the test article, the determinations of the clinical investigator shall be made and, within 5 working days after the use of the article, be reviewed and evaluated in writing by a physician who is not participating in the clinical investigation.

When IRB review cannot be obtained prior to the emergency use of a test article for a single patient, per 21 CFR 56.104 and 21 CFR 50.23 such use of a test article, and the documentation described above, must be reported to the IRB within 5 working days after use of the test article. Any subsequent use of the test article is subject to IRB review.

Expanded Access - Intermediate-size Patient Populations (IPP) (21 CFR 312.315):

FDA may permit an investigational drug to be used for the treatment of a patient population smaller than that typical of a treatment IND or treatment protocol. FDA may ask a sponsor to consolidate expanded access under this section when the agency has received a significant number of requests for individual patient expanded access to an investigational drug for the same use. Expanded access under this section may be needed in the following situations:

- *Drug not being developed.* The drug is not being developed, for example, because the disease or condition is so rare that the sponsor is unable to recruit patients for a clinical trial.
- *Drug being developed.* The drug is being studied in a clinical trial, but patients requesting the drug for expanded access use are unable to participate in the trial. For example, patients may not be able to participate in the trial because they have a different disease or stage of disease than the one being studied or otherwise do not meet the enrollment criteria, because enrollment in the trial is closed, or because the trial site is not geographically accessible.
- *Approved or related drug.* The drug is an approved drug product that is no longer marketed for safety reasons or is unavailable through marketing due to failure to meet the conditions of the approved application, or the drug contains the same active moiety as an approved drug product that is unavailable through marketing due to failure to meet the conditions of the approved application or a drug shortage.

IPP Criteria: In addition to the criteria required per 21 CFR 312.305(a) and described above, the FDA must determine that:

- There is enough evidence that the drug is safe at the dose and duration proposed for expanded access use to justify a clinical trial of the drug in the approximate number of patients expected to receive the drug under expanded access; and
- There is at least preliminary clinical evidence of effectiveness of the drug, or of a plausible pharmacologic effect of the drug to make expanded access use a reasonable therapeutic option in the anticipated patient population.

IPP Submission Requirements: In addition to the submission requirements required per 21 CFR 312.305(b) and described above:

- The expanded access submission must state whether the drug is being developed or is not being developed and describe the patient population to be treated.
- If the drug is not being actively developed, the sponsor must explain why the drug cannot currently be developed for the expanded access use and under what circumstances the drug could be developed.
- If the drug is being studied in a clinical trial, the sponsor must explain why the patients to be treated cannot be enrolled in the clinical trial and under what circumstances the sponsor would conduct a clinical trial in these patients.

IPP Safeguards: Upon review of the IND annual report, FDA will determine whether it is appropriate for the expanded access to continue under this section. If the drug is not being actively developed or if the expanded access use is not being developed (but another use is being developed), FDA will consider whether it is possible to conduct a clinical study of the expanded access use. If the drug is being actively developed, FDA will consider whether providing the investigational drug for expanded access use is interfering with the clinical development of the drug. As the number of patients enrolled increases, FDA may ask the sponsor to submit an IND or protocol for the use under 312.320.

The sponsor is responsible for monitoring the expanded access protocol to ensure that licensed physicians comply with the protocol and the regulations applicable to investigators.

Treatment IND (TI) or Treatment Protocol (TP) (21 CFR 312.320)

Criteria TI/TP: FDA may permit an investigational drug to be used for widespread treatment use providing certain criteria are met. In addition to the criteria required per 21 CFR 312.305(a) described above the FDA must determine that the drug is being investigated in a controlled clinical trial under an IND designed to support a marketing application for the expanded access use, or all clinical trials of the drug have been completed; and the sponsor is actively pursuing marketing approval of the drug for the expanded access use with due diligence;

When the expanded access use is for a serious disease or condition, there is sufficient clinical evidence of safety and effectiveness to support the expanded access use. Such evidence would ordinarily consist of data from phase 3 trials, but could consist of compelling data from completed phase 2 trials.

When the expanded access use is for an immediately life-threatening disease or condition, the available scientific evidence, taken as a whole, provides a reasonable basis to conclude that the investigational drug may be effective for the expanded access use and would not expose patients to an unreasonable and significant risk

of illness or injury. This evidence would ordinarily consist of clinical data from phase 3 or phase 2 trials, but could be based on more preliminary clinical evidence.

Submission Requirements TI / TP: The expanded access submission requirements per 21 CFR 312.305(b) described above apply.

Safeguard TI / TP: The sponsor is responsible for monitoring the treatment protocol to ensure that licensed physicians comply with the protocol and the regulations applicable to investigators. Expanded access use for a treatment IND or treatment protocol (21 CFR 312.320) may begin 30 days after FDA receives the protocol or upon earlier notification by FDA that use may begin.

Procedure

Expanded Access Request for Emergency Use for A Single Patient:

The physician should first contact the holder of the IND to confirm that the investigational agent will be made available under the company's IND.

If so, approval from the FDA must then be obtained. If time permits, a written submission should be made to the FDA using FDA Form 3926. If time does not permit, the request to use the investigational agent for an individual patient may be made by telephone (or other rapid means of communication) to the appropriate FDA review division. (See Appendix A for FDA

Contacts) The physician must be prepared to explain how the expanded access use will meet the requirements of 312.305 and 312.310 noted in the policy section above. The physician must commit to making a submission to the FDA within 15 working days of the FDA's authorization.

If time permits, prior to the emergency use the prescribing clinician should submit a request for expedited review in iRIS describing their intent to utilize an investigational drug for a therapeutic reason at least 24 hours prior to the planned date of the first administration of the drug. An email notification should also be sent to a Regulatory Specialist (RS) within the office (IRB contact information available at <http://research.uchc.edu/rcs/hssp/>) to alert the IRB of the situation such that the submission can be prioritized, and the RS will contact an IRB Chair to arrange for review of the material. If prior review is not possible, the submission in iRIS is to be made within 5 business days of the administration.

The information provided to the IRB for the emergency use of this investigational drug should include the following information:

- assurance from the prescribing person that this use is NOT part of a project that is currently awaiting IRB approval;
- assurance that the use of the drug(s) or biologic is primarily to treat a patient with a specific, clinically urgent, condition; and that the patient is not a research subject;
- a brief written statement explaining the rationale for the use of the investigational drug or biologic;
- a copy of the consent form that will be used by the prescribing person to obtain informed consent from the patient or the patient's legally authorized representative. Such consent form to include a description of the clinical protocol (length of administration, dosage, method of evaluation of efficacy, side effects, etc.);

- a consent form is required unless the investigator/clinician and a licensed physician who is not otherwise participating in the intervention certify in writing that the four criteria for not obtaining consent as noted above in the policy section are met.
- a formal statement from the manufacturer (or distributor) of the investigational drug, that the prescribing person has received approval for use of the investigational agent (e.g. Letter of Authorization from the sponsor of the IND).
- If a submission has been made to the FDA, the completed submission materials. If a submission was not made, a statement or documentation noting the date of the FDA's authorization.

If prospective review from the Chair was not obtained due to the emergent nature of the situation, the clinician must submit the material noted above for review and evaluation by the IRB Chair within 5 working days after the use of the article.

- If consent was not obtained, the clinician who performed the intervention must obtain the written opinion of an independent physician as to whether consent could have been obtained based upon the four criteria in the policy section.
- If in the course of conducting a retrospective review the Chair determines that the investigator was not compliant with policy and regulations, the matter will be considered an instance serious non-compliance. The Chair will inform the investigator and the DHSPO via letter and the DHSPO will follow through with reporting to institutional officials and external agencies.

After review, the IRB Chair (or designee) will issue a letter to the prescribing clinician, indicating that the clinician has complied with the internal policy and FDA regulations regarding the emergency or therapeutic use of an investigational drug for a single patient.

- Copies of this letter will be sent by the IRB staff to the Chair of the Pharmacy and Therapeutics Committee and the Director of Pharmacy Services at John Dempsey Hospital.

If required by the IRB Chair, the prescribing clinician must also report the outcome and side effects following the administration of the drug to the IRB Chair within the specified time frame.

Expanded Access Request for Non-Emergency Use for A Single Patient:

The physician should first contact the holder of the IND to confirm that the investigational agent will be made available. If so, approval from the FDA must then be obtained. A written submission should be made to the FDA using FDA Form 3926 for a non-emergency single patient expanded requests.

The submission to the IRB for the non-emergency use of this investigational drug should include the following information which will be reviewed by the convened IRB (unless the FDA has granted an exception to the requirement for convened IRB):

- assurance from the prescribing person that this use is NOT part of a project that is currently awaiting IRB approval;
- assurance that the use of the drug(s) or biologic is primarily to treat a patient with a specific, clinically urgent, condition; and that the patient is not a research subject;
- a brief written statement explaining the rationale for the use of the investigational drug or biologic;
- a copy of the consent form that will be used by the prescribing person to obtain informed consent from the patient or the patient's legally authorized representative. Such consent form to include a description of the clinical protocol (length of administration, dosage, method of evaluation of efficacy, side effects, etc.);

- a formal statement from the manufacturer (or distributor) of the investigational drug, that the prescribing person has received approval for use of the investigational agent (e.g. Letter of Authorization from the sponsor of the IND).
- The completed submission materials that were provided to the FDA.

The physician is responsible for requesting continuing approval from the IRB if the use expands more than one year from the date of the IRB's determination.

Expanded Access Request for Intermediate-Size Patient Populations, or Treatment IND (TI) or Treatment Protocol (TP):

The submission to the IRB for the above type of expanded access requests should include the following information which will be reviewed by the convened IRB

- Material that was provided to the FDA to make the determinations required per the expanded access regulations as described above
- The informed consent to be used

The IRB will issue a letter indicating its determination regarding the TI/TP

The physician is responsible for requesting continuing approval from the IRB if the use expands more than one year from the date of the IRB's determination.

Related Policies

2009-001 - Reporting Unanticipated Problems to the Institutional Review Board
 2009-004 – Required Reporting to Institutional Officials and External Agencies
 2011-007.0 – Definitions Applied to Policies
 011-008.5 – Informed Consent – Providing and Obtaining

Basis

21 CFR 312, Subpart I
 21 CFR 56

[Emergency Use of an Investigational Drug or Biologic - Information Sheet:](#)

Guidance for Institutional Review Boards and Clinical Investigators
 Individual Patient Expanded Access Applications: Form FDA 3926 Guidance for Industry

Document Attributes

Date Effective: 6/5/2023

Replaced Version: 8/3/2020

Reviewed and Approved By: Richard H. Simon **Date:** 6/5/2023
Richard H. Simon, MD
Director Human Subjects Protection Program

Appendix A to Policy 2011-022.2

FDA Contacts

FDA Contacts Per 21 CFR 312.10(d)(1):

For investigational biological drug products regulated by the Center for Biologics Evaluation and Research, the request should be directed to the Office of Communication, Outreach and Development, Center for Biologics Evaluation and Research, 240-402-8010 or 1-800-835-4709, e-mail: ocod@fda.hhs.gov. For all other investigational drugs, the request for authorization should be directed to the Division of Drug Information, Center for Drug Evaluation and Research, 301-796-3400, e-mail: druginfo@fda.hhs.gov. After normal working hours (8 a.m. to 4:30 p.m.), the request should be directed to the FDA Emergency Call Center, 866-300-4374, e-mail: emergency.operations@fda.hhs.gov.

FDA Contacts per web site [link](#)

For questions about expanded access for emergency contact the Division of Drug Information at 855-543-3784 or 301-796-3400, or for a specific investigational drug, contact the appropriate review division below.

If DDI and the review division are not available, contact the CDER Emergency Coordinator (CEC) of the Counter-Terrorism and Emergency Coordination Staff (CTECS) at phone: 301-796-9900 or 301-796-2210; fax: 301-431-6356; or e-mail at: cdererops@fda.hhs.gov.

