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GA 101  AUTHORITY, PURPOSE AND SCOPE

1. PURPOSE

The purpose of this SOP is to:

- State the institutional authority under which the IRBs are established and empowered
- Define the purpose of the IRBs
- State the principles governing the IRBs to assure that the rights and welfare of research participants are protected
- State the authority of the IRBs
- Define the scope of the IRBs
- Define the relationship of the IRBs to other committees and to officials within the University system

2. POLICY STATEMENT

2.1 Statement of Institutional Authority

The University of Pennsylvania's Institutional Review Boards (IRBs) are established and empowered under the authority of the Trustees of the University of Pennsylvania. The University of Pennsylvania requires that all research projects that meet the definition of human participants' research be reviewed and approved by one of the University of Pennsylvania's IRBs prior to initiation of any research related activities.

2.2 The Purpose of the IRBs

The IRBs purpose is to protect the rights and welfare of humans participating in biomedical and behavioral research conducted at the University of Pennsylvania. The IRBs review and oversee such research to assure that it meets ethical principles and that it complies with federal regulations that pertain to human subject protection at 45 CFR 46 and 21 CFR 50 and 56, and other pertinent regulations and guidance.

2.3 Governing Principles

The IRBs are guided by the ethical principles regarding all research involving humans as participants as set forth in the report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, entitled: Ethical Principles and Guidelines for the Protection of Human Subjects of Research (the "Belmont Report"). These principles are defined in the Belmont Report as follows:

- Respect for Persons – Individuals should be treated as autonomous agents; and persons with diminished autonomy are entitled to protection
- Beneficence – Maximize the benefits and minimize the possible harms
Justice -- The burdens and benefits of research should be justly distributed

2.4 IRB Authority

2.4.1 The IRBs are established to review biomedical and behavioral research involving human participants that is conducted by faculty, staff and students of the University regardless of the source of funding and location of the study if:

- The research is sponsored by the Trustees of the University of Pennsylvania;
- The research is conducted by or under the direction of any employee, faculty, staff, student or agent of the University of Pennsylvania in connection with his or her institutional responsibilities;
- The research is conducted by or under the direction of any employee, faculty, staff, student or agent of the University of Pennsylvania using any property or facility of the University of Pennsylvania;
- The research involves the use of the University of Pennsylvania's nonpublic information to identify or contact human research participants; or,
- The research involves the use or disclosure of protected health information.

2.4.2 Each IRB has the authority to ensure that research is designed and conducted in such a manner that protects the rights and welfare and privacy of research participants. Specifically, each IRB may disapprove, modify or approve or suspend studies based upon consideration of human subject protection aspects.

3.0 SPECIFIC POLICIES

3.1 Federally Funded Research

If the study is part of an application to a sponsoring agency, the human research protocol must be reviewed by the IRB before, or when the application is processed in the Office of Research Services and prior to expenditure of any grant funds.

3.2 Pennsylvania State Law

The IRBs recognize that Pennsylvania laws impose additional requirements. To ensure that the applicable requirements are met, the IRB members or administrative staff will consult with the Office of General Counsel of the University of Pennsylvania for guidance on additional legal requirements under Pennsylvania state law.

3.3 Relationship of the IRBs to University Officials and Other Committees

3.3.1 Review of research by officials and other committees: Research that has been reviewed and approved by the IRB may be subject to review and disapproval by officials or other committees of the University of Pennsylvania. However, those officials or committees may not approve research if it has been disapproved by an IRB.

3.3.2 IRB relationship to university officials and other committees: The IRB functions independently of, but in coordination with, University officials and other committees.
3.3.3 For funded research, research may not begin until the contract is finalized.

3.3.4 When review is required by other University committees, research may not begin until the required committee reviews are complete.

3.4 Use of Policies and Procedures

Each IRB must maintain and follow all written policies and procedures consistent with federal regulations, good clinical practice, and research ethics when reviewing proposed research.

3.5 Number and Scope of IRBs

The Board of Trustees has authorized 9 IRBs to review research involving human participants conducted by faculty, staff and students of the University. The University consists of the undergraduate and graduate schools of the University of Pennsylvania, and the University of Pennsylvania Health System.

In general, IRB applications involving biomedical research or clinical trials are assigned to IRBs 1-7. Research involving social or behavioral sciences is reviewed by IRB 8. Research that is conducted in the Clinical and Translational Research Center (CTRC) is assigned to IRB 3, when necessary. IRB 9 meets on an ad hoc basis to review unanticipated problems, incidents of noncompliance or other items requiring special considerations and is comprised of current IRB Chairs and Members, as well as representatives from other University offices, with specific relevant expertise, including background in issues related to privacy and confidentiality.

4. REFERENCES

Provost HRPP Statement; Belmont Report; 21 CFR 56.108; 21 CFR 56.109; 45 CFR 46.103(b)(4), 45 CFR 46.113

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GA 102  ACTIVITIES REQUIRING IRB REVIEW

1. PURPOSE

The purpose of this policy is to describe specific activities that require IRB review and, conversely, those activities that do not require IRB review.

2. POLICY STATEMENT

The University conducts biomedical and social science and behavioral research. No intervention or interaction with human participants in research, including recruitment, may begin until the IRB has reviewed and approved the research protocol. “Human subjects research” is any activity that either: 1) meets the HHS definition of “research” involving “human subjects” as defined in the HHS regulations or 2) meets the FDA definition of “clinical investigation” that involves “human subjects” as defined in the FDA regulations.

All research involving human participants (as defined above), and all other activities which even in part, involve such research, regardless of sponsorship, must be reviewed and approved by a University of Pennsylvania IRB.

Under certain conditions, the University may rely on another organization’s IRB. The reliance on another IRB will be outlined in an approved IRB Authorization agreement or under the conditions of an approved cooperative agreement.

3.1 Activities that Require IRB Review

Specific activities that require IRB Review include, but are not necessarily limited to:

3.1.1 Any experiment that involves a test article and one or more human subjects, and that either must meet the requirements for prior submission to the Food and Drug Administration under section 505(i) or 520(g) of the Food, Drug, and Cosmetic Act, or need not meet the requirements for prior submission to the Food and Drug Administration under these sections of the act, but the results of which are intended to be later submitted to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit.

3.1.2 Collection and use of data about a series of standard procedures or treatments for dissemination or generalization if the activity meets the definition of “human research”.

3.1.3 Patient care or the assignment of normal participants to any intervention that is altered for research purposes in any way.

3.1.4 A diagnostic procedure for research purposes that is added to a standard treatment.

3.1.5 “Systematic investigations” involving innovative procedures or treatments. For example, if an investigator plans to collect information about an innovative procedure for scientific purposes or will repeat the innovation with other participants in order to compare it to the accepted standard.
3.1.6 Emergency Use of an Investigational Drug or Device. One time emergency uses of an investigational drug or device may proceed without prospective IRB review. When emergency medical care involves an investigational article, the research does not require prospective IRB review and approval, the patient is a research subject as defined by FDA regulations, but may not be considered a research subject as defined by HHS regulations, and data generated from such care cannot be included in any prospectively conceived report of an HHS regulated research activity.

3.1.7 Emergency Medicine Research. Prospectively planned emergency medicine research with investigational drugs, devices, or biologics requires IRB approval. If the researcher intends to waive the requirement for informed consent, additional requirements must be met including community consultation and public disclosure.

3.1.8 Data, Human Cell or Tissue Repository. Human cell or tissue (genetic tissue) research typically involves repositories that collect, store, and distribute human tissue materials for research purposes.

3.1.9 Investigator Initiated Research. A University of Pennsylvania investigator who both initiates and conducts, alone or with others, a research project or clinical trial regardless of source of funding or support.

3.1.10 Student Research. Directed or independent human research projects which employ systematic data collection with the intent to contribute to generalizable knowledge.

These activities include: (i) All master's theses and doctoral dissertations that involve research with human subjects; and (ii) All projects that involve research human subjects and for which findings may be published or otherwise disseminated.

3.1.10 Access to protected health information. Investigators conducting research with protected health information maintained within any of the covered entities of the University of Pennsylvania must provide the IRB with appropriate information to obtain approval of the activity prior to access of the protected health information.

3.1.11 Collaborative Research. Collaborative research requires IRB review by each performance site unless an IRB Authorization or Independent Investigator Agreement is in place or carried out under the terms of a cooperative agreement.

3.2 Activities Not Subject to IRB Review

3.2.1 Proposals that do not qualify as human subjects’ research will not require IRB review. Additionally, activities such as quality assurance or quality control, program and fiscal audits, and certain disease monitoring as prescribed by the Public Health Department generally do not qualify as research.

3.2.2 Case Studies. A single retrospective case report is a medical/educational activity and does not meet the Federal Policy for the Protection of Human Subjects definition of "research" which is "a systematic investigation, including research..."
development, testing and evaluation, designed to develop or contribute to
generalizable knowledge."

In general, the review of medical records for publication of case reports of three or
fewer patients is not considered human research and does not require IRB review
and approval.

Under HIPAA, a single case report is an activity to develop information to be shared
for medical/educational purposes. Therefore, the use of protected health information
to prepare a paper for publication of a single case report does not require IRB review
for HIPAA purposes. If the data are de-identified, no waiver or authorization is
required. If, however the investigator wishes to publish data with HIPAA identifiers an
authorization signed by the patient is required.

Investigators have the option to obtain from the IRB documentation that the activity is not
subject to IRB review. Research that does not meet the regulatory definition of human
research or clinical investigations does not require IRB approval.

3.2 Collaborative Research with the Veterans Affairs Medical Center - Philadelphia

When all work is to be done at the VAMC and the only association with the research at
Penn is the investigator’s dual appointment, there is no requirement for submission or
review by Penn’s IRB.

When research is conducted at both the VAMC and at Penn, the research must be
reviewed and approved by both IRBs.

3.3 Failure to Submit Project for IRB Review

The implications of engaging in activities that qualify as research that is subject to IRB
review without obtaining such review are significant. If an investigator begins a project
without prospective IRB review and approval and later learns of the review requirement,
the investigator should promptly notify the IRB. The IRB may allow (with or without
provisions) or deny use of the data.

If an investigator begins a project and later finds that the data gathered could contribute
to generalizable knowledge, has changed in some fashion as to now require IRB review,
or that he or she may wish to publish the results, the investigator should submit a
proposal to the IRB for review as soon as possible. If the IRB does not approve the
research, the IRB may determine that the data derived from the previously conducted
research cannot be used as part of a study, thesis or dissertation nor may the results of
the research be published.
4.0 REFERENCES

Federalwide Assurance; 45 CFR 46.102(d)(f); 21 CFR 50.3(d)(g); 21 CFR 56.108(b)(1); 45 CFR 46.103(b)(4); 21 CFR 50.24; OPRR Reports, Emergency Medical Care, May 15, 1991; OPRR Reports: Informed Consent Requirements in Emergency Research, October 31, 1996; OHRP Guidance Research Involving Coded Private Information or Biological Specimens, Oct. 16, 2008; OHRP Issues to consider in the research use of stored data or tissues, Nov. 7, 1997; OHRP Guidance; Engagement of Institutions in Research, Oct. 16, 2008

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GA 103  POLICIES AND PROCEDURES MAINTENANCE

1. PURPOSE

The purpose of this section is to state the IRBs’ commitment to maintain, and follow up-to-date policies and procedures that adhere to regulatory mandates and ethical principles.

2. POLICY STATEMENT

Following federal regulations and guidance supported by institutional policies assures that the rights and welfare of the human participants of such research will be overseen and protected in a uniform manner, regardless of changes in personnel. Written procedures must be in place to insure the highest quality and integrity of the review and oversight of research involving human participants and for the adequate documentation of such oversight.

Standard operating policies (SOPs or Policies) and procedures provide the framework for the ethical and scientifically sound conduct of human research.

3. SPECIFIC POLICIES

3.1 Review and Revision of Policies & Procedures

3.1.1 Changes to regulations, federal guidelines, or research practice as well as the policies and procedures of the University of Pennsylvania may require a new policy or a revision to a previously issued policy.

3.1.2 Policies will be reviewed at least every three years, or as needed, by the Director for Human Research Protections and any appropriate IRB staff.

3.2 Policy Dissemination and Training

3.2.1 New or revised policies are approved by the Director for Human Research Protections and will be disseminated to the appropriate individuals and departments.

3.2.2 Training will be provided to all members of the IRB and IRB staff on any new or revised policy and or relevant procedure.

3.2.3 Each new IRB member or staff employee must review all applicable policies prior to undertaking any responsibilities at the IRB.

3.3 Forms

Forms including checklists and worksheets are used to ensure that policies are integrated into the daily operations of research and review throughout the University, and to assist IRB staff and IRB members in the review process. Forms are either controlled or non-controlled. Final versions of controlled forms are uploaded to the submission in the electronic submission system, Human Subjects Electronic Research Administration (HS-ERA) or maintained in the paper file.

3.3.1 Controlled Forms are regulatory documents that become part of the permanent record of IRB review.
3.3.2 Non-controlled forms are management tools designed to assist with the IRB review process and do not become a formal part of the IRB submission.

4.0 REFERENCES

45 CFR 46.103(b)(4)(5); 21 CFR 56.108; 21 CFR 56.115(6)

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1. PURPOSE

This policy describes the training and educational requirements and options for IRB members and staff.

2. POLICY STATEMENT

Training of IRB staff and members is critical if the IRB is to fulfill its mandate to protect the rights and welfare of research participants in a consistent manner throughout the University of Pennsylvania research community.

IRB members, staff and others charged with responsibility for reviewing, approving, and overseeing human subject research should receive detailed training in the regulations, guidelines, ethics and policies applicable to human research protections.

The University of Pennsylvania has written policies and procedures requiring all individuals involved with the Human Research Protection Program to understand and apply their obligation to protect the rights and welfare of research participants. The University requires all researchers and other appropriate personnel to provide evidence of training and qualifications by submitting relevant documentation to the IRB, sponsor, or regulatory authorities.

3. SPECIFIC POLICIES

3.1 Training

3.1.2 Management level staff and members of any IRB who are overseeing research on human participants (human subjects as defined in 46.102(f) and/or 56.102(e) that is managed, funded, or taking place in an entity under the jurisdiction of the Trustees of the University of Pennsylvania will receive initial and ongoing training regarding the responsible review and oversight of research and these policies and accompanying procedures.

3.1.3 The Director for Human Research Protections establishes the educational and training requirements for IRB members and staff who review biomedical and behavioral research at this institution and who perform related administrative duties. Initial and ongoing training is documented by the Associate Director in conjunction with IRB staff members.

3.1.4 Members of the IRB will participate in initial and continuing training in areas germane to their responsibilities.

3.1.5 Chairpersons will receive additional training in areas germane to their additional responsibilities.

3.1.6 IRB staff will receive initial and continuing training in the areas germane to their responsibilities.

3.1.7 IRB members and staff will be encouraged to attend workshops and other educational opportunities focused on IRB functions. The University will support such activities to the extent possible, and as appropriate, for the responsibilities of members and staff.
3.2 Evaluation of IRB Member Performance

The Executive IRB Chair in conjunction with the Director and Associate Director is responsible for periodic evaluation of the performance of IRB members and Chairs and for the periodic evaluation of the composition of the IRBs to meet regulatory and organizational requirements.

4. REFERENCE

Terms of the HHS Federalwide Assurance; 45 CFR 46.107(a); 21 CFR 56.107(a)

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GA 105 MANAGEMENT OF IRB PERSONNEL

1. PURPOSE

This section describes management policies and procedures to promote the long-term commitment of IRB administrative staff employees and ensure the efficient and effective administration and enforcement of IRB decisions.

2. POLICY STATEMENT

The IRB administrative staff provides consistency, expertise, and administrative support to the IRBs, and serves as a daily link between the IRB and the research community. Therefore, the highest level of professionalism and integrity on part of IRB staff is expected.

3. SPECIFIC POLICIES

3.1 Job Descriptions and Performance Evaluations

Members of the IRB staff should have a description of the responsibilities expected of their positions. The performance of IRB staff will be reviewed according to current university policy.

3.2 Staff Positions

Staffing levels and function allocation will be determined according to university policy, management assessment of support requirements and budget constraints. The Senior Vice Provost for Research reviews the IRB budget with the Director for Human Research Protections periodically, and no less than annually, to ensure adequate allocation of resources to IRB administration.

3.3 Hiring and Terminating IRB staff

The human resource policies of the University of Pennsylvania determine the policies for recruiting and hiring staff.

Delegation of specific functions, authorities, or responsibilities may be authorized by the Executive Chair or IRB Director for Human Subjects Protections to an appropriate staff member.

3.4 Documentation

The HR policies of the University of Pennsylvania determine the policies for identifying, documenting and retaining formal staff interactions (such as performance reviews, termination procedures).
4. REFERENCE

None

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GA 106 A MANAGING CONFLICTS OF INTEREST: IRB MEMBERS, CONSULTANTS, AND STAFF

1. PURPOSE

This policy requires any IRB member or consultant with a conflicting interest in a research protocol to disclose that information to the IRB Chair or IRB administrative staff.

2. POLICY STATEMENT

In the environment of research, openness and honesty are indicators of integrity and responsibility, characteristics that promote quality research and can only strengthen the research process. Therefore, conflicts should be eliminated when possible and effectively managed and disclosed when they cannot be eliminated.

This policy applies to all research protocols reviewed by the IRB, regardless of whether the project is exempt or considered during expedited or continuing review or during a review by the convened IRB.

The standard that should guide decisions about conflicting interests whether an independent observer could reasonably question whether the individual's actions or decisions would be based on factors other than the rights, welfare, and safety of the participants.

The Senior Vice Provost for Research has the authority to determine when conflicts of interest (COI) exist as defined by institutional policy and to impose and enforce disciplinary action in the event that COI is not disclosed.

3. SPECIFIC POLICIES

3.1 Definitions

The definition of conflicting interest for IRB members, consultants and staff is aligned with the institutional policies on conflicts of interest for Investigators and the federal regulations, as referenced.

3.2 Disclosing, Managing, and Documenting Conflicts of Interest

No regular, alternate IRB member or consultant may participate in the review of any research project or protocol, in which the member has a conflict of interest, except to provide information as requested.

IRB members are expected to self-identify their conflicting interests for all reviews, including reviews by the convened IRB and reviews using the expedited procedure. For protocols reviewed by the convened IRB, the IRB will document the name of the IRB member with the conflict and will document that the IRB member left the room during the discussion of the protocol. IRB members with conflicting interests do not count towards quorum.
3.3 IRB Staff

Institutional staff whose job status or compensation is impacted by research that is reviewed by the IRB must be absent from IRB deliberations and voting. The IRB staff are required to report possible financial interests and are required to be absent from IRB deliberations and voting on any research protocol, where a potential conflict exists. Any case of disclosure of conflict of interest by staff shall be referred to the Director for development of a management plan.

3.4 Education and Training in COI

IRB members and staff are required to participate in education and training activities related to conflict of interest issues.

4. REFERENCE

45 CFR 46.107(e); 21 CRF 56.107(e); FDA Information Sheets, FAQ, Section II, Question 12

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<th>GA 106 A Managing Conflicts of Interest: IRB Members, Consultants, and Staff</th>
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1. PURPOSE

This policy is concerned with the processing of disclosures of conflicts of interest by investigators engaged in human research and their review by the IRB to ensure adequate protection of participants.

