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University of California, Riverside

Office of Research Integrity

Institutional Review Board (IRB) Standard Operating Policies and Procedures

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1. Introduction

1.1 Mission

The Institutional Review Boards (IRBs) are committed to following the federal regulations to protect the rights and welfare of human subjects involved in research conducted under the auspices of the University of California, Riverside (UCR). UCR's mission is to uphold the highest standards in the ethical conduct of research, including the protection of human participants, while enabling its faculty, staff and students to conduct research in a timely and efficient manner, fostering a research environment that promotes the respect for the rights and welfare of individuals recruited for, or participating in, research.

1.2 Applicability

These Policies and Procedures apply to all research involving human subjects that requires the use of UCR facilities and/or under the supervision of UCR faculty, students or staff, regardless of sponsorship and where the research is being conducted. Additionally, the UCR IRBs provide guidance for determining whether or not studies meet the regulatory definitions of human subject research. That information, along with other relevant information (including information about the "[Common Rule](#)," the criteria for determining human subjects use) can be found on the [IRB website](#).

All domestic or foreign institutional and non-institutional performance sites for UCR will be obligated to conform to ethical principles, which are commensurate to those of UCR, as cited in these Policies and Procedures, or as promulgated by the DHHS Secretary.

The intent of this document is to serve as a record of the UCR IRB policies and procedures, as well as a foundation to orient and guide staff, IRB Members, and researchers on the authority, scope and processes surrounding UCR's IRB and the relevant federal requirements that pertain to the ethical conduct of human subjects research.

2. Institutional Authority

The Chancellor of UCR has designated the Vice Chancellor for Research and Economic Development as the Institutional Official (IO) for carrying out the University's human research protections program.

The UCR IRB has jurisdiction over all human subjects research (as defined below) conducted under the auspices of the institution (see section: [Applicability](#))

2.1 Assurance of Compliance

UCR holds a Federal-wide Assurance (FWA), FWA00001965. As part of its FWA, UCR has agreed to protect the welfare of all human subjects involved in research, whether or not the research is conducted or supported by a federal department or agency. UCR applies protections commensurate to the Common Rule to studies that are not supported by federal monies.

2.2 UCR Office of Research Integrity (ORI)

The UCR ORI reports to the Vice Chancellor of Research and Economic Development (VC-RED) who serves as the IO. ORI provides administrative support to the university's IRBs. The head of ORI serves as the Human Protections Administrator and is the sole point of contact at UCR for the U.S. Office for Human Research Protection (OHRP).

2.3 Applicable Laws

The UCR IRB relies on the Office of Campus Counsel and the UC Office of the General Counsel for the interpretations and applicability of relevant laws of any jurisdiction where research is conducted (including transnational research) as they apply to human subjects research. The information described in these Policies and Procedures, which are applicable to research conducted domestically, also applies to research conducted in other countries, as appropriate. For research being conducted outside the United States, the IRB provides access to the most recent version of OHRP's "International Compilation of Human Research Protections" to assist researchers in complying with local laws and taking into account cultural context. It is the PI's responsibility to comply with these laws and regulations (see section: [International Research](#)).

3. UCR Institutional Review Board

The UCR IRB is an administrative body established to protect the rights and welfare of human research subjects recruited to participate in research activities conducted under the auspices of UCR in accordance with and for the purposes expressed in this policy.

The IRB process is based on rules and regulations for federally funded research, primarily the provisions of Protection of Human Subjects in the Code of Federal Regulations (45 CFR 46), and supporting materials such as the Belmont Report. UCR's IRBs, IRB-SB (socio-behavioral) and IRB-Clin (clinical-biomedical), strive to create an on-campus culture of respect for, and awareness of, the rights and welfare of human research participants, while advancing knowledge and facilitating the highest quality research.

3.1 Authority of the IRB

The IRB reviews and has the authority to approve, require modifications to, or disapprove all research activities conducted under the auspices of UCR in accordance with DHHS applicable regulations and policies (45 CFR 46, Subparts A-D) and FDA regulations (21 CFR Parts 50, 56, 312 and 812) or any other regulations or policies by the sponsor. The IRB will ensure that appropriate safeguards exist to protect the rights and welfare of human subjects in research. [45 CFR 46.111 and 21 CFR 50.111]. In fulfilling these responsibilities, the IRB reviews all the research documents and activities that bear directly on the rights and welfare of the subjects of the proposed research. The UCR General IRB Application form and consent/assent document(s) are examples of documents that the IRB reviews. The IRB also reviews the methods and material(s) that PIs propose to use to recruit subjects (e.g., questionnaires, surveys, fliers, advertisements).

Before any human subjects research is approved by the IRB, the IRB will ensure that the criteria for IRB approval are satisfied as articulated in various sections of these Policies and Procedures.

The IRB has the authority to suspend, place restrictions on, or terminate approval of research activities that fall within its jurisdiction that are not being conducted in accordance with IRB requirements or that have been associated with unexpected problems involving risks to subjects or others. (see section: [Non-Compliance, Suspension, or Termination of IRB Approval or Research](#)). The IRB has the authority to observe or have a third party observe the consent process and the research if the IRB determines it to be warranted. (see section: [Informed Consent](#)).

The IRB functions independently of, but in coordination with, other institutional regulatory committees. The IRB, however, makes its independent determination whether to approve or disapprove an application based upon whether or not human subjects are adequately protected. The IRB has review jurisdiction over all research involving human subjects research conducted by UCR faculty, employees, staff, or students.

Research that has been reviewed and approved by the IRB may be subject to review and disapproval by officials of UCR. However, those officials may NOT approve research if it has not been approved by the IRB.

3.3 Relationships with Non-UCR Researchers & IRBs

In the conduct of cooperative research projects, UCR acknowledges each institution is responsible for safeguarding the rights and welfare of human subjects and for complying with applicable federal regulations. The particular characteristics of each institution's local research context must be considered, either (i) through knowledge of its local research context by the UCR IRB or (ii) through subsequent review by the appropriate designated IOs, such as the Chairperson and/or other IRB members at cooperating institutions.

Researchers, or Principal Investigators (PI's) from different institutions (non-UCR PI's) who wish to conduct a study at UCR must complete and submit the Non-UCR Principal Investigators Accessing UCR Facilities, Patients, or Personnel" form before UCR determines to take one of the following methods of review:

- A. Enter into a joint review and approval arrangement with the other institution. The non-UCR researcher, or PI, will be asked to submit the approved application from their own institution and the application will be subject to the standard UCR protocol review processes.

3.3.1 Reliances and Single IRBs

Under certain situations, the UCR ORI may elect to rely on another institution's IRB, including one at another University of California (UC) campus, a central IRB, or an independent IRB. The UCR PI must contact the ORI well in advance (at least 60 days) if the study has plans to rely on another IRB to obtain prior approval. Additionally, UCR may also choose, on a case-by-case basis, to provide human research protection oversight for another institution.

In order for the University to rely on another institution or serve as the IRB of record, a formal relationship must be established between the University and the other institution through either an IRB Authorization Agreement (IAA), a UC Memorandum of Understanding (MOU), or through the SMART IRB Reliance Registry. This relationship must be formalized before the University will accept any human research proposals from the other institution. Such relationships must be approved by the IO or designate.

When UCR is the lead institution or the coordinating center for a multi-center study, the IRB will require the UCR PI to ensure that IRB approval has been obtained at each participating site prior to initiation of the research at that site and that the process for determining that the informed consent document(s) approved by each site's designated IRB is consistent with the content of the UCR IRB-approved consent document(s). At the time of initial review, the IRB will assess the procedures for dissemination of study information (e.g., unanticipated problems involving risks to subjects or others, protocol modifications, interim findings) to all participating sites.

3.3.2 Commercial IRBs and Clinical Trials

Drug (Phase I-IV) or device (feasibility and pivotal) trials need to be submitted for review through the appropriate contracted independent IRB, which has an agreement in place with the University to assume IRB oversight for these types of studies. For all Clinical Trials, researchers must first contact the ORI prior to submitting an application.

Once the ORI does an administrative review and verifies that the research meets the criteria for commercial IRB review, the ORI will initiate the pre-review screening process whereby each application is reviewed. During

this process, the researchers may be asked to make changes to the application before final submission to the independent IRB. Once the researcher has addressed the pre-review comments, ORI will authorize the submission to be made, along with issuing a clearance notice to the commercial IRB to proceed with conducting their review of the submission. The ORI will assess fees for industry-authored studies. Additionally, investigators and/or sponsors will incur the cost of commercial IRB related fees.

It is the researcher's responsibility to ensure that all approvals are in place prior to conducting research involving human subjects or their specimens.

All continuation, modification and amendment requests must be sent directly to the appropriate commercial IRB by the investigator. The UCR IRB must also be notified if there are changes to any of the following: PI, Co-I(s), study personnel, performance site(s), or a change in investigator.

In the event of an adverse event or unanticipated problem involving risk to subjects or others, the investigator must submit the appropriate form directly to the commercial IRB and notify ORI. If it meets promptly reportable guidelines, the form should be submitted within 5 days.

If the occurrence is serious (death(s) or life-threatening events) and occurred at a UCR site, a copy of the independent IRB report form must be sent to the UCR IRB within twenty-four hours of discovery.

3.4 Conduct of Quality Assurance/Quality Improvement Activities for IRB Operation

The IRB is subject to audit by the UCR Audit and Advisory Services (AAS) per AAS's annual schedule or *for cause*, UCOP, OHRP or other Authorized representatives from various federal agencies/ regulatory entities. If an IRB Chair, member, or staff person feels that the IRB has been unduly influenced by any party, they may make a confidential report to the IO, depending on the circumstances. The institution will conduct a thorough investigation and corrective action will be taken to prevent additional occurrences.

The IRB designate or ORI staff takes all complaints, unanticipated problems, or allegations of non-compliance seriously. Complaints, unanticipated problems and allegations of noncompliance will be responded to promptly. A plan of action will be developed as appropriate. Any complaint, unanticipated problem, or allegation of noncompliance may be investigated, as appropriate

In addition, the staff may conduct *for cause* and *not for cause* audits of research. Some examples of *not for cause* audits are the continuing review process and periodic site inspections to ensure that data are stored and protected as described and approved in a researcher's application. Random inspections of the research setting and records will be scheduled in advance with the research team to accommodate the researcher's schedule. Sites will be selected by the staff and will vary based on risk and random selection.

4. IRB Membership

4.1 Composition of the IRB

UCR adheres to the Federal Regulations, 45 CFR 46.107, regarding the composition of the IRB, which requires at least five members who are:

- Professionally competent;
- Qualified through experience and expertise;
- Of diverse genders, races, cultural backgrounds, and professions; and,

- With sensitivity to such issues as community attitudes to safeguard the rights and welfare of human subjects of research activities commonly conducted by the institution.

The IRB must also include:

- One or more individuals who are knowledgeable about and experienced in working with vulnerable populations that are commonly recruited as UCR research subjects (e.g., children, prisoners, pregnant women, or handicapped or mentally disabled persons);
- At least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas;
- At least one member who represents the perspective of research subjects; and
- At least one member who is not affiliated with UCR and who is not part of the immediate family of a person who is affiliated with UCR.

One member may satisfy more than one membership category.

Individuals with potential competing business interests cannot serve on the IRB or be involved in the day-to-day operations of the review process. For example, the AVC of Sponsored Programs, the VCR or others who are responsible for raising funds or garnering support for research cannot serve on the IRB or be involved in the daily operations of the review process.

4.2 Appointment of Members to the IRB

When the need for a new or replacement member is identified, the IRB Chair, Vice Chair, staff and/or the ORI AVC may nominate candidates qualified for membership based on the prospective member's knowledge, skills, and abilities appropriate to their respective roles. The names of the nominees may be communicated to the IO. The IO or the ORI AVC may contact the appropriate Department Chairs or Program Directors to solicit nominees.

The final decision in selecting a new or replacement member is made by the IO.

Appointments are made for a renewable three-year period of service. Any change in appointment, such as resignation or removal, requires written notification. Members may resign by providing written notification to the IO, IRB Chair, or staff. Members may be removed by the IO or designate if they do not attend meetings or provide timely reviews.

The IRB Chair and the ORI primary analyst review the membership and composition of the IRB on an annual basis to determine if it continues to meet regulatory and institutional requirements.

4.2.1 Alternate members and Ad-Hoc Reviewers

The appointment and function of alternate members is the same as that for primary IRB members. The alternate's designation and training must be comparable to those of the primary member. The IRB roster identifies the primary member(s) and the alternate member's. The alternate member will not be counted as a voting member unless the primary member is absent. When an alternate member substitutes for a primary member, the alternate member will receive and review the same materials prior to the IRB meeting that the primary member received or would have received. The ORI board analysts may also serve as alternates.

Either IRB (SB and Clin), at its discretion, may invite scientists or non-scientists from within or outside of UCR who are not members of the IRB and who have special expertise to function as ad hoc reviewers of a project application to assist the IRB in its review process. These ad hoc reviewers will have access to all documents submitted to the IRB relevant to the specific project under review, may participate at the deliberations and make recommendations on the project, but may not vote with the IRB except in as indicated for research involving prisoners.

If the IRB reviews research-involving prisoners as subjects, at least one individual participating in the review of such research will have the appropriate experience to serve as a prisoner representative. This individual may be an ad hoc member, contributing to the quorum and vote only for projects involving prisoners.

4.3 Training/Ongoing Education of Chair and IRB Members in Regulations and Procedures

A vital component of a comprehensive human research protection program is an education program for the IRB Chair and the IRB members. UCR is committed to providing training and an on-going educational process for IRB members and the staff of the ORI related to ethical concerns and regulatory and institutional requirements for the protection of human subjects and to improve their qualifications and expertise for protecting the rights and welfare of research subjects. This is accomplished by providing training at convened IRB meetings that address current, relative issues related to human subjects research and by inviting members to attend available conferences and seminars. The ORI may provide modest financial support for IRB members to attend conferences.

4.3.1 Initial Education

IRB members and ORI staff are required to complete the UCR training for Human Subjects Research available through the Collaborative Institutional Training Initiative (CITI) Program. IRB members must complete the CITI training before they serve as a Primary Reviewer.

4.3.2 Continuing Education

To ensure that oversight of human research is ethically grounded and the decisions made by the IRB are consistent with current regulatory and policy requirements, continuous education and training will be provided for IRB members throughout their service on the IRB. The Office of Research Integrity will provide continuing education at regularly scheduled, convened IRB meetings and/or via email. Educational activities include, but are not limited to:

- In-service training at IRB meetings (e.g., reviewing applications that utilize novel procedures);
- Regular training workshops;
- ORI seminar series;
- CITI training;
- Review of relevant publications;
- Identification and dissemination by the Chair, IRB members, Director, AVC RI and ORI staff of new information that might have affected the human research protection program, including laws, regulations, policies, procedures, and emerging ethical and scientific issues to IRB members via email, mail, or during IRB meetings.

The IRB administrators and staff will be encouraged to obtain Certified IRB Professionals (CIP) certification.

4.4 IRB Members Roles and Responsibilities

4.4.1 Chairperson of the IRB

The UCR IO, in consultation with the ORI, appoints a Chair and Vice Chair of the IRB to serve for renewable three-year terms. Any change in appointment, such as resignation or removal, requires written notification.

The IRB Chair should be a respected individual, from within or outside the University, fully capable of managing the IRB and the matters brought before it with fairness and impartiality. The task of making the IRB a respected part of the institutional community will fall primarily on the shoulders of the Chair. The IRB must be perceived to be fair, impartial, and immune to pressure by the institution's administration, the PIs whose protocols are brought before it, and other professional and nonprofessional sources.

The duties of the IRB Chair include:

- Conducting the meetings and serving as a signatory for correspondence generated by the IRB;
- Designating other IRB members (e.g., the Vice Chair, members and ORI staff) to perform duties, as appropriate, for review, signature authority, and other IRB functions; and
- Advising the IO and the head of ORI about IRB member performance and competence.

The performance of the IRB Chair will be reviewed on a periodic basis by the head of the ORI in consultation with the IO. If the Chair is not acting in accordance with the IRB's mission, following these policies and procedures, has an undue number of absences, or not fulfilling the responsibilities of the Chair, they will be removed from the position of IRB Chair. The position of the IRB chair is compensated.

4.4.2 Vice Chair of the IRB

The Vice-Chair serves as the Chair of the IRB in the absence of the Chair and has the same qualifications, authority, and duties as the Chair.

4.4.3 Members of the IRB

Members are also required to serve as designated reviewers for applications undergoing expedited review procedures. Members assigned to review applications in this manner are asked to respond within five (5) business days with the expedited or Full Review Checklist and any additional comments and recommendations. The designated reviewer(s) may determine that any specific study requires full committee review and, in this event, the study will be placed on the next agenda as the schedule of meetings reasonably allows. Designated reviewer(s) may also suggest that a study is exempt from review, and in that event, the Chair, Vice-Chair or staff will review the application and the reviewer(s) recommendations and proceed as appropriate.

For IRB members to serve as designees to the IRB Chair for expedited review, they must have:

- Received the appropriate training as required;
- The appropriate disciplinary expertise;
- Attended at least one Committee meeting; and,
- Have no conflict of interest related to the application being reviewed.

IRB members must review research studies in accordance with these Policies and Procedures. Regarding convened IRB meetings, all members are required to review all documents, including the agenda, minutes, and applications and their related materials, prior to the convened meetings. All copies of the convened meeting materials, including applications and their related materials, must be returned to the IRB staff at the

conclusion of the meeting for professional document disposal. Those stored electronically on email or computers must be disposed of confidentially.

4.4.4 Subcommittees of the IRB

The Chair, in consultation with the head of the ORI, may designate one or more IRB members to serve on a subcommittee to perform appropriate duties, which may include review, signature authority, and other IRB functions.

Duties of a Subcommittee may include the following:

- Serve as designees by the IRB Chair for the review of new or continuing applications, and/or modifications of continuing applications.
- Review and approve non-substantive revisions submitted by PIs for a protocol granted provisional approval, i.e., “Approval Pending Revisions,” by the convened IRB.
- Conduct an inquiry into allegations of non-compliance.
- Conduct on-site review or audit of research that requires additional supervision as determined by the IRB (for example, for a PI who is performing particularly risky research, or for a PI who has recently had a study suspended by the IRB due to regulatory concerns).

4.5 UCR Expectations of IRB Members

The UCR IRB is committed to fostering professional and collegial relationships between the UCR research community and the IRB, including its members and staff. As a result, great consideration is given when choosing members who can positively represent the IRB. IRB members are expected to be familiar with applicable federal and state regulations and related documents as set forth in this document and listed on the ORI website

In addition, during convened IRB meetings, IRB members are expected to:

- Carry out their duties in a spirit of collegiality. This entails mutual respect in the deliberations during the convened IRB meetings by listening carefully and courteously to fellow IRB members and guests (such as external consultants and/or the PI).
- Provide constructive criticism and critique.
- Focus on the protection of human subjects, rather than administrative issues; members are encouraged to submit administrative requests for revisions (e.g., grammatical errors in the application) to the IRB staff before or after the convened meeting.
- Be mindful of the amount of time spent on an application or other agenda items. It is understood that weightier issues require more discussion, and administrative and/or non-substantive issues require less discussion. The length of a discussion should be appropriate given the issues at stake.
- Express their concerns, without expecting others to agree with them; a “groupthink” mentality is strongly discouraged.
- Treat the applications, discussions, and deliberations with confidentiality. Members should not disclose the names of IRB members who reviewed or provided comments for specific applications to individuals outside of the IRB.

4.6 Attendance Requirements

Members should attend all meetings for which they are scheduled. If a member is unable to attend a

scheduled meeting, they should inform the ORI staff as soon as possible and, to the extent possible, well in advance of the convened meeting.

An alternate may also serve during a primary member's absence, should the need arise.

If an IRB member is to be absent for an extended period of time, such as teaching responsibilities or sabbatical, they must notify the IRB at least 30 days in advance. If necessary, an appropriate substitute will be obtained in order to sustain the composition of the Board. The replacement can be temporary, for the period of the absence, or permanent if the member is not returning to the IRB.

This policy does not prohibit the replaced faculty attending or voting at a convened IRB meeting. Their presence will be used to count towards a valid vote and for determining a majority. However, their absence cannot be used to count against a valid vote or for determining a majority.

4.7 IRB Members Self-Disclosure of Conflict of Interest

IRB members and consultants will not participate in any IRB action taken, including the initial and continuing review of any project, in which the member has a conflicting interest, except to provide information requested by the IRB. IRB members are expected to self-identify any conflicts of interest, whether they are assigned to review an application as a Primary Reviewer or as an expedited reviewer, and must notify the ORI staff. The ORI staff will then re-assign the application to another reviewer.

An IRB member is considered to have a conflicting interest when the IRB member or an immediate family member of the IRB member:

- A. Is the PI or Co-I of the research project;
- B. Is a member of the research team;
- C. Is the program director of the program under which the study is being run;
- D. Has a financial interest in the research whose value cannot be readily determined or whose value may be affected by the outcome of the research;
- E. Has a financial interest in the research with a value that exceeds the specified monetary threshold in the [California Fair Political Practices Commission Conflict of Interest Policy 700-U Form](#) and/or the Federal thresholds as contained the [UC Federal Financial Disclosure Form](#);
- F. Has received or will receive any compensation whose value may be affected by the outcome of the study;
- G. Has a proprietary interest in the research (property or other financial interest in the research including, but not limited to, a patent, trademark, copyright or licensing agreement);
- H. Is an executive or director of the agency/company sponsoring the research; and/or
- I. Any other situation where an IRB member believes that another interest conflicts with his or her ability to deliberate objectively on a study.

Except when requested by the IRB to be present to provide information and/or answer questions about the IRB application under review, the conflicted IRB member will excuse themselves from the meeting room before the IRB reviews research in which they have a conflicting interest. The absent member is not counted toward the quorum and their absence and the reason for their absence during the discussion and vote on the application will be noted in the IRB meeting minutes.

4.8 Review of IRB Member Performance

The IRB member's performance will be reviewed on a periodic basis by the Chair and the head of the ORI, and

recommendations will be made to the IO concerning any issues that require remediation. For determinations that require remediation, the IO (or designee) will send the member a letter to communicate this determination. The letter may excuse a member from further service or request a meeting with a member for whom re-appointment is in question in order to determine if the person should continue serving on the IRB. If the IO determines that the member in question is unsuitable for re-appointment, the IO will inform the member of this determination via a letter excusing them from the IRB.

IRB members may request to meet with the Chair, head of the ORI, and/or IO during this evaluation period. At that meeting, members can discuss if they would like additional education/training, concerns about procedures, concerns related to ORI staff and/or other IRB members, recommend areas requiring improvement, goals and expectations for the coming year, and other topics they deem necessary.

4.9 Use of Consultants (Outside Reviewers)

When necessary, the IRB Chair or the head of the ORI may solicit individuals from the University or the community with competence in special areas to assist in the review of issues or protocols that require appropriate scientific or scholarly expertise beyond or in addition to that available to the IRB. Individuals who have a conflicting interest or whose spouse or family members have a conflicting interest in the sponsorship of the research will not be invited to provide consultation.

The consultant's findings will be presented to the full board for consideration either in person or in writing. If in attendance, these individuals will provide consultation but will not participate in or observe the vote. Reports and comments provided by consultants will be recorded in the IRB minutes and kept with the IRBs file of the application that was reviewed.

5. IRB Review Process

These procedures and guidelines apply to all research involving human subjects conducted under the auspices of UCR, regardless of sponsorship and performance site.

5.1 Pre-Review of Newly Submitted Applications by ORI Staff

Applications are reviewed by the ORI staff for completeness and regulatory compliance prior to assigning them to a Primary Reviewer for expedited review or review by the convened IRB as appropriate. If substantive omissions to an application are found, which would compromise the ability of the IRB to start a review (insufficient details, missing measures or informed consent document), the staff will notify the PI that the review cannot take place until the necessary documents are received. The pre-review process may be repeated as necessary.

5.1.1 Pre-review of Federally Funded Grant Applications

The staff will review and compare the application for IRB review to the grant application for consistency (i.e., conduct a "congruency" review). Any inconsistency or omission that is not included in the IRB application will be highlighted and forwarded to the IRB for consideration. Additionally, any area of the grant application that includes details of the research study that are not described in the application for IRB review will be forwarded for review by the IRB. The Congruency review is not required by the revised Common Rule after Jan 21, 2019.

5.2 Level of Review

All submissions to the IRB will be reviewed for determination of whether the activity meets the definition of human subjects research. If a submission is determined to not satisfy the definition of human subjects

research, the IRB staff will issue a letter stating that the activity/activities are “Not Human Subjects Research” (NHSR) and no further review is required by the IRB unless the planned activity is modified in a manner to meet the definition of human subjects research.

Once a research activity is determined to meet the definition of human subjects research, the ORI staff and/or the IRB will then determine the level of review based on the activity meeting criteria for exempt, expedited or full board review according to Federal Regulations [45 CFR 46].

5.2.1 Exempt Research

Upon review, the ORI may determine that the proposed research falls into the exempt categories of research [45 CFR 46.101b]. This means that the research is exempt from federal regulations. However, exempt research is not exempt from the ethical guidelines of the Belmont report and is still subject to institutional review. The exempt determination will be made by a qualified ORI staff. Researchers must submit their application to the IRB in order to get an exempt determination prior to beginning their study.