CDER Review Division	Telephone Number	FAX Number
Division of Anti-Viral Products	301-796-1500	301-796-9883
Division of Oncology Products 1	301-796-2330	301-796-9845
Division of Oncology Products 2	301-796-2320	301-796-9849
Division of Hematology Products	301-796-7550	301-796-9849

CDER Review Division	Telephone Number	FAX Number
Division of Reproductive and Urologic Products	301-796-2130	301-796-9897
Division of Medical Imaging Products	301-796-2050	301-796-9848
Division of Gastroenterology and Inborn Errors Products	301-796-2120	301-796-9905
Division of Anesthesia, Analgesia, and Addiction Products	301-796-2280	301-796-9723
Division of Metabolism and Endocrinology Products	301-796-2290	301-796-9712
Division of Pulmonary, Allergy and Rheumatology Products	301-796-2300	301-796-9728
Division of Dermatology and Dental Products	301-796-2110	301-796-9895
Division of Anti-Infective Products	301-796-1400	301-796-9883
Division of Transplant and Ophthalmology Products	301-796-1600	301-796-9881
Division of Cardiovascular and Renal Products	301-796-2270	301-796-9841
Division of Neurology Products	301-796-2250	301-796-9839
Division of Psychiatry Products	301-796-2260	301-796-9838

Contact Information for Emergency Individual Patient INDs

During normal business hours (8 am – 4:30 pm EST weekdays)

For general questions about expanded access for emergency use for investigational drugs, contact CDER's Division of Drug Information (DDI) at phone: 301-796-3400 or 855-543-3784; fax: 301-431-6353; or e-mail: druginfo@fda.hhs.gov.

For questions about expanded access for emergency use for a specific investigational drug, contact the appropriate review division, if known, or DDI, if not known.

If DDI and the review division are not available, contact the CDER Emergency Coordinator (CEC) of the Counter-Terrorism and Emergency Coordination Staff (CTECS) at phone: 301-796-9900 or 301-796-2210; fax*: 301-431-6356; or e-mail at : cdererops@fda.hhs.gov . * Please call or e-mail the CDER Emergency Coordinator before faxing documents.

After hours (after 4:30 pm EST weekdays and all day on weekends)

All questions about and requests for expanded access for emergency use for drugs, biologics and medical devices should be directed to the FDA Emergency Call Center, telephone: 866-300-4374.

Issuing Department: Human Subjects Protection Program (HSPP)

Policy Number: 2011-023.0

Policy Title: Educational Requirements

Purpose:

The purpose of this policy is to set forth educational requirements to be met by research personnel, members of the Institutional Review Board, and HSPP staff.

Definitions:

See policy 2011-007.0 for definitions of:

Human Subject		Research
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Policy:

It is the policy of the HSPP that individuals directly involved in the conduct of human subject research (i.e. investigators, coordinators, persons obtaining consent) or administration of human subjects research (i.e. HSPP staff, IRB members) complete training in the protection of human subjects in research.

The training requirement is most often satisfied initially through completion of an on-line training tutorial provided through the Collaborative IRB Training Initiative (CITI). Alternate mechanisms of training may be accepted by the Director (or designee) of the HSPP or by IRB staff on a case-by-case basis if that mechanism is also an established training tool (e.g., an NIH sponsored tutorial). The HSPP/IRB may review the content of alternate mechanisms to determine if it is an acceptable alternative. The IRB reserves the right to require an individual to complete any/all modules of the CITI program.

Training of study personnel is required regardless of whether the research qualifies for exempt, expedited or full board review, or whether the facilitated review process is utilized. For all research, training of study personnel must be current at the time of initial approval. Training must also be current for an individual added to a study through a request for modification. For exempt research, the PI is responsible for ensuring that training is current for personnel added to the study after initial approval.

Training will be considered current if completed within the past three years. The CITI course, NIH training tutorial, attendance at the annual IRB combined panel meeting, or other appropriate mechanism as noted above, will fulfill the renewal requirement.

All newly appointed IRB members are required to complete CITI training before being assigned as a primary reviewer.

If an investigator is external to the UConn Health, they must submit proof of having completed human subjects protection training. The IRB reserves the right to require the external investigator to provide a letter from their home institution's IRB certifying compliance with local training requirements, and/or to require the investigator to complete some or all of the elements of the CITI training modules.

Additionally, the HSPP strongly encourages individuals acting as the Principal Investigator for the first time at UConn Health to partake in an educational session with the HSPP prior to initiation of their first study at UConn Health. The IRB may also mandate this as a condition of approval.

The Education and Outreach Program (EOP) within the HSPP will also offer voluntary educational opportunities to research personnel and to HSPP staff and IRB members. The EOP will be primarily responsible for developing and implementing these opportunities which may include, but are not limited to, brown-bag lunch sessions, publication of a departmental newsletter, tailored educational sessions as requested,

hosting professional conferences, conducting education at an IRB meeting, convening combined IRB panel meetings to review policies and current developments, HSPP staff attendance at conferences etc.

The EOP will communicate changes to HSPP policies and/or forms, and general educational information, to the research community. Acceptable means of communication include broadcast notices, emails, notices within the electronic submission system and newsletters.

Procedure:

CITI:

Individuals log into the CITI web site to complete the applicable training module based on their primary research function. Individuals self-select from training courses established within the CITI program (e.g., IRB Members /HSPP staff; biomedical investigators, social and behavioral investigators, students).

- Upon receipt of the completion data from CITI, the IRIS system or IRB staff will update the training record in the individual's IRIS user account. Most often notification of completed training will come directly from CITI to designated IRB staff and/or IRIS, however if another mechanism was used to satisfy the training requirement, or CITI completion was affiliated with another institution, the evidence of training may be incorporated into the IRB submission material. In such cases the material within the submission will be utilized to update the training information in the individual's IRIS account.
- It is recommended that individuals upload CITI completion reports to their IRIS account for ease of verification.

Designated IRB staff verify that all investigators and research staff have completed required training by checking the names on an IRB submission, against the database information if necessary. Verification is study specific and done at the time of initial review, or for an individual being added via a request for modification.

- If an individual on the application has not completed the training the IRB staff will notify the PI and the individual through the IRIS system via a contingency for approval.
- The PI may choose to remove the individual from the study and add him/her back via a modification at a later date or to wait until the individual completes the training.
 - If the individual is to remain on the study, final IRB approval will not be released until the requirement is satisfied.
 - If subjects are on active treatment, the PI must request in writing permission from the IRB Chair to continue the research for those subjects already enrolled, confirming that training is in the process of being completed.

The IRB Regulatory Specialists will remind IRB members of their renewal requirements in order to serve as a primary reviewer. Sign-in sheets will be utilized to track attendance at the IRB combined panel meeting.

Use of Alternative Training Mechanism:

Alternative mechanisms must be established mechanisms (e.g., NIH training tutorials). If not established and known to the IRB, the individual must provide the DHSP with an overview of the content of the proposed substitution and an explanation for why the alternative mechanism is being sought. The DHSP will issue a written determination as to whether the exception is granted. The PI will include evidence of this exception as part of the IRB submission process.

First Time PI:

Information is solicited during the IRB application process as to whether the individual is a first time PI. If checked yes, the IRB approval letter directs the individual to contact the EOP. The EOP also receives a copy of this letter and pro-actively reaches out to schedule such sessions.

Obtaining / Sharing Information:

The HSPP administrator ensures mechanisms are in place for continuing education, e.g., through subscriptions to CITI, and to listservs. The HSPP Administrator, designee, or EOP, will share educational information with researchers and IRB staff and member. Mechanisms used to share information will include broadcast messages, email communications, postings to the HSPP / IRB web site. Messages may be in regard to changes in policies, regulations or to recent developments, internal or external to the Health Center. If applicable, effective dates for implementation will be included in the message.

Related Content

2009-005.0 – Monitoring of IRB Approved Studies

Basis

Terms of Federal Wide Assurance
45 CFR 46.107

Document Attributes:

Date Effective: 9/30/2025

Replaced Version: 6/5/23

Reviewed and Approved By:

Shemetra Owens

9/30/2025

Shemetra Owens, CIP, CIM
Associate Director, Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-024.0
Policy Title: File Requirements & Record Retention Requirements

Purpose

The purpose of this policy is to set forth record retention requirements that the Institutional Review Board (IRB) and Principal Investigators (PI) must follow.

Definitions

Policy

IRB Files & Retention: IRB files and documentation are considered privileged information. Every effort will be made to maintain confidentiality and non-disclosure of this information.

The IRB staff will maintain records for each convened meeting, including the minutes, agenda and roster. IRB minutes will document required determinations.

In order to allow a reconstruction of a complete history of IRB actions related to the review and approval of a protocol, the IRB staff will maintain complete files of all active studies on site either in paper or electronic format. Study files will contain all documentation submitted by the PI for IRB initial review, continuing review, review of modifications, and review of problem reports that may constitute an unanticipated problem involving risk to subjects or others, serious non-compliance or continuing non-compliance. Documentation contained in files, as applicable to a study, includes:

- Protocols or research plans.
- Recruitment materials.
- Consent documents.
- Progress reports submitted by researchers.
- Records of continuing review activities.
- Data and safety monitoring reports, if any.
- Modifications to previously approved research.
- Documentation of non-compliance,
- Correspondence between the IRB and the PI,
- Reports of unanticipated problems,
- Reports of injuries to subjects,
- Statements of significant new findings provided to participants
- Investigator brochures,
- Grant applications,
- Results of scientific reviews
- Audit reports, and
- DHHS-sample consents and protocols.
- If applicable, rationale for determining that research appearing on the expedited review list is more than minimal risk

When the expedited procedure is used, the IRB file will also contain the reviewer's determination that the submission qualified for expedited review, the category(ies) under which it qualifies, the action taken by the reviewer, and documentation by the reviewer that required determinations have been met.

When a submission qualifies for exemption, the file will also contain the reviewer's determination that the submission qualifies for exemption and the category(ies) under which it qualifies.

In accordance with Federal regulations, IRB staff will retain IRB study records for at least three years beyond the completion of a study or study cancellation without subject enrollment. For studies to which HIPAA regulation applies, the IRB will retain documents relating to applicable determinations for at least 6 years from the date of study closure. Connecticut currently has no required retention period for IRB records.

A designated member of the IRB staff arranges to have closed paper study files moved to a location off-site for archiving. The IRB staff person maintains a master index of the files archived. Files are retrievable within approximately 48 hours for future reference to allow for inspection and copying by regulatory agencies, including the Food and Drug Administration (FDA) and Office for Human Research Protections (OHRP), at reasonable times and in a reasonable manner.

Investigator Records & Retention: OHRP and the IRB require investigators to maintain research records for 3 years beyond the completion / cancellation of the study.

Per FDA regulations for investigational new drugs investigators must retain records for a period of 2 years following the date a marketing application is approved for the drug for the indication for which it was investigated; or, if no application is to be filed or if the application is not approved for such indications, until 2 years after the investigation is discontinued and the FDA is notified.

Per FDA regulations for investigational devices an investigator or sponsor shall maintain the study records during the investigation and for a period of 2 years after the latter of the following two dates: the date on which the investigation is terminated or completed, or the date that the records are no longer required for purposes of supporting a premarket approval application or a notice of completion of a product development protocol. An investigator or sponsor may withdraw from the responsibility to maintain records for the period required and transfer custody of the records to any other person who will accept responsibility for them. Notice of a transfer must be given to FDA not later than 10 working days after transfer occurs.

Per the HIPAA regulation, investigators are to retain documents relating to uses and disclosures, authorization forms, business partner contracts, notices of practice, responses to requests to amend or correct information, a patient's statement of disagreement, or a complaint from an individual for 6 years from the date of creation or the date when it last was in effect, whichever is later. (See 64 Fed. Reg. 59994)

Investigators are responsible for meeting any additional record retention requirements set forth in clinical trial agreements with sponsors.