2. POLICY STATEMENT

The protection of human participants in research requires that conflicts of interest involving investigators be eliminated or managed so that the results of the research are free from bias. The management of conflicts of interest is the responsibility of the Senior Vice Provost for Research as advised through the Conflicts of Interest Standing Committee (CISC). It is the policy of the IRB that review of the management, minimization or elimination of conflicts of interest involving investigators is an integral part of the review of human research.

In the interests of protecting human participants, the Institutional Review Board requires the following steps be taken to address such potential conflicts of interest in the conduct of human research.

3. SPECIFIC POLICIES

3.1 Submission of Confidential Financial Disclosure Statements

Principal Investigators submitting research applications to the IRB are required to certify:

3.1.1 They have reviewed the University policies on conflicts of interest with all investigators (including staff and family members as defined in the COI policies) and,

3.1.2 As part of the current protocol application, an investigator and others engaged in research must indicate if conflicts of interest exist. If so, the individual with the conflict must submit a financial conflict of interest disclosure in accordance with institutional policies. The IRB application and informed consent documents are available to the Conflict of Interest Standing Committee (CISC) for review.

3.2 IRB Review

It is not the purview of the IRB to reinterpret institutional conflict of interest policies or their implementation. Rather its function is to ensure that subject protection, the integrity of IRB review, and the conduct of a research are not jeopardized by an unidentified and unmanaged conflict of interest. When human research requires review by the CISC, the IRB will not approve the research until the CISC management plan is complete and agreed to by the Investigator(s).

The IRB review shall concentrate on those aspects of any conflict of interest that may reasonably affect human subject protection and may require changes to the protocol or consent form that may include, but are not limited to the following:
3.2.1 The IRB may require an enhanced data safety monitoring plan.

3.2.2 Where applicable, the informed consent will disclose the nature of an investigator’s conflict including but not limited to such conflicts as; consulting or educational activities supported by the sponsor; disclosure that the investigator is the inventor; has an interest in a related patent or technology; or that the investigator or the University may receive financial benefits from development of the technology, and that these financial benefit(s) may depend on the outcome of the research.

3.2.3 The IRB may require consent monitoring, or request additional information from the conflicted investigator about how sponsors or their agents will mitigate or monitor for risks presented.

4. REFERENCE

Principles of Responsible Conduct, Almanac, Volume 54, No. 27, April 1, 2008,
Financial Disclosure Policy for Research and Sponsored Projects, Almanac, Vol.54, No. 1, July 17, 2007,
Financial Disclosure and Presumptively Prohibited Conflicts for Faculty Participating in Clinical Trials, Almanac, Vol. 49, No. 32, May 6, 2003

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SIGNATORY AUTHORITY

1. PURPOSE

This policy describes signature authority for IRB related activities.

2. POLICY STATEMENT

The Senior Vice Provost for Research, IRB Executive Chair, Director for Human Research Protections, Associate Director, and other appointed designees of the IRB Senior Staff are authorized to sign documents in connection with the review and approval of research projects involving the use of humans as participants, which have been reviewed and approved pursuant to University policies and procedures and upon decision of the IRB.

This policy also applies to IRB administrative staff, but only in the capacity of signing IRB correspondence that reflects decisions reached by either the convened IRB or one of the noted signatories above. In all cases individuals must sign their own name and no other and indicate their title under their signature.

3. SPECIFIC POLICIES

3.1 Authorization for Signatory Authority

Authorization to sign documents not described in this policy may be made in writing by the Director or Executive Chair.

3.2 Results of Reviews, Actions and Decisions

The results of reviews and actions taken by the IRB, either via convened or expedited review, that grant Investigators with initial or continuing approval of research, or approval/acknowledgement/acceptance of any other revisions or reports, may be signed by any designated member of the IRB staff. The results of reviews and actions taken by the convened IRB that result in a disapproval may be signed by the IRB Executive Chair, IRB Chair, Director, or Associate Director in attendance at that Committee meeting. Communications regarding determinations of serious or continuing noncompliance or unanticipated problems will be signed by the IRB Executive Chair, IRB Chair or Director for Human Research Protections or designee.

3.3 Routine Internal Correspondence

Any action, letter, memo or e-mail between the IRB or administrative staff and the faculty or staff of the University that provides information concerning the review of research protocols by the IRB or staff and which do not imply or appear to imply approval of this activity may be signed by the staff member.

3.4 Correspondence with External Agencies

Official letters or memos sent to agencies of the federal government, funding agencies (whether private or public) or their agents will be signed by the Senior Vice Provost for Research or the IRB Executive Chair.
### 3.5 Decisions Made by the Chair

Any letters, memos or email sent representing the decision or opinions of the Executive Chair of the IRB, other Chairs of the IRBs or their respective designees, as long as such correspondence does not imply review and approval of research participants, may be signed by designated IRB staff if so designated by the Executive Chair, IRB Chair, or IRB majority in a convened meeting.

### 4. REFERENCE

45 CFR 46.103(b)(5); 45 CFR 46.115(a)(6); 21 CFR 56.108(b), 21 CFR 56.115(a)(6)

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OP 201  COMPOSITION OF THE BOARD

1. PURPOSE

This section states the requirements for the composition of the IRBs responsible for reviewing research conducted in the University of Pennsylvania system.

2. POLICY STATEMENT

The role of the IRB is to assess the acceptability of proposed research in terms of institutional commitments and regulations, applicable law, and standards or professional conduct and practice.

Therefore, each IRB will consist of at least five regular, voting members. Qualified persons from multiple professions will be considered for membership. IRB membership will not consist entirely of men or of women.

The institution will make every effort to have a diverse membership appointed to the IRB, within the scope of available expertise needed to conduct its functions.

3. SPECIFIC POLICIES

3.1 IRB Member Selection Criteria

The members of the IRB will be sufficiently qualified through experience and expertise, of reviewing research proposals in terms of regulations, applicable law and standards of professional conduct and practice and institutional commitments, therefore the IRB will include persons knowledgeable in these areas.

The membership will be diverse, so selection will include consideration of race, gender, cultural backgrounds, research, healthcare or professional experience and sensitivity to such issues as community attitudes to assess the research submitted for review.

There will be at least 1 member whose primary concerns are in scientific areas and at least 1 member whose primary concerns are in nonscientific areas.

There will be at least 1 member who has no affiliation with this institution.

3.2 Composition of the Board

3.2.1 Knowledge, Skills and Abilities

Regular Members: The backgrounds of the regular members will be varied in order to promote complete and adequate reviews of the types of research activities commonly reviewed by the IRB. Regular members must include:

Nonaffiliated member(s): The nonaffiliated member(s), who can be either scientific or nonscientific reviewers, should be knowledgeable about the local community and be willing to discuss issues and research from that perspective. Consideration should be given to recruiting individuals who speak for the communities from which the University will draw its research participants. The nonaffiliated member(s) should not be vulnerable to intimidation by the professionals on the IRB.
Scientific members: IRBs will include members whose primary interests are
scientific. Such members satisfy the requirement for at least one scientist.

When an IRB encounters studies involving science beyond the expertise of the
members, the IRB may use a consultant to assist in the review, as provided by 21
CFR 56.107(f) and 45 CFR 46.107(f). At least 1 member of each board, excluding
the Social/Behavioral Board (IRB 8), must be a physician licensed to practice
medicine in the Commonwealth of Pennsylvania.

Non scientific members: The intent of the requirement for diversity of disciplines is to
include members whose main concerns are not in scientific areas. Therefore,
nonscientific members are individuals whose education, work, or interests are not
solely in medical, behavioral or social science areas.

Representatives of special groups of participants: When certain types of research
are reviewed, members or consultants who are knowledgeable about the concerns
of certain groups or local context may be required. For example, if an IRB reviews
research involving prisoners, a member who can represent this group, either an ex-
prisoner or an individual with specialized knowledge about this group must be
included on the IRB.

Chairs: Chairs will be faculty or senior staff members of the University; be proficient
in human research; and be of sound and ethical character and reputation, without
conflicts of interest that would curtail their ability to serve objectively and according
to the mission of the IRB as defined in applicable laws, regulations, and policies.
Chairs are appointed after agreement by the IRB Executive Chair and the Director,
Human Research Protections. In addition, the Director, Human Research
Protections and the Associate Director, IRB, may fulfill the role of Chair as needed
for coverage for certain meetings, with approval from the IRB Executive Chair for
Research.

IRB Executive Chair: The Executive Chair will be a senior faculty member of the
University with demonstrated knowledge, skills, and abilities in the conduct of
human research and in applicable laws, regulations, and policies regarding human
research protections.

4. REFERENCES

45 CFR 46.107; 21 CFR 56.107; FDA Information Sheets, FAQ Section II, Questions 14 & 15

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OP 202  MANAGEMENT OF THE IRB

1. PURPOSE

To describe staff administration and oversight of the IRBs to ensure continuity of membership that has the expertise and commitment to meet its regulatory and institutional mandates.

2. POLICY STATEMENT

The management of the membership of the IRBs and oversight of member appointments, IRB related activities, communications, and other administrative details are the responsibility of the Director.

3. SPECIFIC POLICIES

3.1 Term of Appointment

The initial term of appointment is one to three years. Reappointment for additional terms may occur, by mutual agreement of the IRB member and IRB Executive Chair. ,

3.2 Appointments

The IRB Executive Chair has the authority to appoint members to the IRB, and will consult with the Senior Vice Provost for Research, if required.

Members will be solicited from the university and the greater Philadelphia communities.

3.2.1 IRB Members Including Alternates

IRB members are nominated from a variety of sources, including previous and current IRB members, division chiefs, department chairs, compliance administrators, and various public groups.

When an individual is nominated or when an individual expresses interest in serving on the IRB a copy of the individual’s curriculum vitae (CV) will be requested. The nominee’s CV and any relevant correspondence are reviewed by the IRB Executive Chair and Senior IRB Administrative staff. Nominees appointed to serve on the IRB receive a letter of appointment signed by the IRB Executive Chair. . Terms of appointments may be for one, two, or three years.

3.2.2 IRB Chairs

The IRB Executive Chair reviews candidates for IRB Chair and determines appointment based on previously noted criteria. During any period of temporary vacancy, the IRB Executive Chair may appoint an interim or acting Chair.
3.2.3 Consultants

The determination that a consultant is required may be made under certain circumstances during the review process. Such circumstances are as follows: senior IRB administrative staff, the IRB Executive Chair, or IRB Chair determines, upon pre-review, that a consultant is required; or, members of the IRB may request at any time during the review process to request a consultant’s review.

This determination will be based on the topic of the protocol and the expertise of the voting members.

The consultant will be selected by the IRB Executive Chair, IRB Chair or Director for Human Research Protections. The Chair may consult with the principal investigator, Department Chair, Division Chief, or any other individual deemed appropriate to determine a suitable consultant. A consultant may be an individual who is either internal or external to Penn. A consultant may be asked to review a protocol or provide education on a topic of specific concern to the IRB; to provide information to the IRB by written report, attending a meeting(s), or both. A consultant may participate in all discussions, however, is not authorized to participate in the deliberations and may not vote.

All individuals who are asked to serve as consultants will be provided with the Conflicts of Interest Agreement to determine whether any conflict of interest exists prior to their work with the IRB. If there is any conflict of interest they will not be allowed to consult, and another consultant will be selected.

The IRB administrative staff, Executive Chair or designee will contact the consultant and will determine how the information will be conveyed to the IRB: i.e., attendance at the meeting or written report.

Key information provided by consultant will be documented in the minutes. All written reports or other documentation of consultant reviews will be maintained in the protocol file.

Use of consultants will be documented in the minutes, as this will be presented to the convened IRB during the discussion of the protocol. For submissions reviewed via the expedited mechanism, use of a consultant will be documented in the protocol file.

3.2.4 IRB Executive Chair.

The IRB Executive Chair is appointed by the Senior Vice Provost for Research.

3.3 Resignations and Removals

A member may resign before the conclusion of his/her term. The vacancy will be filled as quickly as possible. The IRB Executive Chair may remove a member at any time.

3.4 Compensation

Participation by University faculty or staff as an IRB member is considered a component of their job responsibilities as established by their supervisors. Regular members who
are not affiliated with the University shall receive reimbursement for parking and other miscellaneous expenses IRB Chairs and Executive Chair receive salary compensation for their respective roles as permitted by the Senior Vice Provost for Research.

3.5 Liability Insurance

Regular and alternate members have liability insurance coverage as part of their IRB membership in their capacity as agents of the University.

3.6 IRB Rosters

IRB rosters will be maintained by the IRB Administrators and will include:

- Names of IRB members
- Earned degrees
- The representative capacity of IRB members
  - Scientist and nonscientist
  - Affiliated or nonaffiliated member including employment or other relationships between the IRB member and the organization.
  - Knowledge of vulnerable populations, if the member is representing a vulnerable population
  - Indications of IRB members’ experience sufficient to describe each IRB member’s chief contribution.
- Alternate members
- The regular members or class of regular members form whom each alternate may substitute.

4. REFERENCES

45 CFR 46.103(b)(3); 21 CFR 56.115(a)(5)

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OP 203   DUTIES OF IRB MEMBERS

1. PURPOSE

This policy defines the duties required of IRB members.

2. POLICY STATEMENT

Each IRB member's primary duty is the protection of the rights and welfare of the individual human beings that are serving as the participants of that research. The reviewer must understand that he or she is not serving on the Board to expedite the approval of research, but to serve as a link between the investigator and the research participants. In order to fulfill his or her duties, IRB members are expected to be knowledgeable of the regulations governing human subject protection, biomedical and behavioral research ethics, and the policies of the University of Pennsylvania germane to human subject protection. The IRB must be and must be perceived to be fair and impartial, immune from pressure either by the institution's administration, the investigators whose protocols are brought before it, or other professional and nonprofessional sources.

3. SPECIFIC POLICIES

The IRBs are appointed as University Committees. As such, the IRB members serve the University of Pennsylvania as a whole, rather than a particular school or department. Therefore, members must not allow their own interests or that of their departments or schools to supersede their duty to protect the rights and welfare of research participants.

Term of Duty

Regular IRB members and chairpersons are expected to commit to at least a 1-year term and during that time, fulfill certain duties. These duties will be described prior to appointment and each IRB member is expected to fully understand the duties of IRB members prior to accepting appointment as an IRB member. Students of the Masters of Translations Research (MTR) Program serve a shorter term than 1 year as permitted by the IRB Executive Chair.

3.3 Specific Duties

3.3.1 Regular Members: All members are expected to review all actions scheduled for convened review, be familiar with them, and prepared to discuss the materials at the convened IRB meeting.

Nonaffiliated member(s): Nonaffiliated members are expected to provide input regarding their knowledge about the local community and be willing to discuss issues and research from that perspective.

Non-scientific members: Nonscientific members are expected to provide input on areas germane to their knowledge, expertise and experience, professional and otherwise. For example, members who are lawyers should present the legal views of specific areas that may be discussed, such as exculpatory language or state requirements regarding consent. Non-scientific members should advise the Board if
additional expertise in a non-scientific area is required to assess if the protocol adequately protects the rights and welfare of participants and to comment on the comprehension of the consent document.

**Scientific members**: Scientific members are expected to contribute to the evaluation of a study on its scientific and statistical merits and standards of practice. These members should also be able to advise the Board if additional expertise in a scientific or non-scientific area is required to assess if the protocol adequately protects the rights and welfare of participants.

**Chair**: In addition to the above responsibilities (germane to the member’s capacity) the chair leads convened meetings of the IRB. The Chair is empowered to recommend suspending the conduct of a research project deemed to place individuals at unacceptable risk pending concurrence by the either the IRB Executive Chair or convened IRB review.

The Executive Chair may appoint a Co-chair to assist or act on behalf of the chair in particular IRB matters and at IRB meetings, either as a general procedure, or on a case-by-case basis.

3.3.2 **Primary Reviewers**: In addition to the duties described in section 3.3.1 each regular member will be expected to act as a primary reviewer for assigned studies at convened meetings. The primary reviewer presents his or her findings resulting from review of the application materials and provides an assessment of the regulatory criteria and recommends specific actions to the Board. He or she leads the discussion of the study by the convened IRB. The primary reviewer is required to read the entire submission, be familiar with it, and be prepared to conduct an in-depth review of all materials. The primary reviewer is expected to contact the investigator, IRB Executive Chair, IRB Chair, or Administrator in advance of the convened meeting for clarification of unresolved issues related to the submission.

3.3.3 **The Executive Chairperson**: Is expected to provide oversight of all IRBs, determine eligibility for and, where appropriate, conduct expedited reviews. The Executive Chairperson may also designate one or more experienced IRB members to carry out expedited review.

3.3.3 **Alternate members.** The appointment and function of alternate members is the same as that for regular IRB members, and the alternate’s expertise and perspective are comparable to those of the Principal member. The role of the alternate member is to serve as a voting member of the IRB when the regular member is unavailable to attend a convened meeting. When an alternate member substitutes for a regular member, the alternate member will receive and review the same materials prior to the IRB meeting that the Principal member received or would have received.

The IRB roster identifies the regular member(s) for whom each alternate member may substitute. The alternate member will not be counted as a voting member unless the regular member is absent. The IRB minutes will document when an alternate member replaces a regular member.
3.4 Evaluation of IRB Members and Chairs Performance

3.4.1 IRB members and Chairs will be asked to complete Self Evaluation Forms on an annual basis and submit the forms to the appropriate members of the IRB staff.

3.4.2. The IRB Executive Chair and Director for Human Research Protections, in conjunction with appropriate staff members, will review the IRB Member and Chair self assessments on an annual basis to determine education and training needs and to make decisions regarding continuation of IRB membership.

3.5 Periodic Review and Adjustment of the Membership and Composition of the IRBs

The IRB Director and IRB Executive Chair will regularly assess and adjust membership and composition of the IRB to meet regulatory and organizational requirements.

3.6 Allegations of Undue Influence

The Provost and the Senior Vice Provost for Research prohibit attempts by investigators, employees, and sponsors contracting with institutional officials to use or using undue influence with the IRB, any of its members or staff, an investigator or any other member of the research team to obtain a particular result, decision or action.

“Undue influence” means attempting to interfere with the normal functioning and decision-making of the IRB or to influence an IRB member or staff, a investigator or any other member of the research team outside of established processes or normal and accepted methods, in order to obtain a particular result, decision or action by the IRB or one of its members or staff.

IRB members and IRB staff report undue influence to the HRPP Director. The Director is responsible for the initial investigation. The following institutional officials will be notified, as appropriate, of allegations of undue influence and may be asked to review and endorse a corrective action plan. Institutional officials may include the following:

- Provost
- Senior Vice Provost for Research
- Dean of applicable School
- Department Chair
- Office of General Counsel
- Other compliance offices
4. REFERENCES

45 CFR 46.107; 21 CFR 56.107; 45 CFR 46.110(b)(2); 21 CFR 56.110(b)(2); OHRP: IRB Guidebook; FDA Information Sheets: FAQ, Section II, Question 17

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FO 301  RESEARCH SUBMISSION PROCEDURES

1. PURPOSE

This policy outlines the required documents and supporting information required from investigators for IRB assessment.

2. POLICY STATEMENT

IRB members often rely solely on the documentation submitted by investigators, or other parties for initial and continuing review. Therefore this material must provide IRB members with enough information about a study to assess if it adequately meets the IRB's criteria for approval. A submitted protocol will be scheduled for IRB review only when the IRB staff determines that the information and materials submitted present an adequate description of the proposed research.

3. SPECIFIC POLICIES

3.1 Submission Requirements for Initial Review

3.1.1 Electronic submission requirements for initial review are outlined in the IRB Application and supplements available on the HS-ERA website. Investigators applying for initial approval of proposed research must follow the guidance.