Not all research studies are eligible for exemption. Exemptions do not apply if the research specifically recruits vulnerable populations, such as prisoners or persons who are cognitively impaired. Exemption determinations are different from ‘Not Human Subjects Research’ (NHSR) determinations.

Research specifically involving children and persons who are economically or educationally disadvantaged, or pregnant women, human fetuses, and/or neonates *may* be eligible for exempt review on a case-by-case basis.

There are six federal categories of research activities involving human subjects that may be exempt from the requirements of the Policy for the Protection of Human Subjects (45 CFR 46). Additionally, a separate seventh category of exempt (#7) research activities has been adopted by the UC system. This category does not exist in the federal regulations and is used by the University of California’s system of campuses.

- (1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.
- (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
 - (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and
 - (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.
- (3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if:
 - (i) the human subjects are elected or appointed public officials or candidates for public office; or
 - (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.
- (4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the

investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

- (5) Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine:
 - (i) Public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.
- (6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

UC Exempt Category 7

Research that involves no greater than minimal risk to subjects, but does not conform to a specific exempt category under 45 CFR 46.101(b) and does not fall within the exclusions listed below.

Such research is NOT exempt if it involves any of the following:

1. Federally funded research, or funding from non-Public Health Service (PHS) agencies that adhere to federal regulations in their award contracts (for a current list of these agencies see http://sites.nationalacademies.org/PGA/fdp/PGA_070596).
2. Prisoners as subjects.
3. Children/minors as subjects.
4. Federal personnel or the Department of Veterans Affairs.
5. Procedures, devices, or drugs subject to FDA oversight.
6. Biomedical procedures.
7. Clinical interventions.
8. Sponsor or other contractual restrictions.
9. An NIH-issued Certificate of Confidentiality to protect identifiable research data.
10. Deception or incomplete disclosure to subjects.
11. Identifiable, private existing data.
12. The information obtained is recorded in such a manner that subjects can be identified, directly or through identifiers linked to the subjects, and any disclosure of the subject's responses outside of the research could reasonably place the subject at risk of criminal or civil liability, be damaging to the subject's financial standing, employability, insurability, or reputation, or be stigmatizing in any other way.

Category 7 minimal risk exempt research activities that will not induce distress beyond that of daily life may include (but are not limited to) non-physically invasive interventions or performance of tasks such as:

- Reading/writing/drawing tasks
- Physical activities such as walking, sitting, or manipulating an object
- Computer tasks and/or Internet searches
- Talking and/or listening to words, then making selections, or "think-aloud" exercises
- Viewing media

- Role-playing
- Completing a specific physical or mental action (“imagining”)
- Passive monitoring of space (environment) with sensors
- Playing a game
- Height/weight measurements

If the research is determined to qualify for Category 7 exempt status and later becomes federally funded, supported, regulated, or changes so that it includes any of the exclusion factors listed above, the researcher must immediately cease research activities until IRB approval is obtained. This will require submission of a new application.

5.2.2 Expedited Review

For categories of research that may undergo an expedited review procedure, please refer to the [Categories of Research](#) published by OHRP.

The IRB may use the expedited review procedure to review:

- A. some or all of the research appearing on the list of categories that may be reviewed by expedited review and found by the reviewer(s) to involve no more than minimal risk, and/or
- B. minor changes in previously approved research during the period (of one year or less) for which approval is authorized.

A minor change is one which, in the judgment of the IRB reviewer, all added procedures involve no more than minimal risk and fall into categories (1)-(7) of research that could be reviewed using the expedited procedure, makes no substantial alteration in

- (i) The level of risks to subjects;
- (ii) The research design or methodology;
- (iii) The number of subjects enrolled in the research;
- (iv) The qualifications of the research team;
- (v) The facilities available to support safe conduct of the research; or
- (vi) Any other part of the research that would otherwise warrant review of the proposed changes by the convened IRB.

Under an expedited review procedure, the review may be carried out by the IRB Chair or by one or more reviewers (e.g., a subcommittee of the IRB) designated by the Chair, in consultation with the IRB staff, from among members of the IRB.

If a subcommittee is asked to conduct a review using the expedited procedure, the subcommittee submits its majority vote to the IRB staff, who then communicates this vote to the IRB Chair for the final determination of the status of the protocol

5.2.3 Convened IRB Meetings

For all human subjects research that is determined to be greater than minimal risk, the IRB will review the proposed research at a convened meeting at which a quorum is present.

5.2.3.1 Schedule of IRB Meetings

The IRBs meet on a regular monthly basis throughout the year. The meeting schedule may vary due to lack of business, holidays, or lack of quorum. However, if important business necessitates an immediate response, *ad hoc* meetings will be arranged to meet that need.

5.2.3.2 Quorum

A quorum consists of a simple majority of the voting membership, including at least one member whose primary concern is in a non-scientific area. If there is a research application involving prisoners or subjects vulnerable to coercion or undue influence, a representative for each group must be present and included in the quorum. The IRB Chair, with the assistance of the ORI staff, will confirm that an appropriate quorum is present before calling the meeting to order. The IRB Chair will be responsible to ensure that the meetings remain appropriately convened.

A quorum must be maintained for each vote to occur. If a quorum is not maintained, the vote on the application must be tabled or the meeting must be terminated. All members present at a convened meeting have full voting rights, except in the case of a COI. Alternate members present will have voting rights only in the absence of their designated primary member. In order for the research application to be approved, it must receive the approval of a majority of those voting members present at the meeting.

IRB members are encouraged to be physically present at the meeting, however, if physical presence is not possible, a member will be considered present if participating through teleconferencing or videoconferencing. In this case, the member must have received all pertinent material prior to the meeting and must be able to participate actively and equally in all discussions.

Opinions of absent members that are transmitted by mail, telephone, facsimile or e-mail may be considered by the attending IRB members but may not be counted as votes or to satisfy the quorum for convened meetings.

5.2.3.3 Primary Reviewers or co-reviewers

The IRB chair or designate assigns a Primary Reviewer from the members of the appropriate IRB for all applications requiring full IRB review. Reviewers are assigned applications based on related expertise. If the ORI Staff cannot identify a Primary Reviewer with appropriate expertise, the IRB Chair or ORI Staff (in consultation with the IRB Chair), at their discretion, can solicit one or more consultants from the University or the community with competence in special areas to assist in the review of issues or applications, which require appropriate scientific or scholarly expertise beyond or in addition to that available on the IRB.

At the meeting, the Primary Reviewer presents a brief overview of the application, with specific attention paid to the Risk/Benefit Ratio of the research and the adequacy of the consent form in addressing subjects' concerns. The Primary Reviewer will present any problems, questions, or concerns related to the research. Other IRB members are then invited to introduce other areas of concern. The IRB may request to speak with an external consultant or the PI via conference call or in person (previous arrangements would have been made by the ORI Staff to facilitate this). The IRB then makes a determination via majority vote regarding the PI's immediate responses (if applicable), the review that will be sent back to the PI, and the substantive or non-substantive nature of the review, and IRB actions (e.g., approval determinations).

The Primary Reviewer or co-reviewers of the application will also receive the Reviewer's Checklist as a guide to completing their review, as well as any other materials as requested by the reviewer. The reviewers are encouraged to submit their review and comments to the ORI prior to the convened meeting so that their

comments can be shared with the board.

5.2.3.4 Pre-Meeting Distribution of the Agenda and Documents for Review

The place and time of the meeting are set forth on the agenda cover sheet distributed to all IRB members. The agenda, all review assignments, all protocols and supporting documentation to be reviewed, are provided to all IRB members approximately five business days prior to each meeting.

Before the meeting, each application (including background information, project protocol/procedures, and informed consent) must be carefully reviewed by the Primary Reviewer, including at a minimum the following items:

- Complete Application form;
- Research/grant/contract proposals (as applicable);
- The proposed consent, parental permission, and or assent form(s) (translated if necessary);
- Recruitment materials, including access letters, fliers, advertisements;
- Scientific evaluations (if any) that accompany the proposals;
- Investigator Brochures, package inserts, device manuals, and device operation materials;
- The DHHS-approved protocol (as applicable);
- The DHHS-approved sample consent document (as applicable);
- Questionnaires, surveys, standardized instruments, etc. (translated if necessary);
- Research subject/participant materials (e.g., patient diaries, logs, etc.);
- Whether the research specifically involves
 - children; prisoners, probationers, parolees; pregnant women, fetuses, and neonates; cognitively impaired subjects;
 - deception;
 - physiological processes;
 - waiver of the consent procedures or the documentation of consent or
 - the researcher or any research staff have a COI related to the study,
- the appropriate information is provided with any additional documentation;
- any other supporting documents or materials submitted to the IRB (e.g., to document the risks/benefits that are not contained in other materials) or in support of the review request made by the IRB.

All IRB members have access to all information/documents that are submitted for each application. At a minimum, IRB members will review the consent document(s) and for each submission and are encouraged to review the IRB application form and other available information.

5.2.3.5 Administration of a Convened Meeting

While a convened IRB meeting differs depending on the issues at hand, each meeting has a general structure that must be followed in order to meet the goals of these meetings. Below is a description of the normal course of action that must take place during a convened meeting:

- A. The Chair or designate calls the meeting to order and begins by reminding members: to declare any potential COI on any issue before the Committee; that they may submit a minority opinion for the next convened meeting's minutes if they voted in the minority; to keep the discussions of the Committee confidential; and to leave all hard copies of protocol-related documents with the staff for professional disposal.

- B. The IRB reviews and votes on the Minutes from the most recent convened meeting.

- C. The Committee reviews and votes on any previously tabled IRB applications, new IRB applications, amendments, unanticipated problems requiring full committee review (e.g., significant unanticipated problems), and Applications to Extend Approval for applications that were reviewed and approved by the convened IRB within the last 12 months.
- D. The Chair updates members of the progress of applications that were reviewed by the convened IRB and deferred to Chair and staff for non-substantive issues.
- E. The Chair draws the members' attention to a list of expedited approvals that were made after the last convened meeting. Copies of approvals or determinations can be made available for any additional review at the request of any IRB member.
- F. The Staff conducts a mini-training session on a selected IRB policy or a current IRB issue – as appropriate and required.
- G. The IRB Chair, members, and staff are invited to make any Committee-related announcements before the meeting is adjourned.

The IRB Chair has the responsibility of ensuring that the above points are followed as closely as possible during the course of the convened IRB meetings.

Meeting minutes should be captured in an appropriate format that captures all members in attendance, the time at which the meeting is convened and adjourned, all discussion points listed on the meeting agenda, all discussion related to any study protocols reviewed, and any updates or reminders given to committee members.

5.2.3.6 Guests

At the discretion of the IRB, the PI may be invited to the IRB meeting to answer questions about their proposed or ongoing research. The PI may not be present for the discussion or vote on their research.

Other guests may be permitted to attend IRB meetings at the discretion of the IRB Chair and the head of the ORI. Guests are reminded of the need for confidentiality and may not participate in the deliberations unless requested by the IRB. Guests may be asked to sign a non-disclosure agreement.

5.3 Review Process – Criteria for IRB Approval

In accordance with 45 CFR 46.111 and 21 CFR 56.111, in order to approve research, the IRB must determine that all of the following requirements are satisfied as described in the following subsections. These criteria for IRB approval must also be considered during the review of any modification, continuing review or review of an unanticipated problem.

5.3.1 Risk/Benefit Assessment

At the time of initial and continuing review, the IRB will make a determination regarding the risks associated with the research applications. Risks associated with the research will be classified as either “minimal” or “greater than minimal” based on the interpretation of minimal risk. Minimal Risk is defined in 45 CFR 46.102(i) as risk in which the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of

routine physical or psychological examinations or tests. For studies reviewed by full committee, the meeting minutes will reflect the Committee's determination regarding risk levels and risk-benefit ratio.

Scientific Merit. In order to assess the risks and benefits of the proposed research, the IRB must determine that:

- The research uses procedures consistent with sound research design;
- The research design is sound enough to reasonably expect the research to answer its proposed question; and
- The knowledge expected to result from this research is sufficiently important to justify the risk.

In making this determination, the IRB may draw on its own knowledge and disciplinary expertise, or on the knowledge and disciplinary expertise of others, such as reviews by a funding agency or departmental review.

The scientific review conducted by the IRB is completed by reviewers whose knowledge and disciplinary expertise are appropriate to the application they receive. The reviewers certify this on the reviewer's checklist. If deemed necessary by the IRB, Chair, or Staff, expert external consultants are employed to provide information to the IRB.

Goal. The goal of the assessment is to ensure that the risks to research subjects posed by participation in the research are justified by the anticipated benefits to the subjects or to society.

- A. The assessment of the risks and benefits of the proposed research – one of the major responsibilities of the IRB – involves a series of steps:
- B. **Identify the risks** associated with the research, as distinguished from the risks that subjects would encounter if not participating in research (e.g., research involving therapy or intervention versus the risks of standard care)
- C. **Determine whether the risks will be minimized** to the extent possible.
- D. **Identify the probable benefits** to be derived from the research.
- E. **Determine whether the risks are reasonable in relation to the benefits** to subjects, if any, and assess the importance of the knowledge to be gained. In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research – as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research.
- F. **Risks to subjects must be reasonable in relation to anticipated benefits**, if any, and to the importance of the knowledge that may reasonably be expected to result.
 - i. The IRB should not consider possible long-range effects of applying knowledge gained in the research (e.g., the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.
- G. **Ensuring that potential subjects will be provided with an understandable, accurate and fair description** of the potential risks or discomforts and the anticipated benefits.

The IRB will judge whether the anticipated benefit (e.g., new knowledge or of improved health for the research subjects) justifies asking any person to undertake the risks. If risks are judged unreasonable in relation to the anticipated benefits, the research should not be approved.

5.3.2 Risks Are Minimized

Risks to subjects must be minimized (i) by using procedures that are consistent with sound research design and that do not unnecessarily expose subjects to risk; and (ii) whenever appropriate, by using procedures already

being performed on the subjects for diagnostic or treatment purposes.

The IRB may minimize risks by requiring any of the following revisions to the research study:

- Removing or eliminating the risk by requiring that a procedure that posed the risk be removed from the study plan;
- Requiring an alternative procedure – that is substituting the procedure (assuming that the risk was caused by a procedure) that presented the risk to a less risky procedure;
- Adding precautions to the study design that may ameliorate the risks of an intervention or procedure (e.g., requiring an anti-emetic be administered if a therapy or procedure causes nausea);
- Adding safeguards to the study design – for example, adding procedures or interventions to manage harms if they arise or adding/increasing monitoring.

5.3.3 Selection of Subjects is Equitable

The IRB will review the recruitment plan, the recruitment materials, and inclusion/exclusion criteria for the research to ensure equitable selection of subjects. In making this assessment the IRB takes into account the purposes of the research and the setting in which the research will be conducted, and is particularly cognizant of the special problems of research involving vulnerable populations, such as children, prisoners, fetuses, pregnant women, human *in vitro* fertilization, persons who are cognitively impaired, or persons who are economically or educationally disadvantaged.

5.3.4 Recruitment of Research Subjects

The IRB will review all recruitment procedures, materials, and advertisements to ensure that they are consistent with the application, accurate, and non-coercive. When subjects are being paid, IRB will review both the amount of payment and the proposed method and timing of disbursement to assure that neither are coercive or present undue influence. Payment to subjects should not be considered a benefit to participation.

Per-patient incentive payments or referral fees, whether paid for each referral or each enrollment, are not allowed. Such payments may encourage recruiters to put undue pressure on prospective subjects and are illegal in California. Lump-sum payments not tied to the number of patients referred or enrolled may be allowed in particular studies.

5.3.5 Review of Advertisements

All advertisements to recruit subjects must be reviewed by the IRB. The IRB will review the information contained in the advertisement and the mode of its communication. Advertisements must not:

- State or imply a certainty of a favorable outcome or other benefits beyond what is outlined in the consent document and the IRB application form;
- Include exculpatory language;
- Over-Emphasize the payment or the amount to be paid;
- Promise free treatment when the intent is only to say subjects will not be charged for taking part in the investigation.

Once the advertisements are finalized, the final copy of the printed, audio-taped, and/or videotaped advertisements must be submitted to the ORI office and given a stamp of approval by the IRB before they may be utilized.

5.3.6 Informed Consent

If the consent process has not been approved to be waived in any way, the IRB will ensure that informed consent will be obtained and documented from each prospective participant or the participant's legally authorized representative, in accordance with, and to the extent required by federal regulations (45 CFR 46.116 and 21 CFR 50.20), California state law, and UCR policies.

No PI may involve a human being as a participant in research without obtaining the legally effective informed consent of the participant or the participant's legally authorized representative (LAR) unless a waiver of consent has been approved by the IRB. In general, the IRB considers individuals who are unable to consent for their own clinical care to be unable to consent for research participation. It is expected that the PIs will assess the comprehension and capacity of the subjects to understand the consent language by asking a series of follow-up questions that may include, but are not limited, to the following:

- A. In your own words, what do you see as the risks of being in this study?
- B. How will we protect the confidentiality of the information we collect from you?
- C. What are the limits of confidentiality? When are we required by law to reveal information about you or your child?
- D. What is your understanding of the honorarium that you would receive for participating? What will your child receive for participating?
- E. What will we be asking your child to do for the study?
- F. Do you have any concerns about any part of this study? What part?
- G. How can you let us know in the future if you have questions or concerns?
- H. What is your understanding of how you can withdraw from this study now or later or anytime in the middle?

Consent must be sought under circumstances that provide the prospective participant or the representative sufficient opportunity to consider whether or not to participate and minimize the possibility of coercion or undue influence.

The IRB will consider where the consent process will take place and the individual who will be obtaining consent (e.g., the PI, collaborator, or qualified designee) in its determination regarding the appropriateness of the consent process. When the potential participant's understanding of the research may be impaired due to the timing, location, or individuals participating in the proposed consent process, the IRB will require an alternative process.

The information that is given to the participant or the representative must be at the appropriate reading level and in a language understandable to the participant or the representative. Any informed consent document that is translated into another language should be approved by the IRB prior to its use (see section: [Review and Approval of the Informed Consent Form](#))

No informed consent, whether oral or written, may include exculpatory language through which the participant or the representative is made to waive or appear to waive any of the participant's legal rights, nor to release or appear to release the PI, sponsor, institution, or its agents from liability for negligence.

A person knowledgeable about the consenting process and the research to be conducted (i.e., a member of

the project's research team), must obtain the informed consent.

If someone other than the PI conducts the interview and obtains consent, the PI needs to formally delegate this responsibility and the person so delegated must have received appropriate training to perform this activity.

5.3.6.1 Basic Elements of Informed Consent [45 CFR 46.116]

The basic elements of informed consent (pre-2018 Revised Common Rule) are:

1. a statement that the **study involves research**; an explanation of the **purposes** of the research and the expected **duration** of the participant's participation; and a description of the research **procedures** to be followed;
2. a description of any reasonably **foreseeable risks** or discomforts to the participant;
3. a description of any **benefits** to the participant or to others which may reasonably be expected from the research;
4. a disclosure of appropriate **alternative procedures** or courses of treatment, if any, that might be advantageous to the participant;
5. a statement describing the extent, if any, to which **confidentiality** of records identifying the participant must be maintained;
6. for research involving more than minimal risk, an explanation as to the availability of medical treatment in the case of **research-related injury**, including who will pay for the treatment and whether another financial compensation is available;
7. an explanation of whom to **contact** for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the participant; and
8. a statement that participation is **voluntary**, refusal to participate will involve no penalty or loss of benefits to which the participant is otherwise entitled, and the participant may discontinue participation at any time without penalty or loss of benefits to which the participant is otherwise entitled.

Additional elements of informed consent. When appropriate, one or more of the following elements of information shall also be provided to each subject:

1. a statement that the particular treatment or procedure may involve risks to the participant (or to the embryo or fetus, if the participant is or may become pregnant) which are currently **unforeseeable**;
2. anticipated circumstances under which the participant's **participation may be terminated by the PI** without regard to the participant's consent;
3. any additional **costs** to the participant that may result from participation in the research;
4. the **consequences of a participant's decision to withdraw** from the research and procedures for orderly termination of participation by the participant;
5. a statement that **significant new findings** developed during the course of the research, which may relate to the participant's willingness to continue participation, must be provided to the participant (see section: [Disclosure of Individual Research Results and Incidental Findings](#)); and
6. the approximate **number of subjects** involved in the study.

The ORI has developed an Informed Consent Guide and sample Informed Consent templates to assist
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researchers with developing their consents. Those can be found on the ORI [Resources](#) page under 'UCR Templates'.

5.3.7 Documentation of Informed Consent (Signed Consent)

Informed consent must be appropriately documented, in accordance with, and to the extent required by 45 CFR 46.117.

- A. Informed consent is documented by the use of a **written consent** form approved by the IRB and signed and dated by the participant or the participant's legally authorized representative at the time of consent.
- B. A copy of the signed and dated consent form must be given to the person signing the form.
- C. The consent form may be either of the following:
 1. **written consent document** that embodies the elements of informed consent may be read to the participant or the participant's legally authorized representative, but the participant or representative must be given adequate opportunity to read it before it is signed;or
 2. **short form written consent document** stating that the elements of informed consent have been presented orally to the participant or the participant's legally authorized representative.

When this method is used:

- a. there must be a witness to the oral presentation;
- b. the IRB must approve a written summary of what is to be signed by the participant or representative;
- c. for subjects who do not speak English, the witness must be conversant in both English and the language of the participant;
- d. the participant or the participant's legally authorized representative must sign the consent document;
- e. the witness must sign both the short form and a copy of the summary;
- f. the person actually obtaining consent must sign a copy of the summary; and
- g. a copy of the summary must be given to the participant or representative, in addition to a copy of the short form.

5.3.7.1 Waiver of Documentation of Informed Consent [45 CFR 46.117(c)(1-2)]

The IRB may waive the requirement for the PI to obtain a signed consent form for some or all subjects if it finds either that the:

- A. only record linking the participant and the research would be the consent document and the principle risk would be potential harm resulting from a breach of confidentiality (**Note:** Subjects must be asked whether they want documentation linking them with the research, and their wishes must govern. (Example: domestic violence research where the primary risk is discovery by the abuser that the participant is talking to researchers), **or**
- B. research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context. Procedures such as non-sensitive surveys, questionnaires, and interviews generally do not require written consent when conducted by non-researchers.

PIs may request a waiver of documentation of informed consent on the general IRB protocol application. In cases in which the documentation requirement is waived, the IRB has to review a written script of the information to be provided to subjects to be sure that this includes all required and appropriate additional elements of consent disclosures. The IRB will consider whether to require the PI to provide subjects with a written statement regarding the research. The IRB will document the justification for waiver of informed consent either in the minutes of an IRB meeting or in the IRB records.

5.3.7.2 Waiver/Alteration of Informed Consent [45 CFR 46.116(d)(1-4)]

The IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent set forth above, or waive the requirement for informed consent provided the IRB finds and documents that:

1. the research involves no more than minimal risk to the subjects;
 2. the waiver or alteration will not adversely affect the rights and welfare of the subjects;
 3. the research could not practicably be carried out without the waiver or alteration; **and**
 4. whenever appropriate, the subjects must be provided with additional pertinent information after participation;
- or**
1. the research or demonstration project is to be conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or otherwise examine:
 - public benefit or service programs;
 - procedures for obtaining benefits or services under those programs;
 - possible changes in or alternatives to those programs or procedures; or
 - possible changes in methods or levels of payment for benefits or services under those programs; **and**
 - the research could not practicably be carried out without the waiver or alteration.

PIs may request a waiver of informed consent on the general IRB protocol application. The IRB will document the justification for waiver of informed consent either in the minutes of an IRB meeting or in the IRB records.

5.3.7.3 Review and Approval of the Informed Consent Form

The IRB is responsible for the review and approval of the informed consent form prepared by the PI. The wording on the informed consent form must contain all of the required elements and meet all other requirements as described in this section. If the wording of the informed consent has been initially prepared by an external entity (e.g., a pharmaceutical company or a cooperative study group, including National Cancer Institute (NCI) groups) other than by a University PI, the IRB needs to ensure that the wording of the consent meets all the requirements of, or has been reviewed by, the appropriate University committees. IRB approval of the wording of all forms of consent must be documented through the use of a certification stamp on each page of the official, finalized consent document(s) that indicates the date of the most recent IRB approval of the document and the expiration date. If the consent is amended during the protocol approval period, it must bear the approval date of the amendment rather than the date of the approved application.

The IRB can make determinations when parental permission and assent would be applicable when the

research involves children. For example, if it is standard practice to obtain assent for children 7 years of age or older, the IRB can specify that or require changes on a study-by-study basis.

5.3.7.4 Surrogate Consent

This policy is designed to protect human subjects from exploitation and harm and, at the same time, make it possible to conduct essential research on problems that are unique to persons who are incompetent, or who have an impaired decision-making capacity. Regulations generally require that the PI obtain informed consent from subjects. Under appropriate conditions, PIs also may obtain informed consent from a *legally authorized representative* of a participant (surrogate consent).

A *legally authorized representative* means an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective participant to the participant's participation in the procedure(s) involved in the research [45 CFR 46.102(c)]. For research conducted in California, the IRB consults with legal counsel and/or California law to decide which individuals are "legally authorized representatives." When the research is conducted outside of California, the IRB consults with legal counsel.

Such consent may be requested and accepted only when the prospective research participant is incompetent or has an impaired decision-making capacity. The PI must provide the IRB with the procedures that will help make this determination.