Procedure

IRB File Procedures:

- The electronic IRB submission system will house study specific files and all associated documents. For studies that began before implementation of the system the study may have both a paper file and electronic file associated with it. The paper file will be retained in chronological order until such time as the study closes at which point it may be archived. IRB minutes and

agenda will be maintained within the electronic submission system and will also be exported to store in electronic format on a secure shared drive.

- The IRB roster will also be stored on the secure shared drive.

IRB - Record Retention/Archiving:

Upon closure of a study designated IRB staff will archive the paper IRB study folders off site for at least the required retention period.

- staff will record the contents being archived (e.g. IRB numbers) and the identification of the archive box on the master archive index
- after the required retention period has been met, designated staff may request that records be destroyed by filing a records destruction request form with facilities management who in turn coordinate the request with the off-site storage facility.

Electronic files may be periodically purged from the system after the retention requirements have been met.

Investigator Study Files

- Investigators are responsible for satisfying record retention requirements and must confirm in the IRB application that they will do so.

Related Policies

2011-009.3 – Institutional Review Board – Expedited Reviews

2011-009.5 – Institutional Review Board – Review by Convened Board

Basis

45 CFR 46

31 CFR 312

21 CFR 812

45 CFR 164

Document Attributes

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Reviewed and Approved By:

Shemetra Owens

**Shemetra Owens, CIP,CIM
Associate Director, Human Subjects Protection Program**

9/29/2025

Date

Issuing Department: Human Subjects Protection Program
Policy Number: 2015-024.1
Policy Title: Record Retention Formats

Purpose

The purpose of this policy is to set forth acceptable formats for meeting record retention requirements of paper documents.

Definitions

Policy

Policy 2011-024.0, File Requirements & Record Retention Requirements, sets for the documents that must be retained and the minimum time frames for which the files must be maintained. This policy sets forth acceptable formats for the required retention of documents that originated in paper form.

Retention in Paper Format:

Files may be maintained and retained in paper format. If stored off-site the files must be retrievable within a reasonable time frame for inspection and copying. *(Note: Off-site storage must be with an approved UConn Health vendor.)*

Retention of Paper Forms in Electronic Format:

Either during the course of the study, or after study closure, it is acceptable to maintain scanned copies of the original paper documents. The scanned copies must be "Certified Copies" which is defined in FDA Guidance as "a copy of the original information that has been verified, as indicated by a dated signature, as an exact copy having all of the same attributes and information as the original"

For externally funded research the investigator must obtain approval from the funding entity for the electronic storage of the paper forms.

If plans for electronic storage of paper forms were not described in the original submission to the IRB, a request for modification must be submitted. The request, whether submitted at the time of initial review or as a modification, should be inclusive of identification of documents that will be converted to electronic format, a standard operating procedure for verifying that all documents have in fact been scanned completely (e.g. no missing documents, no missing pages within a document, all pages are legible) and saved successfully before any paper versions are destroyed, plans to ensure the confidentiality of the data, plans for secure destruction of the original documents, and if applicable, documentation that the funding entity approves of the electronic storage format.

Prior to scanning, each original paper form must have a written statement similar to the following on the first page "Copy Certified by [insert name] on [insert date]". The scanning must be done by the person certifying the form and on the date the form is certified.

All records stored in electronic format must be available for inspection and copying.

Procedure

As applicable, approval is obtained from funding entity for electronic storage of documents.

Approval is obtained from the IRB, either as part of initial review or through a request for modification, for the electronic storage of certified copies of paper documents. The material to be submitted to the IRB is inclusive of:

- Identification of which documents will be converted to electronic format
- Standard operating procedure for converting paper file to electronic file, including certification process, verification process, and destruction process
- Plans for confidentiality of electronic files
- Approval from the funding entity for the electronic storage, as applicable
- Confirmation that electronic documents will be available for inspection copying.

Related Policies

2011-024.0 – File Requirements & Record Retention Requirements

Basis

Guidance for Industry, Computerized Systems Used in Clinical Investigations, FDA 2007
Replies to Inquires to FDA on Good Clinical Practice, [Recordkeeping and Record Retention, March 5, 2014](#)

Document Attributes

Date Created: 12/18/2015

Replaced Version: NEW

Reviewed and Approved By:

Richard Simon

12/29/2015

Richard Simon, MD Date
Director Human Subjects Protection Office

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2011-025.0
Policy Title: HSPP Authority, Support and Evaluation

Purpose

The purpose of this policy is to recognize the authority granted by the institution to the Director of the HSPP (DHSPP) and also to set forth a mechanism by which the DHSPP will evaluate and if necessary secure additional resources for the department.

Definitions

See policy 2011-007.0 for definitions of the following terms:

Human Subject	IRB Approval	Noncompliance, Continuing
Noncompliance, Serious	Suspension	Termination

Policy

Authority: Institutional policy number 2004-02 charges the DHSPP with the responsibility of protecting human subjects. As such, the DHSPP is empowered to suspend or terminate any study previously approved by the IRB or to require additional reviews. Suspension or termination may be due to serious and / or unexpected increased risks to subjects or continuing or serious non-compliance of the investigator(s) or other factors that the DHSPP deems warrant suspension or termination. The DHSPP cannot influence the decision of the Institutional Review Board (IRB) or approve a study that has not been approved by the IRB.

The DHSPP has the authority to create, change and implement policy related to human subject protections. New policies or changes to policies may be presented to the IRB panels to solicit input from the committee members. The IRB Chairs or Vice Chairs will bring that feedback to the DHSPP. The DHSPP has the final authority on departmental policies.

At the discretion of the DHSPP, input may also be sought from those parties that would be affected by the policy.

Institutional level policies related to human subject protections will be presented to the Executive Policy Committee by the DHSPP or a designated staff representative for review, approval, and implementation.

Institutional Support: The institution provides support to the HSPP, the IRB members and the IRB staff in terms of staffing, office space and operating budgets, legal counsel, conflict of interest review, and educational opportunities. The DHSPP or designee presents the needs of the HSPP to the budget office on an annual basis corresponding with the budget cycle. If necessary, the DHSPP may make appeals to the Institutional Official in efforts to secure additional resources.

Procedure

The DHSPP or designee will periodically review all HSPP / IRB policies. Such review will include an assessment of the accuracy and relevancy of the policies, (e.g., a determination as to whether the policies are in-line with institutional policies, regulations, guidance documents and accreditation standards) and

whether there is a need for new policies to be developed. Reviews will occur at least as frequently as accreditation renewal is required.

On an annual basis, corresponding with the budget cycles, the DHSPP or designee will assess the operations of the HSPP to determine if additional resources are required in terms of supplies, education, staff, and / or equipment. Expenditures from the previous year, response time from the IRB to investigators, number of protocols reviewed per meeting, the number of audits conducted and types of findings, may be among the items included in the assessment. Information will also be solicited from IRB members and staff, and HSPP staff.

The DHSPP/designee will also take into consideration whether there were any activities, supplies or equipment that were previously forgone due to lack of resources.

On an annual basis the HSPP manager or designee will prepare for the DHSPP an evaluation of the overall performance of the HSPP. The evaluation will encompass the review of a number of criteria. If applicable the report will also include actions taken to improve the performance. Upon review of the report the DHSPP may require further action to improve performance. Criteria to be used in the evaluation include the following:

- the number of new full board studies reviewed by each IRB panel within a year in order to assess whether there is an unbalance between the panels that should be addressed, whether the number of panels is appropriate in relation to the volume of work; or whether additional expertise is needed in a certain therapeutic area.
- the findings of the audits conducted by the research compliance monitor to determine if there are common areas of non-compliance that could be improved upon with education, clarification of policy or development of new policies.
- the performance evaluations of IRB members which consider contribution to discussion, attendance, thoroughness of review, volume of work reviewed, and participation in educational activities.
- the nature, number and outcome of subject complaints to determine if proper action was taken or if improvements can still be made.
- the nature, number and outcome of investigator complaints to determine if proper action was taken or if improvements can still be made.
- the educational opportunities which HSPP and IRB members and staff attended throughout the year and whether opportunities were foregone due to lack of funding.
- the educational activities conducted or sponsored by the HSPP for staff and IRB members.
- the nature and number of participant outreach activities offered by the HSPP or other units within the UConn Health. Such activities will be logged by a designated HSPP/IRB staff person as they are announced in Broadcast messages or other media venues if applicable.

Related Policies

2004-02 – Authority of the Human Subjects Protection Office (Institutional Policy)

2009-003 – Imposing and Lifting Suspension of IRB Approval or Imposing Terminations of IRB Approval

2011-007.0 – Definitions Applied to Policies

Basis

45 CFR 46.103(a)(2)

Document Attributes

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Reviewed and Approved By:

Richard H. Simon

11/1/23

Date: _____

Richard H. Simon, MD

Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program
Policy Number: 2011-026.0
Policy Title: Planned Emergency Research

Purpose

The purpose of this policy is to describe the mechanisms for obtaining approval from the IRB for planned emergency research, including how consent from subjects will be addressed.

Definitions

See policy 2011-007.0 for definitions of Legally Authorized Representative

Policy

A protocol for planned emergency research must be approved in advance by the IRB, and when applicable the FDA, and be publicly disclosed to the community in which the research will be conducted.

For planned emergency research subject to FDA regulations the IRB must review and approve the study and the request for waiver of consent and must document the following:

- that the research activity is subject to regulation codified by the FDA and will be carried out under an FDA investigational new drug application or an FDA investigational device exemption, the application for which clearly identified the protocols that would include subjects who are unable to consent, and
- how the requirements on the form to request a waiver of consent for planned emergency research have been met.
 - this provision for waiver does not extend to research involving fetuses, pregnant women, and human in vitro fertilization, or research involving prisoners.

For planned emergency research not subject to FDA regulations the IRB must review and approve the study and the request for waiver of consent for planned emergency research and must document:

- that the research activity *is not* subject to regulation codified by the FDA, and
- how the requirements on the form to request a waiver of consent for planned emergency research have been met,
 - this provision for waiver does not extend to research involving fetuses, pregnant women, and human in vitro fertilization, or research involving prisoners.
- that OHRP has been notified of the IRB's findings to support approval of the research and the waiver of consent.

When making determinations required on the request for waiver form, the IRB must do so with the concurrence of a licensed physician who is a member of or consultant to the IRB and who is not otherwise participating in the clinical investigation/research.

The IRB determinations and the associated documentation are to be retained by the IRB for at least 3 years after completion of the research, and, if subject to FDA regulations, the records shall be accessible for inspection and copying by the FDA.

Procedure

In addition to the standard documents required for an IRB submission, the PI will be required to complete and submit the form to request a waiver of consent for planned emergency research. The form addresses all regulatory criteria for granting such a waiver.

Through assignments in the electronic submission system, IRB staff will provide the IRB members with 1) the standard reviewer sheet used to determine if a protocol meets the regulatory criteria for approval and 2) the request for waiver form that has been completed by the PI.

The reviewer will use the forms as a guide in the review process and discussion at the meeting.

The IRB Regulatory Specialist (RS) will document in the minutes the findings of the convened board for each required criteria for approval and for the waiver. Determinations made at the convened board supersede the opinion of the individual reviewers.

In all cases the IRB RS will prepare communication back to the investigator regarding the decision of the IRB.

- If the IRB cannot approve the research because the research does not meet the criteria for approval, the criteria outlined in the form to request a waiver, or because of other ethical concerns, the IRB must document its findings and provide these findings promptly in writing to the investigator and to the sponsor (via the investigator) of the research.
- When the research is subject to DHHS regulations, the IRB will find, document and report to DHHS that the conditions required for approval (as outlined on the request for waiver form) have been met.