3.2 Submission Requirements for Continuing Review

3.2.1 During the approval period, investigators must submit documentation to inform the IRB about changes in the status of the study. Submission requirements are outlined on the Continuing Review Form. For electronic submissions, the continuing review application must be submitted via HS-ERA.

3.2.2 Progress Reports and/or Request to Renew IRB Approval

For convened review protocols, 90 days prior to IRB approval expiration date, investigators receive a notification that their continuing review application will be required. A notification is also received 45 days from and the day of expiration. The notification reports to the Investigator the process for seeking continuing approval for the protocol. For expedited review protocols, the notifications are sent 45 days from and the day of expiration.

3.3 Action Taken If Documentation is not adequate or Additional Information is Required

If the IRB or IRB staff determines that the submitted documents are not adequate, investigators may be required to submit additional information, or their presence may be requested to answer questions or explain the details of the study. Incomplete submissions will not be reviewed by the IRB.
4. REFERENCES


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1. PURPOSE

The policies in this section provide the framework to ensure that IRB meetings are conducted and documented in a consistent manner in order to meet federal and institutional requirements.

2. POLICY STATEMENT

Except when an expedited review procedure is used, the IRB will review proposed research at convened meetings at which a quorum is present. Each IRB will meet monthly, or at some other frequency determined by the Chairperson and the IRB Director.

3. SPECIFIC POLICIES

3.1 Quorum

3.1.1 A majority of members must be present. Majority is defined as first whole number that exceeds 50%.

3.1.2 A quorum consists of regular and/or alternate members and includes at least one member whose primary concerns are in scientific areas, and one member whose primary concerns is in a nonscientific areas.

3.1.3 An alternate member may attend in the place of a regular member in order to meet the quorum requirements outlined above.

3.1.4 Special consultant(s) will not be used to establish a quorum.

3.1.5 If a member identifies a conflict with an agenda item, that member will leave the room during the discussion and vote of the protocol, and will only return to the discussion to answer directive questions raised by the Committee during the review.

3.1.6 If a member has not reviewed an agenda item or items, they will be expected to abstain from the discussion and vote for those items, but the member will still count towards the quorum.

3.2 Primary Reviewers, Secondary Reviewers, and Regulatory Representatives

Prior to the meeting, the IRB administrator will designate primary and secondary reviewers for each research protocol. For protocols requiring review by a convened meeting of the IRB, the primary reviewer will conduct an in-depth review of all materials and will be prepared to lead the discussion at the convened meeting of the IRB. All other members will review materials provided prior to the meeting and will be prepared to participate in the discussion at the convened meeting.

The Secondary Reviewer is responsible for review specifically related to the content of the informed consent form and a review of the informed consent process. They will also review all materials provided in support of the application to the IRB.
The Regulatory Representative is a member of the Senior IRB staff. These individuals will be in a position to provide additional guidance on currently established research regulations and any additional policies related to protections of human participants in research conducted at Penn or other sites covered by Penn.

3.3 Meeting Materials Sent Prior to IRB Meetings

All IRB members will be sent study documentation required for review in sufficient time prior to the meeting to allow for adequate review. These include:

3.3.1 Agenda: A meeting agenda will be prepared by an IRB administrator or designee and distributed to IRB members prior to each meeting. A copy of the agenda and attached materials will be maintained on file with the meeting minutes.

The meeting agenda will remind members to contact the IRB Administrator or Chair as soon as possible to declare any potential COI they may have with research that will be reviewed by the convened IRB.

3.3.2 Reviewer materials: The materials necessary to successfully review the submissions to verify that the approval criteria are met will be provided to the IRB members, including copies of the completed Pre-Review Forms and all appropriate IRB Reviewer Checklists.

3.4 Minutes

3.4.1 Recording: The IRB administrator or designee will prepare IRB minutes according to an outlined template for organizing content of the minutes.

3.4.2 Draft minutes will be distributed to members at the next IRB meeting following completion by staff for review. Any corrections requested by the IRB will be made by the administrator or designee and the minutes will be included on the agenda of the next IRB meeting. The minutes will be forwarded for acceptance at the next possible convened meeting of the specific board.

IRB administrators will maintain copies of the agendas and minutes.

3.5 Telephone Use

3.5.1 Convened Meeting Using a Speaker Phone

Should a member not be able to be physically present during a convened meeting, but is available by telephone, the meeting can be convened using a speakerphone. The member who is not physically present will be connected to the rest of the members via speakerphone. In this manner, all members will be able to discuss the protocol even though one member is not physically present. Members participating by such speakerphone call may vote provided they have had an opportunity to review all the material the other members have reviewed.
3.5.2 Meetings Conducted Via Telephone Conference Calls

On occasion, meetings may be convened via a telephone conference call. A quorum (as defined above) must participate for the conference call meeting to be convened.

To allow for appropriate discussion to take place, all members must be connected simultaneously for a conference call to take place -- "telephone polling" (where members are contacted individually) will not be accepted as a conference call. Members not present at the convened meeting, or participating in the conference call may not vote on an issue discussed during such a telephone conference convened meeting (no voting by proxy).

3.6 Voting

Members of the IRB vote upon the recommendations made by the primary reviewers according to the criteria for approval (See SOP RR 403 and RR 405). If quorum is lost during a meeting, the IRB cannot take votes until it is restored.

The IRB may take the range of decisions described in RR 407. Members also will determine level of risk and the frequency of review for each protocol.

If an IRB staff member is serving on the Board as a regular or alternate member that staff member will not be responsible for any administrative functions during that meeting, specifically, he or she is expected to contribute to the discussion as a substantive participant.

4. REFERENCES

45 CFR 46.103(b)(4); 45 CFR 46.107(f); 21 CFR 56.107(f); 45 CFR 46.108; 21 CFR 56.108(c); 45 CFR 46.109(a); 21 CFR 56.109(a); 45 CFR 46.115(a)(2); 21 CFR 56.115(a)(2); FDA Information Sheets

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FO 303  ADMINISTRATIVE DISTRIBUTIONS OF MATERIALS

1. PURPOSE

The policies in this section describe the requirements to document pre-review and distribution prior to IRB review.

2. POLICY STATEMENT

The efficiency and effectiveness of the IRBs are supported by administrative procedures that assure that IRB members not only have adequate time for thorough assessment of each proposed study, but that the documentation they receive is complete and clear enough to allow for an adequate assessment of study design, procedures, and conditions.

3. SPECIFIC POLICIES

3.1 Incomplete Submissions

Incomplete applications will be logged into the database and assigned an IRB protocol number for tracking. The IRB Administrative staff will contact the investigator and request all necessary materials or will return the submission to the investigator, if necessary, to provide the materials needed for a complete application.

3.2 Scheduling for Review

If a complete submission meets expedited review requirements, the review will be performed as described in SOP 402. All other applications requiring review by a convened IRB will be placed on an appropriate agenda for review.

3.3 Distribution Prior to IRB Meetings

Primary reviewers, regular members and alternates attending the meeting receive and review the materials listed on the IRB Application Forms. Alternates are required to receive and review the same materials as any other IRB member. Consultants will only receive copies of material that pertain to their requested input as determined by the Director, Associate Director, or Chair.

Electronic submission(s) are made available to the IRB members via HS-ERA and the agendas provided include a confirmation code and protocol number for members to access the submission(s).

Copies of application materials described in Policy 302.3.3 will be distributed to all IRB members attending, prior to the IRB meeting, either via paper or electronically by email. Late submission add-ons will be approved for addition to the agenda by the Director or Associate Director and will be submitted to members via e-mail prior to the IRB meeting.

Original submission materials will be retained by IRB administrative staff and will be available for the IRB meeting.

3.4 Confidentiality

All material received by the IRB will be considered confidential and will be distributed only to meeting participants (regular members, alternate members and special
consultants) for the purpose of review. All application materials will be stored in an IRB study file with access granted to appropriate IRB personnel, IRB members, HS-ERA reviewers, and ancillary Committee members that support human research at Penn.

3.5 Destruction of Copies

All material received by the IRB considered to be confidential and in excess of the required original documentation and appropriate uncontrolled forms will be collected at the end of the meeting and destroyed by a method deemed appropriate by the Director.

4. REFERENCES

45 CFR 45.108(a); 21 CFR 56.108(a)

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FO 304 DOCUMENTATION AND DOCUMENT MANAGEMENT

1. PURPOSE

The policies in this section describe the requirements for document management, including:

- Document Retention
- Administrative Documents
- Archiving

2. POLICY

Institutional Review Board files must be maintained in a manner that contains a complete history of all IRB actions related to review and approval of a protocol, including scientific reviews, if any, continuing reviews, modifications, reports of unanticipated problem increasing risks to participants or others, subject complaints, and reports of serious or continuing noncompliance. All records regarding a submitted study (regardless of whether it is approved) must be retained in an appropriate manner as required by regulatory requirements and/or institutional policy.

Records must be accessible for inspection and copying by authorized representatives of the sponsor, funding department or agency and institutional auditors at reasonable times and in a reasonable manner.

Required documents must be submitted to the appropriate funding entity as required.

3. SPECIFIC POLICIES

3.1 Document Retention.

The IRB must retain all records regarding a project or protocol application (regardless of whether it is approved) for at least three (3) years. For all applications that are approved and the research initiated, the IRB must retain all records regarding that research for at least three (3) years after completion of the research or termination of IRB approval.

3.1.1 Adequate documentation of each IRB's activities will be prepared, maintained and retained, including:

Submissions: Copies of all original research protocols or project descriptions reviewed, scientific evaluations, if any, that accompany the proposals, approved consent documents, progress reports submitted by investigators, and reports of unanticipated problems occurring to participants and reported protocol deviations as submitted.

Regulatory Documents/documentation:
- Correspondence between the IRB and investigator
- Statements of significant new findings provided to participants
- For the initial & continuing review of research by expedited procedure”
  - The specific permissible category
Office of Regulatory Affairs, Institutional Review Board
3624 Market Street, Suite 301 South, Philadelphia, PA 19104-6006

- Description of action taken by reviewer
- Any findings under the regulations
- For exemption determinations, the specific category of exemption
- Unless documented in the minutes, determinations required by the regulations and protocol specific findings for:
  - Waiver or alteration of the consent process
  - Research involving pregnant women, fetuses, and neonates
  - Research involving prisoners
  - Research involving children
- For each protocol’s initial and continuing review, the frequency for the next continuing review.

Copies of all submitted monitoring reports, site visit reports and other continuing review activities.

Reports of any complaints received from participants, regulatory agencies and their resolution.

Agendas and Minutes of all IRB meetings.

3.2 IRB Administration Documents

The IRB must maintain and retain all records regarding IRB administrative activities that affect review activities for at least three (3) years. The IRB must retain all records regarding protocols that are approved and the research initiated for at least three (3) years after completion of the research or termination of IRB approval.

3.2.1 Rosters of regular and alternate IRB members identified by name, earned degrees, representative capacity, and indications of experience sufficient to describe each regular and alternate member’s chief anticipated contribution to the IRB’s deliberations; and any employment or other relationship between each member and the IRB and/or the University (e.g., full-time employee, part-time employee, member of governing panel or board, stockholder, paid or unpaid consultant).

Alternate members will be included on the roster. In addition to the above information, the roster shall indicate the regular member for whom the alternate may substitute

Current and previous membership rosters will remain in the IRB office for review as needed.

The roster of IRB members must be submitted to Office for Human Research Protections (OHRP). Any changes in IRB membership must be reported to the head of the department or agency supporting or conducting the research, unless the department or agency has accepted the existence of an FWA. In the latter case, changes in membership are to be reported to OHRP.

3.2.2 Current and obsolete copies of the Standard Operating Policies.
3.3 Archiving

All documents and materials germane to IRB determinations will be archived according to institutional policy.

4. REFERENCES

45 CFR 46.103; 45 CFR 46.115; 21 CFR 56.115

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RR 401 A  HUMAN RESEARCH

1. PURPOSE

This policy describes the research that does not require IRB review because the activity does not involve human research.

2. POLICY STATEMENT

Human research is any activity that either 1) meets the HHS definition of “research” and involves “human subjects” as defined by the HHS regulations or 2) meets the FDA definition of “clinical investigation” and involves “human subjects as defined by the FDA regulation.

Unless otherwise required pursuant institutional policy, activities that do not meet the definition of human research do not require submission to the IRB.


3. SPECIFIC POLICIES

3.1 Activities that do not require IRB Review

In addition to the Executive Chair, IRB Chairs and delegated IRB members, the Director, Associate Director, Senior IRB Staff and IRB administrators (collectively referred to as “staff”) may determine that an activity does not meet the regulatory definition of human research. Investigators who elect to an official determination may submit the Research Determination Worksheet for review.

Staff will review Research Determination Form and supporting documents. Formal submissions will be logged into the database and filed. Investigators will be notified in writing if proposed activities do not meet the regulatory definition of human research.

4. REFERENCES

21 CFR 50.3; 45 CFR 46.102; 21 CFR 812.3(p)
RR 401B  EXEMPT RESEARCH

1. PURPOSE

This policy describes the process for determining that human research is exempt from further review by the IRB.

2. POLICY

Research activities in which the only involvement of human subjects will be in one or more specific categories may be exempt from IRB review. Determination of exemption must be based on regulatory and institutional criteria and documented. Exempt status may be determined by the IRB Executive Chair, IRB Chairs, delegated IRB members, Director, Associate Director, or IRB Senior Staff.

3. SPECIFIC POLICIES

3.1 Exempt Research Activities

The IRB will exempt from further human research review only those research activities that involve human participants that, fall within one or more of the specified exempt categories.

3.2 Ethical Standards for Exempt Research

When approving exempt research, the IRB will determine that the following criteria are met where applicable:

- The research presents no more than minimal risk to participants.
- Selection of participants is equitable.
- If the research involves interactions with participants, the circumstances of consent minimize coercion and undue influence.
- Participants will be informed that the study involves research, will be provided with information about the study procedures that the research is voluntary, and will be provided with information about whom to contact with questions.
- Provisions for protecting the privacy interests of participants are adequate.
- If private identifying data are recorded, provisions for maintaining the confidentiality of data are adequate.

3.3 Approval Period for Exempt Research

Annual continuing review is not required for research determined exempt. Investigators may submit request to close the research protocol when research is completed.

Investigators are required to report modifications that may change the eligibility of the protocol's exempt status.

It is the investigator’s responsibility to notify the IRB of any changes or modifications that are made to the study’s design, procedures, and so on, that do not fall within one of the categories exempted from the regulations.
4. REFERENCES

45 CFR 46.101(b); 45 CFR 46.102; 21 CFR 56.104

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RR 402 EXPEDITED REVIEW

1. PURPOSE

This policy describes the research that can be reviewed by the IRB chair or designee and outlines the process to determination if the research meets criteria for expedited review.

2. POLICY

An expedited review procedure consists of a review of research involving human participants by an appropriately trained IRB Administrator, who is trained in the application of these particular regulations. The IRB Analyst/Administrator places submissions determined to meet these approval criteria for approval by the Director, Associated Director or an appointed member of the Senior IRB staff.

The categories of research that may be reviewed by the IRB through an expedited review procedure include research activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the specific categories listed in the regulations at 45 CFR 46.110 and 21 CFR 56.110.

This policy pertains to both initial and continuing IRB review of the items included in this policy.

The expedited review process may not be used for classified research involving direct interactions with human participants. Expedited review of an initial submission that requests direct interaction with prisoners will also not apply. Use of data without direct interaction with participants may qualify for expedited review. However, use of prisoner data without direct interaction with participants will still require review by a prisoner representative.

3. SPECIFIC POLICIES

3.1 Authority of the Expedited Reviewer

The Executive Chairperson, Chair, Co-Chair or other experienced IRB member reviewers, designated in writing, by the Executive Chair or Chair, or by the IRB members voting in a convened meeting may exercise all of the authorities of the IRB, except that he/she may not disapprove the research. A research proposal may be disapproved only after review by the convened IRB.

Consultants may assist the IRB in the review of issues that require expertise beyond that available on the committee; but may not carry out the expedited review. Individuals conducting expedited review will contact the Director or Executive Chair to request a consultant’s review.

3.2 Notification of the Board

When the expedited review procedure is used, all regular members will be informed via the IRB minutes of actions taken by the designated IRB reviewer.
3.3 Documentation

The information received by the Primary Reviewer for expedited review is the same information provided to the Primary reviewer for review at a convened IRB meeting.

If the study qualifies for review via expedited review, the designated IRB reviewer will document his/her determination of the applicable expedited review category. Consistent with review by a convened IRB, expedited reviewer will consider:

- All the criteria for review found at 45 CFR 46.111 and 21 CFR 56.111
- All requirements found at Subparts B, C, and D, when applicable
- The requirements for informed consent including altering or waiving the requirement for consent

The IRB’s minutes will include documentation of the studies that were reviewed via expedited review including a brief description of the purpose of the research, the designated IRB reviewer who approved the research and the approval date.

3.4 Additional Items that May be Reviewed by the Chair or Designee

3.4.1 Withheld Approval Pending Minor Revisions or Conditional Re-approvals

Minor revisions to consent documents and documentation submitted as a result of convened IRB review and as a condition to final approval may be reviewed by the Executive Chair, Director, Associate Director, IRB Chair or his/her designee or any IRB experienced member.

However, when the response submission contains substantive clarifications or modifications that are directly relevant to the criteria for approval, the protocol will go back to a convened IRB and not be approved by the IRB Chair or other personnel noted above.

3.4.2 Ongoing Review

The Executive Chair, Director, Associate Director, IRB chairperson or his/her designee may use the expedited review procedure to review minor changes in previously approved research during the period for which approval is authorized. Any protocol revision that entails more than a minimal risk to the participant as determined by the Executive chairperson, IRB chairperson or his/her designee must be reviewed by the convened IRB at a convened meeting.

Revisions to Informed Consent Documents: Minor changes to informed consent documents that do not affect the rights and welfare of study participants, or do not involve increased risk or significant changes in study procedures may be reviewed and approved by the Executive chairperson, IRB chairperson, Director or Associate Director or his/her designee.
Advertisements/Other supplemental documentation: The Executive chairperson or his/her designee may approve new or revised recruitment advertisements, recruitment flyers, and audio or video recruitment materials.

4. REFERENCES

45 CFR 46.102(i); 21 CFR 56.102(i); 45 CFR 46.110; 21 CFR 56.110; Federal Register Vol. 63, No. 216, 11/9/98, pp. 60353-60356; 45 CFR 46.111; 21 CFR 56.111

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RR 403 INITIAL REVIEWS: CRITERIA FOR IRB APPROVAL

1. PURPOSE

This policy elucidates the minimal requirements that all research proposals that involve human subject participation must meet in order to be approved for conduct at the University of Pennsylvania.

2. POLICY

All research proposals that intend to enroll human participants must meet certain criteria before study related procedures can be initiated. The criteria are based on the principles of justice, beneficence and autonomy as discussed in the Belmont Report and are specified below. In addition, certain other criteria that are unique to the University of Pennsylvania may apply and must be met as well before any involvement of human participants may begin.

3. SPECIFIC POLICIES

3.1 Minimal Criteria for Approval of Research

In order for a research project to be approved, the IRB must find that:

3.1.1 Risks to subjects are minimized:

By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and, whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.

3.1.2. Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may be expected to result. In evaluating risks and benefits, the IRB will consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies those 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.