If feasible, the PI must explain the proposed research to the prospective research participant even when the surrogate gives consent. Under no circumstances may a participant be forced or coerced to participate in a research study.

5.3.7.5 Consent and Language Barriers

The IRB may request a "back-translation" into English or consult with language experts. The translation should verify the accuracy of the translation and back-translation.

If the researcher meets a non-English-speaking person who expresses interest in the study, the researcher may not orally translate the approved English consent form or statement. The researcher must submit the appropriate translated consent documents via an amendment requesting approval to recruit non-English speaking subjects.

Sometimes a participant understands English but does not read or write English. The IRB may request that the PI use a short form consent to document that an impartial witness was present during the consent process and this witness certifies that the participant understood the research and consented to participate voluntarily. For more information about the short form consent, please see [Documentation of Informed Consent \(Signed Consent\)](#).

5.3.8 Data Safety Monitoring

The IRB will generally require a data safety monitoring plan for any applications involving more than minimal risk or for which there are potentially substantive risks to subjects that need to be observed and appropriately managed in order that such risks can be minimized. The IRB will review the data safety monitoring plan during the initial review and at continuing review. Additionally, the IRB will consider whether the data safety monitoring plan remains appropriate whenever new information regarding potential risks becomes available (e.g., during review of modifications or unanticipated problems).

The data safety monitoring should include the processes that the research team will perform to evaluate and monitor potential risks to subjects. Data safety monitoring plans, at a minimum, should include:

- A. Details of what data (i.e., test results, primary or secondary endpoints, adverse events, unanticipated problems involving risks) will be monitored to evaluate potential risks to subjects;
- B. How such data will be collected (e.g., on case report forms)
- C. The frequency of such evaluations;
- D. Who will perform the evaluations; and,
- E. To whom (e.g., sponsor, IRB, Coordinating Center, Steering Committee) and how often, concerns or adverse events/unanticipated problems will be reported.

Some research studies that involve greater risks to subjects, especially clinical trials or studies involving a therapeutic intervention may require or warrant additional monitoring by one or more entities outside of the research team. For example, clinical trials usually have additional monitoring performed by the sponsor or a Contract Research Organization (CRO). When appropriate a clinical trial may also have a Data and Safety Monitoring Board (DSMB) or Data Monitoring Committee (DMC) as a separate entity that provides safety monitoring for a study.

For research studies involving clinical trials, the IRB will consider whether a DSMB/DMC is also required in addition to the data safety monitoring that will be provided by the research team.

Generally, monitoring of safety data by only the investigator/research team may be appropriate when:

- the study is uncontrolled or without a comparator group (e.g., Phase I, and many Phase II studies);
- study interventions do not pose major risks;
- study interventions are short term;
- the study is preliminary or exploratory; and,
- the investigator has no personal stake in the outcome.

Generally, a DSMB/DMC will be required when:

- treatment aimed at reducing mortality or morbidity (e.g., Phase III studies);
- potential ethical need to stop a study for an inferior treatment;
- need to maintain a blind of the study intervention for the sponsor and investigators (i.e., have another entity review the data);
- new, potentially dangerous, investigational therapies; studies involving gene transfer or xenotransplantation must have a DSMB/DMC.

Other considerations that may warrant the use of a DSMB/DMC include multicenter studies or inclusion of vulnerable subjects that may be even more susceptible to the potential risks from a study.

5.3.9 Privacy and Confidentiality

The IRB will determine whether adequate procedures are in place to protect the privacy of subjects and to maintain the confidentiality of the data.

Privacy refers to how much an individual has control over the extent, timing, and circumstances of sharing oneself (physically, behaviorally, or intellectually) with others.

The IRB must determine whether the activities in the research constitute an invasion of privacy. In order to make that determination, the IRB must obtain information regarding how PIs gain access to subjects or subjects' information and what the expectation of privacy is for the subject in that situation. This includes data that is subject to HIPAA regulations as outlined in [Health Insurance Portability and Accountability Act \(HIPAA\)](#). PIs must have, or obtain, appropriate authorization to access the subjects or the subjects' information. If the research involves sensitive information, the IRB should ensure that the interaction with subjects is conducted in a location and manner that will protect privacy.

Confidentiality refers to the methods used to ensure that information obtained by researchers about their subjects is not improperly disclosed.

Confidentiality and anonymity are not the same. If anyone, including the PI, can readily ascertain the identity of the subjects from the data, then the research is not anonymous and the IRB must determine if appropriate protections are in place to minimize the likelihood that the information will be inappropriately divulged. The level of the protection of confidentiality should be commensurate with the potential of harm from inappropriate disclosure.

The IRB addresses this IRB criterion for approval by reviewing a plan to protect confidentiality of data for all studies that pose greater than minimal risk if there were a breach of confidentiality. Such plans may include but are not limited to data format (paper records versus electronic data) and data storage (locked file cabinet, locked office, protected hard drive, stand-alone computer, encryption of data). For storage of electronic identifiable information outside of a secure server environment, UCR requires the use of encryption software. If data is identifiable by name, voice, or image or if individual subjects can be identified by use of multiple variables (for example, the combination of race, gender, age, organizational unit, etc.), the IRB will determine the potential risks if a breach of confidentiality occurs and whether the plan appropriately minimizes such risks.

If the research data is sensitive and risks may be minimized by utilizing advanced data encryption methods or protecting against release of identifiable data required by a subpoena. The IRB may require that a Certificate of Confidentiality is obtained for the study. (see section: [Certificate of Confidentiality](#)).

5.3.10 Vulnerable Populations

The IRB determines if appropriate additional safeguards are in place to protect the rights and welfare of subjects if they are likely to be members of a vulnerable population (e.g., persons with diminished autonomy). For detailed policies on vulnerable populations see section: [Vulnerable Populations](#).

5.4 Promoting Research Objectivity (PRO) - formerly the Conflict of Interest Committee

PI's and research staff members (i.e., those who are involved in the design, conduct, or reporting of research) are required to disclose any direct or related financial interest that either they, their spouse, children or any other study personnel may have that might affect, or appear to affect, the rights and welfare of human research subjects on the general IRB Application form.

For more information regarding COI disclosure requirements and the necessary forms, please refer to the ORI [PRO website](#).

5.4.1 Conflict of Interest (COI) Management – General Disclosure

All PIs and research staff must follow the UCR Promoting Research Objectivity (PRO) Policies. Disclosures are reviewed by the PRO Committee and where necessary, a conflict management plan will be developed and sent

to the IRB. Based on the significance of the conflict and the potential for adverse effects on the protection of subjects, conflict management plans can include:

- Disclosure to subjects through the consent process,
- Modifications in the research plan,
- Monitoring by independent reviewers,
- Divestiture of financial interests,
- Appointment of a non-conflicted PI, and/or
- Prohibition of the conduct of the research at the University.

The convened IRB will determine if the conflict will adversely affect the protection of human subjects and if the management plan is adequate. Researchers will be informed whether the convened IRB

- A. Accepts the management plan and recommend approval, or
- B. Recommends changes in the management plan.

A copy of the final, approved, conflict management plan will be filed in the IRB Office.

5.4.2 COI Management – Study-Specific Disclosure

The General IRB Application asks study-specific questions regarding conflict of interest for the PIs, research staff, and immediate family members. For any potential or actual conflict of interest, the PI must complete and submit the appropriate documents for review by the IRB.

As part of its review process, the IRB will make a determination as to whether the conflict adversely affects the protection of human participants. If the answer is “yes” and an approved conflict management plan exists, the IRB will review the plan to determine if it adequately protects the human participants in that study.

If no approved conflict management plan exists, the IRB will forward the conflict information to the University PRO Committee and an appropriate conflict management plan will be developed according to the procedures described above.

Review of conflict management plans are documented in the IRB minutes in the application file for expedited review. If a conflict of interest exists, final IRB approval cannot be given until an approved conflict management plan that adequately protects the human participants in the study is in place.

If the conflict of interest status of a PI changes during the course of a study, the individual is required to promptly notify the IRB of the change. The IRB will review the change as a modification to the application.

At the time of continuing review, the PI will be asked whether there has been any change in the conflict of interest status relating to the research. The IRB will review conflict of interest as part of its continuing review.

5.5 Other Committee Approvals

In the IRB application, the PI is asked specific questions to determine if the research requires approval from other pertinent research compliance committees (Institutional Biosafety Committee, Radiation Safety Committee, IACUC, etc.). If the PI answers “yes” to any of the questions, they will be requested to provide documentation of approval from the other relevant committees.

5.6 Period of Approval

At the time of initial review and at continuing review, the IRB will make a determination regarding the frequency of review of the research applications. All applications will be reviewed by the IRB or ORI staff at intervals appropriate to the degree of risk but no less than once per year. In cases where this requirement is not in place, the IRB will give longer review/approval period. In some circumstances, a shorter review interval (e.g., biannually, quarterly, or after accrual of a specific number of subjects) may be required. The meeting minutes will reflect the IRBs determination regarding review frequency. This determination governs the approval period and expiration date of the application.

Research that meets any of the following criteria will require review more often than annually:

- Significant risk to research subjects (e.g., death, permanent or long-lasting disability or morbidity, severe toxicity) without the possibility of direct benefit to the subjects;
- The involvement of especially vulnerable populations likely to be subject to coercion (e.g., institutionalized psychiatric patients, incarcerated minors); or
- A history of serious or continuing non-compliance on the part of the PI.

The following factors will also be considered when determining which studies require review more frequently than on an annual basis:

- A. The probability and magnitude of anticipated risks to subjects;
- B. The likely medical condition of the proposed subjects;
- C. The overall qualifications of the PI and other members of the research team, including their specific experiences in conducting similar research;
- D. The nature and frequency of adverse events observed in similar research at this and other institutions;
- E. The novelty of the research, making unanticipated adverse events more likely; and
- F. Any other factors that the IRB deems relevant.

In specifying an approval period of less than one year, the IRB may define the period with either a time interval or a maximum number of subjects either studied or enrolled.

Non-exempt federally funded studies require an annual review.

Exempt studies may be assigned approval periods up to 5 years. Although continuing review is not required for exempt studies, periodic follow up with the PIs to assist in the maintenance of current records for both the researchers and the ORI.

5.7 Possible IRB Actions Taken by Vote

- A. **Approval** – the study is approved as submitted. Official UCR notification that a research project or activity involving human subjects has been reviewed and approved by an IRB in accordance with an approved assurance will be sent to the PI and their department.
- B. **Deferred for non-substantive issues** – the application and/or its related submissions require minor revisions, such as wording changes with replacement language provided. The revisions are presented to the PI for incorporation by simple concurrence. The IRB Chair and members determine how these types of revisions are reviewed and approved but typically, the IRB Chair, Vice Chair, a subcommittee of the IRB, or the ORI staff may approve the study upon receipt and approval of the revisions without further action by the IRB.

Note: Approval of the application will not be granted and certification will not be issued until all IRB stipulations for approval (i.e., requests for changes), if any, are addressed to the satisfaction of the IRB.

- C. **Deferred for substantive issues / Tabled**— substantial modification or clarification is required, or insufficient information is provided to judge the protocol application adequately (e.g., the risks and benefits cannot be assessed with the information provided). IRB approval of the proposed research will not occur until the PI submits the requested new or revised material(s), and once this material is received, it is reviewed at the next convened IRB meeting.

If the application is deferred the following will occur:

1. The ORI staff will inform the PI in writing of the IRBs decision, questions, concerns and/or stipulations for approval.
 2. When the ORI staff receives the PI's responses, the Office will forward the submission to the previously assigned sub-committee or place it on the agenda for review at the next convened IRB meeting. The Office will provide the IRB with the PI's response and the revised application.
 3. The outcome of the IRBs deliberations will once again be communicated to the PI in writing.
 4. The IRBs determination concerning the subsequently amended submission will be documented in the minutes of that meeting.
- D. **Disapproved** – concerns are of such significance that the IRB determines that approval of the study is unwarranted. Approval of a previously disapproved application requires full IRB review.
- E. **Approval in Principle [45 CFR 46.118]** – There are two circumstances in which the IRB may grant approval required by a sponsoring agency without having reviewed all of the study procedures and consent documents. One is if study procedures are to be developed during the course of the research, but human subjects research approval is required by the sponsoring agency. The other is if the involvement of human subjects depends on the outcomes of work with animal subjects. The IRB may then grant approval without having reviewed the as yet undeveloped recruitment, consent, and intervention materials. However, if the proposal is funded, the PI must submit such materials for approval at least 60 days before recruiting human subjects into the study, or into any pilot studies or pre-tests. Approval in principle is granted to satisfy sponsoring agency requirements or to allow PIs to have access to funding to begin aspects of the project that do not involve human subjects.

5.8 Reporting IRB Actions

All IRB actions are communicated to the PI, or designated primary contact person for the application, in writing within 1-2 weeks following the convened IRB meeting by the Chair of the IRB or designate.

For proposed research, a notification must be sent to the PI, which includes the determination of the IRB regarding approval or disapproval, along with:

- A. the Board's comments from the convened meeting where the application was reviewed, and
- B. an assessment of proposed informed consent documents.

For approved research:

- A. The IRB will send the PI notice of approval, which is signed by the IRB Chair, Vice-Chair, or designee.
- B. Along with written notification of approval, PIs are informed that:
 - modifications of approved projects must be reviewed and approved by the appropriate IRB before they are initiated;
 - problems listed in [Unanticipated Problems](#) must be reported to the IRB within ten (10) working days of becoming aware of the problem;
 - monitoring may occur; the nature and frequency of monitoring will be determined by the IRB at the time of initial or continuing review, and PIs will be so informed; and
 - the application will expire on a date determined by the IRB unless renewed prior to that date; the period of approval will not exceed the assigned review period and there is no provision for a grace period on or after the expiration date.
 - a copy of the approved consent form, assent form, and other relevant materials containing the stamped approval with the dates of the approval and expiration on each sheet.
- C. For PIs who receive IRB approval for applications sponsored by federal departments or agencies adopting the Common Rule (45 CFR 46), if requested by either the Agency or the sponsored program officer, the ORI Staff will provide the PI with a completed and signed "Protection of Human Subjects, Assurance Identification/Certification/Declaration of Exemption" (Common Rule) form.

If the IRB disapproves a research activity, it will include in its written notification a statement of the reasons for its decision and give the PI an opportunity to respond in person or in writing.

The IRB reports its findings and actions to the institution in the form of its minutes, which are reviewed by UCR IO upon request, and are stored permanently and securely in the ORI Office. They are available to the public via a formal [Freedom of Information Act \(FOIA\) request](#) or a California Public Records Act (CPRA) request.

5.9 Continuing Review of Active Applications (Renewals)

DHHS regulations at 45 CFR 46.108(b) and 109(e) require, respectively, that:

- A. except when an exempt or expedited review procedure is used, the IRB must review proposed research at convened meetings at which a majority of the members of the IRB is present, including at least one member whose primary concerns are in nonscientific areas; and
- B. The approval date and the termination (expiration) date are clearly noted on all IRB approval letters sent to the PI and must be strictly adhered to. PIs should allow a minimum of 60 days for review of renewal submissions.

5.9.1 Continuing review process

In conducting continuing review of research not eligible for expedited review, all IRB members will receive and review the continuing renewal for and a status report on the progress of the research, including the following information from the past year (cumulative data must also be included after the first renewal):

- the number of subjects enrolled;
- number of subjects who withdrew prematurely and reason(s) for their withdrawal
- a summary of adverse events and any unanticipated problems involving risks to subjects or others and any withdrawal of subjects from the research or complaints about the research since the last IRB review, if applicable;
- summary of any amendments or modifications to the research since the last review;
- any other relevant information, especially new information about risks associated with the

research;

- a copy of the current informed consent document and any newly proposed consent document; and
- a copy of the current HIPAA Authorization document, if applicable.

In addition, any IRB member can request access to the complete IRB application file and relevant IRB minutes prior to or during the convened IRB meeting.

When reviewing the current informed consent document(s), the IRB will ensure the following:

- The currently approved or proposed consent document is still accurate and complete; and
- Any significant new findings that may relate to the participant's willingness to continue participation are provided to the participant in accordance with DHHS regulations at 45 CFR 46.116(b)(5).

Review of currently approved or newly proposed consent documents will occur during the scheduled continuing review of research by the IRB, but informed consent documents that would require modification should be reviewed whenever new information becomes available.

5.9.2 Expedited Review of Continuing Review

Generally, if the research did not qualify for expedited review at the time of initial review, it does not qualify for expedited review at the time of continuing review, except in limited circumstances, such as the review category being de-escalated. It is also possible that research activities that previously qualified for expedited review in accordance with 45 CFR 46.110, have changed or will change, such that expedited IRB review would no longer be permitted for continuing review.

However, if a study was approved by the convened IRB but the PI, either, was unable to recruit or enroll subjects, the continuing review may be conducted using expedited review procedures. If the study is finally canceled without participant enrollment, records will be maintained for at least three years after cancellation.

5.9.3 How is the Continuing Review Date Determined?

At UCR, determination of the review interval and the need for additional supervision and/or participation is made by the IRB on a case-by-case basis. For example, for a PI who is performing particularly risky research, or for a PI who has recently had a project suspended by the IRB due to regulatory concerns, an on-site review by a subcommittee of the IRB might occur or approval might be subject to an audit of study performance after a few months of enrollment, or after enrollment of the first several subjects.

IRB approval is considered to have lapsed at midnight on the last day of the approval period.

Several scenarios for determining the date of continuing review apply for applications reviewed by the IRB at a convened meeting. The date by which continuing review must occur depends on the date of the convened meeting at which IRB approval occurs (these examples presume the IRB has determined that it will conduct continuing review no sooner than within 1 year).

Scenario 1: The IRB reviewed and approved an application without any conditions at a convened meeting on October 1, 2006. Continuing review must occur within 1 year of the date of the meeting, that is, by midnight of September 30, 2007.

Scenario 2: The IRB reviewed an application at a convened meeting on October 1, 2006, and defers the application for non-substantive issues (see section: [Possible IRB Actions Taken by Vote](#)) which can be approved by the IRB Chair or designee. On October 31, 2006, the IRB chair or designee confirms that the required minor changes were made and approves the application. The effective date of the initial approval is the date on which the IRB chair or designee reviewed and accepted as satisfactory the changes to the application. Continuing review must occur within 1 year of the date of the initial effective date, that is, by midnight of October 30, 2007.

Scenario 3: The IRB reviews a study at a convened meeting on October 1, 2006, and defers the application for substantive issues (see section: [Possible IRB Actions Taken by Vote](#)) that requires IRB review of the study at subsequent convened meetings on October 15 and October 29, 2006. At their October 29, 2006 meeting, the IRB completes its review and approves the study. Continuing review must occur within 1 year of the date of the convened meeting at which the IRB reviewed and approved the application, that is, by midnight of October 28, 2007.

For a study approved under expedited review, continuing review will generally occur within 1 year of the date the IRB Chair or IRB member(s) designated by the Chair gives final approval to the application. All federally-supported or -conducted studies will have approval periods granted for a maximum of one year to ensure continuing review at least annually. The IRB may approve studies that are minimal risk and that are not federally supported or conducted for a period of greater than one year as part of the IRBs efforts to decrease administrative burden. Such approval periods will be granted only for studies that the IRB determines that protection of human subjects will not be jeopardized with a more frequent continuing review. Review of a change in a study ordinarily does not alter the date by which continuing review will occur. This is because continuing review is a review of the full application, not simply a change to it.

The regulations make no provision for any grace period extending the conduct of research beyond the expiration date of IRB approval. Therefore, continuing review and re-approval of research must occur by midnight of the date when IRB approval expires in order that the research may continue.

When continuing review occurs annually and the IRB performs continuing review within 30 days before the IRB approval period expires, the IRB may retain the anniversary date as the date by which the continuing review must occur. This would be, for example, October 1, 2006, in the above Scenarios 1 and 2, and October 29, 2007, in Scenario 3, even if the continuing reviews took place up to 30 days prior to these dates.

If continuing review is conducted earlier than 30 days prior to the approval expiration date (e.g., due to the scheduled IRB meeting date), the study will be assigned a new approval date – that of the early continuing review. The approval expiration date will be based upon the new approval date for the purposes of future continuing reviews.

5.9.4 What Occurs if There is a Lapse in Continuing Review?

The IRB and PIs must plan ahead to meet required continuing review dates. To assist PIs, the ORI Staff will send PIs the Application to Extend Approval form roughly 60 days in advance of the expiration date. However, it is ultimately the PI's responsibility to initiate a renewal application, allowing sufficient time for the review and re-approval process to be completed before the current approval expires. Turning in this form does not guarantee an extension of approval. Additional information may be requested, and if that information is not received and approved by the expiration date, the full application expires at which point all work covered by IRB application must cease.

By federal regulation, no extension to that date can be granted.

If a PI has failed to provide continuing review information to the IRB or the IRB has not reviewed and approved a research study by the end of the approval period specified by the IRB, the research must stop, including recruitment, advertisement, screening, enrollment, consent, interventions, interactions, and collection of private, identifiable information. The continuation of human subjects research after expiration of IRB approval is a violation of the regulations.

Retroactive approval for work done after the expiration date cannot be granted.

Interventions and interactions on current subjects may continue only when the IRB Chair finds an overriding safety concern or ethical issue involved such that it is in the best interests of individual subjects to continue participating in the research interventions or interactions. For such situations, the PI must submit a request to the IRB with a justification as to why it would be harmful or unethical to interrupt the participation of currently enrolled subjects. Such finding by the IRB Chair must be provided in writing. Enrollment of new subjects cannot occur after the expiration of the IRB approval.

5.10 Modification of an Approved IRB Application

PIs may wish to modify or amend their approved applications. PIs must seek IRB approval before making changes in approved research – even if the changes are planned for the period for which IRB approval has already been given – unless the change is necessary to eliminate an immediate hazard to the participant (in which case the IRB must then be notified at once). This requirement pertains to all applications, whether approved as Exempt, Expedited or Full Board.

Modifications may be approved if they are within the scope of what the IRB originally authorized. For example, if a researcher wishes to add a new population to an existing study, but not alter the study procedures or purpose, a modification request is usually appropriate. Likewise, modifying a procedure without changing the study's purpose or study population may also be appropriate. If, however, the researcher wishes to add a new population and revise study procedures, they will need to submit a new application for approval of human subjects research.

PIs must submit documentation to the IRB to report proposed changes in the research study. This documentation must include, but is not necessarily limited to:

- the completed Amendment Request Form;
- the revised or additional recruitment materials, consent documents, and/or measures; and
- any other relevant documents provided by the PI.

ORI Staff will notify the IRB whether the proposed changes may be approved through an expedited review process, if the changes are minor, or whether the modification warrants review by the convened IRB. Please note: the IRB may request the PI submit a new application should the Board feel the number of differing procedures, scope of changes, populations utilized and/or added under the IRB application results in a study that can no longer be appropriately assessed by the IRB, as mandated by the Code of Federal Regulations, [45 CFR 46](#). Most files would need a re-review and submission every 5-10 years depending on the scope of the proposed changes.

5.10.1 Expedited Review of Application Modifications

An IRB may use expedited review procedures to review minor changes in ongoing previously-approved research during the period for which approval is authorized [45 CFR 46.110; 63 FR 60364-60367, November 9, 1998, and 63 FR 60353-60356, November 9, 1998; 21 CFR 56.110(b)]. An expedited review may be carried out by the IRB Chair or by one or more experienced reviewers designated by the IRB Chair from among members of the IRB.

5.10.2 Full Board Review of Application Modifications

When a proposed change in a research study is not minor (e.g., procedures involving increased risk or discomfort are to be added), then the IRB must review and approve the proposed change at a convened meeting before the change can be implemented. The only exception is a change necessary to prevent apparent immediate hazards to the research subjects. In such a case, the IRB should be promptly informed of the change following its implementation and should review the change to determine that it is consistent with ensuring the subjects' continued welfare. If a Primary Reviewer is assigned to review substantive application modifications, they will be provided with the completed Amendment Request form and, if necessary, the original application, including any amendments, in order for them to proceed with standard review practices. This form, as well as the Primary Reviewer's assessment on the modifications, will be presented during the convened meeting.

When the IRB reviews modifications to previously approved research, the IRB will consider if the modification meets the regulatory criteria for approval, including whether information about those modifications might relate to subjects' willingness to continue to take part in the research and if so, whether to provide that information to subjects.

5.11 Unanticipated Problems

Federal regulations require procedures for the prompt reporting to the IRB of unanticipated problems involving risks to subjects or others (referred to as "unanticipated problems" in this policy). The UCR IRB requires that unanticipated problems are reported to the IRB as promptly as possible but no longer than within 10 working days.

5.11.1 Definitions

Unanticipated problems involving risks to subjects or others are defined as problems that:

- A. are not expected given the nature of the research procedures and the subject population being studied; and
- B. possibly related to the research procedures or interventions; and
- C. suggest that the research places subjects or others at a greater risk of harm or discomfort (including physical, psychological, economic or social harm) related to the research than was previously known or recognized.

Not all unanticipated problems involving risks to subjects or others involve direct harm to subjects. Events can occur which are unexpected and result in new circumstances that increase the *risk* of harm to subjects without directly harming them. In addition, the event may have presented unanticipated risks to others (e.g., the sexual partners of the subjects, individuals the participant may come in contact with, family members, research personnel, etc.) in addition to the subjects. In each case, while the event may not have caused any detectable harm or adverse effect to subjects or others, it nevertheless represents a reportable problem as defined below and should be promptly reported.