Related Policies

2011-007.0 – Definitions Applied to Policies

2011-009.5 – Institutional Review Board - Review by Convened Board

2011-009.12 – Institutional Review Board – Criteria for Approval

Basis

21 CFR 50.24

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Reviewed and Approved By:

Richard H. Simon

Richard Simon, MD

Director Human Subjects Protection Program

15 June 2017

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2013-027.0
Policy Title: Additional Requirements – Department of Defense

Purpose

The purpose of this policy is to set forth additional requirements applicable to 1) research supported by the Department of Defense, inclusive of any component of the Department of Defense (DoD) as listed in Appendix A, or 2) research intentionally recruiting DoD personnel.

Definitions

See policy 2011-007.0 for definitions of the following terms

Administrative Review	DoD Personnel	Detainee	Experimental Subject
Prisoner of War	Legally Authorized Representative		Risk, Minimal

Policy

It is the policy of the HSPP that all non-exempt human subject research supported by the Department of Defense (DoD) or intentionally recruiting DoD personnel (i.e. on active duty / active employment at the time of study participation), will comply with additional requirements set forth by the DoD. The additional requirements are set forth below to aid investigators and the IRB in meeting these obligations.

The University of Connecticut Health Center does not allow research involving chemical or biological agents, including research for prophylactic, protective, or other peaceful purposes involving chemical or biological agents.

The University of Connecticut Health Center does not conduct classified research.

DoD Approval

To ensure all required elements are met prior to the start of the research, Principal Investigators must also obtain approval from the DoD Human Research Protection Official (DHRPO) through the Administrative Review that is required to be conducted per DoD. Recruitment and data collection can not begin until the DHRPO review is complete and notification of approval from the DHRPO has been received by the PI.

Qualifications / Education:

Research personnel and IRB members at UConn Health must be in compliance with local training requirements regarding ethics in human subject research. Such education is to be renewed as stated in the education and training policy (Policy #2011-023.0). Proof of such training for all investigators and a listing of roles/responsibilities for all study personnel must be provided to the DHRPO. A curricula vita or bio-sketch for the Principal Investigator must also be provided. If the DoD or component of the DoD impose stricter or additional specific requirements, the investigator(s) must adhere to such. Investigators should contact the project coordinator at DoD to ensure compliance.

Research Monitor: The DoD no longer requires an independent research monitor for studies greater than minimal risk. Investigators of existing open studies with a independent research monitor may request removal of the requirement for a monitor through a modification request to the IRB.

Confidentiality of Data:

Data or information acquired by the DoD component under a pledge of confidentiality for exclusively statistical purposes must be used exclusively for statistical purposes and may not be disclosed in identifiable form for any other purpose, except with the informed consent of the respondent.

All studies involving large scale genomic data collected on/from DoD-affiliated personnel will apply a DHHS Certificate of Confidentiality.

Research Related Injury:

Investigators should work with the project officer from the relevant DoD component to ensure correct provisions are in place regarding research related injury.

Scientific Review:

New studies and substantive amendments to existing studies must undergo scientific review prior to or at the time of IRB review. Results of scientific reviews conducted prior to the IRB meeting are to be included in the IRB submission. The IRB may rely on outside experts to provide an evaluation of the scientific merit.

Modifications:

Substantive modifications to the research protocol and any modifications that could potentially increase risk to subjects must be submitted to the HRPO for approval prior to implementation. The U.S. Army Medical Research and Material Command (USAMRMC) Office of Research Protections (ORP) Human Research Protection Office (HRPO) defines substantive modification as a change in Principal Investigator, change or addition of an institution, elimination or alteration of the consent process, change to the study population that has regulatory implications (e.g. adding children, adding active duty population, etc.), significant change in study design (i.e. would prompt additional scientific review) or a change that could potentially increase risks to subjects.

Records:

Records maintained that document compliance or non-compliance with DoD regulations will be made accessible for inspection and copying by representatives of the DoD at reasonable times and in a reasonable manner as determined by the supporting DoD component. Both the researcher and the IRB are obligated to maintain records.

Reporting Obligations:

The investigator is responsible for adhering to the following reporting requirements:

1. To report the following to the DoD human research protection officer (DHRPO) within 30 days:
 - Determinations of serious or continuing noncompliance
 - significant changes to the research protocol approved by the IRB
 - the results of the IRB continuing review,
 - a change of the reviewing IRB,
 - knowledge of any notification by any Federal department or agency or national organization that any part of the Human Research Protection program is under investigation for cause involving a DoD-supported research protocol (when related to investigator activity)

- unanticipated problems involving risk to subjects or others, suspensions, clinical holds (voluntary or involuntary), or terminations of the research by the IRB, the institution, the sponsor or regulatory agencies.
2. To report the following to the Component Office of Human Research Protections within 30 days:
 - Reports of audits of DoD-conducted or DoD-supported human subject research by another federal or state agency, official governing body of a Native American or Alaskan native tribe, other official entity, or foreign government.
 - Allegations of serious or continuing noncompliance related to research involving human subjects that are substantiated by investigation, and subsequent actions taken based on the findings.
 - Unanticipated problems involving risks to subjects or others and any subsequent actions taken based on the findings.
 3. To report substantiated allegations related to classified human subject research immediately.

The IRB will report the following to the DHRPO and/or COHRP within 30 days:

- unanticipated problems involving risk to subjects or others, suspensions, clinical holds (voluntary or involuntary), or terminations of the research by the IRB, the institution, the sponsor or regulatory agencies, and if not already done so by the investigator,
- knowledge of any notification by any Federal department or agency or national organization that any part of the Human Research Protection program is under investigation for cause involving a DoD-supported research protocol (when related to IRB/oversight activity)

International Research:

Permission to conduct research outside of the U.S. with non-US citizens and/or with DoD personnel must be obtained from the host country. The research must meet approval criteria of the host country as well as the U.S. The research must undergo an ethics review by the host country, or local DoD IRB with representation from the host country. Proof of such review must be submitted to the IRB prior to commencing the research. Investigators must obtain confirmation of approval from the appropriate DoD component prior to research starting when human subjects research is conducted in a foreign country, unless conducted by a DoD overseas institution, or only involves DoD-affiliated personnel who are US citizens.

Multi-Site Research

The roles and responsibilities of each party at each site involved in the research must be clearly detailed in the DoD Addendum to the IRB application.

When UConn Health (a non-DoD organization) collaborates on research with DoD organizations, UConn Health IRB will not serve as the reviewing IRB.

When serving as the IRB for DoD-supported research, the IRB will report the following to the Component Office for Human Research Protections (COHRP) within 30 days. (DoDI 3216.02 section 3.6):

- When the organization is notified by any federal body, state agency, official governing body of a Native American or Alaskan native tribe, other entity, or foreign government that any part of an HRPP is under investigation for cause involving a DoD-supported research protocol.
- Any problems involving risks to subjects or others, suspension, or termination of IRB approval, or any serious or continuing noncompliance pertaining to DoD-supported human subject research.
- Closure of a DoD-supported study.
- The PI must report the following to the Component Office for Human Research Protections (COHRP) within 30 days. (DoDI 3216.02 section 3.6): When significant changes to the research protocol are approved by the IRB:
 - Changes to key investigators or institutions.
 - Decreased benefit or increased risk to subjects in greater than minimal risk research.
 - Addition of vulnerable populations as subjects.
 - Addition of DoD-affiliated personnel as subjects.
- Change in status when a previously enrolled subject becomes pregnant, or when the investigator learns that a previously enrolled subject is pregnant, and the protocol was not reviewed and approved by the IRBs in accordance with 45 CFR 46, Subpart B.
- Change in status when a previously enrolled subject becomes a prisoner, and the protocol was not reviewed and approved by the IRBs in accordance with 32 CFR 219, Subpart C.

Contracts and Awards:

Investigators receiving funding from DoD must also comply with applicable contracting requirements and processes required by the Office of Research and Sponsored Programs. Investigators are responsible for working with their assigned Sponsored Programs Specialist.

Department of Defense Personnel:

When research involves DoD personnel who will participate while on duty, including military personnel, the following provisions to minimize undue influence must be addressed:

- Officers cannot influence the decision of the subordinates to participate in research
- Officer and senior non-commissioned officers cannot be present at the time of recruitment
- Officers and senior non-commissioned officers must have a separate opportunity to participate in the research
- When recruitment involves a percentage of a unit, an independent ombudsman must be present during the recruitment

DoD-affiliated personnel, military and civilian supervisors, officers, and others in the chain of command must not be present at any human subject recruitment sessions or during the consent process for DoD-affiliated personnel.

For greater than minimal risk research involving DoD-personnel, when recruitment and consent occurs in a group setting, the IRB will appoint an ombudsperson who:

- Does not have a conflict of interest with the research or is part of the research team.
- Must be present during human subject recruitment, monitoring that the recruitment and informed consent explain that participation is voluntary, and that the information provided about the

research is consistent with the IRB-approved script and materials, including digitally provided materials.

- Should be available to address DoD-affiliated personnel's concerns about participation.

Research involving an "experimental subject" is an activity, for research purposes, where there is an intervention or interaction with a living individual for the primary purpose of obtaining data regarding the effect of the intervention or interaction. Research involving "experimental subjects" is a subset of research involving human subjects. This definition relates only to the application of Section 980 of Title 10, U.S.C; it does not affect the application of 32 CFR 219. If non-exempt research is supported by DoD-appropriated funds and involves experimental subjects as defined in DODI 3216.02, consent must be obtained in advance, in accordance with 10 USC 980.

The IRB may waive or alter some elements of informed consent for research involving human beings as experimental subjects, so long as it preserves the informed consent of the subject (i.e., the consent indicates that participation in the research is voluntary, and the subject/representative is informed of research risks).

The following limitations on dual compensation for federal employees or military personnel apply:

- An individual may not receive pay from more than one position for more than 40 hours of work in one calendar week. This limitation on dual compensation includes temporary, part-time and intermittent appointments.
- Individuals may receive compensation for research activities if the research activities take place outside of schedule work hours.
- Federal employees while on duty and non-federal persons may be compensated for blood draws for research up to \$50 for each blood draw.
- Non-federal persons may be compensated for research participation other than blood draws in a reasonable amount as approved by the IRBs according to local prevailing rates and the nature of the research.

Survey Review:

When conducting surveys on DoD personnel, the PI must submit the surveys for review and approval by the DoD Information Management Control Officer (IMCO) after the research protocol has been reviewed and approved by the IRB. When a survey crosses DoD components, the PI must obtain additional reviews as required.

Waiver of Consent

If research participants do not meet the definition of "experimental subjects" then the IRB may waive the consent process. If research participants of a study funded by the DoD or any of its components do meet the definition of experimental subject then a waiver of consent by the IRB is prohibited unless a waiver is obtained from the Assistant Secretary of Defense for Research and Engineering (ASDRE).

The ASDRE may grant a waiver if all of the following are true:

- The research is necessary to advance the development of a medical product for the Military Services.
- The research may directly benefit the individual experimental subject.
- The research is conducted in compliance with all other applicable laws and regulations.
- The research is not classified

Consent from Legally Authorized Representative:

If consent of the experimental subject cannot be obtained in advance, and the research is intended to benefit the subject, a legally authorized representative may provide consent.

Detainee / Prisoners of War

Research involving a detainee or a prisoner of war as a human participant is prohibited.

This prohibition does not apply to activities covered by investigational new drug or investigational device provisions of FDA regulations, when the purpose is for diagnosis or treatment of a medical condition in a patient. Such treatment may be offered to detainees or prisoners of war with their informed consent when the medical products are subject to FDA regulations, and only when the same product may be available to DoD-affiliated personnel consistent with established medical practices.