3.1.3 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 and should be particularly cognizant of the special problems of research involving vulnerable populations, such as children, prisoners, pregnant women, handicapped, or mentally disabled persons, or economically or educationally disadvantaged persons.

3.1.4 Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with and to the extent required by appropriate local, state and federal regulations.
3.1.5 Informed consent will be appropriately documented as required by local, state and federal regulations.

3.1.6 Where appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects.

3.1.7 Where appropriate, there is adequate provision to protect the privacy of subjects and to maintain the confidentiality of data.

3.1.8 When some or all of the subjects, such as children, prisoners, pregnant women, handicapped, or mentally disabled persons, or economically or educationally disadvantaged persons, are likely to be vulnerable to coercion or undue influence or international sites are used, additional safeguards have been included in the study, and in the IRB review process to protect the rights and welfare of these subjects.

3.1.9 The IRB determines that the provisions are adequate to protect the privacy interests of subjects.

3.1.10 The IRB determines that the provisions are adequate to protect the confidentiality of data.

3.1.11 For repository activities, the IRB makes determinations concerning the regulatory status and appropriate use of stored biologic samples.

3.2 Additional Criteria for Studies Involving Protected Health Information

Studies proposing access to or collection of protected health information within the covered entities of the University of Pennsylvania require consideration of additional items to protect the privacy of the protected health information. Therefore the IRB must find that:

3.2.1 Appropriate authorization is obtained from human subjects or their effective representative for the use or disclosure of their protected health information;

3.2.2 The IRB has approved a waiver of such authorization;

3.2.3 The protected health information will be contained in a limited data set with appropriate safeguards to maintain privacy; or,

3.2.4 The protected health information will be de-identified.

3.3 Other Criteria

The IRB may require verification of information submitted by an investigator. The purpose of the verification will be to provide necessary protection to subjects when deemed appropriate by the IRB.
3.4 Reliance on Other IRBs for Review and Approval of Research Conducted at the University of Pennsylvania

The IRB may enter into joint review arrangements, rely upon the review of another qualified IRB, or make similar arrangements for avoiding duplication of effort.

4. REFERENCES


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RR 404   CONTINUING REVIEW

1. PURPOSE

This section elucidates the policy for the continuing review that occurs after approval and prior to review for renewal of IRB approval.

2. POLICY

IRB approval may be withdrawn at any time if warranted by the conduct of the research. The regulations authorize the IRB to establish procedures for the concurrent monitoring of research activities involving human participants. Periodic (continuing or ongoing) review of research activities is necessary to determine whether approval should be continued or withdrawn. All non-exempt research involving human participants must be reviewed (renewed) no less than once per year.

No research related activities may occur after the protocol expiration date unless the PI contacts the Office of Regulatory Affairs, IRB and the Executive Chair (or authorized designee) determines that it is in the best interest of participants to continue during the lapse in IRB approval.

IRB approval for the conduct of a study may be withdrawn at any time if the risks to the participants are determined to be unreasonably high; for example, more than an expected number of adverse events, unexpected serious adverse events; or evidence that the investigator is not conducting the investigation in compliance with IRB or University guidelines. Such findings may result in more frequent review of the study to determine if approval should be withdrawn or enrollment stopped until corrective measures can be taken or the study terminated. Continuing review includes, but may not be limited to the following activities:

- Site Visits and Third Party Verification
- Review of Unanticipated Problems Posing Risks to Participants or Others or any other reportable events
- Review of Significant New Findings
- Modifications

3. SPECIFIC POLICIES

3.1 Site Visits/Audits and Third Party Verification

The IRB has the authority to observe, or have a third party observe, the consent process of research it has approved, and to verify that the study is being conducted as required by the IRB and within the University Policies and Procedures and site-specific procedures as appropriate. Under the direction of the Associate Director, IRB personnel or members may perform site visits or use another party either affiliated with the institution or not, to verify information in the study application, or in any interim, continuing review or renewal submissions.
The IRB will consider the following criteria to determine if a site visit or third party verification process is required:

- The research involves vulnerable populations or high risk procedures.
- The investigator has a history of serious or continuing non-compliance related to continuing review in the past three years.
- The IRB has reason to doubt the veracity of the information provided by the investigator.
- The information provided by the investigator is inconsistent with other information known to the IRB and the inconsistency cannot be resolved through communication with the investigator.
- Any other reason where the IRB believes verification should be required.

Other means of verification; sponsors may be asked to submit copies of monitoring reports. The IRB may conduct interviews with screened and/or enrolled participants as deemed necessary.

3.2 Unanticipated Problems Increasing Risks to Participants or Others and Other Reportable Events

Consistent with federal regulations, the University of Pennsylvania requires reporting to the IRB of unanticipated problems posing risks to participants or others. Unanticipated problems are: (1) unforeseen; and (2) indicate that participants are at increased risk of harm.

The IRB requires researchers to submit reports of the following problems within 10 working days with one exception. The one exception for prompt reporting within 10 days applies to death of a research participant as noted below.

3.2.1 Adverse Event (regardless of whether the event is serious or non-serious, on-site or off-site) that occurs any time during or after the research study, which in the opinion of the principal investigator is both unexpected and related to research procedures.

An event is “unexpected” when its specificity and severity are not accurately reflected in the protocol-related documents, such as the IRB-approved research protocol, any applicable investigator brochure, and the current IRB-approved informed consent document, and (b) other relevant sources of information, such as product labeling and package inserts);

An event is “related to the research procedures” if the event is deemed probably or definitely related.

If the adverse event involved death as unforeseen and indicates participants or others are at increased risk of harm, report in three days.
3.2.2 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 relates to the rights, safety, or welfare of participants.

3.2.3 Information that indicates a change to the risks or potential benefits of the research, in terms of severity or frequency. For example:

- An interim analysis indicates that participants have a lower rate of response to treatment than initially expected.
- Safety monitoring indicates that a particular side effect is more severe, or more frequent than initially expected.
- A paper is published from another study that shows that an arm of the research study is of no therapeutic value.

3.2.4 Any adverse event that represents a serious unexpected problem that is rare in absence of drug exposure (e.g. agranulocytosis, hepatic necrosis, or Stevens-Johnson syndrome).

3.2.5 Adverse event that would cause the sponsor to modify the investigator’s brochure, protocol, or informed consent to assure the protection of human participants.

3.2.6 Withdrawal from marketing for safety concerns of a drug, device, or biologic used in a research protocol.

3.2.7 Change to the protocol taken without prior IRB review to eliminate apparent immediate hazard to a research participant.

Other Reportable events

3.2.8 Complaint of a participant when the complaint indicates unexpected risks or the complaint cannot be resolved by the research team.

3.2.9 Violation, meaning an accidental or unintentional change to the IRB approved protocol) that placed one or more participants at increased risk, or has the potential to occur again.

3.2.10 Breach of confidentiality.

3.2.11 Incarceration of a participant when the research was not previously approved under Subpart C and the investigator believes it is in the best interest of the subject to remain on the study.
The IRB will accept other reports when the investigator is unsure whether the event should be reported, and the IRB will review such reports to determine whether the event meets the threshold for an unanticipated event presenting risk to the participant.

Principal investigators will submit a written report of the above events. Initial reports may be accepted by other means such as e-mail, or phone with a follow up written report.

The convened IRB reviews reports and decides whether the event meets the definition of an unanticipated problem increasing risks to participants or others.

Events that meet these criteria will be considered unanticipated problems involving risks to participants or others, will be reviewed by the convened IRB, and will be reported according to CO 602.

The IRB Administrator selects the primary reviewer. When, possible the IRB member assigned to the initial primary review will review the event. Otherwise, reviewers will be selected based on their education, experience, and areas of expertise.

Primary reviewers will have access to, as applicable, the sponsor protocol, investigator brochure, original IRB application form, consent document, event summary, and any other supplemental information required to complete the review.

All other IRB members will have access to the original application form; consent document, event summary, and any other supplemental information require completing the review.

The IRB may request a consultant opinion or engage the division or department chair to collect additional information on the event.

The IRB considers the following actions:

- Accept report or with no additional requirements
- Approve investigator’s proposed changes
- Administrative hold on the study pending IRB receipt of further information from the PI in a time period not to exceed 90 days
- Modification of the protocol
- Modification of the information disclosed during the consent process
- Providing additional information to current participant the information may relate to the participant’s willingness to continue participation
- Making arrangements for clinical care outside the research or additional follow-up for participants
- Providing additional information to past participants
- Requiring current participants to re-consent to participation
- Alteration of the frequency of continuing review
- Observation of the research or the consent process
- Requiring additional training of the investigator
- Notification of investigators at other sites
- Obtaining additional information
- Termination or suspension of the research: If this action is taken, the Director will notify the Institutional Official to initiate any reporting actions and if the IRB does not consider the event to represent an unanticipated problem involving risks to participants or others, no further action needs to be taken

3.3 Modifications

Federal regulations require that all modifications in approved research, during the period for which approval has already been given, may not be initiated without prior IRB review and approval except where necessary to eliminate apparent immediate hazards to human participants. Sometimes modifications are noted or recognized after they occur. These changes will be reviewed by the IRB as events that may represent unanticipated problems involving risks to participants or others and to determine whether the change was consistent with ensuring the participants’ continued welfare.

3.3.1 The IRB categorizes modifications into 3 types: Amendments, Deviations, and Exceptions that require reporting to the IRB.

Amendment

An amendment is a permanent, intentional action or process that revises/amends/modifies a previously approved research protocol. Information relating to protocol amendments will be provided to research participants when the information may relate to their willingness to continue to be a part of the research. Investigators or sponsors must submit requests for changes to the IRB. Upon receipt of the protocol amendment, an IRB Administrator with the assistance of the Director or Associate Director, or Senior IRB Administrative staff determines the appropriate level of review.

Electronic protocols will have any revisions submitted via HS-ERA.

Minor modifications are defined as those that do not materially affect an assessment of the risks and benefits of the study and do not substantially change the specific aims/design of the study. Representative minor modifications include but are not limited to:

- The addition of research activities that would be considered exempt or expedited if considered independent from the main research protocol;
- A minor increase or decrease in the number of participants;
- Narrowing the inclusion criteria;
- Broadening the exclusion criteria;
- Changes to the dosage form (e.g. tablet to capsule or oral liquid) of an administered drug (when the dose and route of administration remain constant);
- Decreasing the number of biological sample collections, provided that such a change does not affect the collection of information related to safety evaluations;
- An increase in the number of study visits for the purpose of increased safety monitoring;
- A decrease in the number of study visits, provided the decrease does not affect the collection of information related to safety evaluations;
- Changes in remuneration;
- Changes to improve the clarity of statements or to correct typographical errors, provided that such a change does not alter the content or intent of the statement;
- The addition or deletion of qualified investigators;
- The addition or deletion of study sites;
- Minor changes specifically requested by other University Committees with jurisdiction over research.

**Exception**

A one time, intentional action or process that departs from the IRB approved study protocol, intended for one occurrence.

If the action disrupts the study progress, such that the study design and results would be compromised, and the action compromises the safety and welfare of study participants, prior documented IRB approval is required.

**Deviation**

A one time, unintentional action or process that departs from the IRB approved study protocol, involving one incident and identified retrospectively, after the event occurred. If the impact on the protocol disrupts the study design or compromises the safety and welfare of the participants, the deviation must be reported to the IRB within 10 business days.

When the IRB reviews the exceptions and deviations, a determination will be made as to whether information related to protocol changes should be provided to participants when such information might relate to their willingness to continue to
take part in the research. The investigator will be advised if participants need to be informed.

3.4 Significant New Findings

During the course of a study, the IRB may review reports generated from the DSMB, adverse events, current literature, and other sources to ascertain the status of the study and assess whether or not the risk/benefit balance is still acceptable, whether or not new information needs to be conveyed to participants, or if a segment of the population may be bearing an undue burden of research risk or being denied access to promising therapy. Such significant new findings will be reviewed by the Executive Chairperson, chairperson or their designee who shall decide whether such new information merits review by the IRB.

3.5 Reports from Employees, Staff and Faculty

It is the responsibility of the investigative team, medical staff, nursing staff, or any other employee of this institution to promptly report to the IRB any findings, results, occurrence, or new information about a study being conducted at any facility under the jurisdiction of the IRB that could affect the rights and welfare of research participants. It is the responsibility of the IRB staff and members to act on any such information in order to protect research participants.

3.6 Reports of Serious or Continuing Noncompliance Federal Regulation; or the Requirements or Determinations of the IRB

Reports of serious or continuing noncompliance or the requirements or determinations of the IRB will be handled in accordance with SOPs 408 and 409.

3.7 Suspension or Termination of IRB Approval

A decision to suspend or terminate a protocol must include an explicit consideration for the rights and welfare of participants already enrolled in the study. If the suspension or termination is imposed on the investigator, the IRB Executive Chair may be consulted about whether and how to continue the care of enrolled participants. The matter will be discussed at the next convened meeting of the IRB.

Any suspensions or terminations of approval shall include a statement of the reasons for the IRB’s action and shall be promptly reported by the IRB to the investigator, IRB Executive Chair and Institutional Official. The timeframe for notification to the institutional official, sponsors, and regulatory agencies will depend on the urgency of the matter. Situations presenting immediate, unforeseen risk to participants will be reported immediately to the institutional official and sponsors. When the research is sponsored or supported by the Department of Health and Human Services, the Institutional Official will notify OHRP. For FDA regulated research, the Institutional Official will notify FDA in writing after the IRB has considered the matter at the next convened meeting.

Enrolled participants will be notified if a protocol in which they are enrolled is suspended or terminated. The IRB will determine at a convened meeting how and when the notification will take place. The IRB will consider whether to notify former participants if
the reason for termination or suspension was associated with risks not disclosed in the consent process.

4. REFERENCES


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1. PURPOSE

This section elucidates the policy for the continuing review prior to the expiration of the IRB approval period.

2. POLICY STATEMENT

The IRB conducts continuing review of research taking place within its jurisdiction at intervals appropriate to the degree of risk, but not less than once per year, and has the authority to observe or have a third party observe the consent process and the research.

3. SPECIFIC POLICIES

3.1 Interval for Review for Purpose of Renewal

The IRBs must conduct continuing review of protocols for purposes of renewal of the IRB approval period at intervals appropriate to the degree of risk, which is determined at the time of initial review, but not less than once per year. “Not less than once per year” means that the research must be reviewed on or before the one-year anniversary date of the previous IRB review, even though the research activity may not begin until sometime after the IRB has given approval.

The IRB may approve a protocol for a shorter period if warranted by the risks presented to participants. The IRB may approve a study for 6 months or may stipulate the approval on further IRB review after a defined number of participants have been enrolled (e.g., review after the first three participants receive a Phase I drug that has never been tested in humans).

Investigators or qualified designees are required to submit a Request for Continuing Review, or an electronic application requesting continuing review and other materials as outlined. For protocols requiring convened review, the report should normally be filed about eight weeks before the study approval period ends.

3.2 Extensions of Approval Period

There is no grace period extending the conduct of the research beyond the expiration date of IRB approval. Extensions beyond the expiration date will not be granted. If an investigator fails to provide continuing review information to the IRB, or the IRB has not reviewed and approved a research study before the expiration date specified by the IRB, no research related activities may occur after the protocol expiration date unless the PI contacts the Office of Regulatory Affairs and the IRB Executive Chair (or authorized designee) determines that it is in the best interest of individual participants to continue during the lapse in IRB approval.

3.3 Criteria for Renewal

Continuing review must contain the required information needed to determine that the study should be allowed to continue. The IRB (or the reviewer for protocols reviewed under an expedited procedure) must determine that:
the risks to participants continue to be minimized and reasonable in relation to the anticipated benefits;

the selection of participants continues to be reasonable in relation to anticipated benefits;

informed consent continues to be appropriately documented;

there are:
- provisions for safety monitoring of the data,
- protections to ensure the privacy of participants and confidentiality of data,
- and appropriate safeguards for vulnerable populations.

Because it may be only after research has begun that the real risks can be evaluated and the preliminary results used to compute the actual risk/benefit ratio; the IRB can then determine whether or not the study can be renewed at the same risk/benefit, or if new information has changed that determination.

In order to determine the status of the study, the following will be reviewed:

3.3.1 Consent Document: Each member of the IRB shall review the currently approved consent document and must ensure that the information is still accurate and complete. Any significant new findings that may relate to the subject's willingness to continue participation should be provided to the subject in an updated consent document.

3.3.2 Current Approved Protocol including any amendments to Protocol since initial review. A copy of the protocol will be sent to primary reviewer of the continuing review. Amendments to a research protocol should be submitted on an ongoing basis during the course of the study. They may be submitted at the time of continuing review. A separate cover letter describing the amendment and all appropriate documentation (revised consent form) must accompany the continuing review application. The electronic submission system requires two independent submissions for continuing review and modifications.

3.3.3 Continuing IRB review is required unless the project is complete with no participants in follow up and no further contact with participants and all data analysis that requires contact with records or specimens linked to privately identified information is complete.

3.3.4 Continuing Review of DSMB-Monitored Clinical Trials. When a clinical trial is subject to oversight by a Data Safety Monitoring Board (DSMB), whose responsibilities include review of adverse events, interim findings and relevant literature (e.g. DSMBs operating in accordance with the National Cancer Institute Policy for Data and Safety Monitoring of Clinical Trials), the IRB conducting continuing review may rely on a current statement from the DSMB indicating that it has reviewed study-wide adverse events, interim findings and any recent literature that may be relevant to the research, in lieu of requiring that this information be submitted directly to the IRB.
3.3.5 Request for Continuing Review Form: All IRB members shall receive a request for continuing review form or access to the electronic submission for continuing review, for any protocols requiring convened review, which is prepared and submitted by the principal investigator or designee.

3.4 Possible Outcomes of Continuing Review

As an outcome of continuing review, the IRB may authorize continuation of the research, require that the research be modified or halted altogether. The IRB may need to impose special precautions or relax special requirements it had previously imposed on the research protocol such as frequency of monitoring, requirement for interim reports or duration of IRB approval period (so long as the approval period does not exceed one year). Any changes required to obtain continued renewal approval shall be provided to the investigators by the IRB staff.

3.5 Expedited Review for Renewal

A protocol that was originally reviewed using expedited review procedures may receive its continuing review on an expedited basis when one of the following conditions is met:

3.5.1 Where the research was originally reviewed using an expedited review process and the research activities continues to meet the expedited criteria.

3.5.2 Research was previously reviewed by the convened IRB where one of the following conditions is met:

- The research is permanently closed to enrollment of new subject; all research related interventions have been completed; and the study remains open only for long-term follow up;

- No participants have been enrolled and no additional risks have been identified; or,

- The remaining research activities are limited to data analysis.

For multi-center trials “no participants enrolled” means that no participants have ever been enrolled at the University of Pennsylvania; and “no additional risks have been identified” means that no additional risks have been identified at any site.

A protocol that was determined by the full IRB to qualify for expedited renewal at the time of initial review (see categories of expedited review) may be reviewed and re-approved using an expedited review mechanism.

3.5.3 Where the research is not conducted under an investigational new drug application or investigational device exemption and where other expedited review categories do not apply but the IRB has determined that the research involves no more than minimal risk and no additional risks have been identified.

When conducting research under an expedited review procedure, the Executive chairperson, chairperson or his or her designee reviews on behalf of the convened IRB using the same criteria for renewal as stated in this section 3.3 of this policy. If the
expedited reviewer feels that there has been a change to the risks so that they now are more than minimal as determined by the IRB, he or she may refer the study for convened review.