PIs must report to the IRB the following problems as promptly as possible, and no longer than ten (10) working days of becoming aware of the problem:

- Any harm experienced by a participant that was unexpected and is possibly related to the research procedures;
- Any change to the study without prior IRB review to eliminate an apparent immediate hazard to a research participant;
- Any deviation or alteration from the IRB-approved protocol (protocol violation) that is related to participant safety or findings that indicate a new risk of harm;
- Any publication in the literature, safety monitoring report, interim result, or other finding that indicates an unexpected change to the risks or potential benefits of the research;
- Any complaint of a participant that indicates an unanticipated risk or which cannot be resolved by the research staff;
- A breach of confidentiality of research data;
- A breach of privacy, confidentiality, data security, loss of study data, or destruction of study data due to noncompliance; and/or
- Any event that requires prompt reporting according to the sponsor.

PIs may report an unanticipated problem to the IRB via telephone or email correspondence first; however, the ORI staff will require the formal submission of the [Event Report Form](#) in order to document the problem and its resolution.

5.11.2 IRB Review of Reported Unanticipated Problems

- A. Reported unanticipated problems will be reviewed by the IRB Chair and/or another experienced member (s) designated by the Chair. The Chair (or designee) will make the final determination as to whether the event is to be regarded as an Unanticipated Problem involving risks to subjects or others.

All events determined to be unanticipated problems will be reported to the relevant regulatory agencies and IOs according to the procedures in [Reporting to Regulatory Agencies and Institutional Officials](#).

- B. Unanticipated problems involving no more than minimal risk to subjects or others may be handled by the IRB Chair, staff, or designee (with notification to the Chair and IRB) and reported to the full committee.
- C. Unanticipated problems involving more than minimal risk to subjects or others shall be reported to the full IRB committee at a convened meeting. All reviewers shall receive the report of the event as well as a copy of the current consent form(s) and the application. In addition, the reviewers shall have access to the full application.

The IRB or the IRB Chair (or designee) has authority to require submission of more detailed contextual information by the PI, the sponsor, the study coordinating center, or DSMB/DMC about any adverse event occurring in a research protocol as a condition of the continuation of the IRBs approval of the research.

- D. Unanticipated problems for which no modifications to the application or informed consent process/documents are needed, as determined by the IRB or the IRB Chair (or designee), maybe:
1. filed in the IRB records without further review by the convened IRB or,

2. at the discretion of the IRB Chair (or designee), referred to the rest of the IRB members for review and further action, as appropriate, at a convened meeting.
- E. If an unanticipated problem requires modifications to the application and/or informed consent process/documents, either as requested by the PI or determined by the IRB or the IRB Chair (or designee), the PI must submit these modifications as an amendment for review and approval by the IRB chairperson (or designee) under an expedited review procedure. The related report of the unanticipated problem involving risks to subjects or others may be: (i) filed in the IRB records without further review by the convened IRB, or (ii) at the discretion of the IRB Chair (or designee), referred to the rest of the IRB members for review and further action, as appropriate, at a convened meeting

When the convened IRB reviews an unanticipated problem involving risks to subjects or others, the IRB will consider:

- Requesting for a modification of the application,
- Requesting for a modification of the information disclosed during the consent process,
- Requesting that additional information be provided to past subjects,
- Requesting that current subjects re-consent to participation,
- Modifying the continuing review schedule,
- Monitoring the research,
- Monitoring the consent process, and/or
- Referring to other organizational entities.

If the convened IRB determines that modifications are not adequate to reduce the risk to subjects, the convened IRB may require

- F. Notification of current subjects when such information may relate to subjects' willingness to continue to take part in the research; and/or
- G. Suspension of the research;
- H. Termination of the research.
- I. Other corrective actions they deem necessary.

5.12 Further Review/Approval of IRB Actions by Others within the Institution

Research that has been approved by the IRB may be subject to further appropriate review. If applicable, the research study may be subject to approval by other compliance committees or by the department. Additionally, the research study may be disapproval by officials of the institution; however, those officials may not approve research if it has not been approved by the IRB [45 CFR 46.112].

5.13 Appeal of IRB Decisions

If the IRB makes a decision to disapprove a research study or that the PI believes to be unduly restrictive on the proposed research, the PI should first discuss the matter with the Chair of the relevant IRB or the head of ORI, taking care to explain the reasons for believing that the proposed study or procedures are in compliance with University policy and with Federal regulations. If the issue cannot be resolved satisfactorily by negotiation, the PI may appeal the decision in writing to a convened meeting of the IRB. The convened IRB will reconsider the appeal based upon the new information provided. There is no other appeal process.

5.14 Closure of Protocols

The completion or termination of the study is a change in activity and must be reported to the IRB on the

Continuing Review/Closure form. This form requests that the PI provide information that may be used by the IRB in the evaluation and approval of related studies.

ORI staff at their discretion are also able to administratively retire study applications in the following circumstances without prior approval from the PI:

- After repeated attempts to contact the PI have failed for research that is no longer ongoing,
- When the PI expressed interest in retiring a study.
- At the written direction of the PI's faculty advisor or department.

6. IRB Records

The IRB will prepare and maintain adequate documentation of its activities including copies of all items reviewed, such as:

- research proposals and recruitment materials,
- all grant applications (as applicable)
- scientific evaluations (if any) that accompany the proposals,
- Investigator Brochures, package inserts, device manuals, and device operation materials
- the DHHS-approved protocol (as applicable)
- the DHHS-approved sample consent document (as applicable)
- IRB-approved questionnaires, surveys, standardized instruments
- IRB-approved research subject/participant materials (e.g., patient diaries, logs, etc.)
- the description of action taken by the reviewer,
- any findings required under the regulations,
- all versions of the consent documents,
- the specific category of exemption or expedited review,
- the frequency for the next continuing review,
- any proposed amendments or modifications to the research and the IRB action on each amendment/modification,
- progress reports submitted by research investigators
- reports of injuries to subjects
- unanticipated problems involving risks to subjects or others
- documentation of study violations
- subject complaints
- documentation of non-compliance with applicable regulations
- minutes of Board meetings
- list of Board members and their alternates
- data and safety monitoring reports, if any
- records of continuing review activities
- copies of all correspondence between the IRB and the research investigators
- statements of significant new findings provided to subjects as required by DHHS 45 CFR 116(b)(5), FDA 21 CFR 50.25(b)(5)

Documentation of approval of research by expedited review and exempt determinations will include:

- documentation of the justification for exempt determinations

- the justification for using the expedited procedure
- actions taken by the reviewer
- any findings required by laws, regulations, codes, and guidance

The IRB will also maintain the Reviewer’s Checklist, which supports determinations for

- waiver or alteration of the consent process;
- research involving pregnant women, fetuses, and neonates;
- research involving prisoners; and
- research involving children.

Statements of significant new findings provided to subjects will be maintained with the related research proposal and, when reviewed at an IRB meeting, will be documented in the minutes, unless they are already documented in the records.

6.1 Minutes of an IRB Meeting

Proceedings of a previous IRB meeting will be available for review by the next regularly scheduled IRB meeting date. Once approved by the members at a subsequent IRB meeting, the minutes may not be altered by anyone, unless the revision is to appropriately correct an error that was subsequently found (in such cases, the correction should be initialed and dated to indicate the change. Minutes of IRB meetings will contain sufficient detail to show:

- A. Names of attendees at the meetings (including regular members, alternates, and guests) in sufficient detail to demonstrate the presence of a quorum throughout the meeting, including the presence of at least one member whose primary concern is in a non-scientific area. If alternate members attended the meeting, the name of the regular member for whom the alternate served shall be included in the minutes;
- B. The name(s) of an IRB member(s) who recuse themselves during the deliberations or voting on a proposal with which the member has a real or potential COI, as defined by University policy or who recuse themselves or leave the meeting for any reason.
- C. Actions and votes taken by the IRB related to the previous meeting’s Minutes;
- D. Actions taken by the IRB related to applications requiring review by the convened IRB, including:
 1. a summary of the discussion of controverted issues and their resolution;
 2. key information provided by consultants will be documented in the minutes or in a report provided by the consultant
 3. documentation indicating the approval of a waiver or alteration of the HIPAA Authorization, if applicable;
 4. the basis for requiring changes in or disapproving research;
 5. the criteria for IRB approval as required by 45 CFR 46.111 or 21 CFR 56.111, including:
 - determinations regarding the level of risk and ways to minimize risk;
 - determinations that the proposed consent procedures meet the criteria set forth by the applicable regulations for informed consent, the waiver or alteration of informed consent, or the waiver or alteration of the documentation of informed consent (45 CFR 46.116-117);
 6. determinations related to the use of and protection of the vulnerable populations represented by

- the 45 CFR 46 Subparts B, C, and/or D, if applicable;
7. for research involving investigational devices, determination of whether the device is significant risk or non-significant risk;
 8. any other determinations required by laws, regulations, codes, and/or guidance;
 9. the approval period for initial and continuing review;
 10. the frequency of continuing review; and
 11. the vote on actions, including the number of members voting for, against, and abstaining;
- E. Separate deliberations, actions, and votes for each application undergoing continuing review by the convened IRB;
 - F. Separate deliberations, actions, and votes for each modification to an application undergoing review by the convened IRB;
 - G. Applications that have been approved via expedited procedures; and
 - H. Any announcements and continuing education topics that were covered at that meeting.

6.2 Membership Rosters

A current membership list of IRB members is maintained by the ORI staff. The list contains information such as:

- Member's name
- A member's earned degrees
- Affiliated or non-affiliated status (whether the member or any of their immediate family members are affiliated with UCR)
- Status as scientist (scientist or non-scientist)
- Voting status (e.g., member, alternate, Chair, or Vice-Chair); and
- Qualifications as a member, including indications of experience sufficient to describe each IRB member's chief anticipated contributions.
- A résumé or curriculum vitae (CV) for the IRB member will be also be maintained by ORI staff

Changes in IRB membership are reported to the OHRP via the electronic IRB Registration system found at <http://ohrp.cit.nih.gov/efile/Default.aspx>.

6.3 Records Retention Requirements

The above-detailed records are stored securely in the ORI Office and retained for at least three years after completion of the research. If a study is canceled without participant enrollment, IRB records are maintained for at least three years after cancellation.

IRB records relating to a specific research activity shall be maintained for at least three years after completion of the research [45 CFR 16.115(b); 21 CFR 56.115(b)], or longer if required by a grant, contract, or policy. The OHRP, FDA, or other agencies, when appropriate jurisdiction exists and at reasonable times and in a reasonable manner.

IRB records pertaining to research involving children as subjects are stored securely for at least seven years

after the children turn twenty-one years of age, unless otherwise specified. After that time, the records are destroyed.

All records must be accessible for inspection and copying by authorized representatives of the OHRP, sponsors, and other authorized entities at reasonable times and in a reasonable manner.

Currently, the IRB forms are paper and those records (active records) are maintained in ORI staff offices. The staff tracks these records on a database. The forms are available daily to the ORI staff and to the IRB Chair and the IRB members upon request. Records are retained for the designated amount of time specified by the relevant federal and state regulations and the UC Records Retention Schedule. Digital records are maintained on secured servers. When records are required to be destroyed, they are destroyed according to UC Records Retention Schedule.

7. Vulnerable Populations

In those cases, where some or all of the subjects in an IRB application are likely to be vulnerable to coercion or undue influence, the IRB will include additional safeguards to protect the rights and welfare of these subjects. Some examples of vulnerable populations are children, pregnant women, fetuses, neonates, prisoners, adults who lack the ability to consent (e.g., physically or psychologically incapable), students, employees, or homeless persons.

45 CFR 46 includes additional subparts designed to provide extra protections for vulnerable populations, which also have additional requirements for IRBs to follow:

- [Subpart B – Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research](#)
- [Subpart C – Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects](#)
- [Subpart D – Additional Protections for Children Involved as Subjects in Research](#)

Federally funded research that involves any of these populations must comply with the requirements of that agencies' relevant subparts. Research funded by other federal agencies may or may not be covered by the subparts. Researchers must check with the IRB to determine applicability of the subparts.

The following policies and procedures, which are based on the subparts, apply to **non-federally** funded research.

7.1 Research Involving Children [45 CFR 46.401-409 (Subpart D)]

7.1.1 Definitions

Children – 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.

Both common speech and California law define “children” and “minors” inconsistently. In the great majority of cases, people who are “minors” under California law are also “children” under the federal human research regulations. Nevertheless, occasionally the difference is significant, and these guidelines attempt to use the terms consistently as described below.

Federal Regulations Regarding “Children:” Federal regulations state that “‘Children’ are 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.” In other words, who qualifies as a “child” depends on local laws for consent (and not necessarily on local definitions of the word “child”). In California, 18 is the typical age at which people can consent to treatments or procedures, but there are important exceptions, such as when seeking medical care related to the prevention or treatment of pregnancy (see below for limitations).

Important Note: Only “children” under the federal regulations are covered by the additional protections described in Subpart D of 45 CFR 46 and 21 CFR 50 (for example, the requirement for permission of one or two parents in addition to assent from the “child.”)

California Law and “Minors:” For research conducted in California, people considered minors or children by California law are usually also considered “children” in the applicable Federal regulations. California law uses both terms to refer to people who are under 18 years of age.

“Minors” Who Are Not “Children:” In California, certain people under 18 years of age are legally able to consent for treatments or procedures involved in research. In the terms used in these guidelines, they are minors but not children.

For example, [CFC 6925](#) says, “A minor may consent to medical care related to the prevention or treatment of pregnancy.” The minors in a study involving prevention of pregnancy are of legal age to consent to the treatment or procedures involved in the study. Therefore, they are not “children” as defined in federal regulations. They can sign their own consent form as if they were adults, and parental permission is not required.

Other examples of people under 18 able to consent to treatment or procedures in California include *self-sufficient minors* and *emancipated minors*.

Parent – a child’s biological or adoptive parent.

Guardian: An individual who is authorized under applicable state or local law to consent on behalf of a child to general medical care. [In California, a guardian may be a parent, a legally appointed guardian, a guardian *ad litem* as appointed by a court (this is an individual who may have no relationship to the minor who is appointed by the court to protect and represent the interests of the minor before the court), or others as consistent with an order of a court having jurisdiction over the minor. For wards of a court, usually, an order from the judge is required in addition to permission from the person charged with the care of the child.] **NOTE:** For research conducted outside of California, the research must comply with the laws regarding the legal age of consent in all relevant jurisdictions. The [University Office of the General Counsel](#) will provide assistance with regard to the laws in other jurisdictions.

Permission – the agreement of parent(s) or legal guardian to the participation of their child or ward in research.

Assent – a child’s affirmative agreement to participate in research, which may be written or given verbally. Mere failure to object, without a definite affirmative agreement, should not be construed as assent. The IRB of record can also establish guidelines as to when a child’s assent would not be necessary or does not fall within typical practice [45 CFR 46.408(a)].

7.1.2 Allowable Categories

Research on children will be reviewed and categorized by the IRB into one of the following groups:

- A. Research not involving physical or emotional risk greater than that ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests (i.e., **minimal risk**) [45 CFR 46.404].
 - The permissions of both parents are required 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, unless the IRB finds that the permission of one parent is sufficient, even if the other parent is alive, known, competent, reasonably available, and shares legal responsibility for the care and custody of the child.
- B. Research involving greater than minimal risk but presenting the prospect of direct benefit to the individual participant [45 CFR 46.405 and 45 CFR 46.408].
 - The risk is justified by the anticipated benefit to the subjects and this benefit is at least as favorable to the subjects as that presented by available alternative approaches;
 - The permission of both parents is required 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, unless the IRB finds that the permission of one parent is sufficient even if the other parent is alive, known, competent, reasonably available, and shares legal responsibility for the care and custody of the child;
 - Requires assent of the child.
- C. Research involving greater than minimal risk and no reasonable prospect of direct benefit to the individual participant, but likely to yield generalizable knowledge about the participant's disorder or condition [45 CFR 46.406 and 45 CFR 46.408].
 - The risk represents a minor increase over minimal risk;
 - The intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations;
 - Permission of both parents or the legal guardian is required – unless one parent is deceased, unknown, incompetent, or not reasonably available; or only one parent has legal responsibility for the care and custody of the child;
 - Requires assent of the child.
- D. Research not otherwise approvable which presents an opportunity to understand, prevent, or alleviate serious problems affecting the health or welfare of children [45 CFR 46.407].
 - Federally-funded research in this category must be approved by the Secretary of Health and Human Services, and requires consent of both parents or the legal guardian(s).
 - For non-federally-funded research, IRB will consult with a panel of experts in pertinent disciplines (for example: science, medicine, ethics, and law). Based on the recommendation of the panel, the IRB may approve the research based on either:
 1. That the research in fact satisfies the conditions of the previous categories, as applicable; or
 2. The following:
 - i. The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates;
 - ii. The research will be conducted in accord with sound ethical principles; and
 - iii. Informed consent will be obtained in accord with the provisions for informed consent and other applicable sections of this manual.

7.1.3 Parental Permission and Assent

7.1.3.1 Parental Permission

In accordance with 45 CFR 46.408(b) the IRB will determine that adequate provisions have been made for soliciting the permission of each child's parent or guardian.

Parents or guardians must be provided with the basic elements of consent as stated in 45 CFR 46.116(a)(1-8) and any additional elements the IRB deems necessary.

The IRB may find that the permission of one parent is sufficient for research to be conducted under 45 CFR 46.404 or 45 CFR 46.405. The IRB's determination of whether consent must be obtained from one or both parents will be documented in the consent checklist when a study receives expedited review, and in meeting minutes when reviewed by the convened committee.

Consent from both parents is required for research to be conducted under 45 CFR 46.406 and 45 CFR 46.407 unless

- One parent is deceased, unknown, incompetent, or not reasonably available; or
- Only one parent has legal responsibility for the care and custody of the child.

The IRB may waive the requirement for obtaining consent from a parent or legal guardian if:

- The research meets the provisions for waiver in 45 CFR 46.116(d)(1-4) and if the IRB determines that the research study is designed for conditions or a participant population for which parental or guardian permission is not a reasonable requirement to protect the subjects (for example, neglected or abused children).
- An appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and that the waiver is not inconsistent with Federal, State, or local law. The choice of an appropriate mechanism would depend upon the nature and purpose of the activities described in the application, the risk and anticipated benefit to the research subjects, and their age, maturity, status, and condition.

Permission from parents or legal guardians must be documented in accordance with and to the extent required by 45 CFR 46.117.

7.1.3.2 Assent from Children

Because "assent" means a child's affirmative agreement to participate in research [45 CFR 46.402(b)], the child must actively show his or her willingness to participate in the research, rather than just complying with directions to participate and not resisting in any way. The IRB has the discretion to judge all of the children's capacity to assent, or on an individual basis [45 CFR 46.408(a)].

The IRB will take into account the nature of the proposed research activity and the age, maturity, and psychological state of the children involved when reviewing the proposed assent procedure and the form and content of the information conveyed to the prospective subjects. For research activities involving adolescents whose capacity to understand resembles that of adults, the assent procedure should include information similar to what would be provided for informed consent by adults or for parental permission. For children

whose age and maturity level limits their ability to fully comprehend the nature of the research activity but who are still capable of being consulted about participation in research, it may be appropriate to focus on conveying an accurate picture of what the actual experience of participation in research is likely to be (e.g., what the experience will be, how long it will take, whether it might involve any pain or discomfort). The assent procedure should reflect a reasonable effort to enable the child to understand, to the degree they are capable, what their participation in research would involve.

The IRB presumes that children ages 7 and older should be given an opportunity to provide assent. Generally, oral assent through the use of a script may be obtained from children 7-11 years of age. Written assent using a written document for the children to sign may be sought for older children.

At times there may be inconsistency between parent permission and child assent. Usually, a “no” from the child overrides a “yes” from a parent, but a child typically cannot decide to be in research over the objections of a parent. There are individual exceptions to these guidelines (such as when the use of an experimental treatment for a life-threatening disease is being considered). The general idea, however, is that children should not be forced to be research subjects, even when their parents’ consent.

If the IRB determines that the capability of some or all of the children is so limited that they cannot reasonably be consulted and that the intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health or well-being of the children and is available only in the context of the research, the assent of the children is not a necessary condition for proceeding with the research. Even when the IRB determines that the subjects are capable of assenting, the IRB may still waive the assent requirement under circumstances on a case- by- case basis.

7.1.3.3 The Assent Form

Researchers should draft a form that is age appropriate and study specific, taking into account the typical child’s experience and level of understanding, and composing a document that treats the child respectfully and conveys the essential information about the study. The assent form should:

- A. Tell why the research is being conducted;
- B. Describe what will happen and for how long and how often;
- C. Say it’s up to the child to participate and that it’s okay to say no;
- D. Explain if it will hurt, and if so, for how long and how often;
- E. Say what the child’s other choices are;
- F. Describe any good things that might happen;
- G. Say whether there is any compensation for participating; and
- H. Encourage the child to ask questions if need be.

In general, assent should be obtained for all children age seven years and older, unless the requirement for assent is waived by the IRB. For younger children, the document should be limited to one page if possible. Illustrations might be helpful, and larger type makes a form easier for young children to read. Studies involving older children or adolescents may include more information and use language that is more complex.

7.1.4 Children who are Wards

Children who are wards of the State or any other agency, institution, or entity can be included in research

involving greater than minimal risk and no prospect of direct benefit to individual subjects (45 CFR 46.406), but likely to yield generalizable knowledge about the participant's disorder or condition, **only if such research** is:

1. Related to their status as wards; or
2. Conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.

If the research meets the condition(s) above, the IRB must affirm that an advocate has been or will be appointed for each child who is a ward (one individual may serve as advocate for more than one child), in addition to any other individual acting on behalf of the child as legal guardian or in *loco parentis*.

The advocate must be an individual who has the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except in the role as advocate or member of the IRB) with the research, the PI(s), or the guardian organization.

7.2 Research Involving Pregnant Women, Human Fetuses, and Neonates [45 CFR 46.201-207 (Subpart B)]

Most social and behavioral research does not involve neonates. However, any study that involves the use of pregnant women, human fetuses, and neonates (as defined below) must be described in the general IRB application for IRB review and approval. For research that is not federally funded and is also determined by the IRB to have no more than minimal risk to the pregnant woman or fetus, there are no additional restrictions on the involvement of the pregnant women or fetuses in the research (see 45 CFR 46 Subpart B for restrictions on DHHS-funded research).

For research that involves neonates and/or more than minimal risk to pregnant woman or fetuses or which involves neonates, the following definitions apply:

7.2.1 Definitions

Dead fetus – a fetus that does not exhibit heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, or pulsation of the umbilical cord.

Delivery – complete separation of the fetus from the woman by expulsion or extraction or any other means.

Fetus – the product of conception from implantation until delivery.

Neonate – a newborn.

Nonviable neonate – a neonate after delivery that, although living, is not viable.

Pregnancy – the period of time from implantation until delivery. A woman is assumed to be pregnant if they exhibit any of the pertinent presumptive signs of pregnancy, such as missed menses, until the results of a pregnancy test are negative or until delivery.

Viable – as it pertains to the neonate, means being able, after delivery, to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration.

7.2.2 Research Involving Pregnant Women or Fetuses

Pregnant women or fetuses may be involved in research involving more than minimal risk to fetuses if all of the following conditions are met:

- A. Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risks to pregnant women and fetuses;
- B. The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus, or the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means;
- C. Any risk is the least possible for achieving the objectives of the research;
- D. If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, then the consent of the pregnant woman is obtained in accord with the provisions for informed consent;
- E. If the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accord with the provisions for informed consent, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest.
- F. Each individual providing consent under paragraph D or E of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;
- G. For children who are pregnant, assent and permission are obtained in accord with the provisions of permission and assent;
- H. No inducements, monetary or otherwise, will be offered to terminate a pregnancy;
- I. Individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy; and
- J. Individuals engaged in the research will have no part in determining the viability of a neonate.

7.2.3 Research Involving Neonates

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

- A. Where scientifically appropriate, preclinical and clinical studies have been conducted and provide data for assessing potential risks to neonates.
- B. Each individual providing consent is fully informed regarding the reasonably foreseeable impact of the research on the neonate.
- C. Individuals engaged in the research will have no part in determining the viability of a neonate.
- D. The requirements of neonates of uncertain viability or nonviable neonates (see below in this section) have been met as applicable.

7.2.3.1 Neonates of Uncertain Viability

Until it has been ascertained whether or not a neonate is viable, a neonate may not be involved in research covered by this subpart unless the following additional conditions have been met:

The IRB determines that:

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- A. The research holds out the prospect of enhancing the probability of survival of the neonate to the point of viability, and any risk is the least possible for achieving that objective, or
- B. The purpose of the research is the development of important biomedical knowledge which cannot be obtained by other means and there will be no added risk to the neonate resulting from the research; and
- C. The legally effective informed consent of either parent of the neonate or, if neither parent is able to consent because of unavailability, incompetence, or temporary incapacity, the legally effective informed consent of either parent's legally authorized representative is obtained in accord with the provisions of permission and assent, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.

7.2.3.2 Nonviable Neonates

After delivery, nonviable neonates may not be involved in research covered by this subpart unless all of the following additional conditions are met:

- A. Vital functions of the neonate will not be artificially maintained;
- B. The research will not terminate the heartbeat or respiration of the neonate;
- C. There will be no added risk to the neonate resulting from the research;
- D. The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means; and
- E. The legally effective informed consent of both parents of the neonate is obtained in accord with the provisions of permission and assent, except that the waiver and alteration of the provisions of permission and assent do not apply.
- F. However, if either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the informed consent of one parent of a nonviable neonate will suffice to meet the requirements of this paragraph, except that the consent of the father need not be obtained if the pregnancy resulted from rape or incest. The consent of a legally authorized representative of either or both of the parents of a nonviable neonate will not suffice to meet the requirements of this paragraph.