Vulnerable Populations:

Research involving pregnant women, prisoners, and children are subject to the DHHS Subparts B, C, and D.

Pregnant Women: For purposes of applying Subpart B, the phrase “biomedical knowledge” is replaced with “generalizable knowledge”. Per DoD, the applicability of Subpart B is limited to research involving pregnant women as participants in research that is more than minimal risk and includes interventions or invasive procedures to the woman or the fetus or involving fetuses or neonates as participants. However, by internal policy UConn Health applies subpart B to all federally funded or supported non-exempt research, regardless of risk level.

Fetal Research: Fetal research must comply with the US Code Title 42, Chapter 6A, Subchapter III, Part H, 289g which states the following:

(a) Conduct or support by Secretary; restrictions

The Secretary may not conduct or support any research or experimentation, in the United States or in any other country, on a nonviable living human fetus ex utero or a living human fetus ex utero for whom viability has not been ascertained unless the research or experimentation:

- may enhance the well-being or meet the health needs of the fetus or enhance the probability of its survival to viability; or
- will pose no added risk of suffering, injury, or death to the fetus and the purpose of the research or experimentation is the development of important biomedical knowledge which cannot be obtained by other means.

(b) Risk standard for fetuses intended to be aborted and fetuses intended to be carried to term to be same

In administering the regulations for the protection of human research subjects which:

- apply to research conducted or supported by the Secretary;
- involve living human fetuses in utero; and
- are published in section 46.208 of part 46 of title 45 of the Code of Federal Regulations; or any successor to such regulations, the Secretary shall require that the risk standard (published in section 46.102(g) of such part 46 or any successor to such regulations) be the same for fetuses which are intended to be aborted and fetuses which are intended to be carried to term.

For human subject research that would not otherwise be approved but presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of pregnant women, fetuses, or neonates, written approval from the DOHRP must be obtained through the COHPR prior to research starting.

Prisoners: D.O.D. supported research involving prisoners cannot be reviewed by the expedited procedure. When the IRB reviews research involving prisoners, at least one prisoner representative must be present for quorum. In addition to allowable categories of research on prisoners in Subpart C, epidemiological research is also allowable when:

- The research describes the prevalence or incidence of a disease by identifying all cases or studies potential risk factor association for a disease.
- The research presents no more than minimal risk.
- The research presents no more than an inconvenience to the participant.

When a previously enrolled human subject becomes a prisoner, and the protocol has not been reviewed and approved by the IRB in accordance with Subpart C, the investigator must promptly notify the IRB. For DoD-supported research, the DHSP/Designee will notify the DOHRPO and other federal agencies. All research interactions and interventions with the prisoner-subject (including obtaining identifiable private information) must cease until a request to approve a change in the research protocol is approved by the convened IRB and the DOHRP has concurred with the IRB. The convened IRB, upon receipt of notification that a previously enrolled human participant has become a prisoner, must promptly re-review the research protocol to ensure that the rights and wellbeing of the human subject, now a prisoner, are not in jeopardy. The IRB should consult with a subject matter expert having the expertise of a prisoner representative if the IRB reviewing the research protocol does not have a prisoner representative. If the prisoner-participant can continue to consent to participate and is capable of meeting the research protocol requirements, the terms of the prisoner-participant's confinement does not inhibit the ethical conduct of the research, and there are no other significant issues preventing the research involving human participants from continuing as approved, the convened IRB may approve a change in the study to allow this prisoner-participant to continue to participate in the research. This approval is limited to the individual prisoner-participant and does not allow recruitment of prisoners as participants. The DOHRP must concur with the IRB before the participant can continue to participate while a prisoner.

Children: The exemption for research involving survey or interview procedures or observation of public behavior, does not apply to research with children, except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.

Emergency Medicine Research

An exception from consent in emergency medicine research is prohibited unless a waiver is obtained from the Secretary of Defense. The PI must obtain approval from the DOHRP on behalf of the Secretary of Defense for a waiver of the advance informed consent provision of 10 USC 980 and include the documentation of approval with the submission to the IRB.

Procedure

Investigators conducting DoD funded research, or recruiting DoD personnel, must complete the Appendix F to the IRB Application. The appendix is designed to capture information regarding DoD requirements.

IRB Analyst will screen submissions, using the checklists as a tool, to ensure required documents have been provided.

IRB Members will be expected to evaluate the addendum to determine whether the relevant DoD requirements have been met such that the research may be approved.

Related Policies

2011-006.0 – Additional Protections: General
2011-006.1 – Additional Protections: Pregnant Women, Fetuses, Neonates
2011-006.2 – Additional Protections: Prisoners
2011-006.3 – Additional Protections: Children
2011-006.4 – Additional Protections: Other
2011-007.0 – Definitions Applied to Policies
2011-009.3 - Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board - Review by Convened Board
2011-009.12 – Institutional Review Board – Criteria for Approval
2011-016.0 – Scientific Review
2011-023.0 – Educational Requirements

Basis

45 CFR 46, B, C, D
Department of Defense Directive 3216.02 dated 11/8/2011
10 USC 980(a,b)
SECNAVINST 3900.39D
32 CFR 219

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Reviewed and Approved By:

Richard H. Simon

**Richard H. Simon, MD
Director, Human Subjects Protection Program**

11/1/2023

Date

APPENDIX A to Policy 2013-027.0
Components of the Department of Defense

Military Departments

- U.S. Department of the Army
 - United States Army Reserve
 - Army National Guard
- U.S. Department of the Navy,
 - Marine Corps
 - Coast Guard (in time of war)
 - Navy Reserve
- U.S. Department of the Air Force
 - Air National Guard
 - Air Force Reserve

Defense Agencies

- Defense Advanced Research Projects Agency (DARPA)
- Defense Logistics Agency (DLA)
- Missile Defense Agency,
- Pentagon Force Protection Agency (PFPA)
- Defense Commissary Agency
- Defense Contract Audit Agency
- Defense Contract Management Agency
- Defense Finance and Accounting Service
- Defense Information Systems Agency
- Defense Legal Services Agency
- Defense Security Cooperation Agency
- Defense Security Service
- Defense Threat Reduction Agency
- Central Security Service

Office of the Inspector General of the DoD

Offices of the Secretary of Defense

- **Acquisition, Technology and Logistics**
 - Department of Defense Test Resource Management Center
 - Defense Technical Information Center
 - Defense Advanced Research Projects Agency
 - Missile Defense Agency
 - Defense Contract Management Agency
 - Defense Logistics Agency
 - Defense Threat Reduction Agency
 - Office of Economic Adjustment
 - Defense Acquisition University
 - Operational Test and Evaluation Directorate
- **Policy**
 - Defense Security Cooperation Agency
 - Defense Policy Board Advisory Committee

- Defense Prisoner of War/Missing Personnel Office
- Defense Technology Security Administration
- **Comptroller**
 - Defense Contract Audit Agency
 - Defense Finance and Accounting Service
- **Personnel and Readiness**
 - Principal Deputy Under Secretary of Defense for Personnel and Readiness
 - Department of Defense Education Activity
 - Department of Defense Dependents Schools
 - Assistant Secretary of Defense for Health Affairs
 - Military Health System^[11]
 - TRICARE Management Activity^[12]
 - Defense Commissary Agency
 - Defense Human Resources Activity
 - Uniformed Services University of the Health Sciences
 - Defense Equal Opportunity Management Institute
 - Office of the Chancellor for Education and Professional Development
- **Intelligence**
 - Defense Intelligence Agency
 - Defense Security Service
 - National Geospatial-Intelligence Agency
 - National Reconnaissance Office
 - National Security Agency
 - Defense Information Systems Agency
- **Other**
 - Assistant Secretary of Defense for Public Affairs
 - Deputy Assistant Secretary of Defense, Internal Communications
 - Defense Media Activity
 - Director of Administration and Management
 - Pentagon Force Protection Agency
 - Washington Headquarters Services
 - Director, Program Analysis and Evaluation
 - Office of Net Assessment
 - General Counsel of the Department of Defense
 - Defense Legal Services Agency

Field Activities

- Defense Media Activity
- Defense Prisoner of War/Missing Personnel Office
- Defense Technical Information Center
- Defense Technology Security Administration
- Department of Defense Education Activity
- Department of Defense Human Resources Activity
- Department of Defense Test Resource Management Center
- Office of Economic Adjustment
- TRICARE Management Activity
- Washington Headquarters Services

Military Service Academies:

- United States Military Academy (West Point NY)
- United States Naval Academy (Annapolis MD)
- United States Air Force Academy (CO)
- United States Coast Guard Academy (New London CT)
- United States Merchant Marine Academy (Kings Point NY)

Source: *from http://en.wikipedia.org/wiki/Organizational_structure_of_the_United_States_Department_of_Defense*
<http://www.defense.gov/faq/pis/20.html>

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2014-028.0
Policy Title: Additional Requirements – National Institute of Justice

Purpose

The purpose of this policy is to set forth additional requirements that are applicable to research supported by the National Institute of Justice (NIJ). NIJ is a component of the Office of Justice Programs within the Department of Justice.

Definitions

See policy 2011-007.0 for definitions of Privacy Certificate

Policy

For NIJ-funded research:

- all projects are required to have a privacy certificate approved by the NIJ human subjects protection officer;
- all researchers and research staff are required to sign employee confidentiality statements, which are maintained by the responsible researcher.

The consent form must:

- identify the National Institute of Justice as the funding agency.
- include a statement describing the extent to which confidentiality of records identifying the subject will be maintained.
- inform the subject that private, identifiable information will be kept confidential and will only be used for research and statistical purposes.
- if, due to sample size or some unique feature, the identity of the individual cannot be maintained, the participants need to be explicitly notified.
- if the researcher intends to disclose any information, the participant needs to be explicitly informed what information would be disclosed, under what circumstances, and to whom.
- the participant must be informed of any risks that might result from this disclosure and must explicitly provide written consent prior to participating in the research.

Under a Privacy Certificate, researchers and research staff do not have to report child abuse unless the participant signs another consent document to allow child abuse reporting.

At least once a year, the investigator shall provide the chief, Office of Research and Evaluation, with a report on the progress of the research.

A copy of all data must be de-identified and sent to the National Archive of Criminal Justice Data, including copies of the informed consent document, data collection instruments, surveys, or other relevant research materials.

At least 12 working days before any report of findings is to be released, the investigator shall distribute one copy of the report to each of the following: the chairperson of the Bureau Research Review Board, the regional director, and the warden of each institution that provided data or assistance. The investigator shall include an abstract in the report of findings.

In any publication of results, the investigator shall acknowledge the Bureau's participation in the research project.

The investigator shall expressly disclaim approval or endorsement of the published material as an expression of the policies or views of the Bureau.

Prior to submitting for publication, the results of a research project conducted under this subpart, the investigator shall provide two copies of the material, for informational purposes only, to the Chief, Office of Research and Evaluation, Central Office, Bureau of Prisons.

Procedure

Investigators who have obtained funding from National Institute of Justice are required to complete and submit Appendix H which address the additional requirements of NIJ.

When developing the consent form, investigators are to use the consent checklist addendum specific to NIJ funded research to ensure the additional required elements of consent have been incorporated into the consent form. The consent form and checklist are submitted to the IRB.

IRB Regulatory Specialist will screen submissions, using the checklists as a tool, to ensure required documents have been provided.

IRB members will be expected to evaluate the National Institute of Justice Addendum and consent forms to determine whether the National Institute of Justice Requirements have been met such that the research may be approved.

Related Policies

2011-008.0 – Informed Consent Forms

2011-008.5 – Providing and Obtaining Informed Consent

2011-009.3 - Institutional Review Board – Expedited Reviews

2011-009.5 – Institutional Review Board - Review by Convened Board

2011-009.12 – Institutional Review Board – Criteria for Approval

Basis

28 CFR 22

28 CFR 46

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Reviewed and Approved By:

Richard H. Simon

Richard H. Simon, MD

Director, Human Subjects Protection Program

11/1/2023

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2014-031.0
Policy Title: Additional Requirements – Department of Energy (DOE)

Purpose

The purpose of this policy is to set forth additional requirements that are applicable to research supported by the Department of Energy.