3.6 How the Continuing Review Date is Determined

When the IRB has determined that continuing review will occur no sooner than within 1 year, the date of continuing review is determined by using the date the protocol was reviewed and approved by the convened IRB or approved via an expedited mechanism.

4. REFERENCES

45 CFR 46.109(c); 21 CFR 56.109(f); OHRP Guidance on Continuing Review, January 15, 2007; FDA Information Sheets, Continuing Review after Study Approval

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RR 406    STUDY COMPLETION

1. PURPOSE

This section elucidates the policy for the closing a research project or protocol.

2. POLICY STATEMENT

The completion of a study previously determined to qualify for expedited or convened review is a change in activity and should be reported to the IRB in order to receive an official completion approval for the study. Although participants will no longer be "at risk" under the study, a final report/notice to the IRB allows it to close its files as well as providing information that may be used by the IRB in the evaluation and approval of related studies.

3. SPECIFIC POLICIES

3.1 Determining When a Project can be Closed

3.1.1 Externally or internally funded protocols: When the project is complete with no participants in follow up and no further contact with participants and all data analysis that requires contact with records or specimens linked to privately identified information is complete.

3.1.2 Multi-site industry supported clinical trials may be closed when data collection and follow-up is complete at the institutional site and the industry monitor has closed the site.

3.2 Completion Reports

Final Reports should be submitted within 30 days after completion of the study. Final reports may be submitted in any format that provides adequate information about the status of the study, such as computer printouts, telephone reports, letters, etc. Final reports may be submitted by the investigator or his or her designee. The IRB Administrator will review all reports of study completion and, if needed, request further information from the investigator to clarify any questions that may arise.

Notice of the submission of Final Reports or closures will be reported to the Board via the minutes and copies of the reports and any supplement information will be available for the members.

4. REFERENCES

21 CFR 56.108 (a)(3); 45 CFR 46.103(b)(5)

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RR 407 CATEGORIES OF ACTION

1. PURPOSE

This section elucidates the actions the IRB may take as resulting from its review of research.

2. POLICY

As a result of its review, the IRBs may determine to approve or disapprove the proposed research activity, or to require modifications to the project/protocol/documents in order to secure IRB approval of the research activity. Except when the expedited review procedure is used, these actions will be taken by a vote of a majority of the regular and alternate members present, except for those members present but unable to vote in accordance with IRB’s conflict of interest policies. When reviewed via expedited review, the Executive Chairperson, chairperson or their designee can take any of the following actions except to disapprove a study.

3. SPECIFIC POLICIES

3.1 Determinations: Initial Review

Initial Review: The IRB may make one of the following determinations as a result of its review of research submitted to the convened IRB for initial review:

3.1.1 Approval

When an acceptable risk/benefit ratio exists and the regulatory criteria required for approval are deemed acceptable, protocol is approved as submitted, with the following exceptions:

- Administratively Finalized: When additional documentation is needed before research activity may begin (i.e. approval from other sites, etc.)
- Approved Pending Contract: Applies for studies with industry funding, where a contract is not yet executed and enrollment should not commence

3.1.2 Withheld Approval Pending Changes

The IRB determines that the protocol will meet the regulatory criteria for approval provided the investigator agrees to make changes to the IRB application including the informed consent document.

The IRB Executive Chair, Chair or another designated IRB member may subsequently approve the revised research protocol on behalf of the IRB if the conditions for approval are determined to be met. Research may not be initiated until a letter of IRB approval is received and other applicable committee reviews are satisfied.
When the IRB requires substantive changes that are directly relevant to the determinations required by the IRB under federal regulations, the IRB may not grant withheld approval of the protocol.

3.1.3 Tabled

The IRB requires substantive changes that are directly relevant to the determinations required by the IRB under federal regulations; the IRB will table the approval of the protocol pending subsequent review by the convened IRB of the responsive material.

3.1.4 Disapproved

The IRB determines that the research does not meet the regulatory criteria for approval and cannot provide modifications that may allow the protocol to be approved. The IRB will notify the investigator in writing of the reasons for the decision and will give the investigator an opportunity to respond in person or in writing.

3.2 Determinations: Ongoing Review (including modifications submitted)

3.2.1 Approval

When an acceptable risk/benefit ratio exists and the criteria required for approval are deemed acceptable, protocol is approved as submitted.

3.2.2 Conditional Re-approval

When the IRB determines requires minor modification to the protocol or accompanying documents.

3.2.3 Suspension

Study is suspended pending further clarification of substantive issues related to the criteria for approval.

4. REFERENCES

45 CFR 46.109(a); 21 CFR 56.109(a); 45 CFR 46.111; 21 CFR 56.111

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RR 408 NONCOMPLIANCE

1. PURPOSE

This policy affirms the standards of conduct, elucidates the policy for responding to reports of noncompliance and defines the actions the IRB may take as a result of its review of the reports.

2. POLICY

Penn pledges to promote and uphold the highest ethical standards in the conduct of human research. Employees and agents of the organization are required to comply with federal regulations and the requirements and determinations of the IRB.

All employees and agents of the University of Pennsylvania share the responsibility for reporting incidences of noncompliance with the regulations or the requirements or determinations of the IRB.

3. SPECIFIC POLICIES

3.1 Definitions

3.1.1 Noncompliance is defined as a violation of any federal, state, or local regulation that governs human research; any university policy on human research; any deviation from the protocol approved by the IRB or stipulations imposed by the IRB as a condition of approval.

3.1.2 Serious noncompliance is noncompliance that may affect subject safety; increase risks to participants; affect the integrity of the data; violate the rights and welfare of participants; or affect the subject’s willingness to participate in research.

3.1.3 Continuing noncompliance means a pattern of noncompliance that indicates a lack of understanding about the regulations or ethical requirements that may affect the rights and welfare of participants. The pattern of noncompliance is assessed by the number of incidents occurring during the course of a protocol, and whether the same noncompliant action was repeated or many different noncompliant events occurred.

The frequency of noncompliance is assessed mainly by the number of incidents occurring during the course of a protocol, and would also take account of whether the same noncompliant action was repeated or many different noncompliant events occurred.

3.1.4 Allegation of noncompliance: A report of noncompliance that represents an unproven assertion.

3.1.5 Finding of noncompliance: A report of noncompliance that is true or an allegation of noncompliance that is determined to be true.

3.2 Reporting Concerns
3.2.1 Reports of noncompliance in human research may come from many sources including, but not limited to, an investigator (as a self-report); a study monitor; university or school based compliance and audit offices; a sponsor; a research subject; a department chair; a member of the research team; or a person not directly involved with the research.

3.2.2 Persons raising such concerns are encouraged to express them in writing. However, verbal concerns will be received and should be documented accordingly.

3.2.3 Reports of suspected noncompliance may also come from many sources. Within the Perelman School of Medicine, the Senior Vice Provost has delegated to the Office of Human Research (OHR) the responsibility for conducting routine and directed compliance audits within the School. The OHR audit findings are submitted to the IRB for consideration and determinations of noncompliance are made by the convened IRB. The management plan is developed by the IRB in partnership with OHR. Reports of noncompliance from any other school-based audit programs will be communicated in writing to the IRB for consideration.

3.3 Audits and Compliance Reviews

Audits and compliance reviews are conducted in the form of directed audits and periodic compliance reviews. These audits and reviews are designed to assess compliance with local, State, and Federal laws, research participant safety, and IRB policies and procedures.

3.3.1 Directed Audits. Directed audits are conducted to assess the Investigator’s compliance with Federal, State, and local law, university and IRB policies and to identify areas for improvement. Triggers for audit activities may include:

- Any IRB committee directives or concerns;
- A response to an externally initiated complaint (OHRP, FDA or Sponsor) of potential protocol violations or regulatory noncompliance;
- A response to an internally initiated complaint or concern (a participant, a family member, Institutional personnel); or
- An Investigator with a history of poor adherence to Penn policies and procedures.

3.3.2 Periodic Compliance Reviews. Periodic compliance reviews are conducted using a systematic method to review IRB-approved research or IRB records/activities on a regular basis. The above-described periodic compliance review activities may include but are not limited to the following:

- Requesting progress reports from Investigators, including a self-assessment of execution of the research and verification that the research is executed within the parameters outlined in the approved protocol;
- Examining the entire research project;
- Contacting research participants

- Assigning observers to the sites where research involving human research participants and/or the informed consent process is being conducted;

- Auditing advertisements and other recruiting materials;

- Reviewing projects to verify that the Investigator has not initiated unapproved changes since previous review;

- Monitor conflict of interest concerns to assure the consent documents include the appropriate information and disclosures;

- Examining HIPAA authorizations.

### 3.4 Evaluation

3.4.1 The Director/Associate Director/appointed Senior IRB Staff is responsible for the initial review of allegations of noncompliance, review of employee, staff, and faculty reports and complaints and review of audit findings that indicate potential or serious noncompliance.

3.4.2 **Allegations of noncompliance**

When an allegation of noncompliance is referred to the IRB, the Director/ Associate Director/appointed Senior IRB Staff conducts the initial review to verify the veracity of the allegation.

The Staff member assessing the report may choose any of the following methods to gather the required information:

- Conduct the initial review alone

- Conduct the initial review in coordination with the IRB Executive Chair, IRB Chair, or IRB Director

- Request advice from the Office of General Counsel, University or School Offices of Audit and Compliance, or outside consultants

The individual(s) or subcommittee conducting the investigative process may take any of the following actions as they deem necessary to verify the veracity of any allegations and the seriousness or number of occurrences of the actions:

- Review any written materials

- Interview knowledgeable sources

- Collect relevant documentation
A written record of findings and evidence will be made by the staff member processing the report. The report will include an assessment of whether the preponderance of evidence shows that any of the allegations of noncompliance are findings of noncompliance.

If the investigation results in potential findings of noncompliance, the process for assessing if the noncompliance is serious and continuing noncompliance will be followed.

3.4.3 Noncompliance that is not serious or not continuing.

If it is determined by the Associate Director or investigative team that (1) the noncompliance was clearly not serious and not continuing, (2) the research staff recognized the noncompliance, and (3) the research staff took appropriate corrective actions, then the report will be forwarded to the Director, Human Research Protections. No further action is required.

If it is determined by the Associate Director or investigative team that (1) the noncompliance was clearly not serious and not continuing, but the research staff did not recognize the noncompliance or the research staff did not take appropriate corrective actions, the Associate Director will report the event to the PI of the event and offer guidance on the appropriate corrective action plan. The Associate Director may also request a Directed Audit as outlined in 3.3.1 above or may refer the matter to the convened IRB.

3.4.4 Noncompliance that is serious or continuing.

The Staff member assessing the report is responsible for obtaining as much information as possible from the individual who initially reports the incident and for the initial fact finding process to decide whether each incident of noncompliance was serious or continuing.

If the incident is considered serious or continuing based on the Associate Director or investigative team review, then the Staff member assessing the report will follow the steps outlined in the Process Flow Chart and will document the process.

The IRB will receive a detailed explanation of the reported issues and, as applicable, a copy of the protocol, consent form, and the initial application form. The Director/Associate Director, IRB Executive Chair, IRB Chair or assigned IRB member will present the report to the convened IRB. The convened IRB determine will review the report and determine the appropriate way to remedy the noncompliance as outlined in 3.5.
3.5 Actions that the IRB Considers in Responding to Serious or Continuing Noncompliance

3.5.1. The IRB may take the following actions in response to serious or continuing noncompliance:

- No action
- Modification of the research protocol
- Modification of the information disclosed during the consent process
- Additional information provided to past participants
- Notification of current participants (required when such information may relate to participants' willingness to continue to take part in the research)
- Requirement that current participants re-consent to participation
- Modification of the continuing review schedule
- Monitoring of the research
- Monitoring of the consent process
- Suspension of the research
- Termination of the research
- Obtaining more information pending a final decision
- Referral to other organizational entities (e.g., legal counsel, risk management, institutional official)

3.5.2 Appropriate IRB staff will document the results of the IRB's determinations in the meeting minutes. The IRB will notify the investigator in writing of the results of the investigation and of any remedial actions required by the IRB. The letter will include a request for the investigator to respond in writing. The IRB will review the response. The response may be reviewed using expedited procedures or may be referred to the convened IRB.

3.5.3 The IRB minutes will include a description of the nature of the event, the findings, actions taken, and plans for continued investigation or action.

3.6 Notifications

3.6.1 If the noncompliance is determined to be serious or continuing, CO 602 will be followed.
4. REFERENCES

45 CFR 46.103(b)(4)&(5); 21 CFR 56.108(b)

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RR 409  ADMINISTRATIVE HOLDS, TERMINATIONS, AND SUSPENSIONS OF IRB APPROVAL

1. PURPOSE

This policy describes the IRB actions associated with suspending or terminating previously approved research.

2. POLICY STATEMENT

Federal regulations require that the IRB have the authority to suspend or terminate approval of research that is not being conducted in accordance with IRB requirements or that has been associated with unexpected serious harm to participants. Suspensions and terminations represent an action by the IRB to temporarily or permanently withdraw approval for some or all research procedures. This policy describes the IRB actions associated with suspending or terminating previously approved research.

3. SPECIFIC POLICIES

3.1.1 The following officials are authorized to suspend IRB approval pending review by the IRB responsible for continuing review of the protocol: the Senior Vice Provost for Research, Deans of Schools, the Executive IRB, and the Chair of the IRB responsible for continuing review of the protocol, the Institutional Director(s) of Research Compliance, and any other Penn officials who is authorized to take such action by virtue of his or her office or of a policy or procedure of the relevant organization.

The University of Pennsylvania official who suspends a protocol shall immediately notify the Principal Investigator of:

- The requirement to suspend the study or to halt the portion of the IRB approved protocol that poses immediate, material risk to participant health and welfare;
- The reasons for the suspension;
- The opportunity to respond in person or in writing to the official and IRB on the suspension; and,
- The obligation to immediately report the suspension and its basis to the IRB.

The IRB Director or Associate Director will report the suspension to the Senior Vice Provost for Research and will immediately initiate the appropriate procedure for review of the basis for the suspension.
If the suspension of some or all of the protocol involves the withdrawal from the research or modification of participation of current participants, the IRB will direct the investigator to contact the participants to:

- Describe any monitoring and follow-up for safety reasons that will be conducted and
- Provide contact information for the Principal Investigator and the IRB where the participant may report any adverse events or unanticipated problems.

### 3.1 Administrative Hold

A voluntary action initiated by the investigator to place specific research activities on temporary hold. When a study is currently approved by the IRB, the PI may voluntarily place the study on hold as follows:

- Administrative hold of screening/enrollment
- Administrative hold of interaction/intervention
- Administrative hold of follow-up

The investigator will notify the IRB in writing of its decision for Administrative Hold. The notification will include the criteria for the Administrative Hold and will notify the IRB when research related activities resume.

### 3.2 Sponsor-Imposed Suspension

A determination may come from the sponsor of the study to place specific research activities on hold. This determination may be made for interim data analysis; inadequate drug availability; in response to a DSMB report/recommendation; or a pre-planned stopping criteria. The investigator notifies the IRB in writing of sponsor-imposed suspensions.

### 3.3 Suspension for Cause

Suspension for cause is an action to stop temporarily some or all research procedures pending future action by the IRB or by the Investigator or his/her study personnel. The IRB reviews a study for suspension at convened IRB meeting. Examples of these types of circumstances include:

- Falsification of study safety data;
- Failure to comply with prior conditions imposed in writing by the IRB under suspension of the study;
- Repeated or deliberate failure to obtain or document informed consent from human participants, which may include:

  Repeated or deliberate omission of a description of serious risks of the experimental therapy when obtaining informed consent; and/or
Repeated or deliberate failure to provide informed consent in a language understandable to the subject;

- Repeated or deliberate failure to limit administration of the investigational drug or device to those participants under the Investigator’s supervision;

- Repeated or deliberate failure to comply with conditions placed on the study by the University, IRB, sponsor, or FDA;

- Repeated or deliberate failure to obtain prior review and approval of new protocols and on-going human participants research by the IRB;

- Repeated or deliberate failure to maintain accurate study records or submit required adverse event reports to the IRB;

- Repeated or deliberate falsification or concealment of study records, e.g., by substituting in study records the results of biological samples from participants who met the inclusion criteria for samples of participants who did not meet the inclusion criteria, or by fabricating participants.

In addition, the Committee may request an ad hoc review from an independent source with expertise in the type of research being conducted or expertise in the specific area of concern.

The IRB notifies the Investigator in writing of its decision to suspend the study for cause and provide a rationale for its actions. This letter includes an opportunity for the PI to respond to the IRB’s determinations and to attend an IRB meeting to discuss the suspension and provide clarification of the issues.

3.4.1 The IRB will take the appropriate actions to protect the rights and welfare of currently enrolled participants in suspended or terminated research. For example:

- Consider transfer of participants to another investigator.

- Arrange for participants to be provided clinical care by the investigator or another physician.

- Arrange for participants to continue in some research-related activities.

- Require specific procedures for withdrawal of enrolled participants.

- Permit or require follow-up of participants for safety reasons, and if so, require reporting of adverse events or outcomes to the IRB.

- The IRB may request the development of an education plan and/or the completion of a directed audit by the Office of Human Research.

- Suspensions are reinstated for approval after corrective actions are completed to the IRB’s satisfaction. The IRB may approve the study with or without additional restrictions (e.g., mandating a data and safety monitoring committee to oversee
the research at designated intervals, increase in the frequency of IRB review, observation of the consent process).

3.5 Termination for Cause

An action initiated by the IRB to stop permanently some or all research procedures.

The IRB reviews a study for Termination for Cause at a convened IRB meeting.

In addition, the IRB may request an ad hoc review from an independent source with expertise in the type of research being conducted or expertise in the specific area of concern.

The IRB notifies the Investigator in writing of the decision to terminate the study for cause and provide a rationale for its actions. This letter includes an opportunity for the PI to respond to the Committee’s determinations and to attend an IRB meeting to discuss the termination and provide clarification of the issues.

3.6 Reporting of Suspensions for Cause or Terminations

All Suspensions or Terminations are promptly reported per IRB SOP Policy CO 602. The institution may determine that suspensions or terminations associated with a particular study or an Investigator are repetitive and warrant action for issues of serious and continuing non-compliance.

4. REFERENCES

45 CFR 46.103(5)(ii); 21 CFR 56.108(b)(3)

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SC 501 VULNERABLE POPULATIONS

1. PURPOSE

This section presents the policy concerning review of research that involves groups that could be potentially vulnerable to undue influence or coercion, present conditions that may affect risk/benefit determinations or bear an unequal burden in research.

2. POLICY STATEMENT

The IRB shall apply additional protections as necessary to protect potentially vulnerable research participants. Not every human being is capable of self-determination. The capacity for self-determination matures during an individual's life, and some individuals lose this capacity wholly or in part because of illness, mental disability, or circumstances that severely restrict liberty. The extent of additional protection afforded should depend upon the risk of harm and the likelihood of benefit. The judgment that any individual lacks autonomy should be periodically reevaluated and will vary in different situations. In addition, when an IRB regularly reviews research involving a vulnerable population consideration will be given to inclusion of one or more individuals who are knowledgeable about and experienced in working with these participants.

3. SPECIFIC POLICIES

3.1 Prisoners

If an investigator indicates that prisoners will participate in the research, or that participants may reasonably be expected to be incarcerated at some time point during the study, the IRB will adhere to the requirements found at 45 CFR 46, Subpart C. A majority of the IRB (exclusive of prisoner members) has no association with the prison involved apart from membership on the IRB. At least one IRB member who is a prisoner or prisoner representative with appropriate background and experience to serve in that capacity is present at the meeting.

3.1.1 When Participants Become Prisoners During a Research Protocol.

This policy applies whenever any human subject in a research protocol becomes a prisoner at any time during the protocol, e.g., after the research has commenced. This is necessary because it is unlikely that review of the research and the consent document contemplated the constraints imposed by the possible future incarceration of the subject. If a subject becomes a prisoner after enrollment in research, the Principal Investigator is responsible for reporting in writing this situation to the IRB immediately.

At the earliest opportunity after receiving the Principal Investigator's notice or otherwise becoming aware of the prisoner status of a subject the IRB will review the protocol again with a prisoner representative as a member of the IRB.

The IRB will take special consideration of the conditions of being a prisoner. Upon this review, the IRB can either (a) approve the involvement of the prisoner-subjects' in the research in accordance with this policy and all applicable regulations; or (b) determine that this subject must be withdrawn from the research.
Additionally, the IRB should confirm that, when appropriate, the informed consent process includes information regarding when subsequent incarceration may result in termination of the subject’s participation by the investigator without regard to the subject’s consent.

3.2 Children

3.2.1 Definition

Federal regulations define “children” as persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted.

Under Pennsylvania law, persons under the age of eighteen (18) generally meet this definition of “children”, with the exceptions noted below. As a result, permission of the child’s parent(s) or guardian(s) must generally be obtained prior to the participation child’s participation in the research.

The following exceptions to the general rule apply, where a person under the age of 18 does not meet the federal definition of “child” and may provide legally effective consent to participate in research if either:

- The research involves the provision of medical care or treatment, (including care or treatment deemed to be experimental) and the person:
  - has graduated from high school, or
  - is married, or
  - is or has been pregnant.

- The person is an emancipated minor. If an emancipated minor provides consent for himself or herself, the court order should be copied and included in the research records with the consent document.

3.2.2 All individuals defined as “children” will be afforded the protections under Subpart D, 45 CFR 46.401 - 409 and 21 CFR 50.50 - 54, Additional Protections for Children Involved as Participants in Research and as delineated in IRB Policies.

Subpart D Protections are not applicable for minors who do not meet the definition of children. The IRB may consider these participants potentially vulnerable and may choose to apply additional protections.

When a research protocol involves minors who do not meet the definition of children, the IRB will carefully balance the potential risks and benefits of the proposed research and will consult with the Office of General Counsel and the Vice Provost for Research as deemed necessary.

If the research includes enrollment of participants in other states or countries, the principal investigator is responsible for providing the IRB with sufficient information to verify the age at which participants in such jurisdictions have the ability to consent to
participation in research, including any medical treatments or procedures if applicable.

The IRB may, if it appears advisable, require the submission of an opinion rendered by an attorney from any applicable jurisdiction on age at which an individual can consent to participation in research.

3.2.3 Federal regulations at 45 CFR 46 Subpart D and 21 CFR 50 Subpart D define “guardian” as “an individual who is authorized under applicable state or local law to consent on behalf of a child to general medical care.”

Pursuant Pennsylvania law, only the birth parent or a person adjudicated as an adoptive parent(s) or legal custodian may provide the legally effective parental permission on behalf of a child to general medical care.

Except for research involving no greater than minimal risk, if subject a court appointed guardian provides consent, documentation of the court order or legal authorization to consent to general medical care must be copied and included in the investigator’s research records with the documentation of permission.

3.3 Pregnant Women, Fetuses, and Neonates

The University requires adherence to DHHS regulations regarding additional protections required for research involving pregnant women, fetuses, and neonates for research that is supported by HHS. In addition to the other responsibilities assigned to the IRBs under 45 CFR Part 46 Subpart A, the University of Pennsylvania requires each IRB to review research involving these participants by applying the protections of 45 CFR 46 Subpart B for HHS supported research. The IRB will provide for equivalent protections when the research is not supported by HHS. For example, the IRB may consider an FDA regulated study of abortion techniques. Review and approval of such research will be done in consultation with both the Office of General Counsel and the Vice Provost for Research Human Research Advisory Board to ensure adherence to state law.

Pennsylvania Law places additional restrictions on research on the fetus. The IRB will consult with the Office of General Counsel on a case-by-case basis for research protocols involving this class of subject.

3.4 Other vulnerable groups

Federal regulations require that the IRB consider additional protections for other vulnerable populations such as mentally disabled persons and economically or educationally disadvantaged individuals. The IRB will consider these additional protections as part of the criteria for approval.

Although the federal regulations do not list all vulnerable groups, the IRB considers vulnerable groups to include employees of the sponsor, investigator or the University, and those within potentially compromised autonomy. The IRB will determine special protections for these groups on a case by case basis taking into account the risks and benefits and other protections afforded by institutional policies and state and federal law.
3.4.1. Adults with Impaired Decision-Making Capacity

Decisionally impaired adults are individuals who have a diminished capacity for judgment and reasoning due to a psychiatric, organic, developmental, or other disorder that affects cognitive or emotional functions. Other individuals may be considered decisionally impaired or have limited decision-making ability because they are under the influence of or dependent on drugs or alcohol, suffering from degenerative diseases affecting the brain, are terminally ill, or have severely disabling physical handicaps.

There are no regulations specific to research involving adults with impaired decision-making capacity. The IRB takes special care to consider issues such as the selection of participants, privacy and confidentiality, coercion and undue influence, and risk-benefit analysis. Decisions should be made with the utmost deference to the ethical principles underlying human research as set forth in the Belmont Report.

The National Bioethics Advisory Commission (NBAC) has issued 21 recommendations for IRBs, the research community, and Federal regulators to consider regarding the decision-making capacity of particularly vulnerable participants.

The following criteria that should be taken into consideration for adult participants with impaired decision-making capacity involved in a research protocol:

The objectives of the research cannot be met by conducting the research in a population that does not have the disorder that may affect decision making capacity.

The research is designed for a disease or condition relevant to the vulnerable population under study.

The research is either minimal risk, more than minimal risk with a prospect of direct benefit, or more than minimal risk without a prospect of direct benefit, but of vital importance to the vulnerable population.

Adequate provisions are made for obtaining consent from the participant’s legally authorized representative.

Adequate provisions are made for obtaining assent from the participant, unless the IRB determines that assent is not appropriate as a condition of participation or that some or all participants are not capable of providing assent.

The protocol must describe when and how the participants will be assessed for capacity for formal consent or assent and understanding of the proposed research, and the process for a second confirming assessment. Competency should be evaluated on an individual basis to avoid incorrect assumptions as to an individual’s ability to make decisions. Criteria for determining competence might vary according to the degree of risk or discomfort presented by the research procedures and the extent to which therapeutic gain can be anticipated.
The IRB will consider additional safeguards to protect participants. These include:

- Requiring the involvement of participant advocates
- Requiring independent monitoring
- Requiring waiting periods
- Appointing a monitor to supervise the informed consent process

Such decisions may be based on the amount of risk involved in the research and the likelihood that participants will derive health benefits from their participation.

3.4.2 Research involving students or employees of the University.

When research involves students or employees of the University, the IRB requires the investigator to provide information regarding the measures that will be put into place to reduce the likelihood of coercion and to address confidentiality concerns.

4. REFERENCES

The Belmont Report; 45 CFR 46.111(b); 21 CFR 56.111(b); 45 CFR 46.107; 21 CFR 56.107; 45 CFR 46 Subpart B; 45 CFR 46 Subpart C; 45 CFR 46 Subpart D; 50 CFR Subpart D; OHRP FAQs prisoner research; OHRP FAQs on research involving children; Research Involving Persons with Mental Disorders That May Affect Decision Making Capacity (December 1998) http://bioethics.gov; OPRR Protecting Human Research Subjects Guidebook (1993), Chapter 6, Section J, “Students, Employees and Normal Volunteers”.

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SC 502 RESEARCH WITH TEST ARTICLES

1. PURPOSE

This section presents the policy concerning review of specific types of research that require additional considerations by the IRB.

2. POLICY STATEMENT

Certain categories of research involve either methodologies that might require additional considerations or for which there are federally mandated determinations that IRBs are required to make and document. These categories of research include, but are not limited to:

- Clinical investigations involving drugs or biologics
- Clinical investigations involving medical devices
- Gene therapy research
- Prospective research in emergency settings
- Expanded access of an investigational drugs or devices, including single patient treatment use
- Emergency use of an investigational article or product
- Humanitarian use devices

3. SPECIFIC POLICIES

3.1 Research Involving Drugs or Biologics

All research involving use of an FDA regulated drugs or biologics require submission of an Investigational New Drug Application to the FDA unless the research meets the criteria for exemption from the requirements as outlined in the applicable regulations.

Exemption determinations may be made by the IRB, the School of Medicine's Office of Human Research, the Abramson Cancer Center in accordance with written policies and procedures or may be determined by the FDA in response by the sponsor or Principal Investigator.

For sponsored research, applications for research on the use of a drug, unless that research is exempt from the IND regulations, must be accompanied by documentation from the FDA that includes a valid IND number. The IND number must either match the number on the sponsor protocol with the same title as the proposed research, or be listed on communication from the sponsor specific to the proposed research, or on communication with the FDA.

3.2 Research Involving Medical Devices

Research with devices falls into three categories:

- Investigations of significant risk devices to determine safety and effectiveness of the device
- Investigations of non-significant risk devices to determine safety and effectiveness of the device
- Investigations exempted from the IDE regulations

The convened IRB (or Executive Chair or designee if the review is expedited) will determine whether the study presents a significant risk or a non-significant risk of harm to study participants. This assessment will be based on the information provided by the investigator and/or the sponsor.

The IRB’s risk determination will be documented in the IRB meeting minutes. If an investigator submits a Non Significant Risk research protocol that is determined by the IRB to be a Significant Risk study, the investigator and the Sponsor, if necessary, will be notified in writing. No further action will be taken by the IRB on the research until the sponsor or investigator has met the requirements for a SR study described in 21 CFR 812.

3.2.1 Significant Risk Devices
Applications for research on the use of a significant risk device must be accompanied by documentation from the FDA that includes a valid IDE number. The IDE number must either match the number on the sponsor protocol with the same title as the proposed research, or be listed on communication from the sponsor specific to the proposed research, or on communication with the FDA.

3.2.2 Non-significant Risk Devices
When research is conducted to determine the safety or effectiveness of a device, the organization confirms that the device fulfills the requirements for an abbreviated IDE (21 CFR 812.2(b)(1)):

- The device is not a banned device;
- The sponsor labels the device in accordance with 21 CFR 812.5;
- 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, consent under 21 CFR 50 and documents it, unless documentation is waived;
- The sponsor complies with the requirements of 21 CFR 812.46 with respect to monitoring investigations;
- The sponsor maintains the records required under 21 CFR 812.140(b) (4) and (5) and makes the reports required under 21 CFR 812.150(b) (1) through (3) and (5) through (10);
- The sponsor ensures that participating investigators maintain the records required by 21 CFR 812.140(a)(3)(i) and make the reports required under 21 CFR 812.150(a) (1), (2), (5), and (7); and
- The sponsor complies with the prohibitions in 21 CFR 812.7 against promotion and other practices.

If the investigator applies to the IRB for a non-significant risk determination for a device study, but the IRB determines that the device is significant risk, the IRB will notify the investigator and the sponsor, if appropriate.
3.2.3 Investigations exempted from IDE regulations: Clinical investigations that are exempt from IDE regulations still require IRB review and approval. An investigation of a medical device in human participants’ research that is exempt from the IDE regulations must fall into one of the following categories:

- A device legally marketed in the US that is used or investigated in accordance with the indications in the FDA-approved labeling.
- 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 (that is, an in vitro diagnostic device) if the testing:
  - Is noninvasive
  - Does not require an invasive sampling procedure that presents significant risk,
  - Does not by design or intention introduce energy into a subject, and
  - 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 participants at risk.
- A custom device as defined in 21 CFR 812.3(b), unless the device is being used to determine safety or effectiveness for commercial distribution.

3.3 Gene Therapy Research
Gene therapy research may require special considerations. If the project involves gene transfer (administration of recombinant vectors) to human participants for other than clinical purpose review by the Recombinant DNA Advisory Committee (RAC) may be required. The FDA must review any such study prior to final IRB approval. In addition, the protocol will require review by the University of Pennsylvania Biosafety Committee and may require review by the University’s Human Research Advisory Committee.

3.4 FDA Regulated Prospective Research in Emergency Settings

The IRB, with the concurrence of a licensed physician who is either a member of IRB or a consultant and who is not participating in the research being reviewed, may waive the requirement for informed consent in certain emergency research if it finds and documents the following:

The research activity is subject to the regulations codified by the Food and Drug Administration (FDA) at 21 CFR Part 50 and will be carried out under an investigational new drug application (IND) or investigational device exemption (IDE).
The application clearly identifies the protocols that will include participants who are unable to consent.

The protocol is performed under a separate IND or IDE and clearly identifies such protocols as protocols that may include participants who are unable to consent.

The submission of those protocols in a separate IND/IDE is required even if an IND for the same drug product or an IDE for the same device product already exists.

3.3.1 The human participants are in a life-threatening situation, available treatments are unproven or unsatisfactory, and the collection of valid scientific evidence, which may include evidence obtained through randomized placebo-controlled investigations, is necessary to determine the safety and effectiveness of particular interventions.

3.3.2 Obtaining informed consent is not feasible because:

   The participants will not be able to give their informed consent as a result of their medical condition;

   The intervention under investigation must be administered before consent from the participants’ legally authorized representatives is feasible; and

   There is no reasonable way to identify prospectively the individuals likely to become eligible for participation in the clinical investigation.

3.3.3 Participation in the research holds out the prospect of direct benefit to the participants because:

   Participants are facing a life-threatening situation that necessitates intervention;

   Appropriate animal and other pre-clinical studies have been conducted, and the information derived from those studies and related evidence support the potential for the intervention to provide a direct benefit to the individual participants; and

   Risks associated with the investigation are reasonable in relation to what is known about the medical condition of the potential class of participants, the risks and benefits of standard therapy, if any, and what is known about the risks and benefits of the proposed intervention or activity.

3.3.4 The clinical investigation could not practicably be carried out without the waiver.

3.3.5 The proposed investigation or research plan defines the length of the potential therapeutic window based on scientific evidence, and the investigator has committed to attempting to contact a legally authorized representative for each subject within that window of time and, if feasible, attempting to asking the legally authorized representative contacted for consent within that window rather than proceeding without consent.

The investigator will summarize efforts made to contact legally authorized representatives and make this information available to the IRB at the time of continuing review.
3.3.6 The IRB has reviewed and approved informed consent procedures and an informed consent document consistent with 21 CFR 50.25. These procedures and the informed consent document are to be used with participants or their legally authorized representatives in situations where use of such procedures and documents is feasible.

The IRB has reviewed and approved procedures and information to be used when providing an opportunity for a family member to object to a subject's participation in the clinical investigation.

3.3.7 Additional protections of the rights and welfare of the participants will be provided, including, at least:

Consultation (including, where appropriate, consultation carried out by the IRB) with representatives of the communities in which the clinical investigation will be conducted and from which the participants will be drawn;

Public disclosure to the communities in which the clinical investigation will be conducted and from which the participants will be drawn, prior to initiation of the clinical investigation, of plans for the investigation and its risks and expected benefits;

Public disclosure of sufficient information following completion of the clinical investigation to apprise the community and researchers of the study, including the demographic characteristics of the research population, and its results;

Establishment of an independent data monitoring committee to exercise oversight of the clinical investigation; and

If obtaining informed consent is not feasible and a legally authorized representative is not reasonably available, the investigator has committed, if feasible, to attempting to contact, within the therapeutic window, the subject's family member who is not a legally authorized representative, and asking whether he or she objects to the subject's participation in the clinical investigation. The investigator will summarize efforts made to contact family members and make this information available to the IRB at the time of continuing review.

The study plan must assure that, at the earliest feasible opportunity, each subject, or if the subject remains incapacitated, a legally authorized representative of the subject, or if such a representative is not reasonably available, a family member, of the subject's inclusion in the clinical investigation, the details of the investigation and other information contained in the informed consent document.

The study plan must assure that there is a procedure to inform the subject, or if the subject remains incapacitated, a legally authorized representative of the subject, or if such a representative is not reasonably available, a family member, that he or she may discontinue the subject's participation at any time without penalty or loss of benefits to which the subject is otherwise entitled. If a legally authorized representative or family member is told about the clinical investigation and the subject's condition improves, the subject is also to be informed as soon as feasible. If a subject is entered into a clinical investigation with waived consent and the subject dies before a legally authorized
representative or family member can be contacted, information about the clinical investigation is to be provided to the subject's legally authorized representative or family member, if feasible.

3.3.8 If the IRB determines that it cannot approve a clinical investigation because the investigation does not meet the criteria in the exception provided above of this section or because of other relevant ethical concerns, the IRB will document its findings and provide these findings promptly in writing to the clinical investigator and to the sponsor of the clinical investigation.

3.5 HHS Regulated Prospective Research in Emergency Settings

For research that not FDA regulated, requests for waivers of informed consent will be evaluated in accordance with 45 CFR 46.116 and 117 and the OHRP Guidance on Informed Consent Requirements in Emergency Research.

3.6 Emergency Use of Investigational Article or Product

An investigational article may be used in an emergency prior to IRB review, provided that the patient is in a life-threatening situation in which no standard acceptable treatment is available, and in which there is not sufficient time to obtain IRB approval.

Such emergency use is reported to the IRB within 5 working days, and any subsequent use of the test article is subject to IRB review. The report can be submitted via an official IRB application or can be provided as an email or attachment to an email for documentation purposes. This report should be submitted to the Director or Associate Director for consideration.

In such a situation, obtaining informed consent shall be considered feasible except in certain emergency situations where the investigator has adequately documented the necessary exception under the guidelines described in 21 CFR 50.23. The investigator must submit documentation to the IRB for review by the IRB Executive Chair within 5 working days after emergency use of the test-article. In review of the documentation, the IRB will ensure that the investigator and a physician not otherwise participating in the clinical investigation have adequately certified the following in writing prior to use of the test-article:

The human subject was confronted by a life-threatening situation necessitating the use of the test article.

Informed consent could not be obtained from the subject because of an inability to communicate with, or obtain legally effective consent from, the subject.

Time was not sufficient to obtain consent from the subject's legal representative.

There was available no alternative method of approved or generally recognized therapy that provided an equal or greater likelihood of saving the life of the subject.
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, prior to administering the test-article, to obtain an independent physician’s opinion, the determinations of the investigator must be reviewed in writing within 5 days after the use of the test article by a physician not otherwise participating in the clinical investigation. In this event, a copy of the independent review must be submitted to IRB within 5 working days after the use of the test article.

3.5.1 The IRB Executive Chair will review prior notifications to determine that the circumstances of the use follow FDA regulations.

3.5.2 Under FDA regulations, patients given emergency use test articles are considered research participants and data from the emergency use may be used in research through reporting to the sponsor and the FDA. Under HHS regulations, whenever emergency care is initiated without prior IRB review and approval, the patient may not be considered to be a research subject and the data derived from use of the test article may not be used in a prospective systematic investigation designed to develop or contribute to generalizable knowledge.

3.7 Humanitarian Use Devices

Humanitarian use devices (HUD) are intended to benefit patients by providing treatment or diagnosis of diseases that affect fewer than 4,000 individuals in the US per year. The IRB will conduct both initial and continuing review and approve the local use of a HUD. HUD applications will be received either via HS-ERA or may be allowed to be submitted as a paper application.

4. REFERENCES

21 CFR 812; 21 CFR 814; FDA Device Advice; FDA Information Sheets, Medical Devices; 21 CFR 50.24; Federal Register 61(192): 51531-51533; FDA Draft Guidance, Exception from Informed Consent Requirements for Emergency Research, August 29, 2006; OHRP Guidance, informed consent requirements in emergency research, October 31, 1996; IRB Guidance Significant Risk Device Determinations

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1. PURPOSE

This policy describes the IRB actions that must be communicated to the investigator and the importance of open communication among IRBs, investigators, staff, and university committees and officials.

2. POLICY STATEMENT

It is important that staff, participants, and other interested parties have a means of communicating information about the conduct of a research project directly to the appropriate institutional officials. It is vital that IRB members, department heads, and other officials with responsibility for oversight of research have open and ready access to the highest levels of authority within the institution. IRB staff and members do not have the opportunity to communicate directly with study participants. The researcher and research staff interacts with participants; therefore it is vital that open and frequent communication with the investigative team be maintained.

3. SPECIFIC POLICIES

3.1 INVESTIGATOR Notifications

3.1.1 Initial Submission: The investigator will be notified in writing of the IRB’s decision as soon as possible after the meeting. If the approval is withheld pending clarification, based upon receipt and review of requested materials or responses from the investigator or sponsor, the IRB must receive the response within a reasonable timeframe of the date of notification.

3.1.2 Renewals and Revisions: Investigators will be notified in writing as soon as possible as to the action taken by the IRB for any continuing reviews or revisions.

3.1.3 Notification of Final Approval: Investigators will be notified in writing of the final approval. The IRB-approved consent form will be dated with the period of approval and submitted to the investigator with the final approval letter. Standard conditions for continued approval include, but are not necessarily limited to:

- Informed consent is obtained and documented.
- The IRB is notified of serious adverse events within appropriate periods.
- Changes to the protocol, and deviations from the protocol are reported.
- Continuing Review and Request for Re-approval Reports are submitted to the IRB.

3.1.4 Disapproval: correspondence will provide the reason(s) for disapproval and will give the investigator an opportunity to respond in person and in writing to the IRB.

3.2 Investigator Appeal of IRB Action

If an investigator disagrees with a determination of the IRB (substantive or procedural), the investigator may appeal to the Senior Vice Provost for Research. An appeal must be
in writing, state the decision being appealed and the basis of the appeal, and be filed within 30 calendar days of the decision. The Vice Provost may use his or her sole discretion to determine the process for the appeal and grant or deny the appeal, including:

- Notifying the IRB of the appeal and requesting a response and relevant information from its records before making a decision
- Appointing a fact-finder to review the matter and prepare a report for review by the IRB
- Seeking assistance from consultants or internal administrative units such as the Office of the General Counsel who will report their findings to the IRB
- Requesting that the IRB consider additional information or actions in relation to the decision under appeal

The investigator is bound by the IRB decision prior to and during the appeal. The decision on an appeal by the Vice Provost for Research is final.

If, after taking into consideration any additional information, the IRB decides to disapprove a protocol or requires protocol modifications as a condition for approval, neither the Senior Vice Provost for Research, the Provost, nor any other any University of Pennsylvania official or committee may overturn the IRB’s decision.

3.3. Noncompliance

The IRB, through the Director, Human Research Protections and the IRB Executive Chair will notify the investigator in writing, detailing the alleged noncompliance, specifying corrective action, and stating the consequences. Copies of such correspondence shall also be sent to the sponsor, the individual’s supervisor, Dean and the Senior Vice Provost for Research.

The IRB’s responsibility is to protect the rights and welfare of research participants, which could be placed at risk if there is scientific misconduct on the part of an investigator or any member of the investigative team. It is, therefore, the duty of the IRB to be receptive to and act on good faith allegations of scientific misconduct. Allegations of Misconduct in Science, as defined by University Policy must be referred to the Senior Vice Provost for Research.

4. REFERENCES

45 CFR 46.109; 21 CFR 56.109

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CO 602 REPORTING REQUIREMENTS

1. PURPOSE
This policy describes the IRB actions that must be communicated to various parties involved in the research program.

2. POLICY STATEMENT
The University of Pennsylvania complies with all applicable local, state, and federal regulations that pertain to reporting requirements. Federal regulations require institutions to have written procedures in place for prompt reporting to the IRB, appropriate institutional officials, and department and agency heads of:

- Unanticipated problems that involve risks to participants or others;
- Serious or continuing noncompliance with regulations; and,
- Suspension or termination of IRB approval of research; and

The specific procedures for investigating and making pertinent determinations concerning those situations are addressed in SOP RR 404.

The Institutional Official, IRB Executive Chair, Director, Human Research Protections, and the Office of the General Counsel will review the report.

3. SPECIFIC POLICIES

3.1 Communication to Institutional Official of IRB Actions
All IRB minutes shall be available to the Institutional Official.

3.2 Communications to Others

3.2.1 Prospective Emergency Research: If the IRB determines that it cannot approve a clinical investigation because the investigation does not meet the criteria in 21 CFR 50.24 Exemption from Informed Consent Requirements for Emergency Research, notification of disapproval will be conveyed to the sponsor as well as the investigator.

3.2.2 Device studies: If the IRB determines that a study submitted as a non significant risk present significant risk, the IRB will notify the investigator.

3.2.3 Other Reportable Events:

The IRB determines that a problem represents an unanticipated problem that involves risks to participants or others;

The IRB or institutional official suspends or terminates its approval of research; or,

The IRB determines that noncompliance represents serious or continuing noncompliance.
3.3 Report Content
Following a complete investigation of the situation or incident, the IRB Director will prepare a final report that includes the following:

- An overview of the situation or incident
- A description of the manner in which the investigation was conducted
- The findings of the investigation
- A full explanation as to why and how the incident occurred
- The actions taken, including any corrective actions
- Any sanctions taken

The IRB Director, IRB Executive Chair, Chair, the Institutional Official, and the General Counsel, will review the report. The report will be signed by the Institutional Official.

3.4 Report Recipients
The unanticipated event reported by the Institutional Official, will be shared with government agencies and sponsors to the extent legally and contractually required, and with any others at the discretion of the IRB and the Institutional Official. The report will be sent to the following individuals and agencies:

- Office of Human Research Protections (OHRP) when the research is subject to regulation by the OHRP
- Food and Drug Administration (FDA) when the research is subject to regulation by the FDA
- Funding agency when funded by a government entity (e.g., the Departments of Defense, Education, and Justice require copies of such reports)
- Licensing and accrediting bodies, where the report or some portion thereof implicates standards or regulations administered by those bodies
- IRB Chair and members
- Principal investigator (PI)
- PI's Department Chair or supervisor
- The Office of Research Services, when the research is funded by a grant or contract
- Any other external sponsor, when the research is sponsored
A copy of the report is to be placed in the protocol file, as well as any other files that are maintained during an investigation to determine whether an event is reportable.

### 3.5 Reporting Timeframe

The Institutional Official will be notified within 5 working days of events that meet these reporting requirements.

The Institutional Official will report the event to appropriate federal department and agency heads. If federally funded, the Institutional Official will submit any report on behalf of the institution.

### 4. REFERENCES

45 CFR 46.103; 21 CFR 56.108; FDA Reporting Requirements: suspension or termination of IRB approval; OHRP compliance overview

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IC 701  GENERAL REQUIREMENTS AND DOCUMENTATION OF INFORMED CONSENT

1. PURPOSE

This policy describes the general requirements for obtaining informed consent and subject authorization and for documentation of informed consent and subject authorization.

2. POLICY STATEMENT

Informed consent must be legally effective and prospectively obtained. Except as described at IC 702 no investigator may involve a human being as a research subject unless he or she has obtained legally effective informed consent of the subject or the subject's legally authorized representative. Consent shall be sought only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence.

Subject authorization must be obtained for prospective use or disclosure of protected health information for research conducted within one or more of the covered entities of the University of Pennsylvania. Except as described at IC 702 no investigator may involve a human being as a research subject unless he or she has obtained legally effective authorization of the subject or the subject's legally effective representative.

The IRB requires documentation of informed consent by use of a written consent form approved by the IRB and signed by the subject or the subject's legally authorized representative. Authorization may be obtained by the use of a separate HIPAA Authorization Form, or combined with an IRB-approved informed consent document.

3. SPECIFIC POLICIES

3.1 The Consent Form May be:

3.1.1 A written consent document that embodies the elements of informed consent and if necessary the required elements of HIPAA authorization. This form may be read to the subject or the subject's legally authorized representative, but, in any event, the investigator shall give either the subject or the representative adequate opportunity to read it before it is signed. Each participant shall receive a copy of the signed consent document or signed combined consent authorization document.

3.1.2 A "short form" written consent document stating that the elements of informed consent as required have been presented orally to the subject or the subject's legally authorized representative. The short form may be used when an investigator unexpectedly encounters a subject who does not speak English. When this method is used, there will be a person appropriately trained in the consent process to witness the oral presentation. The IRB will approve the translated short form and the process for translation prior to use. Only the subject or the representative signs the short form itself. However, the translator will sign a copy of the stamped informed consent form, and the person actually obtaining the consent will appropriately document the consent process. A copy of the stamped informed consent form shall
be given to the subject or the representative in addition to a copy of the signed short form.

### 3.2 Required Elements of Informed Consent:

3.2.1 A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental or investigational.

3.2.2 A description of any reasonably foreseeable risks or discomforts to the subject, if any.

3.2.3 A description of any benefits to the subject or to others which may reasonably be expected from the research, if any.

3.2.4 A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject.

3.2.5 A statement describing the extent to which, if any, the confidentiality of records identifying the subject will be maintained and that notes the possibility that the Food and Drug Administration and representatives of the IRB may inspect the records.

3.2.6 For research involving more than minimal risk, or if the research proposes compensations for research related injury, an explanation as to whether any compensation and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained. The informed consent document must not waive or appear to waive the rights of the participant or release or appear to release those conducting the study from liability for negligence.

3.2.7 An explanation of whom to contact for answers to pertinent questions about the research and research participants' rights, and whom to contact in the event of a research-related injury to the subject.

3.2.8 A statement that participation is voluntary, that refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and that the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.

### 3.3. Additional Elements

3.3.1 When appropriate, one or more of the following elements of information shall also be provided to each subject:

A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus if the subject is or may become pregnant) which are currently unforeseeable.

Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent.

Any additional costs to the subject that may result from participation in the research.
The consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject.

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.

The approximate number of participants involved in the study.

3.4 Other Requirements

3.4.1 Second Person

The language of the consent document should be in the second person style so the consent form conveys a dialogue with information being provided and that there is a choice to be made by the subject rather than presumption of the subject's consent with the use of the first person style.

3.4.2 Lay Language

The information provided in the informed consent documents must be in language understandable to the subject. The informed consent document should not include complex language that would not be understandable to all participants. Technical and scientific terms should be adequately explained using common or lay terminology.

3.4.3 Exculpatory Language

Informed consent documents may not contain any exculpatory language through which the subject is made to waive or appear to waive legal rights or releases or appears to release the investigator, the sponsor, the university from liability for negligence.

3.4.4 FDA-Regulated Test Articles

For all research involving test articles regulated by the U.S. Food and Drug Administration (FDA), informed consent documents should include a statement that the purpose of the study includes evaluation of the safety or the safety and the effectiveness of the test article. The consent form must also include a statement that the FDA has access to the subject's medical records.

3.4.5 IRB review of consent process.

The IRB will take the following into consideration when reviewing the protocol and consent form:

- Who will conduct the consent process.
- Matters of timing of obtaining informed consent and any waiting period between informing the subject and obtaining consent.
- That the process provides ample time for the person conducting the consent interview and the prospective subject to exchange information and ask questions.
3.4.6 When applicable: translations of consent documents will also be submitted for IRB approval and will be reviewed in an expedited manner. There are two options available to obtain approval of translated consent forms.

Option #1: The IRB-approved consent form is translated by the sponsor or site and submitted to the IRB. The IRB will have a member or consultant fluent in the language of the consent; review the translated document for accuracy. In their opinion it must match the English version.

Option #2: The investigator (or sponsor) may submit the IRB-approved version of the consent to a translator for translation. A second translator may then back translate the consent to the original English. Both original and back-translated consent must be submitted.

Option #3: The translator will submit a signed statement that the consent document is a true and accurate translation.

3.5 Observation of the Informed Consent Process

The IRBs have procedures for observation of the informed consent process in ongoing research, when appropriate. As part of the IRB oversight options, an IRB may require that a staff member or an outside third party observe the consenting of research participants to determine:

Whether the informed consent process has been appropriately completed and documented.

An IRB may require observation of the consent process for selected protocols. Examples of protocols that may require observation of the consent process include:

High risk studies;

Studies that involve particularly complicated procedures or interventions;

Studies involving potentially vulnerable populations (e.g., ICU patients, children);

Studies involving study staff with minimal experience in administering consent to potential study participants.

or,

Other projects where observation is determined to be required by the IRB.
4. REFERENCES

45 CFR 46.116; 21 CFR 50.20; FDA’s Information Sheets: guide to informed consent; OPRR Guidance, obtaining and documenting informed consent of participants who do not speak English

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IC 702 CONSENT WAIVERS

1. PURPOSE

This policy describes the requirements for waiver of certain or all elements of informed consent procedures and waiver of requirements for obtaining informed consent.

2. POLICY STATEMENT

The IRB may approve a consent procedure, which does not include, or which alters some or all of the elements of informed consent (above), or waives the requirement to obtain informed consent if the IRB finds that the research meets specific criteria.

For FDA regulated research, the IRB may not waive informed consent except under the narrow provisions in 21 CFR 50.23 governing emergency research and as clarified in the FDA’s Guidance on Informed Consent for in vitro Diagnostic Device Studies Using Leftover Human Specimens that are Not Individually Identifiable, April 25, 2006.

3. SPECIFIC POLICIES

3.1 Exemptions or Waivers of One or More Requirements of Informed consent

The IRB may approve an informed consent procedure which does not include, or which alters some or all of the elements of informed consent or waives the requirement to obtain informed consent provided the IRB finds and documents that:

- the research involves no more than minimal risk to the participants and, the waiver or alteration will not adversely affect the rights and welfare of the participants, the research could not be practicably be carried out without the waiver or alteration and; whenever appropriate, the participants will be provided with additional pertinent information after participation

The IRB may approve an informed consent procedure which does not include, or which alters some or all of the elements of informed consent or waives the requirement to obtain informed consent provided the IRB finds and documents that:

- the research involves no more than minimal risk to the participants and, the waiver or alteration will not adversely affect the rights and welfare of the participants, the research could not be practicably be carried out without the waiver or alteration and; whenever appropriate, the participants will be provided with additional pertinent information after participation. The IRB application should provide an explanation as to why the study meets all of the four criteria listed above.

For additional information, please see SOP IC 702.
4. REFERENCES


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IC 703 DOCUMENTATION

1. PURPOSE

This policy describes the requirements for documentation of informed consent and circumstances when the IRB may waive the requirement to document informed consent.

2. POLICY STATEMENT

Unless specifically waived by the IRB, all participants, or their legally authorized representatives, must document that they are consenting to participate in any research project that is conducted at the University of Pennsylvania.

3. SPECIFIC POLICIES

Documentation of Informed Consent

Each subject or his/her legally authorized representative must sign and date a copy of the current IRB-approved consent form prior to enrollment or any participation in any phase of the study, unless the requirement is waived by the IRB as allowed, and be given a copy of the signed document.

The IRB may approve procedures for documentation of informed consent that involve (a) a written consent form signed by the subject; (b) a short form written consent form with oral presentation; or (c) in limited circumstances, waiver of signed written consent form.

Each of these three options is described in detail below. It is the responsibility of the IRB to determine which of the procedures described below is appropriate for documenting informed consent in protocols that it reviews. Generally, only option (a) will be appropriate.

3.1 Written Consent Form Signed by Subject or Legally Authorized Representative

In most circumstances, the IRB requires that informed consent is documented by the use of a written consent form approved by the IRB and signed by the subject or the subject's legally authorized representative. The investigator should allow the subject or the legally authorized representative adequate opportunity to read the consent document before it is signed. A copy of the document must be given to the person signing the form.

3.1.1 Mentally disabled or cognitively impaired participants: Studies involving participants who may have impaired decision-making capabilities may take place over extended periods. The IRB should consider whether periodic re-consenting of individuals should be required to ensure that a subject's continued involvement is voluntary. The IRB may require that investigators re-consent participants after taking into account the study’s anticipated length and the condition of the individuals to be included (e.g., participants with progressive neurological disorders). Additionally, the IRB should consider whether and when to require a reassessment of decision-making capacity.
3.1.2 The written informed consent document should embody, in language understandable to the participants of the study, all the elements necessary for legally effective informed consent (see section 701 3.2).

3.1.3 Participants who do not understand English should be presented with an informed consent document written in a language understandable to them.

3.2 Oral Presentation Using Short Form

The written informed consent document should embody, in language understandable to the participant, all the elements necessary for legally effective informed consent. Participants who do not speak English should be presented with an informed consent document written in a language understandable to them.

As an alternative to standard written informed consent documents, oral presentation of informed consent information may be used. In such cases, the subject must be provided with both:

A short form written informed consent document stating that the elements of consent have been presented orally to the subject or the subject’s legally authorized representative; and,

A written summary of the information that is presented orally.

3.2.1 A witness to the oral presentation is required. The witness must sign both the short form written informed consent document and a copy of the written summary. When this method is used the IRB must review the written summary.

3.2.2 The subject or the legally authorized representative must sign the short form written consent document.

3.2.3 The person obtaining consent must sign a copy of the written summary of the information that is presented orally. The person obtaining consent may not be the witness to the consent.

3.2.4 Participants Who Do Not Speak English. Where informed consent is documented using this short form procedure for non-English speaking participants, the written informed consent document should embody, in language understandable to the subject, all the elements necessary for legally effective informed consent.

When this procedure is used with participants who do not speak English, (i) the oral presentation and the short form written informed consent document should be in a language understandable to the subject; (ii) the IRB-approved English language informed consent document may serve as the summary; and (iii) the witness should be fluent in both English and the language of the subject.

The IRB will receive all foreign language versions of the short form as a condition of approval. The information in the protocol must match the information in the informed consent. Expedited review of these versions is acceptable if the protocol, the full English language informed consent document, and the English version of the short form document have already been approved by the convened IRB.
3.3 Waiver of Documentation

The IRB may waive the requirement for the investigator to obtain a signed consent form for some or all participants if the IRB finds that the only record linking the subject and the research would be the consent document and the principle risk would be potential harm resulting from breach of confidentiality.

The IRB may waive the requirement for the investigator to obtain written informed consent if the research presents no more than minimal risk of harm to participants and involves no procedures for which written consent is normally required outside of the research context.

In cases in which the documentation requirement is waived, the IRB may require the Principal Investigator to provide participants with a written statement regarding the research.

3.4 Use of Facsimile or Mail to Document Informed Consent

The IRB may approve a process that allows the informed consent document to be delivered by mail, facsimile or electronically to the potential subject or the potential subject’s legally authorized representative and to conduct the consent interview by telephone when the subject or the legally authorized representative can read the consent document as it is discussed. All other applicable conditions for documentation of informed consent must also be met when using this procedure.

4. REFERENCES

46 CFR 46.117; 21 CFR 50.27; FDA Information Sheets, a guide to informed consent

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IC 704 ASSENT

1. PURPOSE

This policy describes the requirements for assent of cognitively impaired adults and of children.

2. POLICY STATEMENT

The principle of respect for persons requires that the choice of an autonomous person be respected. Under the usual conditions of clinical research, this is accomplished by soliciting the informed consent of the prospective research subject. When prospective participants have diminished capacity to consent, the consent of the parent or legally authorized representative is required (see IC705). However, any individual capable of some degree of understanding (generally, a child of seven or older) should participate in research only with assent. When assent is required, however, the decision of the individual assenting should be binding.

The Department of Health and Human Services' (DHHS) Regulations for the Protection of Human Subjects (Title 45, Part 46 Subpart D of the Code of Federal Regulations) and the Food and Drug Administration (FDA) regulations for the Protection of Human Subjects (Title 21, Part 50, Subpart D) set standards for the informed consent process and assign Institutional Review Boards with the responsibility for ensuring that any research or clinical trials involving children meet the following criteria.

3. SPECIFIC POLICIES

3.1 Use of Assent:

In instances where the subject may not be capable of giving informed consent the IRB must find that adequate provisions are made for soliciting the assent of the subject when in the judgment of the IRB, the subject is capable of providing assent.

3.1.1 "Assent" means a subject's affirmative agreement to participate in research. Mere failure to object should not, absent affirmative agreement, be construed as assent.

3.1.2 In determining whether participants are capable of assenting, the investigator and the IRB shall take into account the age, maturity, and psychological state of the subject involved. This judgment may be made for all participants to be involved in research under a particular protocol, or for each subject, as the IRB deems appropriate. If the IRB determines that the capability of some or all of the participants 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 subject and is available only in the context of the research, the assent of the subject is not a necessary condition for proceeding with the research. Even where the IRB determines that the participants are capable of assenting, the IRB may still waive the assent requirement under circumstances in which consent may be waived as stated in section IC 702.3.1.

3.1.3. When the IRB determines that assent is required, it shall also determine whether and how assent must be documented.
3.2 Parental Permission and Assent for Research involving Children

3.2.1 When children are involved in research, the regulations require the assent of the child and the permission of the parent(s), in place of the consent of the participants.

Given that children have not reached their full intellectual and emotional capacities and are legally unable to give valid consent, involving children in research requires the permission of their parents or legally authorized representatives. The IRB will determine whether the permission of both parents is necessary, and the conditions under which one parent may be considered "not reasonably available". In addition, the IRB will 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.

3.2.2 For research that is FDA regulated, children may be participants of research only if informed consent is obtained from the parents or legal guardian. For other research, parental permission may be waived in accordance with 45 CFR 46.116(c)(2)(d).

The regulations provide that an IRB may find that the permission of one parent is sufficient for research to be conducted if the research is no more than minimal risk or if the research involves greater than minimal risk but presents the prospect of direct benefit to individual participants. Where research is covered by §46.406 - 46.407 of the HHS regulations or §50.53 - §50.54 of the FDA regulations, both parents must give their permission, unless one parent is deceased, unknown, incompetent, or not reasonably available, or when only one parent has legal responsibility for the care and custody of the child.

3.2.3 The IRB will determine for each protocol - depending on such factors as the nature of the research and the age, status, and condition of the proposed participants - whether all or some of the children are capable of assenting to participation. Where appropriate, the IRB may choose to review on a case-by-case basis whether assent should be sought from given individual participants.

When the research offers the child the possibility of a direct benefit that is important to the health or well-being of the child and is available only in the context of the research, the IRB may determine that the assent of the child is not necessary. Additionally, in such circumstances a child's dissent, which should normally be respected, may be overruled by the child's parents, at the IRB's discretion.

When the IRB determines that the assent of the child is required, it will also determine that the provisions for obtaining and documenting assent are adequate.

3.2.4 The IRB will comply all federal regulations and also with state and local law.
4. REFERENCES

45 CFR 46.408 Subpart D; 21 CFR 50.55 Subpart D

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IC 705  SURROGATE CONSENT

1. PURPOSE

The purpose of this Policy is to provide guidelines for the IRB and investigators in proposing, conducting and reviewing research in participants with decisional impairments.

Informed Consent

Federal regulations require that the researcher obtain the legally effective informed consent of the subject or the subject's legally authorized representative prior to medical research. Federal law defers to state law to determine what surrogate is legally authorized to substitute consent. Pennsylvania law requires the informed consent of the subject or the subject's authorized representative before the administration of an experimental medication, the use of an experimental device, or the use of an approved medication or device in an experimental manner. Pennsylvania law also authorizes substituted consent to the performance of experimental biomedical or behavioral medical procedure or participation in any biomedical or behavioral experiment by the subject's court-appointed guardian pursuant to a court order issued after fact finding. Finally, Pennsylvania statutory law further authorizes a person named in the subject’s power of attorney to consent to medical, therapeutic and surgical procedures.

While Pennsylvania statutory law does not explicitly authorize substituted consent in the absence of a power of attorney or court-appointed guardian, case law strongly supports substituted consent by close family members when patients lack capacity to make medical decisions. When the subject is unable to give informed consent, the subject's close family member or significant partner is in the best position to determine the wishes of the subject regarding participation in therapeutic research.

If the research poses no more than minimal risk, and is not FDA regulated, the investigator and IRB may consider waiver of the requirement for informed consent as described in Policy 702.

2. POLICY STATEMENT

It is the policy of the University of Pennsylvania Institutional Review Boards to protect the research subject's right to autonomy. It is also the IRB’s policy to protect those with diminished autonomy or reduced capacity to consent to research or to provide authorization for the use and/or disclosure of their protected health information.

However, the IRB recognizes that substituted consent is necessary in order to offer experimental treatments to participants incapable of making autonomous choices where the research poses more than minimal risk, but where the risks to the subject are reasonable in relationship to any anticipated benefits to participants, and to the importance of the knowledge that may reasonably be expected to result from the research. Accordingly, the following procedure will be followed when the researcher determines that a patient is unable to give informed consent for participation in research and/or is unable to give a HIPAA Authorization.
3. SPECIFIC POLICIES

3.1 Submission and Review of Protocols Involving Participants Unable to Provide Informed Consent for biomedical research.

3.1.1 The investigator shall be responsible for making the determination as to whether the research protocol shall or shall not enroll participants incapable of giving informed consent.

3.1.2 If it is anticipated that the research will involve individuals with diminished capacity to consent, the protocol shall describe the process by which the investigator will determine and document the individual’s ability to provide consent. The protocol shall also describe the process by which the investigator shall obtain assent/surrogate consent.

3.1.3 The IRB shall review such protocols and determine and document whether:

- the risks to the participants are reasonable in relationship to any anticipated benefits to participants and to the importance of the knowledge that may reasonably be expected to result; and,

- the description of the informed consent process to be used is appropriate to the risk of the protocol as assigned by the IRB; and,

- the appropriateness of the assent/surrogate consent content and process; and,

- the appropriateness and effectiveness of the HIPAA Authorization whether it is included as part of the informed consent or assent or provided as a stand-alone document; and,

- all other aspects of the proposed research as provided in Policies RR 402-404 are appropriate.

3.1.4 If the IRB determines that the risk to the subject is greater than minimal risk, it may require additional safeguards to insure that the rights of such participants are protected. Such additional protections may include, but are not limited to:

Witnessing of assent/informed surrogate consent by a third party.

Independent assessment of subject’s ability to assent, and/or surrogates ability to consent by an independent subject advocate or subject’s primary care physician consistent with legal requirements.

Independent documentation of the informed consent process.

The appropriateness of the individual serving as the personal representative/surrogate.

Other safeguards as appropriate.
3.1.5 The IRB shall not approve any research involving the use of surrogate consent if they determine that the risk to the subject is high in relationship to anticipated benefits, if any, to participants, and the importance of the knowledge that may reasonably be expected to result.

3.2 Determination of Participants Ability to Provide Informed Consent in a Research Study

3.2.1 The investigator shall be responsible for determining whether an individual subject can provide informed consent.

3.2.2 The investigator will document in the research record, as thoroughly as possible, the reason for the subject's inability to provide informed consent.

3.2.3 The investigator shall apply and document any additional safeguards as directed by the IRB.

3.3 Individuals Able to Provide Effective Surrogate Consent and/or Surrogate

3.3.1 For research conducted in the Commonwealth of Pennsylvania, following individuals may be considered legally authorized representatives of the subject and capable of providing surrogate consent:

- A court-appointed guardian authorized to consent to the subject's participation in the protocol in a current court order issued within the subject's jurisdiction.
- A health care agent appointed by the subject in a power of attorney.
- A "health care representative" when the subject cannot speak for themselves and where there has been no guardian appointed by the court or health care power of attorney designated by the patient. (PA Act 169). Any member of the following classes, in descending order of priority, who is reasonably available may act as the subject’s health care representative.
  - The spouse (unless an action for divorce is pending) and adult child or children of another relationship.
  - Adult children (18 years of age or older).
  - A parent.
  - An adult sibling.
  - An adult grandchild
  - An adult who has knowledge of the patient’s preferences and values, including but not limited to religious and moral beliefs, who assess how the patient would make decisions.

3.3.2 For human participants research conducted in other states or internationally, requests for the use of surrogate consent will be considered by the IRB in accordance with local state or international law. The investigator or the IRB will contact the legal advisor to the IRB within the Office of General Counsel to assist in determining who under local law may serve as a legally authorized individual.
3.4 Responsibilities of the Authorized Individual in the Surrogate Consent Process

3.4.1 The surrogate should base his or her decision on the subject's expressed wishes or, if unknown, what the subject would have desired in light of his or her prognosis, values, and beliefs. In the event of a disagreement among potential patient surrogates, an attempt to reach consensus shall be made through the intervention of a subject advocate appointed by the IRB if available. If consensus is not possible, a court appointed guardian should be obtained before the subject is enrolled in the study. When a surrogate provides consent, for a subject’s participation in a research project it is preferable for that surrogate to remain the responsible party for all subsequent research decisions including but not limited to withdrawal of consent.

3.5 Requirement for Re-Consent

3.5.1 If at any time after the subject is enrolled in a study through surrogate consent, he or she regains the capacity to provide informed consent, the investigator shall obtain the legally effective informed consent of the subject for continued participation in the research.

3.5.2 Decision-making capacity of participants may fluctuate. The consent process should be ongoing and involve the legally effective representative if at any time the investigator believes that the subject is unable to provide informed consent for continuing in a research project in which the subject initially gave informed consent.

4. REFERENCES

Fiori, 543 Pa. 592, 673 A.2d 905 (1996); PA Act 169

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RI 801       IRB-REQUIRED INVESTIGATOR ACTIONS

1. PURPOSE

This policy describes what the IRB requires of investigators in the conduct of research.

2. POLICY STATEMENT

The regulations require that organizations have written procedures for ensuring prompt reporting to the IRB, appropriate institutional officials, and appropriate federal officials of unanticipated problems involving risks to participants or others, defined as an untoward event that is serious, unexpected and related to the research. Events meeting the definition must be reported under this policy to the appropriate regulatory oversight agency. For research subject to the FDA regulations, reportable events include a subset of serious adverse events as defined by FDA regulations.

It is the Investigator's responsibility to keep the IRB informed of unexpected, protocol related, non-serious and serious adverse events or unanticipated problems that pose risk to participants or others. An investigator is responsible for the accurate documentation, investigation and follow-up of all possible study-related adverse events. Investigators are also responsible for informing government funding agencies and other sponsors of any unanticipated serious events, as appropriate.

3. SPECIFIC POLICIES

3.1 IRB Review of Research

All human participants' research that is conducted by or under the direction of any employee, faculty, staff, student or agent of the University of Pennsylvania in connection with his or her institutional responsibilities must be reviewed by the IRB.

3.2 Informed Consent

The investigator must obtain informed consent from participants prior to their enrollment into the research unless the IRB has waived this requirement. The investigator must use the informed consent document approved by the IRB. Approval dates are indicated on the first page of the consent document. Consent documents are valid only during the dates indicated on the form; and the investigator may use the forms only during the period for which they are valid. Investigators must follow University guidelines for obtaining consent.

3.3 Reporting of Unanticipated Problems Increasing Risks to Participants or Other Reportable Events

The IRB must be informed of unanticipated problems involving risks to participants or others and other reportable events as defined by SOP RR 404.

3.4 Changes in Approved Research

Changes in approved research, during the period for which approval has already been given, may not be initiated without IRB review and approval except where necessary to
eliminate apparent immediate hazards to human participants. Investigators or sponsors must submit requests for changes to the IRB in writing. Upon receipt of the protocol change, the IRB Executive Chair or designee will determine if the revision meets the criteria for expedited review. Minor changes involving no more than minimal risk to the subject will be reviewed by the expedited review process.

3.5 Periodic and Final Reports

The length of time approval is given to a research protocol will be no more than one year, and is dependent on the risk involved with the research. Investigators are responsible for requesting renewal in anticipation of the expiration of the approval period. Investigators or their designees and/or sponsors are required to provide a periodic report regarding their investigation prior to the end of the approval period, or upon completion of the study. In addition, if so determined by the Board, the investigator is required to submit Interim Reports. For renewal of approval, an IRB notification will be provided within 90 days from study expiration date for convened review studies and 45 days for expedited review studies. The sponsor and/or the investigator or his/her designee may submit final reports of study completion.

3.6 Student Conducted Research

Directed or independent Research Projects (e.g., honors or graduate theses), which employ systematic data collection with the intent to contribute to generalizable knowledge require IRB review and approval.

For example, activities that must be reviewed and approved by the IRB include: (i) All master’s theses and doctoral dissertations that involve human participants; and (ii) All projects that involve human participants and for which findings may be published or otherwise disseminated.

Classroom activities, the goal of which is to provide training in research methodology do not require IRB review and approval. Examples are provided in the IRB Guidance: Is IRB Review Required?

All students/fellows applying for IRB review must obtain the signature of their faculty advisor.

3.7 Financial Conflicts of Interest

The protection of human participants requires objectivity in communicating risks, selecting participants, promoting informed consent, and gathering, analyzing and reporting data.

All investigators must report on their application to the IRB whether they or any other person responsible for the design, conduct, or reporting of the research has any economic interest in, or acts as an officer or a director of any outside entity whose financial interests would reasonably appear to be affected by, the research. The IRB will determine whether such conflicts will be disclosed to participants and will refer disclosures of financial conflicts of interest to the Research Conflicts of Interest Standing Committee for management. IRB approval will be contingent upon review and approval of the management plan, if applicable.
4. REFERENCES

None

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RI 802 PRINCIPAL INVESTIGATORS

1. PURPOSE

This policy describes those individuals who may serve as principal investigators on research protocols involving human participants.

2. POLICY STATEMENT

All research involving the use of human participants conducted at the University of Pennsylvania must be conducted by individuals appropriately trained and knowledgeable concerning the protection of human participants.

3. SPECIFIC POLICIES

3.1 Faculty

All human participants research that is conducted by or under the direction of any employee, faculty, staff, student or agent of the University of Pennsylvania in connection with his or her institutional responsibilities must be under the direct supervision of a member of the Standing Faculty, Clinician-Educator or Associate Faculty of the University. Generally, faculty members are considered to be sufficiently knowledgeable to supervise and/or conduct research as determined by their appointment. However, the IRB may at its discretion determine that a faculty member lacks sufficient expertise to carry out any particular research project based on the risks and benefits to the research participants.

When all research activities take place at the Philadelphia Veterans Administration Medical Center (VAMC) and the research is conducted by an investigator whose academic appointment is at the University of Pennsylvania but whose primary hospital appointment is at the VAMC, the research proposal does not have to be submitted to the Penn IRB.

When all research activities take place at the Children's Hospital of Philadelphia (CHOP) and the research is conducted by an investigator whose academic appointment is at the University of Pennsylvania but whose primary hospital appointment is at the CHOP, the research proposal does not have to be submitted to the Penn IRB. Other exceptions are elaborated in the CHOP-Penn IRB Reciprocity Agreement.

3.2 Non Faculty, Academic Support Staff, Postdoctoral Fellows, Graduate Students, and Undergraduate Students

Research conducted by University students or employees must be under the direction of a faculty member as defined in 3.1.

3.3 Other Individuals

Individuals not meeting the above criteria as principal investigators may, by demonstrating sufficient cause and necessary expertise, petition the IRB Executive Chair and the IRB Director for permission to submit an application for approval to serve as a principal investigator of a human research protocol. If the person is permitted to
function in this role, their listing as Principal Investigator on the protocol will document this decision.

### 3.6 Training of Investigators

The IRB shall establish standards of training required for all individuals engaged in human research.

### 4. REFERENCES

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QA 901  QUALITY ASSURANCE AND IMPROVEMENT PROGRAM

1. PURPOSE

This section states the policy concerning quality assurance measures for the IRB.

2. POLICY STATEMENT

Quality assurance and improvement of the daily operations of the IRB ensure that they effectively support the IRB's mandate. Therefore, the QA/QI program consists of three components:

- Periodic review of IRB records; and,
- Regular review and assessment of procedures.
- Training and continuing education of IRB staff.

3. SPECIFIC POLICIES

The IRB Director has the authority to implement a QA/QI program and act on identified deficiencies by implementing corrective action plans. The IRB Director and Associate Director, in conjunction with Senior IRB staff, are responsible for oversight of the IRB's quality improvement activities. Specific IRB personnel may have designated QA/QI responsibilities.

4. REFERENCES

None

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QA 902  AUDITS BY REGULATORY AGENCIES

1. PURPOSE

This section states the policy concerning preparation for regulatory audits of the IRB and appropriate behavior toward regulators.

2. POLICY STATEMENT

Quality assurance and control of the daily operations of the IRB insure that they effectively support the IRB's mandate. Therefore, the IRB must have in place mechanisms and policies for dealing with external auditing and accrediting agencies.

3. SPECIFIC POLICIES

3.1 Preparing for an audit

Certain regulatory and/or accrediting agencies have the authority to audit the operations of IRBs. These include: FDA, OHRP, sponsors or funding entities of research, or others who may also be authorized by regulations or agreement with the University to audit specific documents and procedures.

For external audits involving OHRP or FDA, the following must be notified immediately:

- Senior Vice Provost for Research
- IRB Executive Chair
- Hospital administration if applicable
- Medical Records Supervisor, if applicable

The IRB Director and IRB staff designated to participate in the audit are required to follow the steps outlined by this institution for preparing the site for an audit.

3.2 Participating in an Audit

Researchers and IRB staff members are expected to know and follow the procedures outlined by this institution for the conduct of an internal or external audit of specific studies or study sites.

Prior to being granted access to IRB documentation, inspectors or auditors must exhibit proof of their authority or authorization to conduct an audit to access IRB documents, and no entity other than those listed on the consent forms may have access to any document that includes subject identifiers. The IRB Director is responsible for ensuring the redaction of such information from files prior to an audit as may be required.

Auditors will be provided with adequate working area to conduct an audit and IRB staff and members must make every reasonable effort to be available and to accommodate and expedite the requests of such auditors.

Documents may be copied and taken off-site only by individuals authorized in writing by the Office of General Counsel or the Senior Vice Provost for Research to do so.

3.3 Follow-up after an Audit
Reports of the audit, either verbal or written, should be addressed by the appropriate IRB representatives, or other appropriate individuals or offices, as soon as possible after site-specific audits. Reports of the audit directed to the operation of the IRB should be presented to the Senior Vice Provost for Research and IRB Executive Chair and addressed as soon as possible.

4. REFERENCES

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