7.2.3.3 Viable Neonates

A neonate, after delivery, that has been determined to be viable may be included in research only to the extent permitted by and in accord with the requirements of IRB Review Process and Research Involving Children.

7.2.4 Research Involving, After Delivery, the Placenta, the Dead Fetus, or Fetal Material

Research involving, after delivery, the placenta; the dead fetus; macerated fetal material; or cells, tissue, or organs excised from a dead fetus, must be conducted only in accord with any applicable Federal, State, or local laws and regulations regarding such activities.

If information associated with the material described above in this section is recorded for research purposes in a manner that living individuals can be identified, directly or through identifiers linked to those individuals, those individuals are research subjects and all pertinent sections of this manual are applicable.

7.2.5 Research Not Otherwise Approvable

If the IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates, and the research is not approvable under the above provisions, then the IRB will consult with a panel of experts in pertinent disciplines (for example: science, medicine, ethics, law). Based on the recommendation of the panel, the IRB may approve the research based on either:

- A. That the research, in fact, satisfies the conditions of [Research Involving Pregnant Women or Fetuses](#), as applicable; or
- B. The following:
 - The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates; and
 - The research will be conducted in accord with sound ethical principles; and
 - Informed consent will be obtained in accord with the provisions for informed consent and other applicable sections of this manual.

7.3 Research Involving Prisoners [45 CFR 46.301-306 (Subpart C)]

Prisoners are another class deemed so vulnerable to exploitation in research that there are special rules protecting them. In the past, prisoners were viewed as a convenient research population. They are housed in a single location, constitute a large and relatively stable population, and live a routine life. Unfortunately, all the things that make a prison and prisoners a convenient research population also make prisoners ripe for exploitation.

Because prisoners are under constraints because of their incarceration which could affect their ability to make a truly voluntary and uncoerced decision whether or not to participate as subjects in research, it is the purpose of this policy to provide additional safeguards for the protection of prisoners involved in research activities to which this subpart is applicable [45 CFR 46.302].

Any study that involves the use of prisoners must be described in the General IRB application for IRB review and approval. If federally funded, OHRP must also review the application and provide certification that it agrees with the approval category determined by the IRB before the study may commence.

7.3.1 Applicability

This policy applies to all biomedical and behavioral research conducted under the auspices of UCR involving prisoners as subjects. Even though a University IRB may approve a research application involving prisoners as subjects according to this policy, PIs are still subject to the administrative regulations of any other applicable State or local law [45 CFR 46.301].

7.3.2 Definitions [According to 45 CFR 46.303]

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

Minimal Risk – the probability and magnitude of physical or psychological harm that is normally encountered

in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons.

7.3.3 Composition of the IRB [45 CFR 46.304]

In addition to satisfying the IRB Membership requirements, when reviewing research involving prisoners, the IRB must also meet the following requirements:

- A. A majority of the IRB (exclusive of prisoner members) must have no association with the prison(s) involved, apart from their membership on the IRB.
- B. At least one member of the IRB **must be a prisoner, or a prisoner representative**, with appropriate background and experience to serve in that capacity, except that where a particular research project is being reviewed by more than one IRB, only one IRB need satisfy this requirement.

7.3.4 Additional Duties of the IRB [45 CFR 46.306]

In addition to all other responsibilities prescribed for the IRB, the IRB will review research involving prisoners and approve such research only if it finds that:

- A. The research falls into one of the following **permitted categories** [45 CFR 46.306]:
 - 1. Study of the possible causes, effects, and processes of incarceration, and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;
 - 2. Study of prisons as institutional structures or of prisoners as incarcerated persons, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;
 - 3. Research on conditions particularly affecting prisoners as a class (for example, research on social and psychological problems such as alcoholism, drug addiction, and sexual assaults); for DHHS-funded research, OHRP has consulted with appropriate experts, including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of its intent to approve such research;
 - 4. Research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the participant; for DHHS-funded research which requires the assignment of prisoners in a manner consistent with studies approved by the IRB in control groups which may not benefit from the research, the study may proceed only after OHRP has consulted with appropriate experts, including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of its intent to approve such research.
- B. Any possible advantages accruing to the prisoner through his or her participation in the research, when compared to the general living conditions, medical care, quality of food, amenities and opportunity for earnings in the prison, are not of such a magnitude that his or her ability to weigh the risks of the research against the value of such advantages in the limited choice environment of the prison is impaired;
- C. The risks involved in the research are commensurate with risks that would be accepted by non-prisoner volunteers;
- D. Procedures for the selection of subjects within the prison are fair to all prisoners and immune from arbitrary intervention by prison authorities or prisoners. Unless the PI provides the IRB justification in writing for following some other procedures, control subjects must be selected randomly from the group of available prisoners who meet the characteristics needed for that particular research project;

- E. The information is presented in language which is understandable to the participant population;
- F. Adequate assurance exists that any law enforcement agency or entity will not take into account a prisoner's participation in the research in making decisions regarding parole, and each prisoner is clearly informed in advance that participation in the research will have no effect on his or her parole; and
- G. Where the IRB finds there may be a need for follow-up examination or care of subjects after the end of their participation, adequate provision has been made for such examination or care, taking into account the varying lengths of individual prisoners' sentences, and for informing subjects of this fact.

7.3.5 Waiver for Epidemiology Research

In June 2003, the Secretary of DHHS waived the applicability of 45 CFR 46.305(a)(1) and 46.306(a)(2) for certain epidemiological research conducted or supported by DHHS as long as:

- A. The sole purposes of the research are
 - 1. To describe the prevalence or incidence of a disease by identifying *all* cases, or
 - 2. To study potential risk factor associations for a disease, and
- B. The IRB has approved the research and fulfilled its duties under 45 CFR 46.305(a)(2-7) and determined and documented that
 - 1. The research presents **no more than minimal risk** and **no more than an inconvenience** to the prisoner-subjects, and
 - 2. **Prisoners are not a particular focus of the research.**

The waiver would apply to research related to chronic diseases, injuries, and environmental health that uses epidemiologic methods (such as interviews and collection of biologic specimens) that generally entail no more than minimal risk to the subjects.

In order for a study to be approved under this waiver, the IRB would need to ensure that, among other things, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of the data.

For more information about this waiver, please see Federal Register Volume 68, Number 119 (Friday, June 20, 2003), Rules and Regulations, Pages 36929-36931

7.4 Persons with Mental Disabilities or Persons with Impaired Decision-Making Capacity

Although not specifically covered in the Common Rule, research involving subjects who are mentally ill or subjects with impaired decision-making capacity warrants special attention. Research involving these populations may present greater than minimal risk; may not offer direct medical benefit to the participant; and may include a research design that calls for washout, placebo, or symptom provocation. In addition, these populations are considered vulnerable to coercion.

Any study that involves the use of persons with mental disabilities or impaired decision-making capacity must be described in the General IRB Application for IRB review and approval.

7.4.1 IRB composition

The IRB membership must include at least one member who is an expert in the area of the research involving Persons with Mental Disabilities or Persons with Impaired Decision-Making Capacity. Consideration may be

given to adding another member who is a member of the population, a family member of such a person or a representative of an advocacy group for that population.

7.4.2 Definitions

Disability – a developmental disability (as defined in 42 USC 15002(8)), a mental illness (as defined in 42 USC Section 10802(4)), a disability within the meaning of the Americans with Disabilities Act of 1990, or a disability within the meaning of the California Fair Employment and Housing Act.

The State of California defines any disabilities that originate before an individual attains age 18 years, continues, or can be expected to continue indefinitely and constitutes a substantial disability for that individual as a “developmental disability.” As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation but shall not include other handicapping conditions that are solely physical in nature.

Legally Authorized Representative – an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective participant for participation in the procedure(s) involved in the research [45 CFR 46.102(c)].

According to the California Health and Safety Code Section 24178(c), the State of California uses “legally authorized representative” synonymously with “surrogate decision-maker.” In determining the disabled person’s best interest, the decision-maker shall consider the person’s personal values and his or her best estimation of what the person would have chosen if they were capable of making a decision. For the purpose of clarity, these guidelines will use the term “surrogate decision-maker” hereafter.

7.4.3 Approval Criteria

Research involving persons with impaired decision-making capacity may only be approved when the following conditions apply:

- A. The PI must demonstrate to the IRB that there is a compelling reason to include incompetent individuals or persons with impaired decision-making capacity as subjects. *Incompetent persons or persons with impaired decision-making capacity must not be subjects in research simply because they are readily available.*
- B. The proposed research entails no significant risks, tangible or intangible, or if the research presents some probability of harm, there must be at least a greater probability of direct benefit to the participant. Incompetent people or persons with impaired decision-making capacity are not to be subjects of research that imposes a risk of injury, unless that research is intended to benefit that participant and the probability of benefit is greater than the probability of harm.
- C. Procedures have been devised to ensure that a participant’s surrogate decision-maker is well informed regarding their roles and obligations to protect incompetent subjects or persons with impaired decision-making capacity. Health care agents [appointed under Durable Power of Attorney for Health Care (DPAHC)] or the surrogate decision-maker must be given descriptions of both proposed research studies and the obligations of the person’s representatives. They must be told that their obligation is to try to determine what the participant would do if competent, or if the participant’s wishes cannot be determined, what they think is in the incompetent person’s best interest.

7.4.4 Additional Concerns

Both PIs and IRB members must be aware that for some subjects, their decision-making capacity may fluctuate. For subjects with fluctuating decision-making capacity or those with decreasing capacity to give consent, a re-consenting process with surrogate consent may be necessary.

It is the responsibility of PIs to monitor the decision-making capacity of subjects enrolled in research studies and to determine if surrogate consent must be re-obtained.

The IRB will require PIs to conduct a **competency assessment** whenever there is a possibility of either impaired mental status or decision-making capacity in prospective subjects.

Although incompetent to provide informed consent, some persons may resist participating in a research study approved by their representatives. Under no circumstances must subjects be forced or coerced into participating.

8. Non-Compliance, Suspension, or Termination of IRB Approval of Research

8.1 Complaints, Concerns, and Appeals

UCR provides a variety of safe, confidential, and reliable channels for current, prospective, or past research subjects or their designated representatives to file a complaint, appeal, or express a concern to an informed individual who is unaffiliated with the specific research study in which they participated, such as an IRB Staff member, IO, or Chair via email, or phone call. These persons or delegate will promptly handle and, if necessary, investigate all complaints, concerns, and appeals.

There are additional resources for complaints and concerns:

UCR has a Whistleblower Policy and hotline. Please see the [UC Whistleblower Poster with UCR Contact Information](#) and UC has a [UC Whistleblower Protection Policy](#).

8.2 Non-compliance

All members of the University community involved in human subjects research are expected to comply with the highest standards of ethical and professional conduct in accordance with federal and state regulations and institutional and IRB policies governing the conduct of research involving human subjects. Exempt and NSHR determinations require prospective IRB approval.

8.3 Definitions

Non-compliance – the failure to comply with any of the regulations and policies mentioned and described in this document and/or failure to follow the determinations of the IRB. Non-compliance may be minor, sporadic, serious, or continuing.

Minor or sporadic non-compliance – the failure to comply with IRB policies, which in the opinion of the IRB Chair and head of ORI (or designee), are administrative in nature.

Serious non-compliance – the failure to follow any of the regulations and policies described in this document or failure to follow the determinations of the IRB and which, in the judgment of either the IRB Chair or the convened IRB, increases risks to subjects, decreases potential benefits, or compromises the integrity of the human research protection program. Any human subjects research, regardless of risk, conducted without prior IRB approval is considered serious noncompliance. Does not apply to exempt research.

Continuing non-compliance – a pattern of non-compliance that, in the judgment of the IRB Chair or convened IRB, suggests a likelihood that instances of non-compliance will continue without intervention. Continuing non-compliance also includes failure to respond to a request to resolve an episode of non-compliance.

Allegation of Non-Compliance – an unproved assertion of non-compliance.

Finding of Non-Compliance – a substantial allegation of non-compliance that is proven true or a report of non-compliance that is found to be true. For example, a finding on an audit of an unsigned consent document, or an admission of a PI that the protocol was willfully not followed may represent reports of non-compliance that would require no further action to determine their truth and would, therefore, represent findings of non-compliance. However, such incidents may warrant further investigation to determine the extent of noncompliance.

Suspension – the temporary withdrawal of IRB approval for some or all research activities short of permanent withdrawal of approval of all research activities. Suspensions will result in the mandatory cessation of the recruitment and enrollment of new subjects in the study and the use of data (including publication) collected during the study pending a review by the IRB of the suspected or alleged non-compliance. Continuation of the research procedures for currently enrolled subjects will be determined by the IRB based on the potential harm to subjects that may incur due to the suspension (i.e., withdrawal of potential benefits from the intervention(s) or safety monitoring offered by the study). Suspended research must undergo continuing review.

Termination – the permanent withdrawal of IRB approval for all research procedures. The demands related to suspension as described above, apply. Additionally, terminated research is closed and does not require continuing review.

8.4 Review of Allegations of Non-compliance

All allegations of non-compliance will be reviewed by the IRB Chair and/or the head of ORI.

The IRB Chair and/or the head of ORI will make an initial assessment as to whether the allegation is of a concern that falls under the jurisdiction of the IRB. They may request additional information or an audit of the research in question.

If, in the judgment of the IRB Chair and/or the head of ORI, the reported allegation of non-compliance does not appear to have merit, no further action will be taken and this decision will be documented in the research file. If in the judgment of the IRB Chair and/or the head of ORI, the reported allegation of non-compliance appears to have merit and falls under the jurisdiction of the IRB, the non-compliance will be processed as detailed below. If on the other hand, the reported allegation appears to fall under the jurisdiction of another administrative office or process, the allegation will be referred to the appropriate office or official and also noted in the research file.

If, in the judgment of the IRB Chair and/or the head of ORI, any allegation or findings of non-compliance warrants suspension or termination of the research on an urgent basis before completion of any review or investigation to ensure protection of the rights and welfare of currently enrolled subjects, the IRB Chair may suspend or terminate the research as described below with subsequent review by the IRB.

8.5 Review of Findings of Non-compliance

Once the IRB Chair and/or the head of ORI determine that the reported allegation of non-compliance is true,

they will then make a determination as to whether the non-compliance is serious or continuing. If, in the judgment of the IRB Chair and/or the head of ORI, the reported finding of non-compliance is not serious, not continuing, and the proposed corrective action plan seems adequate, no further action will be required, this will be noted in the research file, and the IRB will be informed at the next convened meeting.

If, in the judgment of the IRB Chair and/or head of ORI, the reported finding of non-compliance is serious or continuing, the matter will be noted in the research file, and presented to the IRB at a convened meeting with a recommendation that a formal inquiry will be held. The convened IRB may:

1. Find that there is no issue of non-compliance;
2. Find that there is non-compliance that is neither serious nor continuing and an adequate corrective action plan is in place;
3. Find that there may be serious or continuing non-compliance and direct that a formal inquiry be held, or
4. Request additional information before making a determination.

8.6 Investigation Procedures

The IRB may request that a formal investigation be held based on several issues that may include but are not limited to the following examples:

- A. Subjects' complaints that rights were violated;
- B. Report(s) that the PI is not following the application as approved by the IRB;
- C. Unusual and/or unexplained adverse events in a study; and/or
- D. Repeated failure of the PI to report required information to the IRB.

A subcommittee will be appointed consisting of IRB members and non-members, if appropriate, to ensure fairness and expertise. The subcommittee will:

- A. Review the application(s) in question;
- B. Review the sponsor audit report of the PI, if appropriate;
- C. Review any relevant documentation, including consent documents, case report forms, subjects' investigational and/or medical file, etc., as they relate to the PI's execution of their study involving human subjects;
 1. The last IRB approval letter and the IRB approval letter at the time of the incident;
 2. The approved IRB application and protocol at the time of the alleged incident;
 3. The last IRB-approved consent document(s) and the IRB-approved consent document(s) at the time of the incident;
 4. The grant, if applicable; and
- D. Any other pertinent information (e.g., questionnaires, DSMB reports, etc.).
- E. All documents relevant to the allegation;
- F. Interview appropriate personnel, if necessary;
- G. Prepare either a written or oral report of the findings to be presented to the convened IRB at its next meeting; and/or

- H. Recommend actions, if appropriate.

8.7 Final Review

The results of the inquiry will be reviewed at a convened IRB meeting where the IRB will receive a report from the subcommittee. If the results of the inquiry substantiate the finding of serious or continuing non-compliance, the IRBs possible actions could include, but are not limited to:

- A. Requiring a corrective action plan from the PI;
- B. Verifying that participant selection is appropriate;
- C. Observing the actual informed consent process;
- D. Increasing the data and safety monitoring of the research activity;
- E. Requesting a directed audit of targeted areas of concern;
- F. Requesting a status report after each participant receives the intervention;
- G. Modifying the continuing review cycle;
- H. Requesting additional PI and staff education;
- I. Notifying current subjects if the information about the non-compliance might affect their willingness to continue participation;
- J. Suspending the study or
- K. Terminating the study
- L. Additional training

The PI will be informed of the IRB determination and the basis for the determination in writing and will be given a chance to respond. If the IRB determines that the non-compliance was serious or continuing, the results of the final review will be reported as per this procedure.

8.8 Additional Actions

A finding of serious or continuing non-compliance may also result in the following sanctions, among others:

- A. Suspension or termination of IRB approval of specific research applications or of all research involving human subjects in which the PI participates.
- B. Sponsor actions. In making decisions about supporting or approving applications or proposals covered by this policy, the DHHS or Agency head may take into account, in addition to all other eligibility requirements and program criteria, factors such as whether the applicant has been subject to a termination or suspension as described above, and whether the applicant or the person(s) who would direct or has directed the scientific and technical aspects of an activity has, in the judgment of the DHHS or Agency head, materially failed to discharge responsibility for the protection of the rights and welfare of humansubjects.
- C. Institutional or individual action by OHRP. OHRP may:
 - withhold approval of all new UCR studies by the IRB;
 - direct that no new subjects be added to any ongoing studies;
 - terminate all ongoing studies, unless doing so would endanger the subjects; and/or
 - notify relevant state, federal, and other interested parties of the violations.
- D. Individual disciplinary action of the PI or other personnel involved in a study, up to and including

dismissal, pursuant to University policies and procedures.

Failure to secure necessary UCR IRB approval before commencing human participant research must be reported to the IO and the appropriate Dean for disciplinary action.

8.9 Suspension or Termination

An IRB has the authority to suspend or terminate approval of research that is not being conducted in accordance with the IRBs requirements or that has been associated with unexpected serious harm to subjects. The IRB Chair and the head of ORI are authorized to suspend or terminate research on an urgent basis, and these suspensions and terminations are promptly reported to and reviewed by the convened IRB. When the IRB suspends or terminates its approval it will include a statement of its reasons in writing and report the suspension or termination promptly to the PI and as described in [Reporting to Regulatory Agencies and Institutional Officials](#).

When study approval is suspended or terminated by the IRB, IRB Chair, and/or the head of ORI in addition to stopping all research activities, the IRB will notify any subjects currently participating that the study has been terminated. The IRB will consider whether procedures for withdrawal of enrolled subjects are necessary to protect their rights and welfare of subjects. If follow-up of subjects for safety reasons is permitted/required by the IRB, the IRB will require that the subjects should be so informed and that any adverse events/outcomes be reported to the IRB and the sponsor.

8.10 Reporting

Serious or continuing non-compliance with regulations or the requirements or determinations of the IRB, and suspensions or terminations of IRB approval, will be reported to the appropriate regulatory agencies and the IO according to the procedures outlined below.

9. Reporting to Regulatory Agencies and Institutional Officials

- A. The IRB office will report cases of serious or continuing noncompliance, unanticipated problems involving risks to subjects or others as defined below, and suspensions or terminations of IRB approval to regulatory agencies and institutional officials as soon as it:
 1. Determines that an event may be considered an Unanticipated Problem as defined in [Unanticipated Problems](#) AND the event results in a modification or revision of the application and/or the informed consent document(s);
 2. Determines that non-compliance was serious or continuing; and/or
 3. Suspends or terminates approval of research.
- B. The IRB chair or designee will submit a report via a letter that contains the following information:
 1. The nature of the event (e.g., unanticipated problem involving risks to subjects or others, serious or continuing non-compliance, and/or suspension or termination of approval of research);
 2. The name of the institution conducting the research;
 3. The title of the research project and/or grant proposal in which the problem occurred;
 4. The name of the PI on the protocol;
 5. The research project number assigned by the IRB and the number of any applicable federal

- award(s) (grant, contract, or cooperative agreement);
6. A detailed description of the problem including the findings of the organization and the reasons for the IRBs decision;
 7. Actions the institution is taking or plans to take to address the problem (e.g., revise the application, suspend participant enrollment, terminate the research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.);
 8. Plans, if any, to send a follow-up or final report by the earlier of
 - i. A specific date, or
 - ii. When an investigation has been completed or a corrective action plan has been implemented;
- C. This letter will be reviewed and modified as needed by the IRB Chair and the IO.
- D. The IO will sign the final letter and return it to the IRB chair or designee.
- E. The head of ORI or designee will send a copy of the report to:
1. The IRB by including the letter in the next agenda packet as an information item
 2. The IO
 3. OHRP, if the study is subject to DHHS regulations or a DHHS federal-wide assurance
 4. OHRP or the head of the agency as required by the agency, if the study is conducted or funded by any Federal Agency other than DHHS that is subject to "The Common Rule"
 5. Reporting to a regulatory agency is not required if the event occurred at a site that was not subject to the direct oversight of the organization, and the agency has been notified of the event by the PI, sponsor, another organization, or other mechanisms.
 6. The PI
 7. The sponsor, if applicable
 8. The contract research organization, if applicable
 9. The chair or supervisor of the PI
 10. The Privacy Officer of a covered entity, if the event involved unauthorized use, loss, or disclosure of individually-identifiable patient information from that covered entity
 11. The Information Security Officer of an organization if the event involved violations of information security requirements of that organization
 12. The Office of Risk Management, if applicable
 13. Others as deemed appropriate by the IO

The head of ORI ensures that all steps of this policy are completed within 30 days of the initiating action. For more serious actions, the head of ORI will expedite reporting.

10. PI Responsibilities

PIs are ultimately responsible for the conduct of their research. PIs may delegate research responsibility; however, they must maintain oversight and retain ultimate responsibility for the conduct of those to whom

they delegate responsibility.

In order to satisfy the requirements of this policy, PIs who conduct research involving human subjects must:

- Develop and conduct research that is in accordance with the ethical principles in the Belmont Report;
- Develop a research plan that is scientifically sound and minimizes risk to the subjects;
- Have sufficient resources necessary to protect human subjects, including supervision, a sufficient number of appropriately trained staff, and appropriate support services;
- Protect the rights and welfare of prospective subjects;
- Have plans to monitor the data collected for the safety of research subjects;
- Have a procedure to receive complaints or requests for additional information from subjects and respond appropriately;
- Ensure that pertinent laws, regulations, and institution procedures and guidelines are observed by participating faculty and research staff, including those laws, regulations, and procedures that apply in any foreign entity where the research will take place;
- Obtain and document informed consent as required by the IRB and ensure that no human participant is involved in the research prior to obtaining their consent;
- Ensure that all research involving human subjects receives IRB review and approval in writing before commencement of the research;
- Comply with all IRB decisions, conditions, and requirements;
- Report the problems listed in [Unanticipated Problems](#) to the IRB within ten (10) working days of becoming aware of the problem;
- Obtain IRB review and approval in writing before changes are made to approved applications or consent forms;
- Seek IRB assistance when in doubt about whether proposed research requires IRB review.

10.1 Co-Is

Only researchers who fall under the PI definition (under policy [527-003](#)) may serve as the PI on a research project involving human subjects. UCR affiliated individuals that do not have PI status (i.e., undergraduate students, graduate students, staff, residents, fellows, etc.) must have a faculty sponsor who will serve as faculty advisor on the study and be responsible for the conduct of the research.

UCR allows for non-UCR PIs to serve as PIs as long as they submit and have approved the “[UCR Administrative Review for Human Research Studies Being Conducted by Non-UCR Principle Investigators Accessing UCR Facilities, Patients or Personnel](#)” form.

The IRB recognizes **one** PI for each study and that PI has ultimate responsibility for all the research activities detailed in their IRB General Application.

Applications that require skills beyond those held by the PI must be modified to meet the PI’s skills or have one or more additional qualified faculty as Co-PI(s).

10.2 Research Team

The research team consists of the PI and other individuals, also known as key personnel, who contribute to the scientific development or execution of a project in a substantive, measurable way, whether or not they receive salaries or compensation under the application. The PI has ultimate responsibility for the actions of any person engaged to participate in the research project as an associate, assistant, or subcontractor to the researcher.

10.3 Study Development

When developing a study, the PI or a member of the research team may contact the ORI by telephone or email for a determination whether the proposed project constitutes human subjects research, and if so, what level of review would be required. The ORI staff will request the PI complete and submit the “Determination of Activity Form” to document the IRBs determination that a proposed project does or does not constitute human subject research. If it is determined the proposed project does *not* constitute human subjects research, the PI will be sent a Notice of Determination of Activity letter indicating that outcome. If it is determined the proposed project *does* constitute human subjects research, the PI will be sent a Notice of Determination of Activity letter directing them to complete and submit the UCR General IRB Application.