Definitions

Policy

DOE requirements apply to all research conducted with DOE funding, at DOE institutions (regardless of funding source), or by DOE or DOE contractor personnel (regardless of funding source or location conducted), whether done domestically or in an international environment, including classified and proprietary research.

- When research involves contractors, DOE “Contractor Requirements Document” describing contractor responsibilities for protecting human research subjects must be included in contracts.
- Research that uses social media data must be submitted to the IRB for human subject research review and determination. (DOE O 443.1C, Section 4(a)(5))
- Research that involves the study of humans in a systematically modified environment must be submitted to the IRB for review and determination.
- Classified and unclassified human subject research that is funded through the Strategic Intelligence Partnership Program (SIPP) must be reviewed and approved by the Central DOE IRB-Classified.
- UConn Health does not engage in Human Terrain Mapping (HTM) research.

When the institution receives funding from the Department of Energy, the institution must periodically conduct self-assessments to ensure compliance with the HSPP procedures and other requirements. This self-assessment is addressed through the Compliance Monitoring Program (Policy 2009-005.0 Monitoring of IRB Approved Studies) and the annual evaluation of the Human Subjects Protection Office (Policy 2011-025.0 HSPP Authority, Support and Evaluation).

- The Principal Investigator must complete and submit, and the IRB must review and approve, Appendix I, the DOE Checklist for Investigators Conducting / IRBs Reviewing Human Subject Research that utilizes personally identifiable information). This form is used to verify that protocols are in compliance with DOE requirements.

The Principal Investigator must also acknowledge on Appendix I that they will ensure compliance with the following reporting requirements:

- Prompt reporting (i.e., within 48 hours) of the following to the human subject research program manager and IRB:
 - Any significant adverse events, unanticipated risks; and complaints about the research, with a description of any corrective actions taken or to be taken.

- Any suspension or termination of IRB approval of research.
- Any significant non-compliance with HSPP procedures or other requirements.
- Immediate reporting (i.e. within 24 hours) of any compromise of personally identifiable information to the human subject research program manager and IRB.

Vulnerable Populations: DOE and DOE site contractors are considered vulnerable subjects when participating in research and additional care must be taken to ensure their participation is truly voluntary (e.g., by ensuring they do not report to members of the research team), and that data collected about them is kept confidential. When research proposes to involve DOE employees or site contractors, the IRB will consider if additional protections are required for the research.

Multisite Research: Research involving human subjects involving multiple DOE sites (e.g., members of the research team from more than one DOE site and/or data or human subjects from more than one DOE site) must be reviewed and approved by one of the Central DOE IRBs prior to initiation, unless review by another appropriate IRB of record is authorized by the DOE and/or NNSA HSP Program Manager. If authorized by the DOE and/or NNSA HSP Program Manager, research may be reviewed by other appropriate IRB of record. In all cases, an IRB Authorization Agreement (IAA) or Memorandum of Understanding (MOU) must be in place between the organization(s) conducting the human subject research and the organization responsible for IRB review.

Classified Research: The following additional criteria apply to classified research:

- Classified research shall not be implemented without IRB approval, followed by approval by the DOE Institutional Official (IO).
- Consent may not be waived.
- Research may not be exempt, nor may the expedited review process be used.
- The identity of the sponsoring Federal agency will be disclosed to subjects, unless the sponsor requests that it not be done, because doing so could compromise intelligence sources or methods; the research involves no more than minimal risk to subjects; and the IRB determines that by not disclosing the identity the investigators will not adversely affect subjects.
- The informed consent will state that the research is classified and what that means for the purposes of that project
- Informed consent may only be waived for classified research if the work meets one of the categories of the minimal risk human subject research addressed at 10 CFR Part 745.104.
- The IRB must have a voting quorum of at least five members which must include a non-scientist and an unaffiliated member.
- The unaffiliated member must be a nongovernmental member with the appropriate security clearance. This individual cannot be a current Federal employee or a DOE site contractor.

- An IRB member can appeal an approval decision to the DOE IO, Secretary of Energy, and Director of the Office of Science and Technology Policy (OSTP) in that order.
- The IRB must determine whether the potential human subjects need access to classified information to make a valid informed consent decision.

The Investigator will notify the HSP Program Manager at DOE or NNSA immediately upon learning of a serious adverse event. The HSP Program Manager(s) shall also be informed of any corrective actions taken and consulted regarding the plan for any remaining corrective actions.

An IRB that believes that a project that is classified, in whole or in part, can be thoroughly reviewed in an unclassified manner, can submit a request for a waiver of the above requirements for the purposes of that study by submitting the DOE Request for Waiver form to the appropriate DOE or National Nuclear Security Administration HSP program Manager

Procedure

The Principal Investigator must complete and submit Appendix I which address DOE requirements.

The IRB must review and approve Appendix I.

The IRB agenda and reviewer form instruct IRB staff/members to refer this policy to ensure additional criteria for classified research are met.

Related Policies

2009-005.0 – Monitoring of IRB Approved Studies
 2011-009.3 - Institutional Review Board – Expedited Reviews
 2011-009.5 – Institutional Review Board - Review by Convened Board
 2011-009.12 – Institutional Review Board – Criteria for Approval
 2011-025.0 – HSPP Authority, Support and Evaluation

Basis –

Department of Energy 443.1B
 Department of Energy – N 443.1

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Richard H. Simon

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**Richard H. Simon, MD,
 Director Human Subjects Protection Program**

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2014-032.0
Policy Title: Additional Requirements – Environmental Protection Agency

Purpose

The purpose of this policy is to set forth additional requirements that are applicable to research supported by the Environmental Protection Agency.

Definitions

Policy

For non-exempt research conducted or supported by the EPA, the EPA:

- prohibits research involving the intentional exposure of pregnant women, nursing women, or children to any substance;
 - the IRB will not approve such research
 - research intended for submission to the EPA will comply with this prohibition
- requires application of 40 CFR 26 Subparts C* (Additional Protections for Pregnant Women and Fetuses Involved as Subjects in Observational Research) and D* (Additional Protections for Children Involved as Subjects in Observational Research) to provide additional protections to pregnant women and children as participants in observational research, i.e., research that does not involve intentional exposure to any substance;
 - research involving intentional exposure of a human subject means a study of a substance in which the exposure to the substance experienced by a human subject participating in the study would not have occurred but for the human subject's participation in the study.
 - observational research means any human research that does not meet the definition of research involving intentional exposure of a human subject
- requires submission of IRB determinations and approval to the EPA human subjects research review official for final review and approval before the research can begin.

For research not conducted or supported by any federal agency that has regulations for protecting human research subjects and for which the intention of the research is submission to the EPA, the EPA regulations protecting human research subjects apply, including:

- EPA extends the provisions of the 40 CFR 26 to human research involving the intentional exposure of non-pregnant, non-nursing adults to any substance.

*equivalent to protections at 45 CFR 46 Subpart B and D

Procedure

If pregnant women or children are to be included in observational research conducted or supported by the EPA, the additional protections described in Policy 2011-006.1 and 2011-006.3 are applicable and the procedures described in Policy 2011 – 006.0 – Vulnerable Populations - General Policy, are to be followed.

Related Policies

2011-006.0 - Additional Protections: General Policy
2011-006.1 – Additional Protections: Pregnant Women, Fetuses or Neonates
2011-006.3 - Additional Protections: Children
2011-008.0 – Informed Consent Forms
2011-008.5 – Providing and Obtaining Informed Consent
2011-009.3 - Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board - Review by Convened Board
2011-009.12 – Institutional Review Board – Criteria for Approval

Basis

40 CFR 26

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Richard H. Simon, MD
Director, Human Subjects Protection Program

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2014-033.0
Policy Title: Additional Requirements – Federal Bureau of Prisons

Purpose

The purpose of this policy is to set forth additional requirements that are applicable to research conducted within the Federal Bureau of Prisons.

Definitions

Policy

Although some research may be exempt from 28 CFR part 46 under §46.101(b)(5), as determined by the Office of Research and Evaluation (ORE) of the Bureau, no research is exempt from 28 CFR part 512, Subpart B.

Implementation of Bureau programmatic or operational initiatives made through pilot projects is not considered to be research.

Requirements for Research Projects and Researchers:

The following requirements must be met:

In all research projects the rights, health, and human dignity of individuals involved must be respected

The project must have an adequate research design and contribute to the advancement of knowledge about corrections.

The project must not involve medical experimentation, cosmetic research, or pharmaceutical testing.

The project must minimize risk to subjects; risks to subjects must be reasonable in relation to anticipated benefits.

The selection of subjects within any one institution must be equitable.

When applicable, informed consent must be sought and documented.

Incentives may not be offered to help persuade inmate participants to participate. However, soft drinks and snacks to be consumed at the test setting may be offered. Reasonable accommodations such as nominal monetary recompense for time and effort may be offered to non-confined research participants who are both:

- No longer in Bureau of Prisons custody.
- Participating in authorized research being conducted by Bureau employees or contractors.

The Researcher must have academic preparation or experience in the area of study of the proposed research.

The Researcher must assume responsibility for actions of any person engaged to participate in the research project as an associate, assistant, or subcontractor to the Researcher.

Except as noted in the consent statement to the participant, the Researcher must not provide research information that identifies a participant to any person without that participant's prior written consent to release the information. For example, research information identifiable to a particular individual cannot be admitted as evidence or used for any purpose in any action, suit, or other judicial, administrative, or legislative proceeding without the written consent of the individual to whom the data pertain.

The research design must be compatible with both the operation of prison facilities and protection of human participants. The Researcher must observe the rules of the institution or office in which the research is conducted.

Any Researcher who is a non-employee of the Bureau must sign a statement in which the Researcher agrees to adhere to the requirements of 28 CFR 512, Subpart B. A non-employee of the Bureau may receive records in a form not individually identifiable when advance adequate written assurance that the record will be used solely as statistical research or reporting record is provided to the agency.

Except for computerized data records maintained at an official Department of Justice site, records that contain non-disclosable information directly traceable to a specific person may not be stored in, or introduced into, an electronic retrieval system.

If the Researcher is conducting a study of special interest to the Office of Research and Evaluation (ORE) but the study is not a joint project involving ORE, the Researcher may be asked to provide ORE with the computerized research data, not identifiable to individual participants, accompanied by detailed documentation. These arrangements must be negotiated prior to the beginning of the data collection phase of the project.

The researcher must submit planned methodological changes in a research project to the IRB for approval, and may be required to revise study procedures in accordance with the new methodology.

Content of Research Proposal.

When submitting a research protocol, the applicant must provide the following information:

- A summary statement, which includes:
 - Names and current affiliations of the Researchers.
 - Title of the study.
 - Purpose of the study.
 - Location of the study.
 - Methods to be employed.
 - Anticipated results.
 - Duration of the study
 - Number of participants (staff or inmates) required and amount of time required from each.
 - Indication of risk or discomfort involved as a result of participation.
- A comprehensive statement, which includes:
 - Review of related literature.
 - Detailed description of the research method.
 - Significance of anticipated results and their contribution to the advancement of knowledge.
 - Specific resources required from the Bureau of Prisons.
 - Description of all possible risks, discomforts, and benefits to individual participants or a class of participants, and a discussion of the likelihood that the risks and discomforts will actually occur.
 - Description of steps taken to minimize any risks.
 - Description of physical or administrative procedures to be followed to:
 - Ensure the security of any individually identifiable data that are being collected for the study.
 - Destroy research records or remove individual identifiers from those records when the research has been completed.

- Description of any anticipated effects of the research study on organizational programs and operations.
- Relevant research materials such as vitae, endorsements, sample consent statements, questionnaires, and interview schedules.
- A statement regarding assurances and certification required by federal regulations, if applicable.
- All formal research proposals will be reviewed by the Bureau Research Review Board.

Access to Bureau of Prison Records:

Employees, including consultants, of the Bureau who are conducting authorized research projects shall have access to those records relating to the subject which are necessary to the purpose of the research project without having to obtain the subject's consent

A non-employee of the Bureau is limited in access to information available under the Freedom of Information Act.

A non-employee of the Bureau may receive records in a form not individually identifiable when advance adequate written assurance that the record will be used solely as a statistical research or reporting record is provided to the agency.

Informed Consent.

Before commencing a research project requiring participation by staff or inmates, the researcher shall give each participant a written informed consent statement containing the following information

- Identification of the Principal Investigator.
- Objectives of the research project
- Procedures to be followed in the conduct of the research
- Purpose of each procedure
- Anticipated uses of the results of the research.
- A statement of benefits reasonably to be expected
- A declaration concerning discomfort and risk, including a description of anticipated discomfort and risk
- A statement that participation is completely voluntary and that the participant may withdraw consent and end participation in the project at any time without penalty or prejudice (the inmate will be returned to regular assignment or activity by staff as soon as practicable).
- A statement regarding the confidentiality of the research information and exceptions to any guarantees of confidentiality required by federal or state law. For example, a Researcher may not guarantee confidentiality when the participant indicates intent to commit future criminal conduct or harm himself or herself or someone else, or, if the participant is an inmate, indicates intent to leave the facility without authorization.
- A statement that participation in the research project will have no effect on the inmate participant's release date or parole eligibility
- An offer to answer questions about the research project.
- Appropriate additional information as needed to describe adequately the nature and risks of the research

A researcher who is a non-employee of the Bureau, in addition to presenting the statement of informed consent to the subject, shall also obtain the subject's signature on the statement of informed consent prior to initiating the research activity. The researcher may not be required to obtain the signature if the researcher can demonstrate that the only link to the subject's identity is the signed statement of informed

consent or that there is significantly more risk to the subject if the statement is signed. The signed statement shall be submitted to the chairperson of the appropriate local research review board.

Reports:

At least once a year, the Researcher must provide the Chief, Office of Research and Evaluation, with a report on the progress of the research.

At least 12 working days before any report of findings is to be released, the Researcher must distribute one copy of the report to each of the following: the chairperson of the Bureau Research Review Board, the regional director, and the warden of each institution that provided data or assistance. The Researcher must include an abstract in the report of findings.

Publications:

A researcher may publish in book form and professional journals the results of any research project conducted under this subpart.

In any publication of results, the Researcher shall acknowledge the Bureau's participation in the research project.

The Researcher shall expressly disclaim approval or endorsement of the published material as an expression of the policies or views of the Bureau.

Prior to submitting for publication the results of a research project conducted under 28 CFR 5112 Subpart B, the Researcher must provide two copies of the material, for informational purposes only, to the Chief, Office of Research and Evaluation, Central Office, Bureau of Prisons.

Procedure

Principal Investigator must review, sign and submit Appendix J to the IRB application.

Principal investigator must also submit form C, if prisoners within the Bureau are to be enrolled.

The IRB will then review the forms in accordance with standard review practices to ensure all required elements have been addressed.

Related Policies

2011-006.0 - Additional Protections: General Policy

2011-006.2 – Additional Protections: Prisoners

2011-009.3 - Institutional Review Board – Expedited Reviews

2011-009.5 – Institutional Review Board - Review by Convened Board

2011-009.12 – Institutional Review Board – Criteria for Approval

Basis

28 CFR 46 / 45 CFR 46

28 CFR 512, Subpart B

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Richard H. Simon

Richard Simon, MD

Director, Human Subjects Protection Program

11/01/2023

Date

Issuing Department: Human Subjects Protection Program (HSPP)
Policy Number: 2014-034.0
Policy Title: Additional Requirements – Department of Education

Purpose

The purpose of this policy is to set forth additional requirements that are applicable to research supported by the U.S. Department of Education (DE); and to identify when requirements of the Family Educational Rights and Privacy Act (FERPA) and Protection of Pupil Rights Amendment are applicable to research.

Definitions

Policy

For research funded by the National Institute on Disability and Rehabilitation Research, a component of the Dept. of Education, when the IRB reviews research that purposefully requires inclusion of children with disabilities or individuals with mental disabilities as research participants, the IRB must include at least one person primarily concerned with the welfare of these research participants.

For research funded by the DE, investigators must maintain compliance with the University's Family Educational Rights and Privacy Act (FERPA) policy (<http://policy.uconn.edu/?p=368>), as applicable. FERPA applies when researchers obtain student records or personal education information from an education program defined as any program principally engaged in the provision of education, including, but not limited to, early childhood education, elementary and secondary education, postsecondary education, special education, job training, career and technical education, and adult education.

Per the University FERPA policy, and with IRB approval, personally identifiable information may be disclosed from an education record of a student without consent if the disclosure is part of an agreement between organizations or researchers conducting studies for, or on behalf of, educational agencies or institutions to:

- Develop, validate, or administer predictive tests.
- Administer student aid programs.
- Improve instruction.

A school district or postsecondary institution that uses this exception is required to enter into a written agreement with the Organization or Researcher conducting the research that specifies:

- The determination of the exception
- The purpose, scope, and duration of the study
- The information to be disclosed.
- That information from education records may only be used to meet the purposes of the study stated in the written agreement and must contain the current requirements in Department of Education regulations on re-disclosure and destruction of information.
- That the study will be conducted in a manner that does not permit personal identification of parents and students by anyone other than representatives of the Organization with legitimate interests
- That the Organization is required to destroy or return all personally identifiable information when no longer needed for the purposes of the study.
- The time period during which the Organization must either destroy or return the information.

Education records may be released without consent under FERPA if all personally identifiable information has been removed including:

- Student's name and other direct personal identifiers, such as the student's social security number or student number.
- Indirect identifiers, such as the name of the student's parent or other family members; the student's or family's address, and personal characteristics or other information that would make the student's identity easily traceable; and date and place of birth and mother's maiden name.
- Biometric records, including one or more measurable biological or behavioral characteristics that can be used for automated recognition of an individual, including fingerprints, retina and iris patterns, voiceprints, DNA sequence, facial characteristics, and handwriting.
- Other information that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community, who does not have personal knowledge of the relevant circumstances, to identify the student with reasonable certainty.

Per the Protection of Pupil Rights Amendment for certain types of research projects directly funded by the U.S. Department of Education, no student will be required, as part of any research project, to submit without prior consent to surveys, psychiatric examination, testing, or treatment, or psychological examination, testing, or treatment, in which the primary purpose is to reveal information concerning one or more of the following:

- Political affiliations or beliefs of the student or the student's parent.
- Mental or psychological problems of the student or the student's family.
- Sex behavior or attitudes
- Illegal, anti-social, self-incriminating, or demeaning behavior.
- Critical appraisals of other individuals with whom respondents have close family relationships.
- Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers.
- Religious practices, affiliations, or beliefs of the student or student's parent.
- Income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program.)

Prior consent means:

- Prior consent of the student, if the student is an adult or emancipated minor.
- Prior written consent of the parent or guardian, if the student is a minor who has not been emancipated.

For certain types of research projects not directly funded by the U.S. Department of Education and conducted in a school that receives funding from the U.S. Department of Education investigators must obtain verification from the school of compliance with U.S. Department of Education regulations that require schools to develop and adopt policies in conjunction with parents regarding the following (rights of parents are applicable when the student is a child):

- The right of a parent of a student to inspect, upon the request of the parent, a survey created by a third party before the survey is administered or distributed by a school to a student.
 - Any applicable procedures for granting a request by a parent for reasonable access to such survey within a reasonable period of time after the request is received.
- Arrangements to protect student privacy that are provided by the agency in the event of the administration or distribution of a survey to a student containing one or more of the following items (including the right of a parent of a student to inspect, upon the request of the parent, any survey containing one or more of such items):

- Political affiliations or beliefs of the student or the student's parent.
 - Mental or psychological problems of the student or the student's family.
 - Sex behavior or attitudes
 - Illegal, anti-social, self-incriminating, or demeaning behavior.
 - Critical appraisals of other individuals with whom respondents have close family relationships.
 - Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers.
 - Religious practices, affiliations, or beliefs of the student or the student's parent.
 - Income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program).
- The right of a parent of a student to inspect, upon the request of the parent, any instructional material used as part of the educational curriculum for the student.
 - Any applicable procedures for granting a request by a parent for reasonable access to instructional material received.
 - The administration of physical examinations or screenings that the school or agency may administer to a student.
 - The collection, disclosure, or use of personal information collected from students for the purpose of marketing or for selling that information (or otherwise providing that information to others for that purpose), including arrangements to protect student privacy that are provided by the agency in the event of such collection, disclosure, or use.
 - The right of a parent of a student to inspect, upon the request of the parent, any instrument used in the collection of personal information before the instrument is administered or distributed to a student
 - Any applicable procedures for granting a request by a parent for reasonable access to such instrument within a reasonable period of time after the request is received.

For research funded by the U.S. Department of Education all instructional material, including teachers' manuals, films, tapes, or other supplementary instructional material, which will be used in connection with any research or experimentation program, or project must be available for inspection by the parents or guardians of the children engaged in such research. Research or experimentation program or project means any program or project in any research that is designed to explore or develop new or unproven teaching methods or techniques. Children are persons enrolled in research not above the elementary or secondary education level, who have not reached the age of majority as determined under state law.

Procedure

When research is funded by the U.S. Department of Education, or conducted in schools that receive funding from the U.S. Department of Education, in addition to the standard documents required for submissions, the following documents must be provided to the IRB:

- Appendix K to the IRB application, which may include an exception to student/parental consent.
- The FERPA Verification Form if the research is to be conducted in a school other than the University itself. If a signed FERPA verification form cannot easily be obtained, an email confirming all of the information included in the FERPA verification form will be acceptable. The email must be from the person at the school with the authority to grant the permission and sent from that individual's institutional email address.

The IRB will then review the forms in accordance with standard review practices to ensure all required elements have been addressed.

Related Policies

2011-006.0 - Additional Protections: General Policy
2011-006.3 - Additional Protections: Children
2011-006.4 – Additional Protections: Other
2011-009.3 - Institutional Review Board – Expedited Reviews
2011-009.5 – Institutional Review Board - Review by Convened Board
2011-009.12 – Institutional Review Board – Criteria for Approval
FERPA Policy, (University wide)

Basis

34 CFR 356.3
34 CFR 98.3
34 CFR 98.4
343 CFR 99

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Richard H. Simon

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Richard H. Simon, M.D.

Director, Human Subjects Protection Program

Issuing Department: Human Subjects Protection Program (HSPP)

Policy Number: 2023-035.0

Policy Title: HSPP Emergency Preparedness Plan

Purpose

The HSPP Emergency Plan is intended to ensure sustainability of the HSPP and continuing protection of research participants during emergencies.

Definitions

Policy

It is the policy of the HSPP to have an emergency preparedness plan in place, to ensure human subjects research decisions during an emergency will be conducted in conjunction with the University of Connecticut Health Center and John Dempsey Hospital Emergency Operations Plan and in accordance with AAHRPP Element I.1.H. The emergency preparedness plan will go into effect when the safety of all HSPP employees involved in carrying out the plan can be ensured.

The Director of the HSPP (DHSP) is responsible for ensuring the HSPP has an emergency preparedness and response plan, that key personnel are educated about the plan, and that the plan is evaluated at least annually (e.g., tabletop emergency exercises). The plan focuses only on human subjects research and is a supplement to the University of Connecticut Health Center and John Dempsey Hospital (JDH) Emergency Operations Plan. Any conflicts with the organization's Emergency Operations Plan will be resolved by the Institution Official (IO) and DHSP.

The IO and DHSP will review this policy at least annually as part of the HSPP evaluation.

On an annual basis, the IO/DHSP will engage in an emergency preparedness tabletop exercise where the key personnel in the HSPP respond in real-time to a scenario and evaluate the emergency preparedness plan based on the exercise and suggests revisions where needed.

Emergencies may occur at the national, state, local, or institutional level. The types of emergencies that the Institution may see can be defined as minor emergencies, limited and potential emergencies, or major disasters.

- **Minor emergencies** are events that are short in duration and may impact a small number of research protocols and may be managed through HSPP policy#2009-001.0, "Reporting Unanticipated Problems to the Institutional Review Board," as applicable. Examples of minor emergencies may include but are not limited to, brief and localized power outages, website/webpage outages, lab equipment failures.
- **Limited and potential emergencies** are events that may be short in duration but may require an extended mitigation plan and may impact more than one research team or group of research protocols, such as weather or storm events which may lead to localized flooding, destruction or disruption to infrastructure, or lengthy power outages, as well as threats posed by chemical, biological, radiologic and nuclear hazards from external or internal events. Limited and potential emergencies are managed according to the severity of the event and specific to the needs of the research group in conjunction with the Institution.

- **Major Disasters** are events which pose a major threat to continual care of research subjects and communication with research subjects. The events may be short in duration, but response and recovery efforts are significant and outside of the standard operations of the HSPP. Examples of Major Disasters include, but are not limited to: Institutional Fire, Institutional Power outage, Institutional Cybersecurity Threats, and Pandemic/Infectious Disease events.

The possible impact of such emergencies, in relation to human subjects research, will be considered in determining the extent of emergency preparedness planning and implementation needs at the time of the emergency categorization.

Responsible Parties

Planning and emergency preparedness procedures shall include and take into consideration the Institution's existing emergency procedures. The Institution Official (IO) shall be knowledgeable of and involved in the Institution's processes and procedures in order to determine appropriate emergency actions to ensure protection of human subjects. The IO is responsible for activating the emergency preparedness plan in response to an event; the DHSPP shall assume responsibility in the absence of the IO. The IO may elect to convene an ad hoc committee of representative members of research administration and the research community to address special considerations related to the nature of the emergency (e.g., IRB, IT, Pharmacy, Environmental Health & Safety).

Emergency Actions

Emergency actions shall be implemented as necessary based on the following designations of research:

1. **Research for which recruitment and/or enrollment should be halted but research activities may continue with existing participants**, such as:
 - Research that has direct benefit for research subjects (a direct benefit does not include subject incentives or financial compensation).
 - The research presents a likelihood of direct benefit to participants (or conversely, studies which include study interventions which may be harmful to subjects if discontinued) shall not be postponed, to the extent possible.
 - Research that meets the definition of a clinical trial as defined in HSPP policy #2011-007.0, "Definitions Applied to Policies" and registered as a clinical trial.
2. **Research that can continue via alternate mechanisms**
 - use of remote study visits, conference calls or video conferencing.
3. **Research that should be postponed**
 - for example, studies with no direct benefit to participants and unable to safely continue through alternative mechanisms.

Based on the type of research as described above, the Principal Investigator may be required to provide a research protocol-specific emergency plan (as a modification request or part of the initial IRB review if emergency actions are in effect or anticipated).

- Emergency plans will be required to be submitted as part of the initial IRB application and/or protocol materials if the project provides direct benefit and is considered an essential need for everyday life.
- Emergency plans shall be written in a manner that takes into account any unique and extenuating circumstances that may impact research and/or external persons. Emergency plans may also

include information in protocols and informed consent form(s) regarding emergency preparedness and the alternative mechanisms that may be utilized to communicate with participants and continue the research study in the event of an emergency.

- A requirement to include emergency plans in any project beyond the scope described in this policy must be approved by the Institutional Official, HSPP Director, and/or the IRB Chairperson.

The IO and DHSPP have the authority during an emergency to transfer existing studies to an external or independent IRB for review. Preference will be given to those IRBs with which UConn Health has pre-existing reliance agreements and which are AAHRPP-accredited. The DHSPP is responsible to ensure reliance agreements are in place with AAHRPP-accredited external IRBs including at least one independent IRB outside of the immediate geographic area in advance of an emergency.

Training and Education

The Education Specialist will have the primary responsibility to develop and implement educational opportunities to the research community, HSPP staff and IRB members on the emergency plan, which may include brown-bag lunch sessions, newsletter articles, broadcast announcements, and training at IRB meetings and HSPP staff meetings. Examples of information that may be covered in these training sessions include conducting consent procedures, remote study visits, alternate mechanisms of delivering investigational drugs, remote monitoring and providing or arranging for the provision of care in the event of a research-related injury.

The Education Specialist will provide education at least annually for the research community on the emergency plan, making recordings of the session available on the HSPP website. Investigators will have access to emergency preparedness planning information through the HSPP website. Principal Investigators are responsible to ensure that all members of their research teams are informed about activation of the HSPP Emergency Preparedness Plan and any study specific emergency preparedness plans, as necessary.

The education plan shall be evaluated annually in coordination with the overall evaluation of the emergency plan.

Procedure

When an emergency is identified, the Institution Official shall:

1. Assess the nature of the risk and the potential impact to the HSPP.

Determine the response based on the nature of the event. Contact the appropriate Institutional personnel to determine whether there are Institutional plans already in place to address the event. If institutional plans are activated, proceed in accordance with those plans and determine whether the HSPP Emergency Preparedness Plan is to be activated. When the HSPP Emergency Preparedness Plan is activated, the IO will notify the HSPP Director/designee, who will notify the HSPP/IRB staff, membership and research community through email, IRIS and website announcements.

2. Assess whether the emergency may impact HSPP operations.

- IRB Meetings:

- If the emergency may prevent one or more IRB meetings from occurring, determine whether to cancel or reschedule the meetings.
- Identify currently approved human research which may expire prior to IRB review. If research will expire, follow HSPP policy #2011-009.13.pdf – Institutional Review Board – Lapse in IRB Approval. For minimal risk research, consider whether to grant an extension of expiration dates due to the emergency.
- IRB Staff submission processing and review:
 - If staff will be unable to complete submission processing and review responsibilities, or if capacity will be limited, the DHSPP/designee shall work with the staff to prioritize reviews.
 - If research will expire, follow policy # 2011-009.13 – Institutional Review Board – Lapse in IRB Approval. For minimal risk research, consider whether to grant an extension of expiration dates due to the emergency.
- Data and records:
 - For emergencies impacting computer systems, consult IT to ensure backup data is secure.
 - If electronic records and submission systems are or will be unavailable, consult with Information Technology (IT) support to ensure alternative procedures are implemented to access backup data and systems.

3. Assess to what extent the emergency may impact the conduct of research and the extent of studies impacted Depending on the nature of the emergency (minor, limited, major), the impact may be localized or widespread.

- In-person interactions with research subjects: If studies involve in-person interactions with research subjects, the IO will determine whether such studies may be conducted as written while adhering to emergency mitigation strategies.
- Sponsored research: When studies have an external sponsor, the Investigator will ensure coordination with each sponsor to confirm mitigation plans.
- Clinical care and/or research facility considerations: If the emergency impacts clinical care standards, which may in turn impact research, the IO will clarify what does and does not require IRB review. For example, in the case of a public health crisis, screening procedures implemented and required by the institution where a clinical trial is being conducted would not require IRB review/approval of the screening procedures, whereas conducting research procedures at an alternate clinical care location may require prospective IRB approval. Emergency response plans must be considered for each existing research location.
- Safety monitoring: If trial participants are unable to come to the investigational site for protocol-specified visits, the investigator must consider alternative methods for ensuring completion of safety assessments. This may include utilizing phone contact, virtual visits, alternative locations for assessment (including local labs or imaging centers) to assure the safety of trial participants.
- Research laboratories, repositories and databases: The IO will identify impacted research laboratories, repositories and/or databases and work with the appropriate institution officials to establish mitigation plans (e.g., environmental health and safety, IT, biosafety officials).
- Drug / Device storage and accountability: The IO will identify impacts to investigational drug/device (storage, dispensing, etc.). Investigators are responsible to consult with Research Pharmacy to ensure the safe storage, handling and control of drugs/devices during the emergency.

4. **Triage the research that will be subject to emergency mitigation strategies.** The Institution Official shall consider the types of research that may continue and the types of research that may need to be temporarily postponed.
 - a. **Research for which recruitment and/or enrollment should be halted but research activities may continue with existing participants,** such as:
 - Research that has direct benefit for research subjects (not inclusive of subject incentives or financial compensation).
 - Research that meets the definition of a clinical trial as defined in HSPP policy #2011-007.0, “Definitions Applied to Policies” and registered as a clinical trial.
 - The research presents a likelihood of direct benefit to participants (or conversely, studies which include study interventions which may be harmful to subjects if discontinued) shall not be postponed, to the extent possible
 - b. **Research that can continue via alternate mechanisms or should be postponed,**
 - Research involving direct interactions or interventions which can continue those interventions via alternate mechanisms.
 - When possible, implement online or remote strategies for research procedures such as recruitment, consent, data collection, debriefing, and follow-up. Identify any additional research activities that can be completed via telephone, video conference, or via online mechanisms. If possible, alter the timing of visits and procedures.
 - Studies which may have an adverse impact on resources required to address the emergency shall be postponed, if possible.
5. **Consider any additional necessary actions to address the impact of the emergency.** The Institution Official shall define the actions to take during the emergency to avoid stopping all research activities.
 - Postpone new study implementation: Consider whether to suspend accepting submissions of new protocols for IRB review for research which is non-interventional in nature, or which presents no direct benefit to participants.
 - Relying on another organization to provide IRB oversight: If needed, identify the external IRBs and reliance agreements in place in accordance with HSPP policy #2011-009.15.b – Institutional Review Board – Reliance on External IRB. Select with preference given to those IRBs with which UConn Health has pre-existing reliance agreements and which are AAHRPP-accredited.
 - Employ strategies to exercise flexibility in oversight: When studies are not federally regulated, examine whether different but equivalent procedures to protect the rights and welfare of research participants may be employed. For example, for non-federally funded research, the IRB may consider extending continuing review dates during the emergency, and/or allowing minor changes in research to be reported to the IRB at the time of continuing review versus in advance of the change. For most minimal risk research regardless of funding, the IRB may consider more widespread use of waivers of documentation of consent, particularly for notifying participants of changes to consent documents.
6. **Identify any new education, training, and communications needed specific to the emergency event.** Develop and distribute any targeted communications and education/training based on roles/responsibilities within the HSPP. Communications will occur via standard communication routes, such as email and web-based platforms, as available, and include instructions and

expectations for impacted personnel. Information will be made available in a designated area of the OVPR/HSPP website for researchers and research staff, IRB Chairs / Members and departmental administrators. If the standard routes are not available, the Institution Official will consult the institutional plans in place to address communications.

The Institution Official and DHSPP will convene on a routine basis during the emergency to assess mitigation strategies and reevaluate any restrictions imposed on research activity. When the emergency has ended, the IO/DHSPP will convene to debrief and evaluate the response to the emergency and make changes to the emergency plan as determined necessary.

Related Policies

2004-02 – Authority of the Human Subjects Protection Office (Institutional Policy)

11-052 - UConn Health John Dempsey Hospital Emergency Management Policy (Institutional Policy)

2009-003 – Imposing and Lifting Suspension of IRB Approval or Imposing Terminations of IRB Approval

2011-007.0 – Definitions Applied to Policies

Basis

AAHRPP Element I.1.H

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