If a PI is asked to submit the UCR General IRB Application, it is the PI’s responsibility to submit the form and all relevant attachments to the ORI office for IRB review.

If the research is federally funded, materials delivered to the ORI office must include the entire sponsoring application; if there is a significant variation between the DHHS application and the IRB application, the ORI staff may ask the PI identify and justify the discordance.

If applicable, the PI must make any changes recommended by the ORI office during their pre-review. The intent is to address problems prior to review by the IRB, thus avoiding delays in receiving approval for the research study.

Following departmental review, and sign-off by Faculty Advisors (if applicable), Department Chairs, or other appropriate official, the PI must submit all the required materials to UCR IRB Office.

10.4 Review of PI Responses

PI submissions and responses to any questions, comments, or reviews are first reviewed by the ORI staff and, if necessary, the Chair. PI responses may be forwarded to the full IRB or a designated sub-committee of the IRB if required or requested. Approval of applications occurs only when the PI’s responses are deemed satisfactory to all members of the sub-committee or a majority of convened IRB reviewers of the application.

Note: PIs who have other individuals write their applications and responses to the IRB must recognize that the ultimate responsibility of any study lies with the PI. It is incumbent upon the PI to check all material that is submitted to the IRB for review.

10.5 Adherence to Terms of Approved Applications

Once the IRB has reviewed and approved an application (with the PI responding to any questions, comments, or concerns that were raised), the application is approved for the time frame suitable to the research and its subjects. The PI and its staff must follow the requirements of the research application or plan and adhere to the policies and procedures set forth in said application and must also follow any requirements placed upon it

by the IRB. Failure to do so may result in a finding of non-compliance that may lead to the suspension or termination of the application.

10.6 Withdrawal of Subjects from Research

The UCR IRB follows the recommendations as set forth in the OHRP [“Guidance on Withdrawal of Subjects from Research: Data Retention and Other Related Issues.”](#) This guidance explains that:

- Subjects have the right to withdraw from (i.e., discontinue participation in) research at any time. If a participant decides to withdraw from all components of a research study, the PI must discontinue all activities involving that participant’s participation in that study (45 CFR 46.116(a)(8)).
- PIs are allowed to retain and analyze already collected data from a participant who chooses to withdraw from a research study or whose participation is terminated by a PI without regard to the participant’s consent, provided that such analysis falls within the scope of the analysis described in the IRB-approved application.
- For research not subject to regulation and review by FDA, PIs, in consultation with the funding agency, can choose to honor a research participant’s request that the PI destroys the participant’s data or that the PI excludes the participant’s data from any analysis.
- Subjects must be fully informed about whether their data will be retained and analyzed even if they choose to withdraw from the research.
- PIs and IRBs consider whether and how the withdrawal of a participant for a research study should be documented.

The complete guidance is available on the OHRP website.

10.7 Changes to Approved Research

PIs must seek IRB approval before making any changes in approved research – even though the changes are planned for the period for which IRB approval has already been given – unless the change is necessary to eliminate an immediate hazard to the participant (in which case the IRB must then be notified at once).

Minor changes (i.e., changes that do not involve increased risk or discomfort) may be authorized by the IRB Chair or their designee. A letter specifying the changes requested and, if applicable, a revised consent form should be sent directly to ORI Office. The IRB Chair, the head of ORI or designee must sign and return a letter to indicate approval.

Note: IRB approved amendments to ongoing research do NOT extend the original approval expiration date.

10.8 Continuing Review after Protocol Approval

Ongoing research studies must be reviewed by the IRB at least annually, or more often, if the IRB finds that the degree of risk to subjects warrants more frequent review. This renewal must take place prior to the end of the approval period noted on the approval letter; otherwise, participant recruitment/enrollment must be suspended and, if the research is DHHS-sponsored, the Agency must be notified.

It is the responsibility of the PI to submit a timely continuing review application. As a courtesy, the UCR IRB Office will send a “Continuing Review/Closure Form” to the PI approximately two months and one month prior to the expiration of each approved application. The PI should allow sufficient time for development and review of renewal submissions.

Note: The “approval date” and the “approval expiration date” are listed on all IRB certifications.

In addition to the usual protocol submissions to the IRB, a progress report must be included with the request for continuation including the following information from the past year (cumulative data must also be included after the first renewal):

- A. Progress of the research;
- B. The number of subjects enrolled;
- C. Number of subjects who withdrew prematurely and reason(s) for their withdrawal;
- D. A summary of adverse events and any unanticipated problems involving risks to subjects or others and any withdrawal of subjects from the research or complaints about the research since the last IRB review (the IRB strongly recommends that the research team maintains an ongoing list of adverse events and unanticipated problems to facilitate oversight of the research and subsequently facilitate submission for continuing review);
- E. Summary of any relevant recent literature, interim findings, and amendments or modifications to the research since the last review;
- F. Any relevant multi-center trial reports; and
- G. Any other relevant information, especially information about risks and risk/benefit ratio associated with the research.

10.9 Required Reports to the IRB

Researchers and research staff must follow reporting requirements in accord with the policies and procedures described in the [Unanticipated Problems section of this procedure](#). The UCR IRB is responsible for reporting to appropriate State and Federal agencies as required.

10.10 Unanticipated Problems

Prompt reporting to the IRB chairperson through the IRB Office is required when any problem listed in [Unanticipated Problems](#) occurs.

PIs should be aware that some sponsors often use more inclusive definitions of adverse events and these definitions should be used if called for by the sponsor.

10.11 Complaints, Non-compliance, and Protocol Deviations

PIs must report all complaints and concerns, non-compliance by the research staff, and any protocol deviations as detailed under [Unanticipated Problems](#) to the IRB within ten (10) working days of discovery or awareness.

10.12 PI-Required Record Keeping

PIs must retain copies of approved IRB documents, and implement a system to comply with approval expiration dates.

In addition to providing a copy of the signed and dated consent form to each participant, a copy must be stored securely by the PI and placed in the participant’s medical record (if the participant is a patient and this requirement has not been waived by the IRB), and a copy must be retained by the PI for a minimum of 5 years, or the minimum that applicable regulations require, after completion of the research.

10.13 COI – PIs

All PIs and research staff members (i.e., those who are involved in the design, conduct, or reporting of research) must follow the UCR Promoting Research Objectivity (PRO) - formerly the Conflict of Interest Committee Policy. For more details, please see section: [Promoting Research Objectivity \(PRO\) – formerly Conflict of Interest](#).

10.14 Training/Ongoing Education of PI and Research Team

One component of a comprehensive human research protection program is an education program for all domestic and foreign individuals involved with research subjects. UCR is committed to providing training and an on-going educational process for PIs and members of their research team (also known as “key personnel”) related to ethical concerns and regulatory and institutional requirements for the protection of human subjects and to improve their qualifications and expertise for protecting the rights and welfare of research subjects. UCR (under its Federal-wide Assurance with the DHHS Office of Human Research Protections and these policies and procedures) requires proof of the completion of a training course for all those members of the research team in a study that is reviewed and approved by the UCR IRB.

A research team consists of anyone involved in data collection and analyses related to that research, including the PI. The following are additional examples of members of a research team:

- undergraduate and graduate research assistants;
- a collaborator at another institution that is relying on the review of the UCR IRB; and
- a collaborator at another institution involved in a contractual relationship with UCR (e.g., being paid via a subcontract when UCR is the prime grant holder.)

10.13.1 Orientation

All PIs and key personnel should review core training documentation, including the “UCR ORI IRB Standard Operating Policies and Procedures” and the “Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research.”

10.13.2 Initial Education Requirement

All PIs and key personnel must meet UCR's education requirement. There are no exceptions to this requirement except what is noted below under “Waiver”. PIs will be required to complete the online Collaborative Institutional Training Initiative (CITI) Program tutorial that discusses the Common Rule and its application to research using human subjects. This training is listed on the ORI website.

New research applications and applications for continuing review will be accepted and reviewed from PIs who have not yet completed the initial education requirement (or the continuing education requirement once the initial education requirement has been satisfied); however, final approval will not be granted until the lead researcher listed in the application (i.e., PI or student), along with any Co-I(s), and the Faculty Advisor has completed the required Human Subjects Protection Training (HSPT) training.

10.13.3 Waiver of Initial Education

If PIs and their key study personnel can verify that they have successfully completed HSPT equivalent to that required by the University, they may request a waiver of the requirement for initial training. However, all PIs or members of their research team must ensure that their HSPT is current and does not lapse by taking the necessary “refresher” courses.

10.13.4 Continuing Education and Recertification

All PIs and key personnel must complete an online training that discusses the Common Rule and its application to research using human subjects *every three (3) years* after they receive a certification of Initial Education for as long as they are involved in human participant research. There are no exceptions to this requirement. PIs who are also the IRB Chair, IRB members, or ORI staff must also satisfy the ongoing training requirements for IRB members and staff.

10.13.5 Additional Resources

- A. Human research protection information will be made available on the ORI website on an ongoing basis to ensure that the University research community remains apprised of current regulatory and policy requirements and training opportunities.
- B. Federal [Office for Human Research Protections \(OHRP\)](#)

10.15 Participant Recruitment

PIs are responsible for recruiting research subjects in a manner that is fair, ethical, and equitable. IRB approval of the wording and format of all recruitment material(s) must be documented through the use of a certification stamp on all official, finalized recruitment material(s) that indicates the date of the most recent IRB approval of the document and the expiration date. If the recruitment material(s) is amended during the application approval period, it must bear the approval date of the amendment rather than the date of the approved application.

IRB approval is required for all recruitment procedures and materials. Recruitment materials must be consistent with the approved IRB application, accurate, and not coercive.

10.16 Payment to Subjects

Payment to research subjects may be an incentive for participation or a way to reimburse a participant for travel and other experiences incurred due to participation. Please note that payment for participation is not considered a research benefit. Regardless of the form of remuneration, PIs must take care to avoid coercion of subjects. Payments should reflect the degree of risk, inconvenience, or discomfort associated with participation. The amount of compensation must be proportional to the risks and inconveniences posed by participation in the study.

The IRB will review both the amount of payment and the proposed method of disbursement to assure that neither entails problems of coercion or undue influence. PIs may allow payment accrual as the study progresses. Payment can be contingent upon the participant completing the entire study but this fact needs to be made known to the participant at the beginning of the study either by the PI informing them verbally or within the Informed Consent Form. If a bonus will be given for completion of the study, the bonus must be reasonable and not so large as to unduly induce subjects to stay in the study when they would otherwise have withdrawn; this also must be disclosed at the beginning of the study.

Per California law (Health and Safety Code section 445), any cash or cash-equivalent payment to any persons or entity that refer prospective subjects, or recommend a person to a physician, hospital, health related facility or dispensary, for any form of medical care or treatment (i.e. "finder's fee") is not permitted. "Bonus payments" used to accelerate recruitment that is tied to the rate or timing of enrollment may not be paid to or accepted by PIs or research staff. All other types of compensation must be disclosed and be approved by the IRB prior to implementation.

The consent form must describe the terms of payment and the conditions under which subjects would receive partial payment or no payment (e.g., if they withdraw from the study before their participation is completed).

If the monies in any form (e.g., cash, coupons, gift cards or certificates, vouchers) for payment are administered through the University, the expenditures of funds for this purpose must fall within all applicable Federal, State and University costing guidelines.

10.17 PI and Research Staff Concerns

PIs and research staff who have concerns, questions, or suggestions regarding UCR's human research protection program may convey concerns or suggestions by telephone or email to the head of the ORI or other responsible parties (e.g., college Dean, departmental Chair) regarding the issue, when appropriate. The IO or designate will research the issue, and when deemed necessary, convene the parties involved to form a response or make necessary procedural or policy modifications, as warranted. In addition, the Chair of the IRB or the head of ORI will be available to address PI or staff's questions, concerns, and suggestions.

11. Health Insurance Portability and Accountability Act (HIPAA)

The [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#) also known as "The Privacy Rule," set standards and regulations to protect patients from inappropriate disclosures of their protected health information (PHI) that could cause harm to their insurability, employability and/or their privacy. While the main impact of the Privacy Rule is the routine provision of, and billing for, health care, the Rule will also affect the conduct and oversight of research. Researchers, IRB staff, and members, as well as research administration, must be aware of these regulations.

11.1 Historical Background

HIPAA is an expansive federal law, only part of which is intended to protect the privacy of health care information. The term "Privacy Rule" is often preceded by "HIPAA," an acronym for the Health Insurance Portability and Accountability Act of 1996. The Department of Health and Human Services (HHS) issued the Privacy Rule in December 2000 to carry out HIPAA's mandate that HHS establish Federal standards for safeguarding the privacy of individually identifiable health information. To clarify certain provisions, address unintended negative effects on health care, and relieve unintended administrative burdens, HHS amended the Privacy Rule on August 14, 2002, and set a compliance date of April 14, 2003.

The objective of the rule is to protect the privacy of an individual's health care information. It creates a federal "floor" of protection so that every person in this country has at least the same basic rights and protections, though some may have additional rights depending on state law.

11.2 Effects of HIPAA on Research

11.2.1 HIPAA's Definition of "Research"

HIPAA's definition of research is identical to that of the Common Rule: "A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge."

11.2.2 Protected Health Information (PHI)

Under HIPAA, "covered entities" must manage what is called "protected health information" (PHI) in accordance with the Privacy Rule. All forms of health information that are associated with any of the 18 identifiers specifically defined by HIPAA, and are maintained by a covered entity, are considered to

be PHI subject to HIPAA. PHI is information created or received by a covered entity relating to:

- The past, present or future physical or mental health or condition of a patient
- Payment for the provision of healthcare to a patient that is transmitted or maintained in any form or medium
- Contains identifiers that can identify a patient or for which there is a reasonable basis to believe the information can be used to identify a patient

The following conditions dictate when PHI may be utilized for Research Purposes:

- [When the PI obtains an individual's HIPAA authorization for use of their PHI](#)
- [When the PI obtains a waiver of HIPAA authorization from the IRB for use of PHI](#)
- [As part of a Limited Data Set & Data Use Agreement](#)
- [When PHI has been De-identified prior to being obtained and utilized](#)
- [As part of activities that are considered to be 'preparatory to research'](#)
- [Research on the Deceased](#)

A critical point of the Privacy Rule is that it applies only to individually identifiable health information held or maintained by a covered entity or its business associate acting for the covered entity. Hence, not all individually identifiable information qualifies as PHI under the HIPAA Privacy Rule.

11.3 Use/Disclosure of PHI & HIPAA Authorization Requirements

The Privacy Rule permits a covered entity (such as a hospital) to use or disclose PHI for research under the following circumstances and conditions, among others:

- If the subject of the PHI has granted specific written permission through a written authorization.
- If a waiver of authorization has been granted by the Privacy Board (the UCR IRB serves as the Privacy Board in most instances) based on the required criteria.

UCR is a hybrid covered entity under HIPAA, which would require researchers to comply with HIPAA rules in certain instances. Additionally, researchers who are working with "protected health information" (PHI) from other institutions that are covered entities will need to comply with the rules on HIPAA.

11.3.1 HIPAA Authorization

Except as otherwise allowed in this policy, written authorization from the research subject or personal representative must be obtained for the use and/or disclosure of PHI for research purposes using the "UCR HIPAA Authorization Form". The actual uses and disclosures made by the researchers and research staff must be consistent with what is stated in the authorization.

A single Authorization form for the utilization of PHI for multiple study activities may be used, so long as the authorization is fully vetted by an accredited IRB and contains the same level of information found in the "UCR HIPAA Authorization Form."

UCR researchers that work with non-affiliated hospitals and clinics, such non-affiliated institutions may also require the use of their version of the HIPAA authorization form to access their medical records. The authorization form originates from the covered entity that owns the PHI. If a covered entity does not have their own authorization form, UCR researchers must still utilize the "UCR HIPAA Research Authorization Form".

11.3.2 Review of Authorization

The UCR IRB does not permit combining the research consent document with HIPAA authorization. For studies in which the HIPAA authorization is not combined with the research consent and the researcher makes any

modification to the stand-alone HIPAA Authorization template for use in a research study, the modifications must be reviewed by the UCR School of Medicine's Compliance Advisory Services office.

Researchers planning to use PHI held by an outside institution are also required to submit an application to the IRB for review and must also follow the HIPAA requirements of the institution(s) holding those records.

If an IRB application is determined not to meet federal requirements for "Human Subjects Research," but still involves the use, disclosure or creation of any PHI, the IRB will request that the PI submit the appropriate HIPAA forms to the UCR School of Medicine's Compliance Advisory Services office for guidance on a case-by-case basis.

11.4 Waivers to HIPAA Authorization

In some cases, an IRB may approve a waiver of HIPAA authorization form. This may occur when the IRB finds that the research could not be practically done without the waiver, and not without access to and use of the PHI, and that disclosure poses minimal risk to privacy; including an adequate plan to protect identifiers from improper use and disclosure, destroy PHI at the earliest opportunity, and provide adequate written assurances that PHI will not be reused or disclosed to unauthorized entities. This waiver would generally come from the IRB of the covered entity that has "ownership" of the PHI.

If a PI requests a waiver of HIPAA authorization, the UCR IRB may approve a complete or partial waiver or an alteration of the HIPAA authorization requirement. A complete waiver occurs when the IRB determines that no authorization will be required for a researcher to use and disclose PHI for a particular research project. A partial waiver of authorization occurs when the IRB determines that an authorization is not needed for some research activities associated with a research study purpose. An alteration of the HIPAA authorization requirement occurs when the IRB reviews and approves a request to alter one or more of the required elements. For example, an alteration may be granted permitting verbal authorization instead of written authorization.

11.5 Patient Rights and Research

Under HIPAA, patients have certain rights. Those that may affect research include the right to receive a Notice of Privacy Practices, the right to access, inspect, and receive a copy of one's own PHI, the right to request an amendment to one's own PHI, and the right to an accounting of certain disclosures of PHI that occur outside the scope of treatment, payment and health care operations that have not been authorized.

California law requires that residents be notified when their electronic medical information or health insurance information has been exposed. The costs of notification can be significant and departments may be at risk for notification costs if identifiable medical data are lost, stolen, or otherwise exposed. In cases of a data breach, researchers must notify the UCR School of Medicine's Compliance Advisory Services office and the ORI. (see section: [Electronic Data Security](#))

12. Special Topics

12.1 Student Research

Students must have a faculty sponsor who fulfills the PI eligibility criteria and who will serve as faculty advisor on the study.

12.1.1 Class projects

The UCR IRB does not usually consider research activities carried out as part of pedagogical instruction or project as being subject to the review and approval of the IRB. Furthermore, the IRB will only review research activities that meet the definition of “Human Subjects Research” according to the Department of Health and Human Services and in [Appendix A](#) of this document.

However, the one exception to this policy is for classes where there may be a high likelihood that data from course-related activities could produce generalizable results that are to be published or presented outside of the class for which it was assigned. Such presented or published presentations may be considered human subjects research, and therefore must be submitted to the IRB before collection of data to determine whether prior review and approval of the IRB are required. In these cases, the following steps should be taken to assure appropriate IRB review:

- A. Instructors of courses in qualitative methods file a general application before the instructional term, listing themselves as PI, and enrolled students as “other project personnel.”
- B. Other project personnel (i.e., the students) complete the online tutorial before collecting any data.
- C. The instructor in the course provides the IRB with updates on the sub-projects being pursued by their students in the form of amendments when there are changes in the subjects being used, the methods employed, or the research questions pursued.
- D. The instructor informs the student researchers that they need to prepare and file a separate application with the IRB if, and as soon as, it becomes apparent that the work begun for instructional purposes may ultimately be used for research purposes, i.e., to contribute to generalizable knowledge, as defined in [Appendix A](#).
- E. Students who wish to use data collected in the course for subsequent research file with the IRB as independent researchers by the end of the course.

12.1.2 Independent Study, Theses, and Dissertations

These research activities may be considered to meet the federal definition of human subjects research and can be independently submitted to the IRB by the student-researcher. However, when students conduct research as part of a course of study, *a faculty member ultimately is responsible for the protection of the subjects*, even if the student is the primary researcher and actually directs the project. Faculty Advisers assume the responsibility for students engaged in independent research, and instructors are responsible for research that is conducted as part of a course.

12.1.3 Department Subject Pools

In conducting research, PIs sometimes rely on entities not under their direct supervision, such as department subject pools. A research subject pool is a registry of individuals who are interested in participating in research and agree to be contacted for potential participation in a study. Subject pools are often used as a research resource by departments and schools in academic settings to facilitate the recruitment of participants into human subjects research studies. Departments are responsible for the management of their subject pools including determining eligibility of volunteers and which researchers access the pool. The UCR IRB provides guidance and oversight of departmental subject pools and reviews all research requesting subject pool access.

As part of a course requirement, students may earn class credit by participating as subjects in studies being conducted by a UCR PI. However, students cannot be required to serve as a human participant, as student’s participation in any research study recruiting from the pool must be completely voluntary; an alternative

assignment involving the same amount of time and for the same amount of extra credit from the instructor must be offered. Examples of alternative assignments are: (1) writing summaries of published research using library resources or (2) participating as a client in one or more simulated sessions for the purpose of training advanced undergraduate and graduate students.

Department subject pools must be constituted and maintained in accordance with the ethical guidelines set forth by the Common Rule, applicable professional organization guidelines, and as appropriate, with the approval of the UCR IRBs. Any researcher (e.g., faculty, graduate student) using the department subject pool must have successfully completed a training course in the protection of human research subjects.

Additional information regarding IRB requirements of researcher's using subject pools can be found in the ORI's [Policy on the Use of Subject Pools in Human Subjects Research](#).

12.1.4 UCR Students and Employees as Subjects

When UCR students and/or employees are being recruited as potential subjects, researchers must ensure that there are additional safeguards for these subjects. The voluntary nature of their participation must be primary and without undue influence on their decision. Researchers must emphasize to subjects that their academic status, grades, or their employment will not be affected by their participation decision.

To minimize coercion, PI's should avoid, whenever possible, the use of their students and employees in procedures which are neither therapeutic nor diagnostic. In these latter situations, PI's should solicit subjects through means such as bulletin board notices, flyers, newspaper advertisements, and announcements in classes other than their own. When entering a classroom to recruit students and conduct research (e.g., administer a survey) it is recommended that PI's do so at the end of the class period to allow non-participating students the option of leaving the classroom, thereby alleviating pressure to participate.

12.2 Deception

The UCR IRB distinguishes between two types of deception: deception by commission and deception by omission. *Deception by commission* occurs when subjects are misled about the true purpose of the research. *Deception by omission* occurs when an important aspect of the research is withheld from subjects.

The IRB recognizes that the use of deception in research is a valuable research technique, although it also presents special challenges to researchers to ensure that research is conducted ethically. PI's who use deception in research will be asked to fully detail this information in the general IRB Application, as well as ensure that suitable debriefing procedures are in place for participants at the conclusion of the study, when appropriate. This information helps the IRB determine whether the use of deception increases risks to subjects, and thus increases the level of IRB review. If such determinations are made, the IRB will communicate this via email to the PI.

12.3 International Research

PIs are encouraged to conduct studies in other countries. Doing so, however, involves greater responsibilities. For example, it is the PI's responsibility to ensure that they and their research staff are qualified to conduct research in another country. Research personnel must be sensitive to and respectful of that country's culture and local laws.

In general, the research should be designed to study a phenomenon or hypothesis that is relevant to the host country. If the research is greater than minimal risks, then the research should be designed to provide

potential benefit to the subjects or the local community. Appropriate justification to conduct a study in the host country will be required whenever this basic premise is not met.

Additionally, an international research trip taken on behalf of UCR should be registered online via the UCR Travel Management/Risk Management program, 'UC Away'.

12.3.1 Regulatory Standards

Any research conducted in another country must comply with the host country's laws and policies. In addition, the research must also comply with the U.S. federal regulations for the protection of human subjects (45 CFR 46 and FDA regulations, when applicable) and UCR policies or equivalent standards such as International Conference on Harmonization (ICH) or Council of International Organization of Medical Sciences (CIOMS).

12.3.2 IRB Review of International Research

A determination will need to be made by the ORI whether a local IRB or ethics committee (that complies with the IRB membership requirements of 45 CFR 46) must also approve the study in addition to the UCR IRB. Such determination will be made on the level of risk in the study and the ability for the UCR IRB to acquire knowledge of the local context of the host country including its laws, standards of professional conduct and practice, cultural norms, and local community attitudes. If a local IRB will be relied upon as the IRB of record, then UCR will need to enter into the appropriate agreement with that entity via one of the avenues delineated in section: [Reliances and Single IRBs](#).

It is the PI's responsibility to coordinate and communicate with local IRBs if required by the ORI. OHRP's "[International Compilation of Human Research Protections](#)" is a helpful resource for finding international IRB websites.

The UCR IRB may require the UCR PI to provide information about the local context in the submission of the application for IRB review.

12.3.3 Local Research Collaborators

If an international institution or agency will be assisting the researcher with the study, such as with recruitment of subjects, a letter of access from the international institution or agency must be submitted. The institution or agency may be a university, government entity, community leader, etc. This letter should be written in or translated into English; the original language of the letter (if applicable) and the translation must both be submitted to the IRB. This letter of access should explain that the institution or agency understands and supports the purpose and procedures of the research. It may also need to include language about respecting participant confidentiality.

Some researchers conducting international research enlist the assistance of local individuals to help conduct the research study. The UCR PI is responsible for ensuring that all members of the research team, including those individuals in the host country who will collaborate on the research, must have appropriate ethics training.

If the PI will include collaborators to help conduct the research, then the PI should provide a plan on how they will provide oversight of the research and the collaborators, especially when they or UCR researchers are no longer in the host country.

12.3.4 Translation of Documents and Consent

If the subjects in the proposed country's official language(s) does not include English, the recruitment materials, consent, and research questions (i.e., surveys, interviews) must be translated to their language and reviewed by the UCR IRB (see [Consent and Language Barriers](#) for policies and procedures related to translations).

12.3.5 Collection of Tissues/Blood

If the research will collect blood, tissues, or other biological samples, a plan for collection, storage, and protection of confidentiality should be provided to the IRB. If the samples will be transported back to the U.S., the plan should also include a section on how the samples will be sent back to the U.S. The plan should comply with both local and U.S. laws/policies.

Unsterilized specimens of human and animal tissues (such as blood, body discharges, fluids, excretions or similar material) containing an infectious or etiologic agent require a permit in order to be imported (USPHS 42 CFR 71) to the U.S. Details on the regulatory requirements, process for obtaining a permit, and shipping and handling of such tissues can be found on the Centers for Disease Control and Prevention (CDC) website.

If the material being imported has been rendered sterile (e.g., radiation or chemical treatment) and is known not to contain infectious agents for humans, a permit is not required for importation.

12.4 Oral History

The following is based on guidance received from OHRP:

A decision whether oral history or other activities solely consisting of open-ended qualitative type interviews are subject to the policies and regulations outlined in an institution's FWA and DHHS regulations for the protection of human research subjects [45 CFR 46] is based on the prospective intent of the PI and the definition of "research" under DHHS regulations at 45 CFR 46.102(d): "a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge."

Specifically, for the purposes of this policy, the evaluation of such activities hinges upon whether the person is engaged in the creation of "generalizable knowledge," that is, whether the activity represents a systematic investigation in which the person engaged in such activities intends to develop or contribute to generalizable knowledge.

12.4.1 General principles for evaluating Oral History type activities

1. Oral history activities, such as open-ended interviews, that only document a specific historical event or the experiences of individuals without intent to draw conclusions or generalize findings would not constitute "research" as defined by DHHS regulations.

Example: An oral history video recording of interviews with Holocaust survivors is created for viewing in the Holocaust Museum. The creation of the videotape does NOT intend to draw conclusions, inform policy, or generalize findings. The sole purpose is to create a historical record of specific personal events and experiences related to the Holocaust and provide a venue for Holocaust survivors to tell their stories.

2. Systematic investigations involving open-ended interviews that are designed to develop or contribute to generalizable knowledge (e.g., designed to draw conclusions, inform policy, or generalize findings) WOULD constitute "research" as defined by DHHS regulations.

Example: An open-ended interview of surviving Gulf War veterans to document their experiences and to draw conclusions about their experiences, inform policy, or generalize findings.

PI's are advised to consult with the IRB Office regarding whether their oral history project requires IRB review.

12.5 Multiple Site Studies

When there are plans to conduct research at external sites the UCR PI must supply UCR's IRB with

- A. Contact information for the external site,
- B. Whether that site has granted permission for the research to be conducted, and
- C. Whether that site has an IRB and if so, whether that IRB has approved the research or will rely upon UCR's IRB.

When the UCR PI plans to conduct research at external sites that are engaged in the research and that site's IRB plans to rely upon UCR's IRB, there will be a clear statement signed by both IRBs that the UCR IRB will be the IRB of record.

When the UCR PI is the lead PI of a multi-site study, applications will include information about the management of information that is relevant to the protection of subjects, such as unanticipated problems involving risks to subjects or others, interim results and protocol modifications. The UCR IRB will evaluate whether the management of information that is relevant to the protection of subjects is adequate.

12.6 Certificate of Confidentiality

12.6.1 Statutory Basis for Protection

Protection against compelled disclosure of identifying information about subjects of biomedical, behavioral, clinical, and other research is provided by the Public Health Service Act §301(d):

“The Secretary may authorize persons engaged in biomedical, behavioral, clinical, or other research (including research on mental health, including research on the use and effect of alcohol and other psychoactive drugs) to protect the privacy of individuals who are the subject of such research by withholding from all persons not connected with the conduct of such research the names or other identifying characteristics of such individuals. Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals.”

Certificates of Confidentiality constitute an important tool to protect the privacy of research study subjects. Certificates are issued by the National Institutes of Health (NIH) to protect identifiable research information from forced disclosure. They require the PI and others who have access to research records to refuse compulsory disclosure of identifying information on research subjects in any civil, criminal, administrative, legislative, or other proceeding, whether at the federal, state, or local level.

The IRB may require PIs to apply for a Certificate of Confidentiality. Under the updated policy, effective October 1, 2017, NIH-funded researchers will no longer have to request a Certificate of Confidentiality, nor will they receive an actual certificate. The certificate will be issued automatically to NIH-funded grants, cooperative agreements, contracts, and intramural research projects research funded wholly or in part by the NIH that collects or uses identifiable, sensitive information. However, researchers whose studies are not funded by NIH can still request a Certificate of Confidentiality.

Certificates of Confidentiality may be granted for studies collecting information that if disclosed could have adverse consequences for subjects or damage their financial standing, employability, insurability, or reputation. By protecting researchers and institutions from being compelled to disclose information that would identify research subjects, Certificates of Confidentiality help achieve the research objectives and promote participation in studies by assuring confidentiality and privacy to subjects. For more information, see the [NIH Certificates of Confidentiality Kiosk](#).

The certificate goes beyond the consent form in ensuring confidentiality and anonymity. Without the certificate, researchers can be required by a court-ordered subpoena to disclose research results (usually as part of a criminal investigation of the subjects).

Any PI engaged in research in which sensitive information is gathered from human subjects (or any person who intends to engage in such research) may apply for a Certificate of Confidentiality. Research can be considered “sensitive” if it involves the collection of:

- Information about sexual attitudes, preferences, practices;
- Information about personal use of alcohol, drugs, or other addictive products;
- Information about illegal conduct;
- Information that could damage an individual’s financial standing, employability, or reputation within the community;
- Information in a participant’s medical record that could lead to social stigmatization or discrimination; or
- Information about a participant’s psychological well-being or mental health.

This list is not exhaustive. Researchers contemplating research on a topic that might qualify as sensitive should contact the IRB Office for help in applying for a certificate.

12.6.2 Limitations

The protection offered by a Certificate of Confidentiality is not absolute. A Certificate protects research subjects only from legally compelled disclosure of their identity. It does **not** restrict voluntary disclosures.

For example, a Certificate of Confidentiality does not prevent researchers from voluntarily disclosing to appropriate authorities such matters as child abuse, a participant’s threatened violence to self or others, or from reporting a communicable disease. However, if researchers intend to make such disclosures, this should be clearly stated in the informed consent form which research subjects are asked to sign.

In addition, a Certificate of Confidentiality does **not** authorize the person to whom it is issued to refuse to reveal the name or other identifying characteristics of a research participant if

- The participant (or, if t legally incompetent, his or her legal guardian) consents, in writing, to the disclosure of such information;
- Authorized personnel of the DHHS request such information for audit or program evaluation, or for investigation of DHHS grantees or contractors and their employees; or
- Release of such information is required by the Federal Food, Drug, and Cosmetic Act or regulations implementing that Act.

12.7 Mandatory Reporting

While preparing an IRB application, PIs must keep in mind that the State of California mandates reporting to designated officials and/or agencies according to the [California Penal Code Sections 11164-11174.3](#).

PIs should consult these sources to determine if potential subjects should be advised of mandatory reporting requirements during the informed consent process and if so, the appropriate language will need to be added to the consent.

12.8 Genetic Studies

The IRB requires investigators to provide a plan to ensure the privacy and confidentiality of participants, minimize the risks associated with genetic research, and provide adequate disclosure of genetic results that may be clinically relevant to the participant.

12.8.1 Types of Genomic Studies (any genetic or genomic testing as described above)

Genomic studies usually fall into one of the following general categories:

- A. Anonymous donors, who are untraceable by any means. This would include samples that have been collected or will be collected solely for non-research purposes, such as pathology samples, where only the samples and not any identifying information linking the samples to individuals will be provided to the researcher.
- B. Donors whose identity is known or traceable, but the investigator does not plan to track the individual. An example would be a study where specimens are obtained, banked, and coded by the investigator, or the investigator obtains samples and associated data from a public, private or commercial repository (and there may be a key linking these to the subject's name/identifying information), but no subject-related genomic analysis is planned at this time. (However, the investigator retains identifying information or ability to identify individual subjects should plans change in future.)
- C. Donors whose identity is known or traceable, where the investigator plans to link genomic analyses to other study data from the specific individual, but will not inform subjects of the results of the analyses. An example would be a study about whether impulse control is hereditary, where the investigator would compare individual DNA data to behavioral assessment data, but would not inform the subject of these results.

12.8.2 Risk of Participants in Genomic Research

Unlike the physical risks presented by many biomedical research protocols, the primary risks involved in genomic research are those of social and psychological harm. Genomic studies that generate information about subjects' personal health risks can provoke anxiety and confusion, damage familial relationships, and/or compromise the subjects' future financial status.

Such risks include:

- Privacy breaches (e.g., previously unknown paternity information) due to possible re-identification or other losses of confidentiality;
- Disclosure of results that lack clinical utility, proven validity, or accuracy (e.g., false positives or false negatives);
- Emotional distress, anxiety, or guilt;
- Psychological or social risks through receiving information that is unexpected or unwanted;
- Effects of the knowledge that one has a disease-related gene that might alter one's life course,

- reproductive decisions, employability, or insurability; and
- Results which could cause stigmatization, discrimination, or psychosocial risks to the participant's family, ethnic community, or to isolated populations.

Investigators need to address factors that may affect the rights and welfare of their study subjects (as outlined above), explain their thoughts on these problems and how they plan to handle the issues, as well as how they plan to communicate them to subjects. If applicable, this information should be reflected in both the protocol and the consent documents.

12.8.3 Genetic Testing and Informed Consent

Given that one's genome contains personal health and other information, its analysis as part of a research study raises a number of issues that the informed consent documents need to address. The informed consent process and consent document(s) must include: a description of the genomic research being conducted, the ways in which participants' samples, genomic data, and health information will be used and might be shared (including unspecified future uses), the risks and benefits of their participation, measures in place to protect their privacy, and circumstances under which information will be returned to them (if any).

Investigators should ensure that the consent process for their study is consistent with program or funding agency data-sharing expectations. In order to facilitate future research and increase the scientific value of the data, if applicable broad consent is generally more useful. For NIH-funded research or research contributing data to one of the NIH-specified repositories, investigators are expected to obtain consent for future uses and broad sharing of genomic and phenotypic data (see "Sharing and Accessing Data through Databases" below). When considering the use of broad or specific consent approaches, investigators should balance the responsibility of protecting participants' interests with the potential loss of opportunities for public benefit due to limitations on future research uses.

Broad consent approach:

In addition to or in combination with obtaining specific consent for research in which genomic testing is the primary aim, participants can be asked to agree to storage of their samples/data and to the use of their samples/data in future unspecified research ("general research use").

Specific consent approach:

Sometimes it may be appropriate to seek consent for more narrowly defined research uses of participant samples and data. These consent approaches may increase participation of people who have concerns about privacy or do not want their samples and data used for research on certain topics. Researchers may include options for data use limitations in the consent form. Examples of such limitations on samples and data include:

- Use of the samples and data must be limited to health/medical/biomedical purposes; does not allow study of population origins or ancestry.
- Use of the samples and data must be related to a specified disease.

Consent for Genomic Sub-Studies:

For studies in which genomic analysis is not an integral part of the overall research study, subjects should be given the option to decline participation in the genomic sub-study. A mechanism for tracking subjects' choices in this regard should be provided—often a separate section or an entirely separate consent addendum for the genomic component is recommended.

Child Assent and Parent Permission for Minors:

When enrolling minors in a study which involves genomic research, all of the above criteria apply. In addition, children should be provided with an assent document containing age-appropriate language, if applicable, and parent permission must also be obtained unless criteria for waiver of assent or permission are met. Furthermore, the application and initial informed consent process should discuss plans for re-contact and/or re-consent for those minor participants who reach the age of majority while enrolled in an ongoing study.

Discontinuing Study Participation:

Participants have the right to withdraw from a research study at any time. However, there are likely to be practical limits on the ability of participants to withdraw samples, genomic data, or health information that have been contributed to a biorepository. The potential limitations of withdrawing samples and data from research should be discussed in the consent form and as part of the consent process. For genomic studies that involve bio-banked samples and/or storage of associated data in unrestricted or controlled-access databases, complete withdrawal of samples and data may not be possible once samples or data have been distributed to other laboratories. However, it may be possible to withdraw samples or data from future distributions. In such circumstances, the consent document and the informed consent process should include a full explanation of the extent to which withdrawal of samples or data is possible and what the process is.

12.8.4 Confidentiality and Privacy in Genomic Research

Each person's DNA sequence includes health and other information about them and their families. Technological advances mean that it is now cheaper and easier than ever to sequence and interpret genomic information. It is important to consider how best to ensure that the individual's privacy is respected. While laws and policies exist that serve to protect the privacy of individual's genomic information, there is ongoing debate as to whether further measures are needed.

Identifiable Populations:

Ethnically, geographically, and linguistically identifiable populations present particular concerns with regard to privacy, stigmatization, and discrimination since the ability to protect the privacy of these individuals or groups participating in research is diminished. For small communities or groups, relatively few numbers of family lines may make it especially challenging to protect participants' privacy, even if research samples are de-identified. Depending on the community that the researcher aims to work in, approval to conduct the research from the authorized representative(s) of the community and/or group may need to be obtained prior to consenting individual subjects.

Involvement of Family Members:

Genomic research may reveal new information about the research subject's health; in addition, the heritable nature of genetic information raises implications for the subject's relatives. Information about family members not involved in the study may be indirectly obtained through the research subject. Furthermore, genomic research using family pedigrees that can trace disease history may reveal family members who are carriers of a disease or will be affected themselves. These indirect results pose an ethical conflict between a possible duty to warn research subjects' family members and the protection of subjects' privacy.

If an investigator intends to obtain identifiable private information about the subject's family members, the family members may be considered human research subjects. In such instances, the IRB will consider the necessity and/or appropriateness of a consent process for these "secondary subjects." Also, if the subject will be given genetic or genomic test results, the subject's consent to contact family members may be required.

Protections for Subjects:

- A. Genetic Information Nondiscrimination Act: The Genetic Information Nondiscrimination Act (GINA) prohibits health insurers and employers from requesting or requiring genetic information from an individual or an individual's family members, and further provides legal protection against discrimination on the basis of a person's genetic information.
- B. HIPAA: The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes protections to maintain the confidentiality of patients' individually identifiable health information. In 2013, as required by the Genetic Information Nondiscrimination Act, the Privacy Rule was modified to establish that genetic information is health information protected by the Privacy Rule to the extent that such information is individually identifiable, and that HIPAA covered entities may not use or disclose protected health information that is genetic information for underwriting purposes. For more information, see the HIPAA Guidelines.
- C. Certificates of Confidentiality: When dealing with sensitive data, the IRB may require that the investigator obtain a "Certificate of Confidentiality" ("CoC"). Certificates of Confidentiality are issued by the National Institutes of Health (NIH) to protect identifiable research information from forced disclosure. CoC's are automatically issued to NIH funded studies; however, researchers with eligible studies may request a certificate from NIH. CoC's allow the investigator and others who have access to research records to refuse to disclose identifying information on research subjects in any civil, criminal, administrative, legislative, or other proceeding, whether at the federal, state, or local level. However, there are limitations to this protection (e.g., it does not apply to any state requirement to report certain communicable diseases, or to legal or ethical requirements for researchers to report child abuse to appropriate authorities, etc.). (see section: [Certificate of Confidentiality](#))

12.8.5 Disclosure of Individual Research Results and Incidental Findings

The return of individual research results (IRRs) and incidental findings (IFs) from genomic research is an issue of interest among researchers, ethicists, sponsors, policy makers, research subjects, and others. As indicated above, when conducting clinical research studies, scientists may discover new health-related information about volunteers who have chosen to participate in the studies. This raises the question of when and how it is appropriate for scientists to share such research findings.

IRRs are the results for a specific study subject from a scientific investigation. For example, in genomic research, an IRR could indicate whether a research subject possesses a particular gene variant under study. IFs are a subset of IRRs, findings that are not related to the objectives of an investigation. An example of an IF in genomic research would be finding that a subject in a study of heart disease possesses a gene variant related to Alzheimer's disease.

Currently, the only federal law regarding the return of individual genetic testing research results and incidental findings is the Clinical Laboratory Improvement Amendments of 1988 (CLIA), which sets quality standards for all laboratories performing clinical testing. CLIA prohibits the return of individual research results to study subjects unless the tests were physician-ordered and the results were obtained in a CLIA-certified laboratory.

12.8.5.1 Reporting results to individual subjects or their physicians

For diagnostic or health-related uses, the tests must be physician-ordered and performed at a CLIA-certified laboratory. The IRB application should include the fact that testing will be conducted consistent with CLIA requirements. Additionally, the Risks and Benefits sections of the application should discuss how the benefits of providing the results outweigh the associated risks, and what efforts will be taken to minimize such risks.

12.8.5.2 Withholding results from individual subjects

When research subjects are asked to give biological samples for laboratory testing, they frequently expect that test results will be provided to them. It is important to clarify with subjects from the outset that the tests are research-related, and that the exact test results will not be shared, rather, if the subject agrees, the researcher will inform the subject of any unusual results so they may obtain the appropriate follow-up evaluation by their primary physician. Accordingly, the consent documents should include language such as: “The [requested laboratory tests are] done for research purposes only. The [laboratory] test or scan being done is designed to answer research questions, not to medically examine you or provide a clinical diagnosis. The [laboratory] test or scan is not a substitute for one a physician would order. It may not show problems that would be picked up by a medical [laboratory] test or scan. The researchers are not professionally qualified to act as your medical provider. However, if we see something unusual in your scan, we will inform you so that you can obtain appropriate follow-up evaluation by your physician. We will also provide you or your physician with a copy of the scan results upon request. Any follow-up evaluation or treatment that you seek will be at your own expense. Even if your physician rules out any problems, you may be unnecessarily worried if a problem is suspected.” The IRB generally recommends that individual research results of genetic or other genomic testing for research purposes rather than clinical reasons should not be shared with subjects or their families. For such studies, the fact that this information will not be passed on to subjects must be made clear in the application and consent form(s). However, if the investigator does intend to share results of genetic or other genomic testing with subjects, they will need to provide ethical and scientific justification for passing on such information to the subjects or family members. The IRB will determine if disclosing genetic or other genomic testing results is appropriate, considering factors including:

- Clinical relevance and implications of the genetic or other genomic testing results.
- Reliability of genetic or other genomic testing results.

In addition to presenting justification for sharing results, the investigator must provide:

- A plan in the application outlining how such disclosure will be managed, including methods by which subjects will be informed of their results (verbal communication of an incidental finding should be done in a timely fashion, and documented in writing by a letter), qualifications of individuals who will disclose results (e.g., training and experience in discussing social, psychological and other non-physical risks); whether counseling will be offered, and if so, the qualifications of the counselors and who will pay such costs. This plan should also include how the investigator will minimize the risks of such disclosure and preserve confidentiality of test results.
- A consent process and document(s) giving subjects the option of receiving test results (e.g., by initialing boxes in the signature block), and providing information about plans for minimizing risks, preserving confidentiality, etc.

12.8.6 Sharing or Accessing Data through Databases

In 2008, NIH implemented the Genome-Wide Association Studies (GWAS) Policy. A genome-wide association study is an approach used in genetics research to associate specific genetic variations with particular diseases. This policy requires data from NIH-funded GWAS to be shared with the research community in a central data repository maintained by NIH (i.e., the database of Genotypes and Phenotypes (dbGaP), Gene Expression Omnibus (GEO), Sequence Read Archive (SRA), and Cancer Genomics Hub (CaHUB). To protect research subjects' privacy, access to sensitive data in dbGaP is through a controlled access policy. To further expand genomic data sharing of all types, NIH released a Genomic Data Sharing (GDS) Policy that went into effect on January 25, 2015. This policy applies to all NIH-funded research that generates large-scale human or non-

human genomic data for more than one hundred individuals, regardless of the funding level, as well as the use of these data for subsequent research. Large-scale data include whole genome, single nucleotide polymorphisms (SNP) arrays, whole genome sequence (DNA), gene expression (RNA), transcriptomic, metagenomics, epigenomic and other specified data. This policy states that NIH expects investigators to obtain consent for subjects' data to be used for future research purposes and to be shared broadly through databases. If researchers plan to use existing samples, documentation of consent to allow the samples and associated data to be deposited into a shared database must be furnished. If consent did not include language to explicitly allow the sharing of samples and data, subjects must be re-consented. When depositing specimens into an NIH repository, there are strict standards for IRB review and informed consent before inclusion in the database will be considered. For more detailed information, see: NIH Points to Consider for IRBs and Institutions in Their Review of Data Submission Plans for Institutional Certifications under NIH's Policy for Sharing of Data Obtained in NIH Supported or Conducted Genome-Wide Association Studies (GWAS). For every new data submission to NIH, the IRB is required to determine that submission of data to the NIH GWAS data repository and subsequent sharing for research purposes received appropriate IRB review and approval. The IRB must also certify that the informed consent that was obtained from subjects is consistent with NIH requirements. Finally, when researchers are ready to submit data to NIH for GWAS, the IRB will provide a signed data submission certification letter to the investigator. Similarly, when researchers wish to access samples and data stored in NIH databases, the IRB must review and approve the appropriate IRB application.

Once approved, the IRB will provide a signed certification letter to the investigator. Researchers should contact the IRB directly if they intend to access data from an NIH database.

12.8.7 Storage of Samples

Information must also be included in the application regarding how, where, and by whom genetic samples obtained for the study will be stored, plans for maintaining subjects' privacy and confidentiality of the genetic data, whether data will be collected prospectively, and state explicitly that the data, including a detailed description of the data being submitted, will be sent to NIH for GDS. This should be outlined in the PI's IRB application and reported to the appropriate committee.

12.8.8 Financial Reimbursement, Costs, and Commercialization

In keeping with current University of California policy, subjects must be informed that while there may be future commercial use of their samples or genomic data, or production and distribution of derivatives such as cell lines, subjects will not receive any future profits if the research results in products that are eventually developed and sold for commercial purposes.

Consent forms for studies which utilize genomic samples/data are required by UC Office of the President (UCOP) policy to include language conveying this information, also known as the "Moore Clause," e.g.:

"Biospecimens (such as blood, tissue, or saliva) collected from you for this study and/or information obtained from your biospecimens may be used in this research or other research, and shared with other organizations. You will not share in any commercial value or profit derived from the use of your biospecimens and/or information obtained from them."*

*For more information on Moore Clause language, see UCOP's Standard Language in Research Informed Consent Forms for Research and OHRP's draft Guidance on Exculpatory Language in Informed Consent (2017).

12.9 Research Involving Coded Private Information or Biological Specimens

This UCR policy is based on the OHRP guidance document entitled, Coded Private Information or Specimens

Use in Research, Guidance (2008). This document:

- Provides guidance as to when research involving coded private information or specimens is or is not research involving human subjects, as defined under DHHS regulations for the protection of human research subjects [45 CFR 46].
- Reaffirms OHRP policy that, under certain limited conditions, research involving **only** coded private information or specimens is not human subjects research.
- Clarifies the distinction between (a) research involving coded private information or specimens that does not involve human subjects and (b) human subjects research that is exempt from the requirements of the HHS regulations.
- References pertinent requirements of the HIPAA Privacy Rule that may be applicable to research involving coded private information or specimens.

For purposes of this policy, *coded* means that: (1) identifying information (such as name or social security number) that would enable the PI to readily ascertain the identity of the individual to whom the private information or specimens pertain has been replaced with a number, letter, symbol, or combination thereof (i.e., the code); and (2) a key to decipher the code exists, enabling linkage of the identifying information to the private information or specimens.

Under the definition of human participant, obtaining identifiable private information or identifiable specimens for research purposes constitutes human subjects research. *Obtaining* means receiving or accessing identifiable private information or identifiable specimens for research purposes. This includes a PI's use, study, or analysis for research purposes of identifiable private information or identifiable specimens that have been provided to the PI from any source or were already in the possession of the PI.

In general, private information or specimens are considered to be individually identifiable when they can be linked to specific individuals by the PI(s) either directly or indirectly through coding systems. Private information or specimens are not considered to be individually identifiable when they cannot be linked to specific individuals by the PI(s) either directly or indirectly through coding systems.

Research involving only coded private information or specimens does not involve human subjects if the following conditions are both met:

1. The private information or specimens were not collected specifically for the currently proposed research project through an interaction or intervention with living individuals; and
2. The PI(s) cannot readily ascertain the identity of the individual(s) to whom the coded private information or specimens pertain because, for example:
 - i. the PIs and the holder of the key enter into an agreement prohibiting the release of the key to the PIs under any circumstances, until the individuals are deceased (note that the DHHS regulations do not require the IRB to review and approve this agreement);
 - ii. there are IRB-approved written policies and operating procedures for a repository or data management center that prohibit the release of the key to the PIs under any circumstances, until the individuals are deceased; or
 - iii. there are other legal requirements prohibiting the release of the key to the PIs, until the individuals are deceased.

This guidance applies to existing private information and specimens, as well as to private information and specimens to be collected in the future for purposes other than the currently proposed research. The following

are examples of private information or specimens that will be collected in the future for purposes other than the currently proposed research: (1) medical records; and (2) ongoing collection of specimens for a tissue repository.

In some cases, a PI who obtains coded private information or specimens about living individuals under one of the conditions cited in 2(a)-(c) above may (1) unexpectedly learn the identity of one or more living individuals, or (2) for previously unforeseen reasons now believe that it is important to identify the individual(s). If, as a result, the PI knows, or may be able to readily ascertain, the identity of the individuals to whom the previously obtained private information or specimens pertain, then the research activity now would involve human subjects. Unless this research is determined to be exempt (see section: [Exempt Research](#)), IRB review will be required. Informed consent from subjects also would be required unless the IRB approved a waiver of informed consent (see section: [Waiver/Alteration of Informed Consent](#)).

12.9.1 Who Should Determine Whether Coded Private Information or Specimens Constitutes Human Subjects Research

The Office of Research Integrity or the IRB of record will determine if the research involving coded information or specimens requires additional IRB review. If the request is verbal (by phone or in person) or by email, it is the PI's responsibility to maintain documentation of such a decision. If the PI submits a formal submission, the request must include sufficient documentation of the activity to support the determination. Formal submissions will be responded to in writing and a copy of the submitted materials and determination letter/email will be kept on file.

12.10 Review of Devices

12.10.1 Review of Research Involving Medical Devices

Before reviewing research involving a medical device for human use, the Board will determine if the device is a Significant Risk (SR) Device, a Non-Significant Risk (NSR) Device, or whether the research use of the device is exempt from the Investigational Device Exemption (IDE) regulations.

- A. If the Board determines that the device is NSR, this finding will be included in the minutes, and the Board may proceed to review the research activities and investigator under its normal procedures for reviewing research projects.
- B. If the FDA has issued an IDE for the proposed use of the device, then it is automatically an SR device. This finding will be noted in the minutes.
- C. If FDA has not issued an IDE for the proposed use of the device, then the Board shall consider the following elements in determining if the device is SR:
 1. An explanation provided by the sponsor of why the device is not a significant risk device, and
 2. Whether the use of the device might cause harm to any of the subjects, and the nature of the harm that may result from use of the device.

Note: If the subject must undergo a medical procedure as a part of the study, and that medical procedure is not one that the subject would otherwise undergo as part of standard medical care, the Board must consider the risks associated with the procedure, as well as the risk associated

with the use of the device. If potential harm to subjects could be life-threatening, could result in permanent impairment of body function, or permanent damage to body structure, the device should be considered SR.

- D. If the Board determines the device is SR, and there is no IDE assigned, it will provide the investigator and, if appropriate, the sponsor, with its finding. The sponsor is responsible for notifying the FDA of the Board's SR determination. The Board will not review the research until the sponsor provides proof that the FDA has granted an IDE to the sponsor. The proof, required above, may consist of a letter from the FDA granting IDE approval or a letter from the sponsor to the FDA showing that an IDE application was submitted at least 30 days prior to the date on which the Board reviews the research.
- E. If the Board determines that the investigation meets one of the IDE exemptions listed at 21 CFR 812.2(c), this finding will be noted in the minutes, and the Board will not make an SR/NSR determination. Also, if the investigation involves a device that is cleared for marketing through the PMA process, and the device is being studied for the purpose(s) for which the device is labeled, the Board will consider the investigation exempt from the IDE regulations. This finding will be noted in the minutes, and the Board will not make an SR/NSR determination.

Research involving a medical device for human use that qualifies as a NSR Device (unless the device is banned), may begin upon approval by the IRB and does not require the issuance of an IDE by the FDA (FDA 21 CFR 812.2 (b)(1)).

Research involving a medical device for human use that does not qualify as a NSR device is classified as a SR Device. Research involving SR devices cannot begin until the FDA issues an IDE and approval is granted by the IRB (FDA 21 CFR 812.30 (a)).

A SR device means an investigational device that meets any of the following criteria (FDA 21 CFR 812.3(m)):

- Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject.
- Is purported or represented to be for use in supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a subject.
- Is for a use of substantial importance in diagnosis, curing, mitigating, or treating disease, or otherwise preventing impairment of human health, and presents a potential for serious risk to the health, safety, or welfare of a subject, or
- Otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

12.10.2 Review of Humanitarian Use Devices (HUD)

A Humanitarian Use Device (HUD) is intended to benefit subjects in the treatment or diagnosis of diseases or conditions that affect or manifest in fewer than 4,000 individuals in the United States per year. HUDs are considered by the FDA to be approved for marketing.

IRB review of HUDs is required under Federal Regulation (FDA 21 CFR Part 814). Before reviewing a HUD, the

Board shall:

Determine that the FDA has granted a Humanitarian Device Exemption (HDE) to the sponsor.

Determine that the investigator intends to use the HUD according to its FDA approved use.

After the Board has determined that the FDA has granted an HDE, the Board may proceed to review the Research activities and investigator under its normal procedures for reviewing Research projects.

Informed consent is not required for use of a HUD in accordance with its FDA approved use. However, the Board may require consent in such instances at its discretion. The Board will require informed consent for the **research use** of a HUD.

13. Agency-Specific Regulations

Research funded by some agencies must also comply with that agency's regulations in addition to the regulations set forth in the Common Rule.

13.1 Department of Education

The U.S. Department of Education (ED) has additional regulations governing human subjects research that must be followed by the IRB, PIs, and research staff.

For example, ED funded research must indicate that access to instructional material used in the research or experimentation program¹ will be available for inspection by the parents or guardians of the children² engaged in such research. This includes teachers' manuals, films, tapes, or other supplementary instructional material.

¹ED defines research or experimentation programs or projects as any programs or projects in any research that is designed to explore or develop new or unproven teaching methods or techniques.

²Children are defined by the ED as persons not above the elementary or secondary education level, who have not reached the age of majority as determined under state law.

Additionally, for ED research that purposefully includes of children with disabilities or individuals with mental disabilities as research subjects and is specifically funded by the National Institute on Disability and Rehabilitation Research, the IRB is required to include at least one person primarily concerned with the welfare of these research subjects during the review process.

Other general requirements are described in the Family Educational Rights and Privacy Act (FERPA), a Federal law that protects the privacy of student education records, and the Protection of Pupil Rights Amendment (PPRA).

13.1.2 Family Educational Rights and Privacy Act

Under the FERPA, parents, and students must provide permission/assent to release a student's education records, *unless* the records are released to organizations conducting studies for, or on behalf of, educational agencies or institutions to:

- Develop, validate, or administer predictive tests;
- Administer student aid programs; and/or

- Improve instruction.

If the purpose of the research is as described above, PIs must receive IRB approval to waive parent/student permission/assent and submit the original written agreement with the school or school district that specifies:

- The determination of the exception;
- The purpose, scope, and duration of the study;
- The information to be disclosed;
- That information from education records may only be used to meet the purposes of the study stated in the written agreement and must contain the current requirements in 34 CFR 99.31(a)(6) on re-disclosure and destruction of information;
- That the study will be conducted in a manner that does not permit personal identification of parents and students by anyone other than representatives of the organization with legitimate interests;
- That the organization is required to destroy or return all personally identifiable information when it is no longer needed for the purposes of the study; and
- The time period during which the organization must either destroy or return the information.

PIs who are *not* developing, validating, or administering predictive tests; administering student aid programs; and/or improving instruction may obtain education records without parent/student permission/assent under FERPA *if all personally identifiable information has been removed* including:

- Student's name and other direct personal identifiers, such as the student's social security number or student number.
- Indirect identifiers, such as the name of the student's parent or other family members; the student's or family's address, and personal characteristics or other information that would make the student's identity easily traceable; date and place of birth and mother's maiden name.
- Biometric records, including one or more measurable biological or behavioral characteristics that can be used for automated recognition of an individual, including fingerprints, retina and iris patterns, voiceprints, DNA sequence, facial characteristics, and handwriting.
- Other information that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community, who does not have personal knowledge of the relevant circumstances, to identify the student with reasonable certainty.

The process to grant exceptions to parental/student permission/assent consent to release student records for research will be delegated to the IRB or another individual or component of the organization (e.g., a FERPA committee).

13.1.3 Protection of Pupil Rights Amendment

All research involving children at school, *regardless of their funding source*, must comply with the Protection of Pupil Rights Amendment (PPRA) in that:

- Parents of students have, upon the request of the parent, the right to inspect or obtain more information about
 1. any instrument used in the collection of personal information, *including research surveys*;
 2. any instructional material used as part of the educational curriculum for the student;

3. the administration of physical examinations or screenings that the school or agency may administer to a student; and
 4. the collection, disclosure, or use of personal information collected from students for the purpose of marketing or for selling that information (or otherwise providing that information to others for that purpose), including arrangements to protect student privacy that are provided by the agency in the event of such collection, disclosure, or use.
- Such requests by a parent for reasonable access to such information and/or materials must be granted within a reasonable period of time after the request is received.

In addition, parents must be informed of how student responses to the following questions will be kept confidential:

- Political affiliations or beliefs of the student or the student's parent;
- Mental or psychological problems of the student or the student's family;
- Sex behavior or attitudes;
- Illegal, anti-social, self-incriminating, or demeaning behavior;
- Critical appraisals of other individuals with whom respondents have close family relationships;
- Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers;
- Religious practices, affiliations, or beliefs of the student or the student's parent; and,
- Income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program).

If the research *is* funded by ED, prior consent *must* be obtained from the student (if the student is an adult or emancipated minor), or the parent or guardian (if the student is an un-emancipated minor), before the student may participate in an ED-funded survey, analysis, evaluation, psychiatric examination, testing, or treatment, or psychological examination, testing, or treatment, in which the primary purpose is to reveal one or more of the items above.

13.2 Department of Justice

Research funded by the U.S. Department of Justice (DoJ) must comply with DoJ regulations in addition to the regulations set forth in the Common Rule.

For example, all DoJ-funded research must have a privacy certificate approved by the NIJ Human Subjects Protection Officer. This certificate is signed assurance that any identifiable data obtained through the research will only be used for research or statistical purposes and that compliance with the request for information is not mandatory. The privacy certificate, therefore, supersedes all mandatory reporting laws (see section: [Mandatory Reporting](#)). For example, under a privacy certificate, the investigator and their research staff do not have to report child abuse unless the participant signed another consent form to allow child abuse reporting. However, if a participant reports immediate harm to him/herself or others, the investigator will break their confidentiality agreement with the participant. The participant must be informed of this caveat during the informed consent process.

The privacy certificate also includes the PI's assurance that participation in a project may be terminated at any

time, and that subjects will be informed if findings in a project cannot, by virtue of sample size or the uniqueness of the participant, be expected to totally conceal the identity of an individual.

In addition to the privacy certificate, all researchers and research staff are required to sign employee confidentiality statements, which are maintained by the responsible researcher.

A copy of all data must be de-identified and sent to the National Archive of Criminal Justice Data, including copies of the informed consent document, data collection instruments, surveys, or other relevant research materials.

13.2.1 Bureau of Prisons

DoJ has additional regulations for research conducted within the Bureau of Prisons (BOP).

13.2.1.1 Study Design

Implementation of BOP programmatic or operational initiatives made through pilot projects is not considered to be research. PIs must still notify the UCR IRB of their involvement in these projects.

Research conducted within the BOP must meet the requirements of 28 CFR 512, such as:

- The project must not involve medical experimentation, cosmetic research, or pharmaceutical testing.
- The research design must be compatible with both the operation of prison facilities and protection of human subjects. The researcher must observe the rules of the institution or office in which the research is conducted.
- Any researcher who is a non-employee of the BOP must sign a statement in which the researcher agrees to adhere to the provisions of 28 CFR 512.
- All research proposals will be reviewed by the BOP Research Review Board.

The project must have an adequate research design and contribute to the advancement of knowledge about corrections.

PIs conducting research within the BOP must have academic preparation or experience in the area of study of the proposed research. Research proposals must be submitted on the general IRB Application (which includes the general descriptors required under 28 CFR 512.12) with the basic IRB requirements for a protocol submission (including consent documents and measures) and a comprehensive statement as required by the BOP that includes:

- A review of related literature;
- Specific resources required from the BOP;
- A description of any anticipated effects of the research study on organizational programs and operations;
- The significance of anticipated results and their contribution to the advancement of knowledge;
- Relevant research materials such as vitae, endorsements, and interview schedules; and
- A statement regarding assurances and certification required by 28 CFR 46, if applicable.

13.2.1.2 Selection of Subjects

The selection of subjects within any one organization must be equitable. Incentives may not be offered to help persuade inmate subjects to participate. However, soft drinks and snacks to be consumed at the test setting may be offered. Reasonable accommodations such as nominal monetary recompense for time and effort may be offered to non-confined research subjects who are participating in authorized research being conducted by BOP employees or contractors and are no longer in BOP custody.

13.2.1.3 Confidentiality

Regarding the confidentiality of data acquired from research conducted within the BOP, non-employees of the BOP may receive unidentifiable data *if* advance adequate written assurance that the record will be used solely as a statistical research or reporting record is provided to the agency.

PIs must not provide research information that identifies a participant to any person without that participant's prior written consent to release the information. For example, data that identifies a particular individual cannot be admitted as evidence or used for any purpose in any action, suit, or other judicial, administrative, or legislative proceeding without the written consent of the individual to whom the data pertain.

Records that contain non-disclosable information directly traceable to a specific person may not be stored in, or introduced into, an electronic retrieval system, unless this data is maintained at an official Department of Justice site.

If the PI is conducting a study of special interest to the National Institute of Justice (NIJ) Office of Research and Evaluation (ORE) but the study is not a joint project involving ORE, the PI may be asked to provide ORE with the computerized research data, not identifiable to individual subjects, accompanied by detailed documentation. *These arrangements must be negotiated prior to the beginning of the data collection phase of the project.*

13.2.1.4 Consent

In addition to the basic elements of informed consent, consent documents to be used for research conducted within the BOP must include the following elements of disclosure:

- Identification of the researchers.
- Anticipated uses of the results of the research.
- A statement that participation is completely voluntary and that the participant may withdraw consent and end participation in the project at any time without penalty or prejudice (the inmate will be returned to regular assignment or activity by staff as soon as practicable);
- A statement regarding the confidentiality of the research information and exceptions to any guarantees of confidentiality required by federal or state law. For example, a researcher may not guarantee confidentiality when the participant indicates intent to commit future criminal conduct or harm himself or herself or someone else, or, if the participant is an inmate, indicates intent to leave the facility without authorization.
- A statement that participation in the research project will have no effect on the inmate participant's release date or parole eligibility.

13.2.1.5 Reporting Requirements

At least once a year, the researcher conducting research within the BOP shall provide the ORE Chief a report on the progress of the research.

At least 12 working days before any report of findings is to be released, the researcher shall distribute one copy of the report to the chairperson of the BOP Research Review Board, the regional director, and the warden of each institution that provided data or assistance. This report must include an abstract of the findings.

Prior to submitting for publication the results, the researcher shall provide two copies of the material, for informational purposes only, to the ORE Chief.

Any publication of results shall acknowledge the BOP's participation in the research project and expressly disclaim approval or endorsement of the published material as an expression of the policies or views of the BOP.

13.3 Department of Defense

Regulations specific to the U.S. Department of Defense (DOD) may be found at 32 CFR 219.

13.3.1 DoD Training Requirements

The ORI will notify the IRB and the research community of new regulations, guidance, and educational/training requirements from DoD. However, it is ultimately the responsibility of the researcher to ensure that they and their research staff meet all of DoD and the applicable component's (e.g., Department of the Navy, Department of the Army, etc.) current educational requirements before the commencement of the research.

13.3.2 Participant Recruitment

DoD defines "research involving a human being as an experimental participant" as an activity, for research purposes, where there is an intervention or interaction with a human being for the primary purpose of obtaining data regarding the effect of the intervention or interaction ([DoD Directive 3216.02 E2.1.3](#)). Examples of interventions or interactions include, but are not limited to, a physical procedure, a drug, a manipulation of the participant or participant's environment, and/or the withholding of an intervention that would have been undertaken if not for the research purpose.

If a participant of DoD-funded research meets the definition above, a waiver of the consent process may only be obtained through the Secretary of Defense. If a participant does not meet this definition, the IRB may waive the consent process.

For research involving U.S. military personnel policies and procedures, the DoD requires additional protections for military research subjects to minimize undue influence:

- Officers are not permitted to influence the decision of their subordinates.
- Officers and senior non-commissioned officers may not be present at the time of recruitment.
- Officers and senior non-commissioned officers have a separate opportunity to participate.
- When recruitment involves a percentage of a unit, an independent ombudsman is present.

U.S. military personnel may not receive dual compensation for their participation in research. Specifically, an individual may not receive pay or compensation for participation in research during duty hours. Compensation may only be received when the individual's participation in research takes place when they are not on duty.

Research involving prisoners of war is prohibited. The IRB and PI must review the definition of "prisoner of war" for the DoD component granting the addendum to ensure that no prisoners of war are included in the

research.

13.3.3 Research Monitoring

The IRB will appoint a research monitor for DoD-funded research if the study involves greater than minimal risk. The IRB may also require a research monitor for studies involving no more than minimal risk, if appropriate.

The independent research monitor will be appointed by name by the IRB and will be given the authority to stop a research study in progress, remove individuals from the study, and take any steps to protect the safety and well-being of subjects until the IRB assesses the situation.

13.3.4 Other DoD Requirements

- If DoD-funded research is conducted outside of the United States, the PI must follow all of that country or region's local laws, regulations, customs, and practices. In addition, the PI must obtain permission to conduct research in that country by certification or local ethics review. This certification must be submitted to the IRB office for documentation in the PI's file(s) before the PI and his/her research staff may begin collecting data.
- Surveys to be administered to DoD personnel must be submitted, reviewed, and approved first by the IRB, and then by the Department of Defense before they may be used.
- Consent documents must describe the provisions for research-related injury that follow the requirements of the DoD component. PIs should contact their DoD Funding unit's liaison to determine specific disclosure requirements.
- For multi-site research receiving funding from DoD, a formal agreement between the organizations that specifies the roles and responsibilities of each party must be submitted to the IRB.
- Serious or continuing non-compliance related to DoD-funded research will be reported to the DoD Director, as described in [Reporting to Regulatory Agencies and Institutional Officials](#).
- DoD may require submission of records to DoD for archiving.

13.4 State of California

13.4.1 Experimental Bill of Rights

California law, under Health & Safety Code §24172, requires all investigators performing a "medical experiment" to offer their subjects a copy of the "Experimental Subject's Bill of Rights." Failure to do so may result in civil or criminal penalties.

A "[medical experiment](#)" is defined as:

The severance or penetration or damaging of tissues of a human subject, or the use of a drug or device as defined in section 109920 of 109925 (of the Health and Safety Code), electromagnetic radiation, heat or cold, or a biological substance or organism, in or upon a human subject in the practice or research of medicine in a manner not reasonably related to maintaining or improving the health of such subject or otherwise directly benefitting such subject. The investigational use of a drug or device as provided in Sections 111590 and 111595. Withholding medical treatment from a human subject for any purpose other than maintenance or improvement of the health of the subject.

The UC has interpreted this definition to include almost all studies involving biomedical procedures, placebo

controls, innovative therapy and/or normal volunteer subjects.

For non-biomedical studies, the IRB may recommend use of the Experimental Subject's Bill of Rights, though it is not required by law.

13.4.2 Electronic Data Security

Federal regulations require IRBs to determine the adequacy of provisions to protect the privacy of subjects and to maintain the confidentiality of their data. To meet this requirement, federal regulations require researchers to provide a plan to protect the confidentiality of research data.

Today, the majority of data is collected, transmitted or stored electronically at some point. UCR offers a wide range of information technology services for all faculty, staff, and students to safeguard this data. In addition to these services provided by the institution, all investigators and research staff should be familiar with information security policies and procedures of their department or unit, UCR and the University of California, federal privacy laws, and the state of California laws.

California Law AB 1298, enacted in 2007, requires that residents be notified when their electronic medical information or health insurance information has been exposed. The costs of notification can be significant and departments may be at risk for notification costs if identifiable medical data are lost, stolen or otherwise exposed. For more information on AB 1298 please read the [Legislative Update on the Privacy Office web site for the California Department of Health Services](#). (see sections: [Privacy and Confidentiality](#) and [Patient Rights & Research](#))

14. Appendix A

14.1 Abbreviations

Abbreviation	Full Name
AAS	Audit and Advisory Services
ACR	Assistant Vice Chancellor
BOP	Bureau of Prisons
CDC	Centers for Disease Control and Prevention
CIOMS	Council of International Organization of Medical Sciences
CITI	Collaborative Institutional Training Initiative
COI	Conflict of Interest
CPRA	California Public Records Act
CRO	Contract Research Organization
DHHS	Department of Health and Human Services
DMC	Data Monitoring Committee
DOD	U.S. Department of Defense
DOJ	U.S. Department of Justice
DPAHC	Durable Power of Attorney for Health Care
DSMB	Data and Safety Monitoring Board
ED	U.S. Department of Education
FDA	Food and Drug Administration

FERPA	Family Educational Rights and Privacy Act
FWA	Federal-Wide Assurance
HDE	Humanitarian Device Exemption
HIPAA	Health Insurance Portability and Accountability Act
HUD	Humanitarian Use Devices
IAA	IRB Authorization Agreement
IACUC	Institutional Animal Care and Use Committee
ICH	International Conference on Harmonization
IDE	Investigational Device Exemption
IO	Institutional Official
IRB	Institutional Review Board
LAR	Legally Authorized Representative
MOU	Memorandum of Understanding
NCI	National Cancer Institute
NHSR	Not -Human -Subjects Research
NIH	National Institutes of Health
NIJ	National Institute of Justice
NSR	Non-Significant Risk
OHRP	Office for Human Research Protection
ORE	Office of Research and Evaluation
ORI	Office of Research Integrity
PHS	Public Health Service
PHI	Protected Health Information
PI	Principal Investigators
PPRA	Protection of Pupil Rights Amendment
PRO	Promoting Research Objectivity
SR	Significant Risk
U.S.	United States
VCR	Vice Chancellor of Research

14.2 Definitions

Term	Definition
Allegation of Non-Compliance	an unproved assertion of non-compliance
Assent	a child's affirmative agreement to participate in research, which may be written or given verbally.
Children	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
Confidentiality	refers to the methods used to ensure that information obtained by researchers about their subjects is not improperly divulged
Continuing Non-Compliance	a pattern of non-compliance that, in the judgment of the IRB Chair or convened IRB, suggests a likelihood that instances of non-compliance will continue without intervention. Continuing non-compliance also includes failure to respond to a request to resolve an episode of non-compliance.

Dead Fetus	a fetus that does not exhibit heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, or pulsation of the umbilical cord
Delivery	complete separation of the fetus from the woman by expulsion or extraction or any other means
Disability	a <u>developmental disability</u> (as defined in 42 USC 15002(8)), a <u>mental illness</u> (as defined in 42 USC Section 10802(4)), a <u>disability within the meaning of the Americans with Disabilities Act of 1990</u> , or a <u>disability within the meaning of the California Fair Employment and Housing Act</u> .
Fetus	the product of conception from implantation until delivery
Finding of Non-Compliance	an allegation of non-compliance that is proven true or a report of non-compliance that is clearly true
Guardian	An individual who is authorized under applicable state or local law to consent on behalf of a child to general medical care
Legally Authorized Representative	an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective participant to the participant's participation in the procedure(s) involved in the research
Minimal Risk	risk in which the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests
Minor or Sporadic Non-Compliance	the failure to comply with IRB policies, which in the opinion of the IRB Chair and head of ORI (or designee), are administrative in nature
Neonate	A newborn
Noncompliance	the failure to comply with any of the regulations and policies mentioned and described in this document and/or failure to follow the determinations of the IRB. Non-compliance may be minor or sporadic, serious, or continuing
Nonviable Neonate	a neonate after delivery that, although living, is not viable
Parent	a child's biological or adoptive parent
Participant	A living individual who takes part in a research study. Used interchangeably with 'subject'
Pregnancy	the period of time from implantation until delivery.
Prisoner	any individual involuntarily confined or detained in a penal institution
Privacy	refers to how much an individual has control over the extent, timing, and circumstances of sharing oneself (physically, behaviorally, or intellectually) with others
Permission	the agreement of parent(s) or legal guardian to the participation of their child or ward in research.
Serious Non-Compliance	the failure to follow any of the regulations and policies described in this document or failure to follow the determinations of the IRB and which, in the judgment of either the IRB Chair or the convened IRB, increases risks to subjects, decreases potential benefits or compromises the integrity of the human research protection program. Any human subjects research, regardless of risk, conducted without prior IRB approval is considered serious noncompliance. Does not apply to exempt research
Subject	A living individual who takes part in a research study. Used interchangeably with 'participant'

Suspension	the temporary withdrawal of IRB approval for some or all research procedures short of permanent withdrawal of approval of all research procedures
Termination	the permanent withdrawal of IRB approval for all research procedures
Viable	as it pertains to the neonate, means being able, after delivery, to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration.