University of Southern California
Human Subjects Protection Program (HSPP)
Policies and Procedures

Office for the Protection of Research Subjects (OPRS)
Health Sciences Institutional Review Board (HSIRB)
University Park Institutional Review Board (UPIRB)

2016
Institutions are charged with establishing policies and procedures for the protection of human research subjects according to federal policy. As the Institutional Official named in the University of Southern California (USC) Federalwide Assurances, it is my responsibility to provide and oversee these policies and procedures. These policies are regularly updated as practices and regulatory changes dictate.

The USC Human Subject Protection Policy and Procedures are designed to facilitate the protection of human subjects involved in research conducted under the auspices of the University. Investigators, IRB members and staff are encouraged to familiarize themselves with the policies and procedures and utilize them during the submission, review, and conduct of human subjects research.

Protecting the rights and welfare of human subjects is an important responsibility that can best be met through education of all parties involved in the conduct of human subject’s research and implementation of practices designed to minimize risks and maximize benefits associated with these activities.

Thank you for your cooperation in our joint effort to protect the human subjects involved in our research studies.

Randolph W. Hall, Ph.D.
Vice President of Research
Statement of the University of Southern California

CODE OF ETHICS
OF THE UNIVERSITY OF SOUTHERN CALIFORNIA

At the University of Southern California, ethical behavior is predicated on two main pillars: a commitment to discharging our obligations to others in a fair and honest manner, and a commitment to respecting the rights and dignity of all persons. As faculty, staff, students, and trustees, we each bear responsibility not only for the ethics of our own behavior, but also for building USC’s stature as an ethical institution.

We recognize that the fundamental relationships upon which our university is based are those between individual students and individual professors; thus, such relationships are especially sacred and deserve special care that they not be prostituted or exploited for base motives or personal gain.

When we make promises as an institution, or as individuals who are authorized to speak on behalf of USC, we keep those promises, including especially the promises expressed and implied in our Role and Mission Statement. We try to do what is right even if no one is watching us or compelling us to do the right thing.

We promptly and openly identify and disclose conflicts of interest on the part of faculty, staff, students, trustees, and the institution as a whole, and we take appropriate steps to either eliminate such conflicts or insure that they do not compromise the integrity of the individuals involved or that of the university.

We nurture an environment of mutual respect and tolerance. As members of the USC community, we treat everyone with respect and dignity, even when the values, beliefs, behavior, or background of a person or group is repugnant to us. This last is one of the bedrocks of ethical behavior at USC and the basis of civil discourse within our academic community. Because we are responsible not only for ourselves but also for others, we speak out against hatred and bigotry whenever and wherever we find them.

We do not harass, mistreat, belittle, harm, or take unfair advantage of anyone. We do not tolerate plagiarism, lying, deliberate misrepresentation, theft, scientific fraud, cheating, invidious discrimination, or ill use of our fellow human beings—whether such persons be volunteer subjects of scientific research, peers, patients, superiors, subordinates, students, professors, trustees, parents, alumni, donors, or members of the public.

We do not misappropriate the university’s resources, or resources belonging to others which are entrusted to our care, nor do we permit any such misappropriation to go unchallenged.

We are careful to distinguish between legal behavior on the one hand and ethical behavior on the other, knowing that, while the two overlap in many areas, they are at bottom quite distinct from each other. While we follow legal requirements, we must never lose sight of ethical considerations.

Because of the special bonds that bind us together as members of the Trojan Family, we have a familial duty as well as a fiduciary duty to one another. Our faculty and staff are attentive to the well-being of students and others who are entrusted to our care or who are especially vulnerable, including patients, volunteer subjects of research, and the children in our daycare and community outreach programs.

By respecting the rights and dignity of others, and by striving for fairness and honesty in our dealings with others, we create an ethical university of which we can all be proud, and which will serve as a bright beacon for all peoples in our day and in the centuries to come.

Adopted by the Board of Trustees of the University of Southern California, March 28, 2004
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Commitment of USC to Human Subjects Protection

At USC, protection of research subjects is a university-wide function that merits and receives the highest level of institutional support, commitment, visibility, and rigor. A vast and successful research enterprise is a catalyst for societal benefits and economic well-being. Thus, maintaining public trust in USC’s academic research is a critical goal. An excellent Human Subjects Protection Program (HSPP) is a vital part of retaining this trust and assuring that priority is given to the rights and welfare of those who participate in research.

The policies, procedures, and commitment established by this document reflect the practices, expectations and standards to which this Institution adheres.
Chapter 1: USC Human Subjects Protection Program

Chapter Contents

1.1 – Human Subjects Protection Program (HSPP)
1.2 – Human Subjects Protection Program Components
1.3 – How the Organization Works Together to Protect Subjects
1.4 – Research Involving the Community
1.5 – Flexibility Policy and Coalition
Chapter 1
USC Human Subjects Protection Program

This chapter describes the purpose and composition of the USC Human Subjects Protection Program (HSPP). It also addresses how the Program protects human subjects and how USC involves the community in research. Lastly, this chapter introduces the USC Flexibility Policy.

1.1 Human Subjects Protection Program (HSPP)

The University of Southern California (USC) Human Subjects Protection Program (HSPP) oversees all research involving human subjects at USC. At USC, the HSPP program has the full support of the upper levels of the administration including the Board of Trustees, the President, the Provost and the Provost’s staff. The members of the program include the Vice President of Research, Executive Director and staff of the Office for the Protection of Research Subjects (OPRS), and staff, Chairs, members of the Institutional Review Boards (IRBs) for the University Park (UPIRB) and Health Sciences (HSIRB).

The HSPP team is supplemented by faculty from both campuses and the Office of Compliance for guidance and issue resolution. The primary responsibility of the HSPP is to assure the protection of subjects participating in USC research and continuing to meet and exceed accreditation standards. For studies involving USC neighboring communities, USC involves the community in planning, designing and participating in the conduct of research.

The University of Southern California is committed to conduct biomedical and behavioral research involving human subjects following the ethical principles embodied in The Belmont Report: Ethical Principles and Guidelines for the Human Subjects of Research found in the Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

The USC IRBs have been established in compliance with existing regulations of the federal government under U.S. Department of Health and Human Services (DHHS) regulations in 45 CFR 46, the Food and Drug Administration (FDA) regulations in 21
**Chapter 1: USC Human Subjects Protection Program**

**CFR 50, 56** as well as other applicable federal regulations and state and local laws. **USC complies with requirements stipulated by other federal agencies when they serve as sponsors or have oversight of research conducted at USC.** For a list of applicable federal regulations, refer to [Appendix M](#).

The IRBs are in compliance with [International Conference on Harmonization Good Clinical Practice Consolidated Guidelines](http://www.ich.org) insofar as those guidelines are consistent with the FDA and DHHS regulations pertaining to the protection of human subjects in research.

The USC IRBs operate with a Federalwide Assurance issued by the DHHS, Office for Human Research Protections ([OHRP](http://www.hhs.gov/ohrp)). The USC IRB’s are registered in the OHRP/FDA IRB database.

USC has chosen to limit the scope of its Federalwide Assurance (FWA) to federally funded research (by “unchecking the box”), the terms of which allow an appropriate level of flexibility for research involving no greater than minimal risk. This provides an appropriate level of administrative flexibility without compromising subject protections. Subject protections remain equivalent for all studies whether funded or not. For research involving no greater than minimal risk and receiving no federal funds, USC has created an innovative flexibility policy adapted by other Institutions nationwide.

**ALL** human subject research projects at USC must be reviewed and approved by an IRB before research can begin. While the principal investigator has primary responsibility for the conduct of the study, the USC IRBs are responsible for protecting the rights and welfare of study subjects under Federal Wide Assurances (FWAs) granted by DHHS ([http://www.hhs.gov/ohrp/assurances/assurances/index.html](http://www.hhs.gov/ohrp/assurances/assurances/index.html)) to the University Park Campus and the Health Science Campus. This fundamental commitment to the protection of human subjects applies to all USC research involving human subjects regardless of whether the research is funded through government, non-profit or industry sponsors, through University funds, or not funded at all, and regardless of the location of the research.

The University and its researchers adhere to federal, California, and local regulations and laws as appropriate. **USC will comply with requirements stipulated by other federal agencies when they serve as sponsors of research conducted at USC.** Ethical and procedural guidelines by recognized organizations are also used for achieving best practices.
The OPRS oversees university wide human subjects’ protections through program oversight, education, policy setting, and outreach.

The IRBs at USC are delegated the authority to review all human subjects research proposals - funded or not - that are conducted by USC faculty, staff, graduate, and undergraduate students.

USC IRBs review, approve, and monitor all research involving human subjects under the jurisdiction of their FWAs. Each IRB office provides administrative support to the IRB committees, provides assistance to investigators who are preparing IRB applications, and maintains records of IRB reviews and approvals for investigators.

The University Park IRB is responsible for the review of research proposals conducted by the faculty, staff, and students of the USC University Park Campus, other than those in the Health Sciences Campus. The UPIRB is generally responsible for review of social and University-wide behavioral research. Student studies that administer medication will not be allowed at UPC.

The Health Sciences IRBs are responsible for review of Health Science research and all research conducted on the Health Sciences Campus. There are three HSIRBs: 2 review initial study submissions and 1 continuing review submissions. The HSIRBs are generally responsible for biomedical research, social and behavioral research conducted on the Health Sciences Campus, and research conducted by investigators in the schools of pharmacy and medicine. However, at the discretion of the Chairs, either IRB may defer to the other campus’s IRB based upon recruitment site, expertise required, or other special circumstances.

The Office of Compliance and/or the Office of General Counsel are available for assistance and legal counsel in applying laws to research involving human subjects.

Note: the terms “subject” and “participant” are used interchangeably throughout the Policies & Procedures
Human Subjects Protection Program (HSPP)
Organizational Chart

USC Board of Trustees

USC President

Provost

Vice President of Research (VPR)

Executive Director OPRS

Program Director

IRB Student Mentor

Program Administrator

HSIRB
Chair
Vice Chairs
Committee Members
Director
Manager
Staff

UPIRB
Chair
Committee Members
Director
Staff

Clinical Trials Office* (CTO)

iStar Staff

OPRS Responsibilities at HSC
--- Sets policy / communication / education / training / advice and consultation

VPR Responsibilities at HSC
--- Budgetary decision and staff size
1.2 Human Subjects Protection Program Components

Institutional Official/Human Subjects Research

Vice President of Research  
University of Southern California  
3720 South Flower Street, 3rd Floor  
Los Angeles, CA  90089-4019  
TEL: (213) 740-6709  FAX: (213) 740-8919

Office for the Protection of Research Subjects

Executive Director  
Program Director  
Program Administrator  
Graduate Assistant/IRB Student Mentor  
University of Southern California  
3720 South Flower Street, 3rd Floor  
Los Angeles, CA  90089-1146  
TEL: (213) 821-1154  FAX: (213) 740-9299  
E-mail: oprs@usc.edu  
Web: https://oprs.usc.edu/

University Park Institutional Review Board (UPIRB)

Chair  
IRB Director  
Credit Union Building (CUB) Third Floor 310, MC 0702  
Los Angeles, CA  90089-0702  
TEL: (213) 821.5272  FAX: (213) 821-5276  
E-mail: upirb@usc.edu  
Website: https://oprs.usc.edu/upirb/
Health Sciences Campus Institutional Review Board (HSIRB)

Chair
Vice-Chairs
IRB Director
IRB Manager
General Hospital (GNH), Fourth Floor, Suite 4700
1200 North State Street
Los Angeles, CA 90033
TEL: (323) 223-2340 FAX: (323) 224-8389
E-mail: irb@usc.edu
Website: https://oprs.usc.edu/hsirb/

iStar/Electronic Submission

General Hospital (GNH), Fourth Floor, Suite 4700
1200 North State Street
Los Angeles, CA 90033
TEL: (323) 223-2340 FAX: (323) 224-8389
E-mail: istar@usc.edu
Web: https://istar.usc.edu

Clinical Trials Office (CTO)

Director
2011 N. Soto Street
Los Angeles, CA 90032
TEL: (323) 442-7218 FAX: (213) 342-0947
Web: https://research.usc.edu/clinical-trials-at-usc/
1.3 How the Organization Works Together to Protect Subjects

The Human Subjects Protection Program oversees the ethical and regulatory affairs related to the protection of research subjects. The Program consists of the Vice President of Research, the Office for the Protection of Research Subjects (OPRS), four Institutional Review Boards, and the Department of Contracts and Grants. USC faculty, staff, and students are also participants in the HSPP. All these groups carry out their individual functions and endeavor to work together where their responsibilities intersect in human subjects protection.

The University’s commitment to ethical and compliant human subjects research is embodied in the USC Code of Ethics, Faculty Handbook, and the HSPP Policies and Procedures.

Office for the Protection of Research Subjects

Responsible for: promoting excellence in human subjects research programs across the University, overseeing the IRB, providing human subjects education, seeking out and adopting best practices, advising the Vice President of Research, maintaining accreditation, and providing a national voice and presence in human subjects protections.

Accountability within the HSPP is expected of all levels of responsibility. Communication is routinely shared among all components of the HSPP. IRB members are encouraged to directly contact the IRB staff, Directors, Chairs and Vice Chairs or OPRS with questions, concerns, or suggestions. Regulatory and IRB policy changes are provided to the members and staff via email, through the OPRS listserv, and at IRB meetings. Education sessions are held for members and staff at the meetings, and for researchers special education sessions are given on an as-needed basis.

Human Subjects Working Group

Human Subjects Working Group consisting of OPRS, IRB Chairs and Directors meet regularly on monthly phone calls to discuss best practices, address and solve issues, and share news or concerns that affect the HSPP. Any IRB related issues taking place on either campus can be discussed at that time.
Other meetings and phone calls take place, as necessary, to deal with any problems, issues, concerns. These calls or meetings can be initiated by any member of the HSPP team.

### OPRS/IRB Websites

OPRS/IRB websites receive thousands of visits per month, and provide a wealth of information to all stakeholders in human subjects research. Not only is there guidance for investigators and IRB staff, there is also information for research participants/subjects. The websites are continually updated with the most recent human subjects research policies, regulations, guidance, and news.

### Human Subjects Research Listserv

Human Subjects Research Listserv is used by OPRS to communicate with IRB staff and members, as well as USC faculty, staff and students conducting human subjects research. This listserv includes the most recent information on federal and state regulations, IRB education opportunities at USC, human subjects news, legislation, and other pertinent human subjects research information that the USC community should be aware of.

### Program Communication

IRBs have weekly staff meetings to ensure that issues within that IRB can be addressed and that all staff are made aware of any new regulations or guidance that may be available. Staff problems or concerns are also addressed at this time, or can be done on an individual basis. Issues that can benefit or educate others in the HSPP are forwarded to the OPRS for discussion and distribution to the entire HSPP team.

The Executive Director of the Office for the Protection of Research Subjects and Vice President of Research meet as needed. In these meetings, issues pertaining to the HSPP are addressed as are new suggestions or decisions, needing input at the Provost level.

### 1.4 Research Involving the Community

USC promotes the involvement of community members, when appropriate, in the design and implementation of research and the dissemination of results. Community involvement builds public awareness and trust in research. Additionally, the more involved the community is, the more likely it is to benefit from research discoveries.
Researchers have flexibility to develop their own approach to engagement, in keeping with the needs of a particular community. However, the approach must be rooted in ethical considerations – respect for persons, equitable selection of subjects, and beneficence – and should emphasize community outreach, consultation, involvement and collaboration.

At USC, the preponderance of community-engaged research occurs in Preventive Medicine at HSC and in the School of Social Work at UPC. When appropriate, the researcher will promote the involvement of community member in the design and implementation of research and the dissemination of results.

Several initiatives have been established by the Southern California Clinical Translation Science Institute (SC-CTSI) that provide guidance for conducting community-engaged research as outlined in A Quick Start Guide to Conducting Community-Engaged Research. For example, some research studies fund community activities that open the dialogue to USC research in general while also providing study-specific information. From such collaborations, researchers can identify community research needs and community members can identify research risks not known to researchers.

In addition to CTSI resources, the Office for the Protection of Research Subjects (OPRS) website provides information for prospective research participants about types of research being offered at USC, questions to consider before participation, and contact information for reporting research complaints and concerns. Brochures are available in English and Spanish to inform individuals in the community about what to know before participating in a research study. For additional information see references below.

**Helpful Links**

- OPRS Community Engaged Research webpage
  [http://oprs.usc.edu/initiatives/cm/](http://oprs.usc.edu/initiatives/cm/)

- OPRS Participating in Research webpage
  [http://oprs.usc.edu/about/participating/](http://oprs.usc.edu/about/participating/)

- SC CTSI website
  [http://sc-ctsi.org/](http://sc-ctsi.org/)

- SC CTSI Community Engagement Partners
1.5 Flexibility Policy and Coalition

Flexibility Policy

The University of Southern California IRBs operate with a Federalwide Assurance issued by the DHHS, Office for Human Research Protections (OHRP). The USC IRB’s are registered in the OHRP/FDA IRB database. USC has chosen to limit the scope of its Federalwide Assurance (FWA) to federally funded research (by “unchecking the box”), the terms of which allow an appropriate level of flexibility for research involving no greater than minimal risk. This provides an appropriate level of administrative flexibility without compromising subject protections. Subject protections remain equivalent for all studies whether funded or not. For research involving no greater than minimal risk and receiving no federal funds, USC has created an innovative flexibility policy adapted by other Institutions nationwide.

The Flexibility policy is limited to unfunded studies involving no greater than minimal risk. Should the funding status of a study reviewed under this policy change, it is the responsibility of the Principal Investigator to notify the IRB. Under no circumstances will federally funded or FDA regulated research be reviewed under this policy.

The IRB may make exceptions to the funding exclusion when the funding is not federal funding.

All human subjects research projects conducted or supported at USC remain subject to USC IRB policies and review, whether they qualify for this policy or not. When questions of applicability arise, studies will be reviewed on a case by case basis.

Inclusion/exclusion of any research project will be at the discretion of the USC Institutional Review Boards (IRBs).

This Flex policy creates exempt categories not found in the federal regulations, (for projects that do not directly conform to a specific exempt category in 45 CFR 46). These projects will be reviewed using an approval process identical to that used for exempt research categories 1-6 under 45 CFR 46.101(b).

This policy also provides up to three-year approvals for nonexempt unfunded projects that are not FDA regulated involving no greater than minimal risk. These projects will be processed under expedited review according to 45 CFR 46.110 but approval will be valid for up to three years, rather than one year as required in 45 CFR 46.109(e).
Research projects that meet the federal definition for human subject research and exceed minimal risk are subject to the criteria for approval articulated in the regulations at 45 CFR 46 and/or FDA regulations as applicable and do not qualify for review under the flexibility policy.

For additional details about the Flexibility Policy, refer to Appendix H.

**Flexibility Coalition**

A Flexibility Coalition was established by the University of Southern California to disseminate flexibility policies and encourage similar programs at academic Institutions across the United States. Currently, the Flexibility Coalition consists of more than 75 Institutions from across the nation that have achieved a more flexible approach to increasingly problematic federal requirements, by finding simpler ways of reviewing studies. The freedom to be compliant yet flexible, is permitted for Institutions which have opted to “uncheck the box” on the Federalwide Assurance for the Protection of Human Subjects. Unchecking the box limits HHS oversight to projects funded and regulated by OHRP. The coalition goals are to identify additional areas of flexibility that can be implemented without diminishing the protection of human subjects, and benefit from the knowledge and experience of members. This Coalition has been a major success for USC.
Chapter 2: Ethics

Chapter Contents

2.1 – Nuremberg Code
2.2 – Declaration of Helsinki
2.3 – National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research
2.4 – Belmont Report
Chapter 2
Ethics

This chapter examines the history and development of current human research subjects protections in the US by summarizing the significant ethical and regulatory documents: Nuremberg Code, Declaration of Helsinki, National Institute of Health’s Policies for the Protection of Human Subjects, National Research Act, and the Belmont Report. This chapter further describes the boundaries between ‘medical practice’ and research and the basic principles for conducting ethical human subjects research.

2.1 Nuremberg Code

Modern human subjects protections began in 1948 with the Nuremberg Code developed for the Nuremberg Military Tribunal as standards by which to judge the human experimentation conducted by the Nazis. The Code captures many of what are now taken to be the basic principles governing the ethical conduct of research involving human subjects. The first provision of the Code states that “the voluntary consent of the human subject is absolutely essential.” Freely given consent to participation in research is thus the cornerstone of ethical experimentation involving human subjects. The Code goes on to provide the details implied by such a requirement: capacity to consent, freedom from coercion, and comprehension of the risks and benefits involved. Other provisions require the minimization of risk and harm, a favorable risk/benefit ratio, qualified investigators using appropriate research designs, and freedom for the subject to withdraw at any time.

2.2 Declaration of Helsinki

Recommendations similar to the Nuremberg Code were made by the World Medical Association in its initial Declaration of Helsinki 1965. The current Declaration of Helsinki 2013 further distinguishes therapeutic from non-therapeutic research and restrict use of placebos in clinical trials, a position not accepted by the US.
2.3 National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research

In July of 1974, the passage of the National Research Act established the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The Commission (established partly in response to outrage over the Tuskegee study funded by the U.S. Public Health Service) met from 1974 to 1978. In keeping with its charge, the Commission issued reports and recommendations identifying the basic ethical principles that underlie the conduct of biomedical and behavioral research involving human subjects and recommended guidelines to ensure that research is conducted in accordance with those principles. The Commission also recommended Department of Health, Education, and Welfare (DHEW) administrative action to require that the guidelines apply to research conducted or supported by DHEW. The Commission’s report set forth the basic ethical principles that underlie the conduct of biomedical and behavioral research involving human subjects which is titled The Belmont Report.

Boundaries between Practice and Research

While recognizing that the distinction between research and therapy is often blurred, practice is described as “interventions that are designed solely to enhance the well-being of an individual patient or client and that have a reasonable expectation of success. The purpose of medical or behavioral practice is to provide diagnosis, preventive treatment, or therapy to particular individuals.”

The Commission distinguishes research as “designating an activity designed to test a hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge (expressed, for example, in theories, principles, and statements of relationships). Research is usually described in a formal protocol that sets forth an objective and a set of procedures designed to reach that objective.”

The Report recognizes that “experimental” or innovative procedures do not necessarily constitute research, and that research and practice may occur simultaneously. It suggests that the safety and effectiveness of such “experimental” procedures should be investigated early, and that Institutional oversight mechanisms, such as medical practice
committees, can ensure that this need is met by requiring that “major innovation(s) be incorporated into a formal research project.”

### 2.4 Belmont Report

On September 30, 1978, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research submitted its report titled *The Belmont Report: Ethical Principles and Guidelines for the Human Subjects of Research*. The Report sets forth the basic ethical principles underlying the acceptable conduct of research involving human subjects. Those principles, respect for persons, beneficence, and justice, are now accepted as the three essential requirements for the ethical conduct of research involving human subjects.

#### Respect for Persons

**Informed consent**, required by the moral principle of respect for persons contains three elements: *information, comprehension, and voluntariness*. First, subjects must be given sufficient *information* on which to decide whether or not to participate, including the research procedure(s), purposes, risks and anticipated benefits, alternative procedures (where therapy is involved), and a statement offering the subject the opportunity to ask questions and to withdraw at any time from the research.

Where persons with limited ability to comprehend are involved, they should be given the opportunity to choose whether or not to participate (to the extent they are able to do so), and their objections should not be overridden, unless the research entails providing them a therapy unavailable outside of the context of research. Each such class of persons should be considered on its own terms (minors, persons with impaired mental capacities, the terminally ill, and the comatose). Respect for such persons may require that the permission of third parties also be given in order to further protect these persons from harm.

Finally, consent to participate must be *voluntarily* given. The conditions under which an agreement to participate is made must be free from coercion and undue influence. IRBs should be especially sensitive to these factors when particularly vulnerable subjects are involved.
**Beneficence**

Closely related to the principle of beneficence, risk/benefit assessments “are concerned with the probabilities and magnitudes of possible harms and anticipated benefits.” The Report breaks consideration of these issues down into defining the nature and scope of the risks and benefits, and systematically assessing the risks and benefits. All possible harms, not just physical or psychological pain or injury, should be considered. The principle of beneficence requires both protecting individual subjects against risk of harm and consideration of the benefits for the individual, as well as reasonably achievable societal benefits.

In determining whether the balance of risks and benefits results in a favorable ratio, the decision should be based on thorough assessment of information with respect to all aspects of the research and systematic consideration of alternatives. The Report recommends close communication between the IRB and the investigator and IRB insistence upon precise answers to direct questions. The IRB should: (1) determine the validity of the theory underpinning the proposed research; (2) distinguish the “nature, probability and magnitude of risk…with as much clarity as possible;” and (3) “determine whether the investigator’s estimates of the probability of harm or benefits are reasonable, as judged by known facts or other available studies.”

Five basic principles or rules apply when making the risk/benefit assessment: (1) “brutal or inhuman treatment of human subjects is never morally justified;” (2) “risks should be minimized, including the avoidance of using human subjects if at all possible;” (3) IRBs must be scrupulous in insisting upon sufficient justification for research involving “significant risk of serious impairment” (direct benefit to the subject or “manifest voluntariness of the participation”), (4) the appropriateness of involving vulnerable populations must be demonstrated; and (5) the proposed informed consent process must thoroughly and completely disclose relevant risks and benefits.

**Justice**

The principle of justice mandates that the selection of research subjects must be the result of fair selection procedures and must also result in fair selection outcomes. The “justness” of subject selection relates both to the subject as an individual and to the subject as a member of social, racial, sexual, or ethnic groups.
With respect to their status as individuals, subjects should not be selected either because they are favored by the researcher or because they are held in disdain (involving “undesirable” persons in risky research). Further, “social justice” indicates an “order of preference in the selection of classes of subjects (adults before children) and that some classes of potential subjects (the institutionalized mentally infirm or prisoners) may be involved as research subjects, if at all, only on certain conditions.”

Investigators, Institutions, or IRBs may consider principles of distributive justice relevant to determining the appropriateness of proposed methods of selecting research subjects that may result in unjust distributions of the burdens and benefits of research. Such considerations may be appropriate to avoid the injustice that “arises from social, racial, sexual, and cultural biases institutionalized in society.”

Subjects should not be selected simply because they are readily available in settings where research is conducted, or because they are “easy to manipulate as a result of their illness or socioeconomic condition.” Care should be taken to avoid overburdening institutionalized persons who “are already burdened in many ways by their infirmities and environments.” Non-therapeutic research that involves risk should use other, less burdened populations, unless the research “directly relate(s) to the specific conditions of the class involved.”
Chapter 3: Federal Regulations and State Laws

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3.1 – Department of Health and Human Services (DHHS)
3.2 – Department of Defense (DOD) / Department of the Navy (DON)
3.3 – Department of Justice (DOJ)
3.4 – Department of Energy (DOE)
3.5 – Department of Education (ED)
3.6 – State Laws that Apply to Human Subjects Research
Chapter 3 Federal Regulations and State Laws

This chapter provides an overview of the federal regulations and California law that govern human subjects research at USC. These include: Health and Human Services, Defense, Justice, Energy, Education and California law. The chapter concludes with a brief discussion of California laws that impact human subjects research.

3.1 Department of Health and Human Services (DHHS)

Common Rule (45 CFR 46)

In 1981, in response to the Commission’s reports and recommendations, both the Department of Health and Human Services (DHHS, formerly DHEW) and the FDA promulgated significant revisions of their human subjects regulations. The revisions were concerned with details of what the IRB is expected to accomplish and some of the procedures it must follow.

The DHHS regulations are codified at Title 45 Part 46 of the Code of Federal Regulations. Those “basic” regulations became final on January 16, 1981, and were revised effective March 4, 1983, and June 18, 1991. The June 18, 1991, revision became the adoption of the Federal Policy for the Protection of Human Subjects. The Federal Policy (or “Common Rule,” as it is sometimes called) was jointly promulgated by the sixteen federal agencies that conduct, support, or otherwise regulate human subjects research; the FDA also adopted many of its provisions. As is implied by its title, the Federal Policy is designed to make uniform the human subjects protection system in all relevant federal agencies and departments that adopt it. The “common” part of title 45 part 46 is also known as subpart A.

*Additional federal agencies/departments have since adopted 45 CFR 46.

Chapter 3: Federal Regulations and State Laws

Additional protections for various vulnerable populations have been adopted by DHHS in the subparts of title 45 Part 46 as:


- **Subpart C**, “Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects” became final on November 16, 1978.

- **Subpart D**, “Additional Protections for Children Involved as Subjects in Research” became final on March 8, 1983, and was revised for a technical amendment on June 18, 1991.

**FDA (21 PARTS 50 AND 56)**

Food and Drug Administration (FDA) regulations on the protection of human subjects are codified at **Title 21 Parts 50 and 56** of the Code of Federal Regulations. **Part 50**, which sets forth the requirements for informed consent. Subpart C provides special protections for prisoners. Subpart D provides Additional Safeguards for Children in Clinical Investigations. **Part 56** sets forth the provisions for Institutional Review Boards.

Additional FDA regulations that are relevant to IRB review of research are **Parts 312** (Investigational New Drug Application), **600** (Biological products), **812** (Investigational Device Exemptions) and **860** (Medical Device Classification Procedures).

For a comparison of FDA and HHS Human Subject Protection Regulations, click [here](http://www.hhs.gov/about/news/2013/01/17/new-rule-protects-patient-privacy-secures-health-information.html).

For additional information about FDA-regulated research, refer to [Chapter 18 – FDA-Regulated Research](#).

**HIPAA (45 PARTS 160 AND 164)**

The HIPAA Privacy Rule is under the jurisdiction of the Office of Civil Rights which is responsible for interpreting, establishing guidelines, and any subsequent modifications of the rule. Information regarding the most recent version of the Privacy Rule - Health Information Technology for Economic and Clinical Health (HITECH Act), may be found at: [http://www.hhs.gov/about/news/2013/01/17/new-rule-protects-patient-privacy-secures-health-information.html](http://www.hhs.gov/about/news/2013/01/17/new-rule-protects-patient-privacy-secures-health-information.html)
3.2 Department of Defense (DOD) and Department of the Navy (DON)

In 2006, the Department of the Navy (DON) enhanced its human subject protection requirements, including the application of those requirements to extramural performers. DOD guidance to the addendum for those members of the USC research community involved in human subjects research supported by or in collaboration with DON.

USC has signed an assurance with the Department of Defense (DOD) / Department of the Navy (DON) which requires USC to apply DOD/DON regulations and policies for the protection of human research participants when conducting, reviewing, approving, overseeing, supporting or managing Department of the Navy supported human subjects research. To view the DON’s applicability and scope, and citations for key additional requirements, go to https://oprs.usc.edu/files/2013/01/DOD-FWA-Addendum-HSC-FINAL-Oct-2012.pdf.

USC's DOD addenda, approved by the Navy Surgeon General (UPC: DoD N-A3060 and HSC DoD N-A3286), are recognized by all DOD components: the Navy, Army, Air Force, and Personnel and Readiness. However DOD components may have specific requirements for reviewing research protocols they support, and these requirements must be followed.

Researchers should be cognizant that DOD requirements may lead to additional costs related to the conduct of the study.

Researchers are urged to anticipate any specific subject protection costs that might be directly associated with the DOD project. For example, if a project poses greater-than-minimal risk and therefore requires a Research Monitor, costs associated with the monitor might qualify as direct costs. For assistance in identifying such costs and dealing with the funding agency, please consult with the USC Office of Contracts & Grants for assistance.

Note: If you are designing a project that will involve other entities as collaborators or sub-contractors, you are strongly encouraged to consult with the DOD or the sponsor to identify additional requirements.
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Research Supported by the Department of Defense (DOD)

When submitting a study to the USC IRB that is supported by or in collaboration with DOD, specific additional information must be included in the iStar application. In addition to IRB requirements, federal regulations, state laws and institutional policies, the DOD (including the Navy, Army, Air Force, and Personnel and Readiness) requires the Institution to:

- Conduct initial and continuing research ethics education for personnel who are engaged in human subject research (who review, approve, oversee, or manage research)

- Document determination by a designated staff person (other than investigators) whether research meets criteria for exemption

- Ensure new research and substantive scientific amendments to approved research shall undergo scientific review and that the review is considered by the IRB

- Ensure additional protections for military research subjects to minimize undue influence

- Explain to subjects any provisions for medical care for research-related injury

- Report unanticipated problems, adverse events, research-related injury, and suspensions or terminations of research within 30 days from the determination that the event is reportable

- Appoint a Research Monitor when necessary

- Safeguard for research conducted with international populations

- Protect pregnant women, prisoners, and children

- Comply with DOD limitations and modifications to research with pregnant women, fetuses and neonates [refer to “Research Supported by the Department of Defense (DOD)” in Section 14.2 – Pregnant Women, Fetuses and Neonates in Research (45 CFR 46 Subpart B)]
• Include women and minorities as subjects, if study is a clinical investigation including Armed Services personnel

• Comply with DOD limitations on research where consent by legally authorized representatives is proposed

• Comply with DOD limitation on exceptions from informed consent (10 USC 980, 45 CFR 46, and 21 CFR 50)

• Comply with limitations on dual compensation for U. S. military personnel

• Follow DOD requirements for additional review for DOD-sponsored survey research or survey research within DOD

• Address and report allegations of non-compliance with human research protections

• Address and report allegations of research misconduct

• Follow procedures for addressing financial and other conflicts of interest

• Prohibit research with prisoners of war (POW) and detainees

• Comply with all provisions for research with human subjects using investigational test articles (drugs, device, and biologics)

• Follow recordkeeping requirements

• Support oversight by the sponsoring DOD Component (which may include DOD Component review of the research and site visits)

An explanation of some of the additional requirements follows:
Researcher Responsibilities

To ensure the DOD component conducts an administrative review, PIs are responsible for submitting documentation to the DOD Human Research Protection Official (HRPO) prior to starting a USC IRB-approved study.

Additionally, the following shall be reported promptly (within 30 days) to the DoD Human Research Protection Official:

- Significant changes to the research protocol approved by the IRB
- Results of the IRB continuing review
- Change of reviewing IRB
- Notification by any Federal department, agency or national organization that any part of the HRPP is under investigation for cause involving a DoD-supported research protocol
- Any suspension or termination of DoD-supported research

Potential for Undue Influence

The military structure expects loyalty and participation and thus has the potential to unduly influence a prospective subject’s decision about whether to participate in research. Commanding Officers (CO) should be alert to the potential for undue influence in research with those in employer-employee status (worker), teacher-student, supervisor-subordinate relationships, or deployed active duty personnel. Regardless of the risk level of the research, no superiors (civilian supervisors, officers, and noncommissioned officers (NCOs)) shall influence the decisions of their subordinates (junior enlisted personnel) whether to participate as research subjects.

“Minimal Risk” Interpretation

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

A research monitor is required for all research involving greater than minimal risk. The IRB may determine that a research monitor is appropriate for other research. A research monitor has the authority to stop a research study, remove individuals from a study, observe group recruitment, and take whatever steps are necessary to protect the safety and well-being of participants. The IRB must approve the research monitor by name and a written summary of the monitors’ duties, authorities, and responsibilities. When a research monitor is required, consult with the IRB Chair.

Research Related Injury Compensation

Every research protocol involving greater than minimal risk shall provide an arrangement for emergency treatment and necessary follow-up of any research-related injuries to subjects. IRBs will determine whether research involving minimal risk also might include a similar arrangement for research-related injury. Subjects should be informed about how the costs for research related injuries will be covered.

Waiver of Informed Consent Prohibited

If the research involves an intervention or interaction with subjects a waiver of consent or parental permission is prohibited unless a waiver is obtained from the Secretary of Defense.

International Research

If the research involves human subjects who are not US citizens or DOD personnel, it is conducted outside the United States, and its territories and possessions additional DOD requirements must be met.

Military and Civilian Personnel in Research

Civilian personnel may experience "pay check" vulnerability when research is conducted in the workplace. In addition, research findings may have unintended consequences for military and civilian personnel, such as loss of job, career, or benefits. Those involved in the research enterprise must recognize that non-participation may have subtle consequences and make every effort to avoid even the appearance of undue influence or coercion.
“Minors” in the Military

Individuals may join the military with parental permission when they are less than the state-mandated age of majority (generally 18 years). However, military members who are considered minors under state law must have parental permission, in addition to their assent, to participate in research.

Research with Data, Documents, Records, and Specimens

Access to data, documents, records, and specimens for research purposes requires IRB review. Examples include: mishap reports, blood specimens, training records, medical records, performance evaluations, employee records, fitness results, diving records.

Women in the Military

Federal regulations encourage women of childbearing potential to participate in drug development trials, but require additional safeguards.

State Laws

Military commands must comply with relevant state laws.

Research with Investigational Agents (Drugs, Devices, and Biologics)

In addition to complying with DOD/DON regulations for research on investigational drugs, devices, and biologics, investigators must also adhere to the Food and Drug Administration regulations (21 CFR Part 56 - IRBs and 21 CFR Part 50 - Informed Consent). The FDA and DOD regulations on basic requirements for IRBs and for informed consent generally are consistent.

Research Supported by the Department of the Navy (DON)

Studies that are supported by (or done in collaboration with) the Department of the Navy (DON) are subject to requirements in addition to those imposed by the Department of Defense as described below.
Researcher Responsibilities

PIs are responsible for submitting documentation to DON prior to starting an IRB-approved study and upon subsequent reviews by the IRB (addenda, continuing reviews). DON uses such documentation to conduct a “headquarters-level administrative review.”

Investigators should always report any serious adverse events, noncompliance, unanticipated problems involving risks to subjects or others, and protocol deviations and actions taken regarding the reports to the DON.

Two DON components have documentation requirements. See the following links for the documentation requirements of each (note that the requirements differ):

- Office of Naval Research (ONR)
- Department of the Navy Human Research Protections Program (DON HRPP)

IRB Reporting Requirements

The IRB may be required to notify DON and the sponsor (if there is a non-DON sponsor) of serious adverse events, noncompliance, unanticipated problems involving risks to subjects or others, and protocol deviations and actions taken regarding the reports.

The DON must be notified of any audits, investigations or inspections of DON-supported research. IRB will report such inspections to DON only when the IRB conduct or are aware of the inspection.

DON HRPP requires certain IRB documentation to be submitted that is not maintained by the PI (such as IRB meeting minutes). The IRB will provide the PI with a copy of this documentation, and it is the PI’s responsibility to provide this information to the DON HRPP directly.

The contact information for submission to ONR is provided at the ONR website above. The contact information for submission to the DON HRPP is:

Department of the Navy
Office of Research Protection (M00R)
Bureau of Medicine and Surgery
2300 E St., NW
Washington, DC 20372-5300
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Fax: 202-762-0976    E-Mail: humanresearch@us.med.navy.mil

If you are asked to provide a copy of the DOD/DON Addendum to USC’s Federalwide Assurance for both HSC and UPC, click on the attached link to print or download a copy.

For additional information, refer to Appendix K – Requirements for Department of Defense (DOD) Supported Research.

DON Personnel as Subjects

DON policies do not apply when DON personnel are not the targeted subject population but incidentally participate as subjects in a project that is not supported by the DON.

Publications

DON requires that the IRB receive and maintain copies of publications, presentations or reports based on the research protocol. Please include such items (if any) when submitting an application for continuing review or closing the study in iStar.

Questions

If you have questions regarding Navy requirements, please contact the IRB for assistance.

Helpful Links:

- Department of Defense Directive 3216.02: “Protection of Human Subjects and Adherence to Ethical Standards in DoD-Supported Research”

- Department of Defense Directive 3210.7: “Research Integrity and Misconduct”

  http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title32/32cfr219_main_02.tpl

- Secretary of the Navy Instruction 3900.39D, Section 4(a)(1) – Human Research Protection Program
3.3 Department of Justice (DOJ)

When research is supported by the Department of Justice, USC fulfills its obligations with regard to the assurances and certification required by 28 CFR 46. The specific requirements for research supported by the Bureau of Prisons and National Institute of Justice are listed below.

Research Supported by the Bureau of Prisons

Compliance with 28 CFR 512

USC, USC IRBs, and researchers and research staff must follow the requirements of 28 CFR 512, including:

- 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 Bureau 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 Bureau Research Review Board.

Pilot Projects are not Considered Research

Implementation of Bureau programmatic or operational initiatives made through pilot projects is not considered to be research.

Research Design

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

Subject Selection and Incentives

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

**Confidentiality**

A non-employee of the Bureau may receive records in a form not individually identifiable when advance adequate written assurance that the record will be used solely as a statistical research or reporting record is provided to the agency.

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

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

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

**Disclosure and Informed Consent**

Required elements of disclosure include:

- 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)
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- 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.

Research Proposal Requirements

When submitting a research proposal, the applicant shall provide the following information:

- A summary statement, which includes:
  - Names and current affiliations of the researchers
  - Title of the study
  - Purpose of the study
  - Location of the study
  - Methods to be employed
  - Anticipated results
  - Duration of the study
  - Number of participants (staff or inmates) required and amount of time required from each
  - Indication of risk or discomfort involved as a result of participation

- A comprehensive statement, which includes:
  - Review of related literature
  - Detailed description of the research method
  - Significance of anticipated results and their contribution to the advancement of knowledge
  - Specific resources required from the Bureau of Prisons
  - Description of all possible risks, discomforts, and benefits to individual participants or a class of participants, and a discussion of the likelihood that the risks and discomforts will actually occur
  - Description of steps taken to minimize any risks

- Description of physical or administrative procedures to be followed to:
  - Ensure the security of any individually identifiable data that are being collected for the study
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- Destroy research records or remove individual identifiers from those records when the research has been completed
- Description of any anticipated effects of the research study on organizational programs and operations
- Relevant research materials such as vitae, endorsements, sample consent statements, questionnaires, and interview schedules
- A statement regarding assurances and certification required by 28 CFR 46, if applicable.

### Investigator Requirements and Responsibilities

- The researcher must have academic preparation or experience in the area of study of the proposed research.
- The researcher must assume responsibility for actions of any person engaged to participate in the research project as an associate, assistant, or subcontractor to the researcher.
- At least once a year, the researcher shall provide the chief, Office of Research and Evaluation, with a report on the progress of the research.
- At least 12 working days before any report of findings is to be released, the researcher shall distribute one copy of the report to each of the following: the chairperson of the Bureau Research Review Board, the regional director, and the warden of each institution that provided data or assistance. The researcher shall include an abstract in the report of findings.
- In any publication of results, the researcher shall acknowledge the Bureau's participation in the research project.
- The researcher shall expressly disclaim approval or endorsement of the published material as an expression of the policies or views of the Bureau.
- Prior to submitting for publication the results of a research project conducted under this subpart, the researcher shall provide two copies of the material, for informational purposes only, to the Chief, Office of Research and Evaluation, Central Office, Bureau of Prisons.
Research Supported by the National Institute of Justice (NIJ)

Privacy Certificate

All projects are required to have a privacy certificate approved by the NIJ Human Subjects Protection Officer. Under a privacy certificate, researchers and research staff do not have to report child abuse unless the participant signs another consent form to allow child abuse reporting.

Confidentiality Statement

All researchers and research staff are required to sign employee confidentiality statements, which are maintained by the responsible researcher.

Disclosure and Informed Consent

The confidentiality statement on the consent form must state that confidentiality can only be broken if the participant reports immediate harm to participants or others.

National Archive of Criminal Justice Data

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.

3.4 Department of Energy (DOE)

When research is supported by the Department of Energy, USC fulfills its obligations with regard to the assurances and certification required by 28 CFR 0 443.1B. The specific requirements for research supported by the Department of Energy are listed below.

Human Subjects Research

- Research involving human participants also includes studies of the intentional modification of the human environment; generalizable includes the study of tracer chemicals, particles or other materials to characterize airflow.
• Generalizable also includes studies in occupied homes or offices that:
  o Manipulate the environment to achieve research aims
  o Test new materials
  o Involve collecting information on occupants’ views of appliances, materials, or devices installed in their homes or their energy-saving behaviors through surveys and focus groups
  o Generalizable should be viewed in terms of the contribution to knowledge within the specific field of study

**Personally Identifiable Information**

Researchers are required to follow DOE requirements for the protection of personally identifiable information by completing and complying with the requirements of the “Checklist for IRBs to Use in Verifying That HS Research Protocols Are in Compliance with DOE Requirements.”

**Reporting Requirements**

Researchers must promptly (within 48 hours) report the following to the human subject research program manager:

• Any significant adverse events, unanticipated risks, and complaints about the research, with a description of any corrective actions taken or to be taken
• Any suspension or termination of IRB approval of research
• Any significant non-compliance with HRPP procedures or other requirements
• Any compromise of personally identifiable information must be reported immediately (as soon as the breach is discovered)

### 3.5 Department of Education (ED)

When research is supported by the Department of Education, USC fulfills its obligations with regard to the assurances and certification required by 34 CFR Sections 97 Subpart D (equivalent to 45 CFR Section 46 Subpart D), 24 CFR Section 356.3 and 34 CFR Section 99. The specific requirements for research supported by the Department of Education are listed below.
### Access to Instructional Materials Used in Human Subjects Research

- All instructional material – including teachers' manuals, films, tapes, or other supplementary instructional material – which will be used in connection with any research or experimentation program or project must be available for inspection by the parents or guardians of the children engaged in such research.
- Research or experimentation program or project means any program or project in any research that is designed to explore or develop new or unproven teaching methods or techniques.
- Children are persons enrolled in research not above the elementary or secondary education level, who have not reached the age or majority as determined under state law.

### 3.6 State Laws that Apply to Human Subjects Research

In addition to federal regulations 45 CFR 46 and Food and Drug Administration (FDA) regulations 21 CFR 50, 56, researchers are also expected to follow state and local laws. In California, there are additional state laws applicable to human subjects research. It is the responsibility of the Institution and researchers to know and follow these laws. Visit the [Official California Legislative Information website](https://leginfo.legislature.ca.gov/) to access California Codes.

Investigators and IRB personnel with questions regarding how state or federal regulations apply to a specific research project should contact the Chair of the IRB and/or the Office of Compliance. Additional options include seeking guidance or interpretation from the USC Office of General Counsel. Final interpretation and expectations with respect to California law reside with the Office of Compliance, and Office of General Counsel at USC.

The California Protection of Human Subjects in Medical Experimentation Act ([Section 24170-24179.5](https://leginfo.legislature.ca.gov/)) requires all medical experimentation to be “undertaken with due respect for human life and the right of individuals to determine what is done to their own bodies”.

A “medical experiment” is defined (section 24174 California Health and Safety Code) as follows:
Chapter 3: Federal Regulations and State Laws

- 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 or 109925, 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 the subject or otherwise directly benefiting the 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

All subjects participating in a medical experiment must be provided a written “experimental subject’s bill of rights” in addition to informed consent. Refer to Section 10.11 – California Experimental Subject’s Bill of Rights for additional information.
Chapter 4: Federalwide Assurances

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4.1 – Federalwide Assurance (FWA)
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4.4 – FWAs and the “Unchecked Box”
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Chapter 4
Federalwide Assurances

This chapter describes the University of Southern California (USC) Federalwide Assurances of compliance maintained with the Office for Human Research Protections (OHRP)/Department of Health and Human Services (DHHS). The University is required to enter into this agreement because it receives federal funding for research involving human subjects.

4.1 Federalwide Assurance (FWA)

A Federalwide Assurance (FWA) is a binding written agreement between USC and OHRP. It states that the University is guided by the ethical principles of the Belmont Report and will comply with federal regulations 45 Code of Federal Regulations Part 46, or simply 45 CFR 46 for all federally funded human subjects research. The UPIRB and the HSIRB each have FWAs with OHRP (click here to view).

USC complies with requirements stipulated by other federal agencies when they serve as sponsors or have oversight of research conducted at USC. For a list of applicable federal regulations, refer to Appendix M.

The USC IRBs are registered in the OHRP/FDA IRB database.

4.2 Specific FWA Requirements

FWA requirements must be met before OHRP/FWA is issued. These requirements pertain to the Institution, the intuitional official, and the IRBs:

- All human subjects research conducted under the auspices of USC will be guided by the ethical principles of The Belmont Report

- The FWA applies to all federally funded research in which USC is engaged. Refer to Section 4.5 – Engagement in Research

- The FWA requires compliance with the Federal Policy for Protection of Human Subjects (45 CFR 46)
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- The USC IRBs have written procedures for reporting unanticipated problems involving risks to subjects or others, serious or continuing noncompliance with federal regulations or IRB requirements and suspension or termination of IRB approval. USC must also ensure that a qualified person or persons determine research is exempt from IRB review. Finally, the USC IRBs have clear written procedures for conducting IRB initial and continuing review; approving research; reporting IRB findings to the investigator and Institution; determining which projects require review more than annually; how the IRBs ensure that changes to ongoing research are reported promptly and are not initiated without IRB review and approval (except when necessary to eliminate apparent immediate hazards to subjects).

- The FWA grants authority to the IRBs to approve, require modifications to or disapprove covered human subject research.

- The FWA expects detailed informed consent requirements for research conducted under the auspices of USC.

- The FWA requires that USC secure assurances from other Institutions participating in collaborative research with University investigators when applicable.

- The FWA requires that the University secure written agreements of commitment relevant to human subject protection policies and USC IRB oversight if the investigator is not an employee or agent of the University and the USC IRB agrees to review the research.

- The FWA requires that the University provide the IRB with resources and professional and support staff sufficient to carry out their responsibilities under the assurance.

- The FWA recommends that the Institutional Official, IRB Administrator(s) and IRB Chair(s) complete a training module detailing major responsibilities of these individuals.
The FWA recommends that the University establish educational training and oversight mechanisms to ensure that research investigators, IRB members and staff and other appropriate personnel maintain continuing knowledge of, and comply with, relevant ethical principles, relevant federal regulations, OHRP guidance, other applicable guidance, state and local laws and University policies for the protection of human subjects.

The FWA details the conditions under which the FWA must be renewed.

### 4.3 Responsibilities Defined under the FWA

The Federalwide Assurance also describes the responsibilities of the Institution, the Designated Institutional Official, the Institutional Review Boards and the investigator, which are detailed below. All investigators at USC are expected to conduct research in accordance with the provisions of the Federalwide Assurance and ensure that the rights and welfare of the individuals involved are protected. Faculty members who assign or supervise research conducted by students are responsible for overseeing the research to ensure that students adequately safeguard the rights and welfare of subjects and conduct the research as approved.

#### Investigator Responsibilities

The investigator is responsible for acquiring the appropriate knowledge regarding human subject protections, ethics, federal regulations, training, and monitoring to conduct his/her proposed research. The PI must assure that key study personnel are adequately trained and knowledgeable regarding human subject protections, ethical considerations, and federal regulations applicable to the proposed research. The PI is responsible for complying with the training, monitoring, and human subject research guidance as outlined in the FWA and USC IRB policies and procedures.

#### IRB Committee Responsibilities

The IRB Committee is to review all human subjects research activities and document findings regarding ethical considerations, scientific merit, adherence to federal regulations and IRB policies and procedures. The IRB Committee must review and
monitor ongoing human subjects research for adherence to the Federal regulations and IRB policies and procedures.

**IRB Staff Responsibilities**

In addition to routine IRB staff duties, the OPRS/IRB staff will participate in ongoing auditing (refer to Section 19.3 – Audits and Assessment) and monitoring activities to assure adherence to the federal regulations. The IRB staff will participate in the revisions of the IRB policies and procedures as applicable.

**IRB Administration Responsibilities**

All information provided under Federalwide Assurances must be updated at least every five years, even if no changes have occurred, in order to maintain an active Assurance approved by OHRP. Amendments to the Assurance are to be reported promptly to OHRP. This includes changes to IRB Committee rosters, IRB Chair/Vice Chair, or a legally recognized entity of USC. USC will maintain policies and procedures reflecting the current practices of the IRB in conducting reviews and approvals under its Assurance. These policies and procedures will be maintained and kept current by the USC OPRS. They will be reviewed and revised as needed at least every three years. Changes in policy are to be finalized by the Executive Director of OPRS.

The IRB’s budget will be reviewed annually, by the Executive Director of OPRS, and the Vice President of Research and modified, as necessary, to accommodate the volume and type of research reviewed, education, space, facilities, and staff.

**4.4 FWAs and the “Unchecked Box”**

As discussed in Section 4.1 – Federalwide Assurance (FWA), a Federalwide Assurance is a binding agreement between USC and OHRP, the federal agency responsible for human subjects protection. It states that the University is guided by the ethical principles of the Belmont Report and will comply with federal regulations 45 CFR 46 for all federally funded human subjects research.

FWAs may include research that is not federally funded but this is optional.
When this option is selected, the assurance is inclusive of all research regardless of funding source as well as unfunded research. Institutions that select this option often face substantial regulatory burdens without the benefit of additional human subjects protection. Further, regulations for human subjects research primarily address biomedical research. Adapting regulations to social behavioral research often results in additional hurdles with little, if any, benefit to subjects.

USC, like many universities and Institutions, has also chosen to limit the scope of its FWA. The choice to do so is commonly referred to as “unchecking the box” in reference to the box (Item 4b in an FWA) that is filled in when not federally funded studies are included in FWAs. “Unchecking the box” does not eliminate the ethical requirement for IRB review of human subjects research but rather places the responsibility for oversight of non-federally funded and unfunded research with the Institution. The Human Subjects Research protections are equivalent whether the box is unchecked. Reporting requirements, however, may vary.

Unfunded projects for which Subpart A is not applied are all minimal-risk. These projects are all reviewed under the USC Flexibility Policy or are reviewed similar to Subpart A criteria.

### 4.5 Engagement in Research

The USC IRBs define engagement in research according to OHRP’s 2008 guidance on the engagement of Institutions in research and OHRP’s 2011 Correspondence on “Non-engaged Scenarios”.

An Institution becomes “engaged” in human subjects research when its employees or agents (all individuals performing institutionally-designated activities or exercising institutionally-delegated authority or responsibility, including faculty and students):

- Intervene or interact with living individuals for research purposes
- Obtain individually identifiable private information for research purposes [45 CFR 46.102(d),(f)]
- Obtain the informed consent of human subjects
An Institution is automatically considered to be “engaged” in human subjects research whenever it receives a direct HHS award to support such research. In such cases the awardees Institution bears ultimate responsibility for protecting human subjects under the award.

**IMPORTANT NOTE:** The USC IRBs require review by a USC IRB and by the IRB(s) at other location(s) (if the other Institution is “Engaged in the Research”) regardless of funding, unless an IRB Authorization Agreement (IAA) is required or obtained.

**Examples of Engaged Research**

(For more examples see the [OHRP 2008 Guidance for Engaged Research](https://www.hhs.gov/ohrp/policies/2008-engagement-guidance/index.html):

In general, Institutions are considered engaged in an HHS-conducted or -supported non-exempt human subjects research project (and, therefore, would need to hold or obtain OHRP-approved FWAs and certify IRB review and approval to HHS) when the involvement of their employees or agents in that project includes any of the following:

- Institutions that receive an award through a grant, contract, or cooperative agreement directly from HHS for the non-exempt human subjects research (awardee Institutions), even where all activities involving human subjects are carried out by employees or agents of another Institution

- Institutions whose employees or agents intervene for research purposes with any human subjects of the research by performing invasive or noninvasive procedures. Examples of invasive or noninvasive procedures include drawing blood; collecting buccal mucosa cells using a cotton swab; administering individual or group counseling or psychotherapy; administering drugs or other treatments; surgically implanting medical devices; utilizing physical sensors; and utilizing other measurement procedures [See scenarios B.(1), B.(2), and B.(3) in [OHRP guidance](https://www.hhs.gov/ohrp/policies/2008-engagement-guidance/index.html) for limited exceptions]

- Institutions whose employees or agents intervene for research purposes with any human subject of the research by manipulating the environment. Examples of manipulating the environment include controlling environmental light, sound, or temperature; presenting sensory stimuli; and orchestrating environmental events or social interactions [See scenarios B.(1) and B.(3) in [OHRP guidance](https://www.hhs.gov/ohrp/policies/2008-engagement-guidance/index.html) for limited exceptions]
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- Institutions whose employees or agents interact for research purposes with any human subject of the research. Examples of interacting include engaging in protocol dictated communication or interpersonal contact; asking someone to provide a specimen by voiding or spitting into a specimen container; and conducting research interviews or administering questionnaires [See scenarios B.(1), B.(2), B.(3), and B.(4) in OHRP guidance for limited exceptions]

- Institutions whose employees or agents obtain the informed consent of human subjects for the research

- Institutions whose employees or agents obtain for research purposes identifiable private information or identifiable biological specimens from any source for the research. It is important to note that, in general, Institutions whose employees or agents obtain identifiable private information or identifiable specimens for non-exempt human subjects research are considered engaged in the research, even if the Institution’s employees or agents do not directly interact or intervene with human subjects. In general, obtaining identifiable private information or identifiable specimens includes, but is not limited to:
  - observing or recording private behavior
  - using, studying, or analyzing for research purposes identifiable private information or identifiable specimens provided by another Institution
  - using, studying, or analyzing for research purposes identifiable private information or identifiable specimens already in the possession of the investigators

In general, OHRP considers private information or specimens to be individually identifiable as defined in 45 CFR 46.102(f) when they can be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems. [See scenarios B.(1), B.(2), B.(3), B.(7), B.(8), B.(9), and B.(10) in OHRP guidance for limited exceptions.]
Examples of NOT Engaged Research

(For more examples see the OHRP 2008 Guidance for Engaged Research):

Institutions would be considered **not** engaged in an HHS-conducted or -supported non-exempt human subjects research project (and, therefore, would not need to hold an OHRP-approved FWA or certify IRB review and approval to HHS) if the involvement of their employees or agents in that project is **limited to one or more** of the following. The following are scenarios describing the types of institutional involvement that would make an Institution **not** engaged in human subjects research; there may be additional such scenarios:

1. Institutions whose employees or agents perform commercial or other services for investigators provided that **all** of the following conditions also are met:
   
   a. the services performed do not merit professional recognition or publication privileges
   
   b. the services performed are typically performed by those Institutions for non-research purposes
   
   c. the Institution’s employees or agents do not administer any study intervention being tested or evaluated under the protocol

The following are some examples, assuming the services described would not merit professional recognition or publication privileges:

- an appropriately qualified laboratory whose employees perform routine serum chemistry analyses of blood samples for investigators as a commercial service

- a transcription company whose employees transcribes research study interviews as a commercial service

- a hospital whose employees obtain blood through a blood draw or collect urine and provide such specimens to investigators as a service

- a radiology clinic whose employees perform chest x-rays and send the results to investigators as a service
2. Institutions (including private practices) not selected as a research site whose employees or agents provide clinical trial-related medical services that are dictated by the protocol and would typically be performed as part of routine clinical monitoring and/or follow-up of subjects enrolled at a study site by clinical trial investigators (medical history, physical examination, assessment of adverse events, blood test, chest X-ray, or CT scan) provided that all of the following conditions also are met:
   a. the Institution’s employees or agents do not administer the study interventions being tested or evaluated under the protocol
   b. the clinical trial-related medical services are typically provided by the Institution for clinical purposes
   c. the Institution’s employees or agents do not enroll subjects or obtain the informed consent of any subject for participation in the research
   d. when appropriate, investigators from an Institution engaged in the research retain responsibility for:
      i. overseeing protocol-related activities
      ii. ensuring appropriate arrangements are made for reporting protocol-related data to investigators at an engaged Institution, including the reporting of safety monitoring data and adverse events as required under the IRB-approved protocol

Note that Institutions (including private practices) not initially selected as research sites whose employees or agents administer the interventions being tested or evaluated in the study—such as administering either of two chemotherapy regimens as part of an oncology clinical trial evaluating the safety and effectiveness of the two regimens—generally would be engaged in human subjects research (see scenario B.(3) in OHRP guidance for a limited exception). If such an Institution does not have an FWA, its employees or agents may be covered by the FWA of another Institution that is engaged in the research through an Individual Investigator Agreement. See http://www.hhs.gov/ohrp/policy/guidanceonalternativetofwa.pdf.

3. Institutions (including private practices) not initially selected as a research site whose employees or agents administer the study interventions being tested or
evaluated under the protocol limited to a one-time or short-term basis (an oncologist at the Institution administers chemotherapy to a research subject as part of a clinical trial because the subject unexpectedly goes out of town, or is unexpectedly hospitalized), provided that all of the following conditions also are met:

a. an investigator from an Institution engaged in the research determines that it would be in the subject’s best interest to receive the study interventions being tested or evaluated under the protocol

b. the Institution’s employees or agents do not enroll subjects or obtain the informed consent of any subject for participation in the research

c. investigators from the Institution engaged in the research retain responsibility for:

i. overseeing protocol-related activities

ii. ensuring the study interventions are administered in accordance with the IRB-approved protocol and

iii. ensuring appropriate arrangements are made for reporting protocol-related data to investigators at the engaged Institution, including the reporting of safety monitoring data and adverse events as required under the IRB-approved protocol and

iv. an IRB designated on the engaged Institution’s FWA is informed that study interventions being tested or evaluated under the protocol have been administered at an Institution not selected as a research site

4. Institutions whose employees or agents:

a. inform prospective subjects about the availability of the research

b. provide prospective subjects with information about the research (which may include a copy of the relevant informed consent document and other IRB approved materials) but do not obtain subjects’ consent for the research or act as representatives of the investigators
c. provide prospective subjects with information about contacting investigators for information or enrollment and/or

d. seek or obtain the prospective subjects’ permission for investigators to contact them

An example of this would be a clinician who provides patients with literature about a research study at another Institution, including a copy of the informed consent document, and obtains permission from the patient to provide the patient’s name and telephone number to investigators.

5. Institutions (schools, nursing homes, businesses) that permit use of their facilities for intervention or interaction with subjects by investigators from another Institution. Examples would be a school that permits investigators from another Institution to conduct or distribute a research survey in the classroom; or a business that permits investigators from another Institution to recruit research subjects or to draw a blood sample at the work site for research purposes.

6. Institutions whose employees or agents release to investigators at Institution identifiable private information or identifiable biological specimens pertaining to the subjects of the research. Note that in some cases the Institution releasing identifiable private information or identifiable biological specimens may have institutional requirements that would need to be satisfied before the information or specimens may be released, and/or may need to comply with other applicable regulations or laws. In addition, if the identifiable private information or identifiable biological specimens to be released were collected for another research study covered by 45 CFR part 46, then the Institution releasing such information or specimens should:

a. ensure that the release would not violate the informed consent provided by the subjects to whom the information or biological specimens pertain (under 45 CFR 46.116), or

b. if informed consent was waived by the IRB, ensure that the release would be consistent with the IRB’s determinations that permitted a waiver of informed consent under 45 CFR 46.116 (c) or (d)

Examples of Institutions that might release identifiable private information or identifiable biological specimens to investigators at another Institution include:
schools that release identifiable student test scores

- an HHS agency that releases identifiable records about its beneficiaries and

- medical centers that release identifiable human biological specimens

Note that, in general, the Institutions whose employees or agents obtain the identifiable private information or identifiable biological specimens from the releasing Institution would be engaged in human subjects research. [See scenario A. (6) in OHRP guidance]

7. Institutions whose employees or agents:

   a. obtain coded private information or human biological specimens from another Institution involved in the research that retains a link to individually identifying information (such as name or social security number), and

   b. are unable to readily ascertain the identity of the subjects to whom the coded information or specimens pertain because, for example:

      i. the Institution’s employees or agents and the holder of the key enter into an agreement prohibiting the release of the key to the those employees or agents under any circumstances

      ii. the releasing Institution has IRB-approved written policies and operating procedures applicable to the research project that prohibit the release of the key to the Institution’s employees or agents under any circumstances, or

      iii. there are other legal requirements prohibiting the release of the key to the Institution’s employees or agents

For purposes of this document, coded means that:

   o identifying information (such as name or social security number) that would enable the investigator to readily ascertain the identity of the individual to whom the private information or specimens pertain has been replaced with a number, letter, symbol, and/or combination thereof (the code), and
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- a key to decipher the code exists, enabling linkage of the identifying information to the private information or specimens

Although this scenario resembles some of the language in OHRP’s Guidance on Research Involving Coded Private Information or Biological Specimens, it is important to note that OHRP’s Guidance on Research Involving Coded Private Information or Biological Specimens addresses when research involving coded private information or specimens is or is not research involving human subjects, as defined in 45 CFR 46.102(f) (see http://www.hhs.gov/ohrp/policy/cdebiol.html). As stated in Section II of the OHRP guidance, the Guidance on Engagement of Institutions in Human Subjects Research should only be applied to research projects that have been determined to involve human subjects and that are not exempt under HHS regulations at 45 CFR 46.101(b).

8. Institutions whose employees or agents access or utilize individually identifiable private information only while visiting an Institution that is engaged in the research, provided their research activities are overseen by the IRB of the Institution that is engaged in the research.

9. Institutions whose employees or agents access or review identifiable private information for purposes of study auditing (a government agency or private company will have access to individually identifiable study data for auditing purposes).

10. Institutions whose employees or agents receive identifiable private information for purposes of satisfying U.S. Food and Drug Administration reporting requirements.

11. Institutions whose employees or agents author a paper, journal article, or presentation describing a human subjects research study.

Investigators should review all information included in the OHRP 2008 Guidance and 2011 Correspondence on “Non-engaged Scenarios”. For additional questions or further clarification, investigators can contact the IRB.
IRB Approval at a Non-USC Site Engaged in Research

USC faculty/staff/students conduct research at other sites, both domestic and international. When USC is engaged in research with another Institution, alternative arrangements for IRB review may be used (see Section 4.6 – IRB Authorization Agreements and Appendix J – IRB Requirements for Research with Other Sites).

If non-USC sites are engaged in research (45 CFR 46) and have their own IRB(s) or equivalent ethics board, the USC IRB expects the non-USC sites to obtain their own IRB review for research carried out at their site, unless an IRB Authorization agreement is sought or obtained.

When conducting research at a non-USC site, USC investigators are required to provide the following information in the iStar application:

- Site name and address
- Description of activities that will take place at the site
- Whether the non-USC site has an IRB
- Confirmation of the IRB’s and/or equivalent authority’s approval to conduct the research
- Approved informed consent form(s) and recruitment documents, if appropriate

Helpful Link

  http://www.hhs.gov/ohrp/policy/engage08.html

4.6 IRB Authorization Agreements

An IRB Authorization Agreement is an arrangement in which one Institution relies on another Institution’s IRB for initial approval and continued oversight of specified research.

IRB Authorization Agreements are required in the following circumstances:
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- Non-USC site without its own IRB relies on USC’s IRB:

  - Under the terms of the USC Federalwide Assurance, when research is conducted at a non-USC site without its own IRB and the site agrees to rely on the USC IRB review and approval, an IRB Authorization Agreement must be signed by both Institutions.

  Note: an IRB Authorization Agreement is not required if the research is not federally funded and is not subject to FDA regulations, unless the outside Institution requests an Agreement. If requested by the outside Institution, USC will comply with the request. Additionally, USC may require an IRB Authorization Agreement at its discretion.

- USC is “engaged” in the research, the risk occurs at the non-USC site, and the site has its own IRB:

  - When USC is engaged in the research, (USC may be the recipient of Federal funding) and the greatest level of risk to study subjects occurs at the non-USC site, USC may agree to rely on the non-USC site for IRB approval and continued oversight. This requires an IRB Authorization Agreement between USC and the non-USC site and includes the same information noted above. This policy assumes the IRB at the non-USC site will have the required reviewer expertise. If it does not, the IRB with the required reviewer expertise will be selected from among the engaged Institutions. Any IRB reserves the right to conduct its own review. An alternative option, if OHRP permits on a case-by-case basis, is for USC to waive the engagement obligation under 45CFR46 and forego any responsibility for approval and continued oversight of the research.

  Note: an IRB Authorization Agreement is not required if the research is not federally funded and is not subject to FDA regulations, unless the outside Institution requests an Agreement. If requested by the outside Institution, USC will comply with the request. Additionally, USC may require an IRB Authorization Agreement at its discretion.
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- When conducting multi-site research sponsored by the Department of Defense (DOD), a formal agreement between Institutions is required to specify the roles and responsibilities of each party.

IRB Directors facilitate the IRB authorization agreement process and are responsible for:

- executing the authorization agreements
- sending a copy of the agreement to the IRB at the non-USC site
- sending a copy of the agreement to the USC PI to include the agreement in their IRB application

The Office of Research maintains copies of signed IRB Authorization Agreements.

For help or more information, contact the appropriate IRB office.

Helpful Links

  https://oprs.usc.edu/files/2013/01/IRB_Authorization_Agreement_020411_Clean.doc

  http://oprs.usc.edu/files/2013/01/IRB_Authorization-1.doc

- Required IRB Documents for Research with Other Sites
  https://oprs.usc.edu/files/2013/02/IRB-Required-Documents-for-Research-with-Other-Sites.pdf
Chapter 5: Conflicts of Interest

Chapter Contents

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Chapter 5
Conflicts of Interest

This chapter describes conflicts of interest disclosures and management in relation to research. The focus is on conflict of interest specific to investigators, research team, IRB members, consultants and USC as an Institution.

USC Conflict of Interest policies reflect the U.S. Department of Health and Human Services (DHHS) and Public Health Service (PHS) regulations effective 8/24/12 and the USC Office of Compliance policies.

5.1 Conflicts of Interest

An individual conflict of interest can arise when financial or other personal considerations compromise, or have the appearance of compromising, an individual’s professional judgment in proposing, conducting, supervising, or reporting research. Conflicts can exist at the individual or institutional levels and involve financial and non-financial interests.

Conflicts of Interest may include but are not limited to the following:

- Equity (stocks or options, do not include mutual funds)
- Recruitment incentives (bonus payments) (these are prohibited)
- Consulting Fees
- Speaking Fees
- Travel Reimbursement
- Gifts
- Corporate Officer or Board of Directors
- Other Employment Relationship
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- Trademarks/Copyrights
- Licensing Agreements
- Royalty Payments
- Patent Holdings

An Institutional Conflict of Interest (ICOI) may occur when a financial interest of the University (investments held by the University in a company) has the potential to bias or coerce results of research conducted by its employees or students, or creates an unacceptable risk to human subjects. A Significant Institutional Conflict of Interest is deemed “significant” when a research project includes human subjects and any of the following condition applies:

- The University holds any private equity in the outside entity, or
- The University has the potential to receive cash payments from existing licensing arrangements with the outside entity, or
- The University maintains an ownership interest or an entitlement to equity in a publicly-traded sponsor of human subjects research as a result of technology licensing activities.

To address these conflicts (either individual or institutional), the university established the USC Conflict of Interest in Research Committee (CIRC) to fairly examine and manage conflicts of interest.

5.2 USC Conflict of Interest in Research Committee (CIRC)

The Conflict Of Interest in Research Committees (CIRC) are charged with reviewing conflict of interest disclosures and formulating recommendations to manage, reduce, or eliminate conflicts of interest. The Health Sciences Campus and University Park Campus each have their own committees. When investigators report an actual or apparent conflict of interest for a research activity, the research cannot begin until a conflict management plan has been obtained from the CIRC. Additionally, investigators are not permitted to
begin an external activity that would create a conflict of interest relative to an ongoing research activity before they receive a conflict management plan. Investigators and research team members must comply with all the elements of the Conflict of Interest in Research Committee (CIRC) management plan. Once the CIRC determination is made and/or management plan is issued it is uploaded to the IRB application. CIRC management plans are reviewed and acknowledged by IRB members.

For full board studies, the convened IRB will document member receipt and acknowledgment or edits of the COI management plan and acknowledge. Any IRB-required changes will be noted and may be returned to the PI for action, or referred back to the CIRC for further consideration. The IRB may not limit or reduce the conditions imposed by the management plan but may impose a higher standard, if necessary, to establish that the regulatory criteria for approval of the research has been satisfied. For studies that qualify for exempt or expedited review, the COI management plan will be evaluated and acknowledged by the exempt or expedited reviewer respectively.

For COIs disclosed after full board approval of a study, subsequent CIRC review of COI and development of management plan are provided to the PI. The PI must submit an amendment in iStar and upload the management plan with any applicable changes to the study (e.g., COI disclosure in consent document). The convened IRB will document the review of the COI management plan and note any IRB-required changes, as appropriate.

At any time during the execution of a study, the disclosure of a possible COI to the CIRC results in the creation of an alert notice in iStar that identifies the study noting “A possible conflict of interest has been indicated” and or, “Possible COI has not been cleared”. For full board studies this alert creates an IRB agenda item for review of the subsequent management plan, and resolution by the original convened IRB. In the case of exempt and expedited studies, the IRB reviewer will acknowledge that the resulting management plan is acceptable.
5.3 Investigator and/or Research Team Conflict of Interest Disclosures

Disclosures in the IRB application (iStar)

Potential or actual conflicts of interest must be disclosed at the time of submission of the initial and continuing review application to the IRB and at any time when the investigator and/or research team member establish a new outside relationship or change an existing relationship that creates a potential conflict of interest. Also, informed consent documents must disclose conflicts of interest, as applicable.

Conflicts of interest must be declared when the participating study investigators or other research personnel (or their immediate family/domestic partner) have an aggregated financial interest, and/or intellectual property interest in the sponsor or products used with the project, equal to or exceeding $5,000 per year. Additionally, investigators must inform the IRB of monies received below $5,000 for specific conditions defined in the iStar application. When these conditions are met, the potential conflict of interest is reviewed by the Office of Compliance.

Disclosures in USC’s diSClose system

All disclosure of potential or actual conflict of interests must be made online using the diSClose system. Additionally, the IRB application includes conflict of interest questions for initial and continuing review applications. Investigators must also report conflict of interests if these arise during a study by submitting an amendment. Informed consent documents must disclose conflicts of interest, as applicable.

Disclosures for Research Funded by the Health and Human Services

Researchers who are proposing or have received HHS (including NIH, CDC, HRSA, and AHRQ) support must also make an annual disclosure of all financial interests related to their institutional responsibilities to USC, regardless of whether any of these interests give rise to a conflict of interest related to their research. The annual disclosure must be completed before a proposal can be submitted to HHS, and any identified conflicts must
be managed before an account can be established. In addition, all HHS investigators must complete training on conflicts of interest once every four years.

**Disclosures to Sponsors**

Investigators must adhere to sponsor-specific disclosure requirements, as applicable.

## 5.4 Institutional Conflict of Interest (ICOI)

An institutional conflict of interest may occur when a financial interest of the University (investments held by the University in a company) has the potential to bias research conducted by its employees or students, or creates an unacceptable risk to human subjects.

All Institutional Conflict of Interests that do not present a Significant Institutional Conflict of Interest shall be managed by disclosing the University’s relationship with the outside entity in all relevant publications, proposals, consent documents and presentations.

An Institutional Conflict of Interest is deemed “significant” when a research project includes human subjects and any of the following condition applies:

- The University holds any private equity in the outside entity, or
- The University has the potential to receive cash payments from existing licensing arrangements with the outside entity, or
- The University maintains an ownership interest or an entitlement to equity in a publicly-traded sponsor of human subjects research as a result of technology licensing activities.

Significant Institutional Conflicts of Interest are presumed to be unacceptable, unless compelling circumstances are present that justify allowing the research to proceed at the University despite the presence of a significant conflict. The University conducts a fact-specific inquiry to determine whether the specific circumstances of a relationship are compelling or not. For more information, refer to the USC Institutional Conflict of Interest in Research: Policy and Procedure.
The Vice President of Research (VPR) will determine on a case by case basis the need for an independent IRB review of studies involving ICOI. Independent review by an outside bioethicist will provide evaluation to determine whether the ICOI meets the threshold necessary to seek review by an independent IRB.

If the VPR determines that the ICOI does not meet such criteria – the study will be reviewed by the USC IRB.

### 5.5 IRB Members and IRB Consultants Conflict of Interest

Conflict of Interest policy considerations apply to IRB members. The IRB prohibits the participation in IRB initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB.

An IRB member is considered to have a Conflict of Interest if:

- The IRB member or a Close Relation of the IRB member (spouse, mutual financial dependent, significant other, or person in an intimate relationship, child, parent, or sibling (including in-laws and step-relations), grandparent, grandchild, niece or nephew, aunt or uncle, or cousin) is involved in the conduct of the research

- When the IRB member or Close Relation of the IRB member has a supervisory, managerial or ownership interest in the research sponsor, or licensee, or a company having an economic interest in the research

- Equity interest held by an IRB member or Close Relation of an IRB member in a research sponsor, or licensee, or in any company having an economic interest in the research

- Incentive payments, bonus payments or finder’s fees relating to the proposal paid to the IRB member or Close Relation

- Consultation arrangements between the IRB member or Close Relation of an IRB member and an organization or individual having an economic interest in the
research, which, when aggregated for the IRB member and the Close Relations of the IRB member, is equal to or exceeds $5,000

- Gifts, gratuities, or special favors from the sponsor, which, when aggregated for the IRB member and the Close Relations of the IRB member, is equal to or exceeds $5,000

- Honoraria, travel expenses reimbursement, or other reimbursements from the sponsor, which, when aggregated for the IRB member and the Close Relations of the IRB member, is equal to or exceeds $5,000

- Intellectual property rights related to the research IRB member and the Close Relations of the IRB member

- An arrangement has been entered into where the amount of compensation/ value of ownership interests will be affected by the outcome of the research

The IRB member Conflict of Interest policy also applies to consultants. The IRB Chair or Vice Chair will be responsible for providing the consultant with a copy of the IRB member Conflict of Interest policy prior to their review of the study. Once the consultant has read the policy, the IRB Chair or Vice Chair will ask the consultant if a conflict exists. If answered in the affirmative, the consultant may not review the study. All consultants are required to maintain confidentiality and are notified of this prior to reviewing proposed research for the IRB.
Chapter 6: USC Institutional Review Boards (IRBs)

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Chapter 6
USC Institutional Review Boards (IRBs)

This chapter describes the purpose, role, composition and general procedures of the USC Institutional Review Boards (IRBs). The USC IRBs are responsible for the review all human subjects research conducted at USC.

6.1 Description of USC IRBs

This chapter covers the composition of the IRB membership, the roles and requirements of IRB members, Chairs, Vice-Chairs, and reviewers at the University of Southern California (USC). Additionally, this chapter explains the use of consultants, the role of IRB staff, voting requirements, and IRB record keeping.

There are four Institutional Review Boards at the University of Southern California (one on the University Park Campus, and three on the Health Sciences Campus). These IRBs review and approve research in accordance with Department of Health and Human Services (DHHS) regulations in 45 CFR 46. For studies involving products regulated by the Food and Drug Administration (FDA), the University of Southern California IRBs review research and comply with the requirements set forth in 21 CFR 50 and 56, as well as 21 CFR 312 and 812. In addition, the IRBs comply with HIPAA and its regulations set forth in 45 CFR 160 and 164 and California law as it pertains to human subjects research.

USC IRBs have been delegated the following authority by the Institutional Official in his delegation memo dated 11/23/2005:

- USC IRBs have the authority to approve, disapprove, or suspend human subject research projects. No USC faculty, staff, or student may conduct human subjects research without obtaining approval from the appropriate IRBs at either the Health Sciences or University Park Campuses.

- USC IRBs have the authority to observe, or have a third party observe, the consent process and the conduct of the research.
6.2 The Membership of the IRB Committees

Number, Qualifications and Diversity of Members

Each IRB has a minimum of five, but generally between eight and fifteen members with varying backgrounds to adequately review the research activities commonly conducted by the Institution. Major clinical and selected basic science departments are represented to provide the experience and expertise sufficient for review of the research activities conducted at the Institution. The IRB member with appropriate scientific expertise for each protocol will be designated to review the application. The IRB includes at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in non-scientific areas. Also, the IRB consists of at least one member is not otherwise affiliated with the Institution and is not part of the immediate family of a person who is affiliated with the Institution.

To enable each IRB to ascertain the acceptability of proposed research in terms of institutional commitments, regulations, applicable law, and standards of professional conduct and practice, each IRB includes persons knowledgeable in these areas and may include representatives of administration. Each IRB is sufficiently qualified through the experience, expertise and diversity of its members – including consideration of race, gender, cultural backgrounds, and sensitivity to such issues as community attitudes – to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects.

Because the IRBs may review research that involves a vulnerable category of subjects (children, pregnant women, prisoners, and handicapped or mentally disabled persons), each IRB includes – as members or consultants as appropriate – individuals who are knowledgeable about, and experienced in, working with these categories of subjects.

Every nondiscriminatory effort will be made to ensure that each IRB does not consist entirely of men or entirely of women. The Institution will consider qualified persons of both sexes – so long as no selection is made to the IRB on the basis of gender.

Alternate Members

When deemed necessary by the IRB Chair, and when requested by department Chairs or deans, alternates will be appointed for IRB members. Formally appointed alternate IRB members may represent IRB members, provided the alternate's qualifications are comparable to the primary member to be replaced. The IRB membership rosters identify
the primary member(s) for whom each alternate member substitutes. Prior to the IRB meeting, materials required for review are made available electronically through iStar to all members.

The IRB minutes document when an alternate member replaces a primary member. When an alternate member substitutes for a primary member, the alternate must receive and review the same material the primary member received or would have received. Members and their alternates may not both vote. Alternates are not counted as “members” in establishing the numerical quorum of the IRB, except when they substitute for members during the IRB meeting. Alternates are invited to attend all IRB meetings, whether they are eligible to participate as voting members or not, in order to assure familiarity with the IRB practices and continuing education.

Ex-Officio Members

The IRB may include ex-officio members depending on the relevance of their office and their expertise and experience. The positions they hold preclude full IRB membership and therefore ex-officio members are not voting members of the IRB.

IRB Student Member

The IRB student member is a USC student selected by the Office for the Protection of Research Subjects and the UPIRB for outstanding commitment to the USC community, knowledge about scientific research, and legal and ethical principles guiding research involving human subjects. The IRB student member reviews IRB applications, prepares review comments, and is a full voting member of the UPIRB.

The IRB student member’s participation in the IRB process increases the level of student involvement in the effort to help USC research maintain the legal and ethical standards established by law and society.

6.3 IRB Member Requirements

Selection and Appointment

The members and alternates of the IRBs may be recommended for appointment by their Dean or Department Chair. Non-affiliate members not associated with the Institution are identified by interest and relevance and are recommended for appointment by members
of the IRB, IRB staff, Departments or Schools. The formal appointments of IRB members are made by the Vice President of Research. Typically, individuals who are responsible for business development are not selected to serve as IRB members.

IRB committee membership lists can be found on the IRB websites:

- **HSIRB** [http://oprs.usc.edu/hsirb/hsirb-membership-list/](http://oprs.usc.edu/hsirb/hsirb-membership-list/)
- **UPIRB** [http://oprs.usc.edu/upirb/membership/](http://oprs.usc.edu/upirb/membership/)

### Length of Service

Appointments to the IRBs are for a period of 1 year. Expertise and diverse membership are expectations for both campuses. Continued tenure on the IRB is at the discretion of the IRB Chair/Director.

Evaluations of IRB composition and individual members are conducted at the end of the fiscal year at the time of IRB budget review/approval. Appointment letters indicating satisfactory evaluation of returning members are sent to IRB members at the end of one fiscal year for the next fiscal year. The duties and responsibilities of IRB members are stated in appointment letters from the Vice President of Research. Members who fail to meet IRB expectations, as outlined in the IRB appointment letters, are sent correspondence informing them that their service is no longer needed.

### Duties

Members of each IRB or their designated alternates are required to:

- Participate in agreed upon number of convened IRB meetings
- Review the IRB application and informed consent form for research proposals
- Pre-review and complete a written critique of research proposals including review of clinical trial protocol, grant application, questionnaire(s), advertisement(s), investigator’s drug brochure, and informed consent form when assigned as a reviewer by the Chair, Vice Chair, or IRB staff
- Review expedited review actions of the Chair, Vice Chair, and IRB designee
Chapter 6: USC Institutional Review Boards (IRBs)

- Review and promptly inform the Chair of corrections or additions to Full Board meeting minutes

- If designated by the IRB Chairperson, review and verify that contingencies have been satisfied and further review by the IRB is not required. This does not constitute expedited review.

Selected IRB members may be appointed as expedited reviewers and can review changes to previously approved research during the period covered by the original approval. Changes that may be reviewed by an expedited reviewer are those that do not alter the original approval criteria. Additional training is provided to IRB members who are appointed to be expedited reviewers.

For additional information and examples, refer to Appendix I – Verification that IRB Contingencies were Satisfied.

The IRB prohibits the participation in IRB review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. Refer to Section 5.5 – IRB Members and IRB Consultants Conflict of Interest for more information.

Attendance Requirements

Members and alternates serve at the discretion of the OPRS, IRB Chair and/or Institutional Official. Members who do not attend meetings will be removed from the IRB. If a member is unable to attend a meeting, the IRB office must be informed, sufficiently in advance, so that an alternate can be invited to attend. Frequent absences among members will be cause for removal.

Honorarium to Non-Affiliate IRB Members

An honorarium is paid to non-affiliate IRB members based on meeting attendance. Faculty members are not paid to attend meetings.

Liability for IRB Members

IRB members and alternates fulfill their administrative and institutional service responsibilities to the University, in part, by serving on an IRB committee. Accordingly, the University will indemnify IRB members in the event of a legal dispute relating to the
actions of the committee, provided that the IRB member has acted in good faith and in accordance with federal requirements, state and local laws and University policy.

**Training of the Chair, Vice Chairs and Members**

Chairs and Vice Chairs are expected to attend professional conferences (including PRIM&R conferences) to enhance their education and IRB expertise. IRB members and alternates are initially trained as guests (non-voting capacity) of the IRBs, and also offered support to attend appropriate courses, and local or national meetings. Ongoing education of the IRB membership includes an education session preceding an IRB meeting approximately once per month. In addition, access to educational materials is provided to all IRB members (such as “IRB: A Review of Human Subjects Research”). IRB members and alternates are required to take the Protection of Human Subjects education modules provided online through the CITI website [https://www.citiprogram.org/](https://www.citiprogram.org/).

**Evaluation of IRB Members**

The duties and responsibilities of IRB members will be stated in appointment letters from the Vice President of Research. Expectations and subsequent evaluation of IRB members will be addressed through different mechanisms at HSC and UPC.

- At UPC, IRB members will be re-appointed annually if expectations are met. The re-appointment letter will acknowledge that the IRB member has been evaluated and satisfied the membership criteria described in HSPP policy and as provided in the appointment letter.

- At HSC, the IRB appointment letter will provide the criteria upon which a member will be evaluated and retained but will not state a term of service. An annual letter will acknowledge that their performance has been evaluated and found satisfactory.

- For any member who fails to meet the expectations outlined in the IRB appointment letter correspondence will be sent informing them their service is no longer needed.

The IRB members will be informally evaluated annually by the IRB Chair and Director. During the evaluation, the following areas will be considered when applicable:

- Knowledge and application of federal regulations and ethical principles
Chapter 6: USC Institutional Review Boards (IRBs)

- Knowledge and application of IRB policies and procedures
- Constructive participation in IRB discussion
- Attendance (notifies staff when confirming or declining to attend meetings)
- Participates in educational sessions/completes required member training
- Reviews projects as requested in a timely, comprehensive, knowledgeable manner and resolves as many issues with the investigator as possible, prior to meetings
- Reviews all IRB application materials, meeting minutes, and expedited actions

The IRB Chairs/vice Chairs are informally evaluated by the Vice President of Research, and the OPRS on an annual basis. They are evaluated on how well they manage IRB meetings, attendance, knowledge of federal regulations and state laws, collegiality with fellow members, IRB staff, and their review (quality / quantity / timeliness) of IRB applications.

6.4 IRB Use of Consultants

Each IRB may, at its discretion, invite individuals with competence in special areas to assist in the review of issues that require expertise beyond, or in addition to, that available on the IRB. These consultants are not counted as “members” in establishing the numerical quorum for each IRB and may not vote with the IRB. An honorarium for consultants may be provided at the discretion of the IRB Chair and/or the IRB Director.

If it is determined that a consultant is needed for the review of a protocol, the IRB Chair or Vice Chair will ask the IRB members and colleagues to refer them to individuals that would have experience with the specific type of research being reviewed. The consultants will be provided with the same information that the primary and secondary reviewers receive.

The IRB member Conflict of Interest policy also applies to consultants. The IRB prohibits the participation in IRB review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. Refer to Section 5.5 – IRB Members and IRB Consultants Conflict of Interest for more information.

Copies of the consultant review are supplied to the IRB members. Consultant(s) may be asked to attend the meeting for further clarification, if deemed necessary by the IRB.
Chair or Vice Chair. Key information from the consultant will be included in the IRB meeting minutes and a copy of all documentation will be kept in the study file.

## 6.5 IRB Support Staff

The IRB support staff assists the Chair and Vice Chairs in IRB activities. The support staff is responsible for submitting written correspondence to investigators regarding IRB actions. IRB staff shall document meeting minutes in accordance with federal regulations and guidance. Required documents are listed in Section 6.8 – IRB Records.

IRB staff training may be provided by the IRB Director, OPRS, or IRB Chair. Staff member training also includes taking the CITI education courses, familiarity with federal, state, and local regulations, and institutional the policies and procedures. A Bachelor’s Degree or prior IRB experience is required. Annual reviews are conducted to evaluate IRB staff.

The IRB staff will be evaluated annually, at the time of budget reviews, by the IRB Chair/Director. The following criteria: knowledge of the IRB process and regulations, continuing training, work attendance, and, overall ability to function as an asset to the IRB, will be measured. If a staff member is found to be deficient in a particular area or areas, they will be further educated on the IRB process. If gross errors have been uncovered, further actions, as described in University policies will be taken. The evaluation will be reflected in the annual salary determination.

### IRB Support Staff Duties:

- Screen submissions before IRB review
- Prepare IRB meeting agenda
- Prepare meeting minutes (see “Meeting Minutes” in Section 6.8 – IRB Records)
- Prepare correspondence
- Facilitate review of IRB applications
- Customer service
- Database and information management
- Train student mentors
Respond to subject concerns

Follow office procedures

Follow IRB policy and procedures and make suggestions/recommendations

Undertake and provide education and training

Intra-institutional relationships

Handle meeting logistics

Review and approve non-material contingencies such as those related to personnel changes (excluding change of PI), punctuation and wording or verification that something missing has been supplied

Preliminary review of initial/continuing review documents (confirm all required documents have been submitted by the investigator, confirm the consent document submitted by investigator matches the one on file, identify issues and concerns for IRB consideration)

Selected IRB staff may be appointed as IRB members (or alternate members). Additional training is provided to IRB staff who are also IRB members.

For additional information and examples, refer to Appendix I – Verification that IRB Contingencies were Satisfied.

6.6 IRB Chairs and Vice Chairs

Chairperson

Selection and Appointment

The Chair is selected from among the faculty of the Institution and appointed by the Institutional Official. The Chair should have previously served as a member of the IRB.

Selection Criteria

The criteria used to select a Chair include experience with, and knowledge of, applicable federal regulations, state laws, and Institutional policies. They must be willing to commit their service to the IRB; must have past experience as an IRB member; and must
demonstrate excellent communication skills, along with an understanding of clinical research. They must also demonstrate a thorough understanding of ethical issues involved in clinical/social behavioral research.

### Length of Term/Service

The term of appointment of the Chair is determined by the Institutional Official in consultation with the Executive Director of the Office for the Protection of Research Subjects.

### Attendance Requirements

The Chair is required to attend the majority of the convened IRB meetings.

### Duties

The Chair of the IRB convenes and chairs the meetings of the IRB. The Chair may conduct or delegate expedited review of research that qualifies as expedited, review the responses of investigators to contingencies in expedited studies or studies that qualify for the expedited procedure. The Chair reviews and approves expeditable amendments in previously approved research, unless the change affects the approval criteria. The Chair may delegate such authority to IRB expedited reviewers.

### Project Referrals

The Chair may, at their discretion, refer the review of a research project to the IRB of the other campus if it is determined that more appropriate expertise lies in the other IRB.

### Vice Chairpersons

#### Selection and Appointment

Vice Chairs are selected from among the faculty at the Institution and are appointed by the Institutional Official (the Vice President of Research) in consultation with the Chairs / IRB Director and Executive Director of the Office for the Protection of Research Subjects. The Vice Chairs must have previously served as members of the IRB.
### Length of Service

The term of appointment of the Vice Chair is determined by the Institutional Official in consultation with the Chairs / IRB Director and the Executive Director of the Office for the Protection of Research Subjects.

### Attendance Requirements

Vice Chair will be assigned to Chair an IRB meeting when the Chair is unable to conduct the meeting.

### Duties

The Vice Chairs of the IRB are designated by the Chair to carry out expedited review of research that qualifies for such review. The Vice Chairs shall be authorized by the Chair to review the responses of investigators to contingencies of the IRB (to secure IRB approval) and to review minor changes in previously approved research during the period covered by the original approval. The Chair, Vice Chairs, IRB Director, or IRB staff assigns the primary reviewers to pre-review new research proposals submitted to the IRB for consideration at the Full Board meetings.

### 6.7 IRB Voting Requirements

Reviews of proposed research are conducted at a convened IRB meeting at which a majority of the members are present. At least one IRB member whose primary concerns are in non-scientific areas, one member whose primary concerns are in scientific areas, and one non-affiliate member must be present. In the event a majority of members are not present, or there is no member whose primary concerns are non-scientific, or a non-affiliate member is not present, the meeting will not be called to order (or if any of these circumstances arises after the meeting has been called to order, it will be adjourned or suspended until quorum is reestablished) and will be rescheduled. The IRB staff will monitor the members that are present at the meeting and determine that the meetings are appropriately convened and remain so.

In order for the research to be approved at the convened meeting it must receive the approval of a majority of the members present at the meeting. The IRB roster will show which members are in attendance for each vote taken during an IRB meeting.
Votes submitted prior to a convened meeting by mail, telephone, fax or e-mail are not permissible. Comments of the absent members may be submitted and considered by the attending IRB members.

### 6.8 IRB Records

#### IRB Membership Roster

The IRB maintains rosters of IRB membership including: name, earned degrees, representative capacity, experience (such as board certifications and licenses) sufficient to describe each member’s chief anticipated contributions to IRB deliberations, and any employment or other relationship between each member and the Institution. Changes to the IRB membership roster are reported to OHRP by the IRB Staff or IRB Director.

#### Written Procedures and Guidelines

The IRB maintains written procedures as required by 45 CFR 46.103(b)(4), (5).

#### Meeting Minutes

For each IRB, an IRB administrator will maintain detailed records of meeting minutes that will specify which members were present, that a quorum was maintained for each action, the number of votes for each action during the meeting, documentation of a non-scientist member for each vote, and documentation that an IRB member knowledgeable about or experienced in working with specific/vulnerable populations was assigned as a reviewer and/or was present for the vote.

Each IRB will keep a roster of all members and, for each action, record which members voted. This document will be kept separate from the distributed minutes.

Additionally, IRB staff shall document all meeting minutes according to federal regulations and the requirements listed below.

The IRB meeting minutes include:

- Confirmation that quorum was maintained for each vote
- Attendance for each action
- Summary of discussion of controversial issues (if any) and their resolution
• Record of IRB decisions (actions taken by the IRB)
• Record of voting (including the number of members voting for, against, and abstaining) for each action
• The basis for requiring changes in or disapproving research
• Names of IRB member(s) recused and not present during the discussion or vote in any research protocol under review and of those who abstain due to conflicts of interest
• Description of the materials reviewed for both new and continuing review proposals. Such materials might include the IRB application, clinical protocol, investigators brochure, informed consent form documents, continuing review form, primary reviewer’s evaluation (for continuing review) and any other materials submitted for review
• All applicable waivers are discussed and documented (with justification) in the IRB minutes including, waiver or alteration of informed consent and written informed consent
• Protocol specific determinations on studies involving vulnerable populations (45CFR46 Subparts B, C, D) are documented and justified according to the regulations
• Approval period for initial and continuing reviews
• Rationale for significant risk/non-significant risk device determinations
• If an IRB member has a Conflict of Interest regarding a study being reviewed, they will recuse themselves from the review of the study. The name and reason for absence will be included in the minutes
• When an alternate member replaced a primary member

Minutes from each IRB meeting are distributed to all IRB members, to the Vice President of Research and relevant institutional administration for review according to the Federalwide Assurance. IRB members are required to review the minutes and note any corrections or additions at the first meeting following distribution of the minutes.
Records Retained in the IRB Files

IRB files contain the following documents and information for each study:

- iStar application
- Draft/Approved consent documents
- Clinical protocol, including amendments/revision
- Investigators brochure(s)
- Grant application(s)
- Scientific evaluations, if any, that accompany the proposals
- Budget
- Supporting information that accompanies the studies (staff reviews, recruitment documents, IRB reviews)
- Amendments
- Reportable events
- Category of approval for exempt, expedited, Full Board (when necessary), and continuing review submissions
- Progress reports submitted by investigators
- All continuing review activities
- Reports of injuries to subjects
- Statements of significant new information/findings provided to subjects
- Emergency use reports
- IRB minutes
- Correspondence between the IRBs and investigator
Record Retention Requirements

Copies of all documentation relating to IRB review, even when a project is cancelled without subject enrollment, are maintained by the IRB office. Generally, records are maintained for a minimum of three years after completion of the research or as determined by the University’s policy or sponsor requirements. Additionally, in accordance with federal HIPAA privacy regulations, records containing protected health information are retained for at least six years after completion of the research. However, USC, like many research institutions, retains IRB research records indefinitely.

For additional information, refer to the USC Record Retention Policy.

Access to Files

IRB records are accessible for inspection and copying by authorized representatives of federal agencies or departments at reasonable times and in a reasonable manner.

6.9 Development, Approval, and Maintenance of IRB Policies and Procedures

The USC IRB Policies and Procedures are written and applied according to federal regulations and state and local laws. In addition, University policies and procedures, and accrediting and funding agencies policies will be considered. To assure continued compliance, the following will be conducted:

- USC IRB policies and procedures are to be reviewed every three years and when changes in regulations, laws, and institutional policies necessitate revision

- USC IRB policies and procedures are developed and maintained by the Human Subjects Working Group under the direction of the Executive Director for the Office of the Protection for Research Subjects

- The HSPP is charged with the appropriate implementation and enforcement of IRB policies and procedures consistent with other University policies and procedures
Investigator Responsibilities with Respect to Policies

The investigator will review USC IRB policies and procedures as part of the required initial training for conducting human subjects’ research at the University of Southern California. Current policies and procedures are located on the IRB website at http://oprs.usc.edu/rules/. It is the responsibility of the investigator to routinely view the IRB website for new or revised IRB policies and procedures. The investigator should contact IRB staff for clarification of policies and procedures, when necessary.

IRB Staff Responsibilities with Respect to Policies

IRB staff will routinely view the OHRP and FDA websites for issuance of guidance documents, changes in regulations, and determination letters. The IRB Working Group will contact the Office of General Counsel and Office of Compliance, when necessary, to discuss changes and assist in the interpretation of federal, state and local regulations affecting IRB policies and procedures. The IRB staff and Office for the Protection of Research Subjects staff will provide educational sessions to the IRB members and staff regarding IRB policies and procedures, as well as updates or revisions.

The IRB staff will use the IRB policies and procedures posted on the IRB website when reviewing IRB applications. The IRB staff may consult with other IRB officials for guidance in applying the IRB policies and procedures. If the IRB staff notices that a policy or procedure is inaccurate or out of date, he/she should bring it to the attention of the IRB Director who will communicate to the Human Subjects Working Group. It is the responsibility of all IRB staff to assist in keeping the IRB policies and procedures current and applicable to the daily processes of the IRB offices and to follow the policies as stated.
# Chapter 7: Types of IRB Submissions

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Chapter 7
Types of IRB Submissions

All USC human subjects research projects must undergo review and approval by an IRB prior to initiating research activities. This chapter defines human subjects research, outlines what kind of studies require and do not require IRB approval and details the types of submissions and review categories.

This chapter will establish what Human Subjects Research is and what is not Human Subjects Research followed by an overview of types of IRB submissions.

The USC IRBs review all human subjects research activities at USC to determine the appropriate category of review. An investigator may request a particular category of exemption, but the final determination is made by the IRB Chair, Vice Chair, or IRB designee.

7.1 Human Subjects Research: What is and What is Not

The initial determination of whether a study is or is not human subjects research is made by referring to the federal (45 CFR 46) definitions of human subjects and research (FDA has slightly different definitions). Any activity that meets OHRP definitions of both “research” and “human subjects” or the FDA definitions of both “clinical investigation” and “human subjects” is considered human subjects research.

What is Human Subjects Research (HSR)

Defining Human Subjects

OHRP (45 part 46) defines a human subject as a living individual about whom an investigator (whether professional or student) conducting research obtains: (1) Data through intervention or interaction with the individual, or (2) Identifiable private information.
Intervention includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject’s environment that are performed for research purposes.

Interaction includes communication or interpersonal contact between investigator and subject.

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

**FDA** (21 part 50.3) defines a human subject as “an individual who is or becomes a participant in research, either as a recipient of the test article or as a control. A subject may be either a healthy human or a patient.”

When an investigational device is used on a specimen, the specimen may be considered a “human subject” under FDA definitions.

Note: The **Department of Defense (DOD)** [32 CFR 219.102(f) reference (c)] defines “Research Involving a Human Being as an Experimental Subject” as: “An activity, for research purposes, where there is an intervention or interaction with a human being for the primary purpose of obtaining data regarding the effect of the intervention or interaction. Examples of interventions or interactions include, but are not limited to, a physical procedure, a drug, a manipulation of the subject or subject’s environment, the withholding of an intervention that would have been undertaken if not for the research purpose.” (DODD 3216.02, E2.1.3)

### Defining Research

**OHRP** (45 part 46) defines research as “a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.” Activities that meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes.
FDA (21 part 50.3) defines “clinical investigation” as “any experiment that involves a test article and one or more human subjects and that either is subject to requirements for prior submission to the FDA under section 505(i) or 520(g) of the act, or is not subject to requirements for prior submission to the FDA under these sections of the act, but the results of which are intended to be submitted later to, or held for inspection by, the FDA as part of an application for a research or marketing permit. The term does not include experiments that are subject to the provisions of part 58 of this chapter, regarding non-clinical laboratory studies.”

Note: Sections 505(i) and 520(g) refer to any use of a drug other than the use of an approved drug in the course of medical practice and 520(g) refers to any use of a medical device other than the use of an approved medical device in the course of medical practice.

**What is Not Human Subjects Research (NHSR)**

Certain activities have the characteristics of research but do not meet the federal definition of research and/or the federal definition of human subjects according to OHRP and FDA regulations. Examples of NHSR are classroom research, institutional research, oral history, research with autopsy specimens, program evaluations, quality improvement projects and literature searches.

If it is clear after reading the preceding examples, that the research study does NOT require approval by the IRB, it does NOT need to be submitted to the IRB. If there is a question as to whether the study requires approval by the IRB, contact the IRB office. If a study does not meet the definition of human subjects or research, the IRB can issue a letter, if requested by the investigator, stating that the study does not qualify as human subjects research and therefore does not need to be approved by the IRB. Refer to Section 7.5 – Not Human Subjects Research (NHSR) Submissions.

OHRP (45 Part 46) defines a human subject as a "living" individual, so research involving autopsy materials or cadavers is not considered human subjects research and does not require review by the IRB. The activity may still be subject to the Health Insurance Portability and Accountability Act (HIPAA) regulations. Contact the IRB office for questions.

The intent to publish in professional journals and/or present at national or regional meetings does not automatically make a project human subjects research requiring IRB
review and approval. If you have questions regarding publishing or presenting, please contact the IRB office for further guidance.

Now that HSR and NHSR have been established, the various submission types will be discussed.

## 7.2 Exempt Review

Research activities in which the only involvement of human subjects will be in one or more of the categories listed below are exempt from federal regulations listed under 45 CFR 46.101, unless otherwise required by department or agency heads [45 CFR 46.101(b)]. Exempt review studies require IRB submission. The IRB determines whether a study qualifies as an exempt study; investigators do not have the authority to make exempt determination themselves.

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;
   ii. and any disclosure of the human subjects’ responses outside of 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 45 CFR 46.101(b)(2) if:
Chapter 7: Types of IRB Submissions

i. The human subjects are elected or appointed public officials or candidates for public office; or

ii. Federal statutes require 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 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

   ii. or 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 FDA or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

General Restrictions on Exempt Review

For research involving prisoners, exemption categories DO NOT apply [45 CFR 46.101(i)].
For research involving children, exemption category 2 DOES NOT apply unless research only involves observation of public behavior when the investigator(s) do not participate in the activities being observed.

FDA does not recognize exemption categories 1 through 5. Only exempt category 6 may qualify as exempt.

Deception in exempt research is discussed in Section 17.9 – Research Using Deception.

## Duration of Project Approval

Exempt studies do not expire and do not require annual IRB review of the project. However, if changes to the study are proposed that may affect the risk/benefit ratio of the study, investigators must inform the IRB. Additionally, when a study is completed or terminated, investigators should update the status of the IRB application (refer to Section 9.3 – Project Closure).

### 7.3 Expedited Review

The IRB may use an expedited procedure to conduct initial review of research provided that research activities do not fall under any of the general restrictions, present no more than minimal risk to human subjects, and involve procedures listed in one or more of the following categories (45 CFR 46.110(a)/21 CFR 56.110(a)):

1. Clinical studies of drugs and medical devices only when condition (a) or (b) is met:
   a. Research on drugs for which an investigational new drug application 21 CFR Part 312 is not required. (NOTE: Research on marketed drugs that significantly increases the risks, or decreases the acceptability of the risks associated with the use of the product, is not eligible for expedited review.)
   b. Research on medical devices for which:
      i. an investigational device exemption application 21 CFR Part 812 is not required, or
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ii. the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

2. Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:

   a. From healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an eight-week period and collection may not occur more frequently than two times per week, or

   b. From other adults and children*, when the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected are considered. For these participants, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an eight-week period and collection may not occur more frequently than two times per week.

   *Children are defined in the federal regulations as "persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted" see 45 CFR 46.402(a).

3. Prospective collection of biological specimens for research purposes by noninvasive means.

   Examples: (a) Hair and nail clippings in a non-disfiguring manner; (b) Deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) Permanent teeth if routine patient care indicates a need for extraction; (d) Excreta and external secretions (including sweat); (e) Uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue; (f) Placenta removed at delivery; (g) Amniotic fluid obtained at the time of rupture of the membrane before or during labor (h) Supra and sub gingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance
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with accepted prophylactic techniques; (i) Mucosal and skin cells collected by buccal scrapping or swab, skin swab, or mouth washings; (j) Sputum collected after saline mist nebulization; (k) Vaginal swabs that do not go beyond the cervical os; (l) Rectal swabs that do not go beyond the rectum; and/or (m) Nasal swabs that do not go beyond the nares (procedures k-m addressed on OHRP Correspondence 9/22/11, “Clarification of ‘noninvasive’ in expedited review category 3”).

4. Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.

Examples: (a) Physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject’s privacy; (b) Weighing or testing sensory acuity; (c) Magnetic resonance imaging; (d) Electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, Doppler blood flow, and echocardiography; (e) Moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

5. Research involving materials (data, documents, records, or specimens) that have been collected or will be collected solely for non-research purposes (such as medical treatment or diagnosis). (NOTE: Some research in this category may meet exemption under 45 CFR 46.101(b) (4). This listing refers only to research that is not exempt.)

6. Collection of data from voice, video, digital, or image recordings made for research purposes.

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language,
communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may meet exemption under 45 CFR 46.101(b) (2); this listing refers only to research that is not exempt.)

8. Continuing review of research previously approved by a full IRB as follows:

   a. Where (i) the research is permanently closed to the enrollment of new subjects; (ii) all subjects have completed all research-related interventions; and (iii) the research remains active only for long-term follow-up of subjects; or

   b. Where no subjects have ever been enrolled and no additional risks have been identified; or

   c. Where the remaining research activities are limited to data analysis.

9. Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories (2) through (8) do not apply but the IRB has determined and documented at a convened full IRB meeting that the research involves no greater than minimal risk and no additional risks have been identified.

General Restrictions on Expedited Review

- Expedited review procedures may not be used for research involving prisoners unless the research is minimal risk and meets the criteria of expedited review as indicated in the federal regulations (45 CFR 46, Subpart C). In most cases, expedited review procedures are not appropriate for research involving prisoners. However, if a project meets the criteria for expedited review, the IRB Chair/Vice Chair or designee will consult with the prisoner representative of the IRB to determine if the submission could be reviewed by expedited procedures. If the prisoner representative agrees that expedited procedures are appropriate, the representative will be assigned as one of the designated reviewers. For more information on prisoner research, refer to Section 14.3 – Prisoners in Research.
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- The expedited review procedure may not be used where identification of the subjects and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the subjects’ financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.

- The expedited review process may not be used in the review of classified research (such as DOD projects).

### Duration of Project Approval

Federal regulations adhered to by USC require that every approved study receive continuing review “not less than once per year.” Accordingly, an approval period cannot exceed 364 days. In some cases, the IRB may grant a shorter approval period if the complexity or risk level merits more frequent continuing review. Examples include: the nature of risks posed by the study, the degree of uncertainty regarding the risks involved, the vulnerability of the subject population, the experience of the clinical investigator in conducting clinical research, the IRB’s previous experience with the investigator and/or sponsor, the projected rate of involvement and whether the study involves novel therapies. Alternatively, the IRB may grant an approval period based on a number of subjects accrued, rather than a specific time period. This type of approval period is usually assigned when there are questions regarding the potential risks of participation.

Each IRB approval letter notes an initial approval date and an ending approval date. The initial approval date is the date all contingencies are satisfied. The procedure for setting the effective approval date and the duration of protocol approval are based on harmonized guidance from the Office for Human Research Protections (OHRP) and the Food and Drug Administration (FDA). For additional information, refer to [http://www.hhs.gov/ohrp/policy/continuingreview2010.html#section-g2](http://www.hhs.gov/ohrp/policy/continuingreview2010.html#section-g2) and [http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM294558.pdf](http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM294558.pdf).

### 7.4 Full Board Review

All human subjects research projects involving more than minimal risks to subjects (or involving minimal risk to subjects but do not qualify for expedited review) are reviewed at a fully-convened IRB meeting. A majority of IRB members must be present to
conduct the meeting and to satisfy voting requirements. At least one member whose primary concern is in nonscientific areas and at least one member who is not affiliated with USC must be present.

### Duration of Project Approval

Federal regulations adhered to by USC require that every approved study receive continuing review “not less than once per year.” Accordingly, an approval period cannot exceed 364 days. In some cases, the IRB may grant a shorter approval period if the complexity or risk level merits more frequent continuing review. Examples include: the nature of risks posed by the study, the degree of uncertainty regarding the risks involved, the vulnerability of the subject population, the experience of the clinical investigator in conducting clinical research, the IRB’s previous experience with the investigator and/or sponsor, the projected rate of involvement and whether the study involves novel therapies. Alternatively, the IRB may grant an approval period based on a number of subjects accrued, rather than a specific time period. This type of approval period is usually assigned when there are questions regarding the potential risks of participation.

Each IRB approval letter notes an initial approval date and an ending approval date. The initial approval date is the date all contingencies are satisfied. The procedure for setting the effective approval date and the duration of protocol approval are based on harmonized guidance from the Office for Human Research Protections (OHRP) and the Food and Drug Administration (FDA). For additional information, refer to [http://www.hhs.gov/ohrp/policy/continuingreview2010.html#section-g2](http://www.hhs.gov/ohrp/policy/continuingreview2010.html#section-g2) and [http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM294558.pdf](http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM294558.pdf).

### 7.5 Not Human Subjects Research (NHSR) Submissions

A Not Human Subjects Research (NHSR) submission is an information request to determine if a project is subject to IRB review and approval. Its purpose is to streamline the system to exclude projects that do not meet the regulatory definitions of human subjects research. If a project submitted as NHSR is determined to be a human subjects research study, a new study application will be requested by the IRB.

Studies are considered “Not Research” when they do not meet the [45 CFR 46](https://www.hhs.gov/ohrp/policies/sections/46.html) definitions of human subjects and/or research. Investigators who believe their project may qualify as
NHSR can submit an on-line request “Does my project qualify as Not Human Subjects Research?” through the iStar system. This determination is made by the IRB / IRB designee and not by the investigator.

Projects that involve FDA-regulated products are required to be submitted as an IRB application. If a project involving FDA-regulated products is submitted through the NHSR information request it will be returned with instructions to submit a regular IRB application.

7.6 Coded Specimens / Data Submissions

The Office for Human Research Protections (OHRP) considers private information, or specimens, not to be identifiable when they cannot be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems. Study of specimens or data that meet this criterion is considered as not human subject research. (Guidance on Research Involving Coded Private Information or Biological Specimens). This type of study submission is applicable when both of the following conditions are met:

1) The private information or specimens were not collected specifically for the currently proposed research project through an interaction or intervention with individuals; and

2) The investigator(s) cannot readily ascertain the identity of the individual(s) to whom the coded private information or specimens pertain because, for example:

(a) The investigators and the holder of the key enter into an agreement prohibiting the release of the key to the investigators under any circumstances, until the individuals are deceased (note that the HHS regulations do not require the IRB to review and approve this agreement); or

(b) 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 investigators under any circumstances, until the individuals are deceased; or
(c) There are other legal requirements prohibiting the release of the key to the investigators.

## 7.7 Newborn Dried Bloodspots

The Newborn Screening Saves Lives Reauthorization Act of 2014 explicitly states that the use of newborn dried bloodspots for research is considered to involve human subjects if the research is federally supported and the bloodspots are collected on or after March 18, 2015. The identifiability (or not) of the bloodspots is irrelevant. In other words, if a researcher is receiving de-identified or anonymous bloodspots for research, the research is considered to involve human subjects. A detailed summary of recommendations is provided by the U.S. Department of Health and Human Services, Secretary’s Advisory Committee on Human Research Protection (SACHRP). The goal of this recommendation is to provide thoughtful consideration of this act and allow for important research to take place. Refer to: [https://oprs.usc.edu/files/2016/05/SACHRP-Newborn-Dried-Bloodspots.docx](https://oprs.usc.edu/files/2016/05/SACHRP-Newborn-Dried-Bloodspots.docx)

## 7.8 Grant and Contract Only Submissions

Grant and Contract Only submissions are projects that lack definite plans for involvement of human subjects (the PI must submit a new study application prior to any human subject involvement). Grant and Contract Only Submissions include:

- Applications for approval of Center, Training or Program Project Grants, where the application outlines the administrative core requirements and does not include a plan for the involvement of human subjects. Review of data coordinating centers, or similar entities that involve access to private and identifiable information about living individuals, requires review by a designated or expedited reviewer.

- Applications requesting approval for development purposes only under 45 CFR 46.118 and 46.119, where the proposals lack definite plans for the inclusion of human subjects.
The Principal Investigator (PI) is required to submit a grant/contract application through iStar. The IRB will review the application and send correspondence acknowledging the submission of the grant and that the project does not have definite plans to involve human subjects.

### 7.9 Humanitarian Use Device

A Humanitarian Use Device (HUD) is a device that is intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 4,000 individuals in the United States per year. FDA developed this regulation to provide an incentive for the development of devices for use in the treatment or diagnosis of diseases affecting these populations.

An approved Humanitarian Device Exemption (HDE) application authorizes marketing of the HUD.

Use of an HUD for its approved indication does not constitute human subjects research. However, FDA regulations require that the Institution’s IRB review and approve the use of the HUD at the Institution. The IRB’s responsibility in this case is to conduct a special limited review to verify that the proposed (non-research) use of the device is consistent with the HDE’s FDA-approved indication (21 CFR 814.124(a)). After granting initial approval, the IRB may use expedited procedures for conducting subsequent continuing reviews, which must be performed at least annually. FDA regulations do not require an informed consent form for clinical use of an HUD. However, sponsors often provide a sample consent form and the IRB or the Institution may require the investigator to use an informed consent form specific for HUDs. For additional information, refer to Section 18.5 - Humanitarian Use Devices (HUD).

### 7.10 Ceded Review

Ceded review submissions involve research conducted at USC or by USC personnel that utilize approval by a non-USC IRB. Ceded review can involve multi-site studies (such as cancer cooperative group studies) as well as studies conducted in collaboration with another Institution (such as Cedars-Sinai Medical Center or CHLA). Because these studies are approved by another Institution’s IRB, submission to the USC IRB involves only an abbreviated application.
National Cancer Institute

USC is participating in the National Cancer Institute (NCI) Central IRB (CIRB). CIRB is the sole IRB of Record responsible for review of the study as well as review of local context issues for enrolled Institutions. Local policy, conflict of interest, HIPAA authorization, and ancillary committee approvals are still the responsibility of the USC IRB.

Agreements with Other Institutions

The Ceded Review process is used for studies conducted at USC and other Institutions. A formal mechanism such as a Memorandum of Understanding or IRB Authorization Agreement establishes a Ceded Review agreement. For a list of current USC agreements with other Institutions, refer to: http://oprs.usc.edu/initiatives/agreements/.

7.11 Continuing Review

In accordance with federal regulations, the USC IRB requires that ongoing research protocols undergo continuing review at intervals appropriate to the degree of risk, but not less than once per year. The frequency and extent of continuing review for each study is based upon the nature of the study, the degree of risk involved, the novelty of the research procedures, the experience of the clinical investigator in conducting clinical research, the IRB’s previous experience with the investigator and/or sponsor, the projected rate of enrollment and the vulnerability of the study subject population. After a careful consideration of each of these factors, each protocol is assigned an approval period, after which it must be re-reviewed by the IRB. In some instances, such as when research involves the use of innovative techniques, the IRB may choose to grant an approval period based on a small number of subjects accrued rather than on a specific time period. This type of approval is usually assigned when there are concerns regarding the potential risks of participation.

Each investigator must abide by the approval period imposed by the IRB at the time of the most recent IRB approval. Each IRB approval notice designates a period of time during which activities involving human research subjects may be undertaken. No research project may continue to recruit, enroll, or treat subjects or analyze data after the IRB approval expiration date. Continuation of the research after the date of expiration of IRB approval is a violation of federal regulations.
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To assist investigators in fulfilling the requirement for continuing review, the IRB sends expiration notices through iStar at 90, 60, 45, and 30 days prior to expiration to the investigator, faculty advisor, and study coordinator. If investigators do not submit a completed application for continuing review at least 30 days before the protocol expiration date, the IRB cannot guarantee that the application will be reviewed before the date of expiration.

It is the investigator’s responsibility to ensure that approval for an active protocol remains current. The IRB expiration date can be found on the main study page in the iStar online submission system, in the IRB approval letter, and in the expiration notices.

For more information, refer to Section 9.2 – Continuing Review.

Note: Studies involving less than minimal risk and that are not federally funded can be reviewed at intervals greater than once per year under the USC Flexibility policy.

7.12 Amendments

Investigators must submit and obtain approval from the IRB before implementing any changes to a previously approved study, except when the changes are necessary to eliminate apparent, immediate hazards to subjects.

The mechanism for proposing modifications to a previously approved research is an amendment application in iStar. The amendment application process involves a “summary” that explains all proposed changes followed by the modified study application. IRB review of amendment submissions focuses on the effect of the proposed changes on human subjects. The IRB analyzes whether the amendment poses additional risks to subjects or represents a significant change in study procedures. When the IRB approves the amendment, the modified study replaces the previously approved study.

Study personnel changes, with the exception of changes to the Principal Investigator, Co-Investigator(s), Faculty Advisor, or anyone obtaining informed consent, can be made to the IRB application without submitting an amendment. To do this, research staff can select the “Edit Study Personnel” activity in iStar for the specific study and add or delete study personnel. However, study personnel added to a study must have current human subjects training.
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For more information, refer to Section 9.1 - Amendments – Changes to Research after Approval.

7.13 Significant New Information and/or Findings (SNIFs)

Regulations require that subjects be provided with significant new information/findings (SNIF) developed during the course of the research, that may affect a subject’s willingness to continue participation [45 CFR 46.116(b)(5) and 21 CFR 50.25(b)(5)]. SNIF can be communicated to current subjects by a SNIF form or a revised informed consent document. All future subjects must be consented with a revised consent form. All SNIF materials must be submitted to and approved by the IRB before use except when necessary to eliminate apparent immediate hazards to subjects. Refer to Section 10.14 - Providing Significant New Information / Findings (SNIF) to Participants for more information.

7.14 Reportable Events

USC investigators are required to inform the IRB about specific events that occur in a study. These are called reportable events. An overview of reportable events including definitions and reporting timeline is provided here. For detailed information about reportable events, refer to Section 9.8 – Reportable Events and Chapter 20 – Reportable Events, Noncompliance, Suspensions, and Terminations.

Adverse Events

Adverse events (AEs) are defined as “any untoward medical occurrence associated with the use of a drug in humans, whether or not considered drug related” by the Federal Drug Administration (FDA). In contrast, the Office for Human Research Protections, (OHRP), defines adverse events as “any untoward or unfavorable medical occurrence in a human subject, including any abnormal sign (for example, abnormal physical exam or laboratory finding), symptom, or disease, temporally associated with the subject’s participation in the research, whether or not considered related to the subject’s participation in the research.”
At USC, only AEs that are unexpected, related or possibly related, and are either serious or place subjects or others at a greater risk of harm than was previously known or recognized, must be reported to the IRB through iStar, using the Reportable Event application. Reporting to the USC IRB must be as soon as possible, but not later than 10 working days after the investigator becomes aware of the event.

Additional requirements are in effect for investigators who are also sponsors (sponsor-investigators). Refer to Section 13.2 – Investigator-Initiated Research and Sponsor-Investigators and Section 18.4 – Sponsor-Investigators for additional information.

**Adverse Device Effects**

An unanticipated adverse device effect (UADE) is “any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects”.

UADEs must be reported by the clinical investigator to the sponsor and the reviewing IRB as soon as possible, but in no event later than 10 working days after the investigator first learns of the event. Investigators must report the UADE to the IRB through the Reportable Event application in the iStar system.

Additional requirements are in effect for investigators who are also sponsors (sponsor-investigators). Refer to Section 13.2 – Investigator-Initiated Research and Sponsor-Investigators and Section 18.4 – Sponsor-Investigators for additional information.

**Unanticipated Problems Involving Risk to Subjects or Others (UPX)**

An unanticipated problem involving risks to subjects or others (UPX) includes any incident, experience, or outcome that meets all of the following criteria:

- *unexpected* (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent document; and (b) the characteristics of the subject population being studied
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- related or possibly related to participation in the research (in this guidance document, possibly related means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research), and

- suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized

UPXs should be reported to the IRB as soon as possible, but not later than 10 working days after the investigator becomes aware of the event, using the Reportable Event application in iStar. For sponsored research, the terms of the contract may define a shorter reporting timeframe.

PIs of research reviewed and approved by the NCI CIRB are responsible for reporting any potential UPXs occurring at the local site. The PI submits a reportable event application in iStar. If the event is determined to be a UPX, the PI must report the event to the NCI CIRB.

Noncompliance

Noncompliance is the failure to follow federal, state, or local regulations governing human research, requirements or determinations of the IRB, or institutional policies. This may include action of any University employee or agent, such as investigators, research staff, IRB members, IRB staff, employees, or institutional officials.

Additionally, if any reasonable individual would foresee the event as compromising the rights and welfare of a subject or others, the noncompliance may be considered serious. Further, if repeated actions or omissions by an individual (investigator, research staff, IRB member, IRB staff, employee, or institutional official) indicate a pattern of deficiency in the ability or willingness of an individual to comply with federal, state or local regulations, USC HSPP policy, or determinations or requirements of the USC HSPP; if the noncompliance could reasonably be expected to develop into serious noncompliance; or if the noncompliance recurs after a report of the activity has been evaluated and corrective action has been mandated, noncompliance may be deemed to be continuing noncompliance.
Protocol Deviations

A protocol deviation refers to those occasions when protocol required procedures are accidentally or intentionally not met. These can result when new staff conduct a study, when records may be unavailable, or when an individual subject may require deviations from the procedures of the study. The determination as to which deviations or errors must be reported to the IRB is driven by sponsor/monitor requests or concerns of the principal investigator or research staff. There is no regulatory language that defines those that meet the level of required reporting. When the choice is made to report a deviation, it should be submitted through iStar as a reportable event.

Participant Complaints

A participant complaint is an expression of dissatisfaction by the participant (or his/her representative) that may or may not involve a breach in human subjects rights or research ethics. Participants may choose to report complaints to the study team, the IRB, or to a third party (such as hospital administration). Therefore, it is important that during the consent process, subjects receive consent forms and information sheets that include investigator and IRB contact information so that participants have resources to ask questions about the study and report complaints.

Subject complaints must be reported by the study team (or by the IRB Director, if the complaint was received by the IRB) in iStar using the “Participant Complaint” form in the “Reportable Events” application.

7.15 Reports

Depending on the study, clinical trials may require submission of reports to the IRB, particularly those related to safety progress reports including data safety monitoring reports and annual reports for Investigational Device Exemption studies.

Data Safety Monitoring Reports

A data safety monitoring report is an interim analysis that is conducted by a committee (such as a Data Safety Monitoring Board or a Data Monitoring Committee) independent of the research team and the IRB. The report is submitted to the IRB through the iStar
Investigational Device Exemption (IDE) Annual Report

Investigators conducting research with a device subject to Investigational Device Exemption (IDE) regulations must submit annual progress reports to the IRB. The annual IDE report is submitted to the IRB through the iStar reportable event application.

Investigators who are also sponsors of an IDE study must comply with additional regulations (refer to Section 18.4 – Sponsor-Investigators). For additional information about Investigational Device Exemptions, refer to Section 18.3 – Investigational Medical Devices.
## Chapter 8: Process of IRB Submissions

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Chapter 8
Process of IRB Submissions

This chapter focuses on the IRB submission and review processes. It includes an overview of iStar, the electronic application system used to submit all human subjects proposals to the IRB, the criteria for IRB approval, the review process for the different submission types, and IRB determinations and correspondence details.

8.1 IRB Online Application (iStar)

The IRB Submission Tracking and Review (iStar) online system supports all applications: new study, continuing review, amendment, and reportable event (for safety and other reports). Access to the iStar system is granted to the research team and IRB staff depending on roles and oversight responsibilities.

The application guides users to questions specific to the nature of their research, and ensures that information required for regulatory purposes is appropriately collected. For example, if a protocol includes minor subjects, users are required to select a child risk category and explain the process for obtaining assent and parental permission.

iStar maintains the currently approved study. With each amendment submission, the investigator is required to update the previously approved study to reflect the changes under review. iStar systematically records all changes and stores previous versions of the application and study documents in an accessible manner.

Among the documents available in iStar are:

- iStar submission (initial and continuing review)
- Informed consent and assent forms (if applicable, these documents are available in both approved and draft form)
- Scientific protocol
- Study grant
- Recruitment documents
• Surveys and questionnaires
• Approval documents from collaborating Institutions
• Ancillary committee approvals
• Reportable events and reports
• IRB and study team correspondence
• IRB approval notices
• Other documents related to IRB review

In addition to being a submission and document storage system, iStar creates historical records and provides audit trails of the IRB review process. All study-specific correspondence between the research team and the IRB are created and stored in iStar.

8.2 Criteria for IRB Approval of Research

In order to approve research, federal regulations (45 CFR 46.111) require that the IRB (reviewer or Full Board) determine that all of the following requirements are satisfied:

• Risks to subjects are minimized: (a) By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and (b) Whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.

• Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result. In evaluating risks and benefits, the IRB will consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research). The IRB will not consider possible long-range effects of applying knowledge gained in the research (for example, the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.
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- Selection of subjects is equitable. In making this assessment the IRB must take into account the purpose(s) of the research and the setting in which the research will be conducted and must be particularly cognizant of the special problems of research involving vulnerable populations, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons.

- Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by 45 CFR 46.116.

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

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

- When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data. When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, the IRB will ensure additional safeguards have been included in the study to protect the rights and welfare of these subjects. Refer to Chapter 14 – Vulnerable Subject Populations.

In addition to these regulations, the IRB must also consider:

- PI/study team qualifications, including credentialing and hospital privileges
- Adequacy of research description and methodology
- Certification that all study personnel have completed required training
- Conflict of Interest (PI and study staff)
- Subject recruitment
- Privacy and confidentiality
- Risk/benefit ratio
- HIPAA applicability and waivers
Scientific merit is a basic expectation of human subject research and is an integral part of the IRB review. It is not ethical to expose subjects to risk and inconvenience if the research has no merit. At HSC, the IRB takes into consideration any scientific review conducted by other committees or outside entities before the study was submitted to the IRB.

Federal regulations (45 CFR 46) as well as the Association for the Accreditation of Human Research Protection Programs (AAHRPP) require the IRB to review the scientific merit of proposals.

Peer or scientific review by USC institutional scientific committees such as the Cancer Center Clinical Investigations Committee and the Clinical Trials Unit (CTU), reviews by committees external to USC such as NIH cooperative groups, NIH study sections, sponsor review committee(s), and regulatory agencies such as the Food and Drug Administration provide assurance that experts have evaluated the study and found it meritorious. At HSC, for protocols that have not undergone peer/scientific review, additional reviewers with knowledge in the relevant discipline may be assigned to provide confidence in the scientific merit of the study. This process assures that in addition to all other review criteria scientific merit is properly addressed.

The IRB reviews all studies to ensure that:

- The research uses procedures consistent with sound research design
- The research design could allow the proposed research questions to be answered
- The risk/benefit relationship is acceptable
- The purpose and specific aims are clear and feasible, and the research will contribute to generalizable knowledge

Experts agree that the IRB should approve only research that is both valid (can answer questions posed) and of value. The IRB may request for an expert consultant to review a
proposed research project or defer to scientific review committees in order to determine whether a study has sufficient scientific value (merit) and/or if a study design places subjects at unnecessary risk. Before the consultant reviews the study, the IRB office will confirm with the consultant(s) that there is no potential conflict of interest.

**Student research** is expected to be reviewed by a dissertation committee for scientific validity. Further, projects that do not provide an actual benefit to society or have compelling scientific merit can still be approved by the IRB if all other approval criteria are met.

For **Department of Defense** sponsored research, review of scientific merit is required prior to initial IRB approval. In addition, any substantive amendment to approved research sponsored by DOD must undergo scientific review prior to the review by the convened IRB.

### Review of Research Funds/Budget

Knowledge of adequacy of financial resources for proposed research is inherent in the IRB’s responsibilities and obligations in the protection of human subjects. If research cannot be carried through to its completion, subjects may be put at risk. The PI must respond to IRB inquiries concerning financial resources. However, individual salary information does not have to be included in the study budget. The PI must also respond to IRB inquiries about financial payments to the study team for potential financial conflicts of interest (see [USC Conflict of Interest policies](#)). At HSIRB, clinical trials budgets are further scrutinized by the Clinical Trials Office.

Initial letters of award, and/or sponsor/donor documentation must be included in the IRB application. If a researcher is funded via private donor(s), researchers must set up an account with Contracts & Grants or the researcher’s department/school must handle the disbursement of funds. In both cases, the IRB must be provided with funding documentation.

The IRB requires a copy of the grant/contract proposal; a copy of the final award letter (proof of funding) is not necessary. When donations from sponsors/donors support unspecified research, documentation to that effect must be uploaded to iStar. The IRB will not approve a study without required funding information.
8.3 Review of Exempt Research

To obtain an exempt determination, the investigator must submit an exempt iStar application with appropriate attachments. The PI indicates the exemption category believed to be appropriate [45 CFR 46.101(b)] and replies to all requests for revisions and/or clarifications requested by reviewers via iStar.

At USC, select IRB staff or designees as well as the Chair and Vice Chairs have the authority to approve exempt studies. Reviewers of exempt determinations conduct a review of the project to determine if it qualifies for exempt status according to IRB policy, human subjects research regulations, and ethical standards. To facilitate review, additional revisions may be requested by the IRB. If the study does qualify, the PI is notified and no further IRB review is needed.

When the study does not meet exempt criteria, the IRB staff and/or designee determines the appropriate level of review, notifies the investigator, and guides the investigator with resubmission at the required level. If exempt determination is unclear, the Chair, Vice Chair, or designee may assist with the determination. Exempt determinations are distributed to all IRB members electronically and acknowledged by each committee.

IRB reviewers have access to all necessary application materials in the iStar system, including:

- A completed iStar application with conflict of interest statement
- Proposed information sheet(s) and/or scripts as appropriate
- Surveys, questionnaires, or videos
- Letters of assurance or cooperation with research sites
- Relevant grant applications
- Recruitment materials and advertising intended to be seen or heard by potential subjects, including email solicitations
Amendments and Revisions to Exempt Research

Requirements for submission of proposed amendments in exempt research are different depending on whether the study is reviewed at the University Park IRB (UPIRB) or the Health Sciences IRB (HSIRB).

At the UPIRB, once a project is determined by the IRB to be exempt, changes (such as personnel, methodology/procedures, subject population, recruitment materials) that DO NOT affect the level of risk, level of IRB review, or the subject’s willingness to participate DO NOT require further IRB review. However, when a proposed change increases the level of risk, the investigator is required to submit proposed revisions through the iStar amendment application.

In contrast, HSIRB requires investigators to submit modifications to previously approved exempt studies through an amendment in iStar. IRB approval of the amendment must be granted before any changes are implemented in the study. If a change is necessary to eliminate apparent immediate hazards to the research subjects or others, the investigator must promptly (within 30 days) inform the IRB of the change by submitting a reportable event in iStar. The IRB will review the change to determine that it was consistent with ensuring participants’ continued welfare. The IRB approval letter sent to the investigator outlines this responsibility.

8.4 Review of Expedited Research

To submit a project for expedited review, the investigator must submit an expedited iStar application with appropriate attachments. IRB staff initially evaluates all submissions and may request changes/clarifications from the investigator. IRB staff then prepares a staff review that is forwarded to an expedited reviewer for review and approval. In the staff review the reasons why the submission meets expedited review criteria are noted by citing the appropriate expedited review category or summarizing the nature of the modification. The expedited reviewer is prompted to either concur or disagree with the staff recommendation for expedited processing and any related contingencies or necessary revisions.

The expedited reviewer has access to all necessary application materials in the iStar system, which includes the following:
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- A completed iStar application with conflict of interest statement
- Investigator’s or sponsor’s protocol
- Proposed informed consent document(s) and/or script as appropriate
- Surveys, questionnaires, or videotapes
- Letters of assurance or cooperation with research sites
- Relevant grant applications
- Recruitment materials and advertising intended to be seen or heard by potential subjects, including email solicitations

The expedited reviewer is responsible for evaluating the project to ensure that the rights and welfare of human subjects are protected and that all criteria for IRB approval have been met. The expedited reviewer is also responsible for determining whether the study can be approved with or without changes and whether clarifications are required.

The reviewer may request review of the research by an expert consultant for issues which require expertise beyond or in addition to that available on the IRB committee. A determination that the consultant does not have a conflict of interest is made.

The expedited reviewer may send requests for clarification directly to the PI, or can forward requests to the PI through the assigned IRB staff member. If the application requires modifications, the IRB correspondence identifies the modifications that must be made by the investigator before the study can begin. The investigator’s response to correspondence arising from expedited review procedures need only be evaluated by the expedited reviewer. In the event that the expedited reviewer makes a recommendation that is not accepted by the investigator, the expedited reviewer has two options: (1) Accept the investigator’s justification for not incorporating the recommendation and proceed with the approval of the study; or (2) Reject the justification and forward the submission to the next Full Board IRB meeting for further consideration of the issue.

All studies meeting criteria for approval under the expedited criteria must meet the requirements for informed consent or its waiver or alteration (see Section 10.10 – Waivers of Informed Consent).
If the study is approvable, the approval notice indicates expedited review procedures were followed and notes the expedited review categories under which the approval was granted.

Information or proposed changes submitted in an amendment, adverse event, sponsor notification, or sponsor notification may disqualify a study from being approved under the expedited review procedure. In this situation, the study is forwarded to the full IRB for determination.

Expedited determinations and actions are distributed to all IRB members electronically and acknowledged by each committee.

**Expedited Reviewers**

Expedited review may be carried out by the IRB Chair, Vice Chair, or by an experienced IRB member formally designated by the IRB Chair. To qualify as an expedited reviewer, the IRB member, according to the judgment of the IRB Chair, must have the experience and education required to conduct expedited review.

Expedited reviewers may exercise all of the authorities of the IRB, except for disapproving the research (a research activity may be disapproved only after review by the full committee). If the reviewer and investigator cannot agree on the changes required to secure approval, the application will be sent to the convened IRB for review. The reviewer may refer the application to the Full Board for review at any time.

Although expedited review requires fewer steps than full committee review, it is not a lesser review process. All of the requirements for the protection of human subjects are applied equally in expedited review and the same requirements for informed consent (or its waiver or alteration) apply to expedited categories of research.

If a research study is found to be ineligible for expedited review, it will be added to the next possible full committee meeting agenda for review.

**8.5 Review of Full Board Research**

To submit a project for Full Board review, the investigator must submit a Full Board iStar application. The IRB staff reviews the application to ensure it is complete, and if necessary, will request revisions and/or clarifications from the investigator. The staff
review is available on iStar. The IRB staff schedules the study for the next available IRB meeting. The IRB Chair or IRB Director selects primary and secondary (and tertiary when applicable) reviewers. The reviewers’ comments, questions, and contingencies are posted in the iStar system and discussed during the Full Board meeting. Study materials and reviewer comments are available to all committee members.

The Full Board review process is described below:

- A majority of the members of the IRB and at least one non-scientist and one non-affiliated member (can be the same member with dual roles) must be present.

- If the required number of members is lost during a meeting no action may be taken until the quorum is restored.

- In order for a research project to be approved, it must receive the approval of a majority of the members present at the meeting.

- The IRB Chair reminds the IRB members of the requirement to disclose conflicting interests. The Chair polls the members present for any conflicting interests not previously declared or identified by IRB staff.

- IRB members cannot vote on a study if they are an investigator or member of the study team, if they significantly contributed to the design and conduct of the proposed study, if they meet the criteria for a financial conflict of interest, or if they have other interests that may affect their objectivity.

- A member with a potential conflicting interest may be invited to answer preliminary questions about a study, but then leave the meeting until the final vote is taken. The meeting minutes will record the name of any member who does not participate in the final vote on a study because of a conflicting interest.

- For studies involving subjects who may be vulnerable to coercion or undue influence, the IRB Chair, Director, or staff will ensure that one or more individuals who are knowledgeable about or have experience working with the subjects will review the study. These individuals may be current IRB members and/or consultants.

- For studies involving the recruitment of prisoners, the IRB Chair, Director, or Staff will ensure that a prisoner representative will be present at the meeting.
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- A meeting may be conducted by conference call provided that each participating IRB member has received all pertinent material prior to the meeting and can actively and equally participate in the discussion of all protocols. Meeting minutes must clearly document that these two conditions have been satisfied and should specify which members were present via conference call.

- IRB meeting deliberations (UPIRB only) are tape recorded to assist with the drafting of meeting minutes and correspondence. Audiotapes of IRB meetings are maintained until the finalized version of the minutes is approved by the IRB.

- IRB meetings are scheduled at regular intervals appropriate to the amount of research requiring review and with sufficient frequency to ensure that the IRB can adequately oversee the progress of the research it has previously approved.

- Each protocol undergoing initial or continuing review will be discussed and voted upon separately.

**Full Board Reviewer Assignments**

The IRB uses a "primary reviewer" system for review of all new research proposals at its convened meeting. Members will be assigned studies for which they will be responsible for providing a detailed review. Reviewer assignments are made with the following goals in mind: to ensure review by a member with appropriate expertise and to equally distribute assignments. The expectation is that each IRB member will be familiar with every study on a meeting agenda.

The number of assigned reviewers differs according to the nature of the submission and whether previous peer review(s) for scientific merit is available (such as review by the USC Clinical Investigations Committee (CIC), the USC Clinical Trials Unit (CTU), NIH cooperative groups, NIH study sections, sponsor review committees, and regulatory agencies such as the Food and Drug Administration). Peer reviews provide assurance that experts have evaluated the study and found it meritorious. At HSC, for protocols that have not undergone peer/scientific review, additional reviewers with knowledge in the relevant discipline may be assigned to provide confidence in the scientific merit of the study. This process assures that in addition to all other review criteria scientific merit is properly addressed.
Primary and Secondary Reviewer Responsibilities

The IRB has developed comprehensive reviewer checklists/guidelines to assist IRB members and staff in performing thorough reviews. The checklists can be downloaded from the IRB website “Tips for IRB Submissions” page under IRB Reviewer Guidelines/Checklists (also refer to Appendix B). IRB staff and IRB members receive education on the reviewer checklists/guidelines and are encouraged to use them.

The primary reviewer should be knowledgeable about the medical or social-behavioral issues relevant to the protocol. The primary reviewer performs a detailed review of the protocol in order to ensure that the study is appropriately designed to protect subjects and to achieve the stated goals of the project. If primary reviewers do not believe they possess the required expertise, they must contact the IRB Chair or staff and request the study be assigned to another primary reviewer.

For the HSIRBs, the secondary reviewer is asked to focus most of the review on the documents that will be provided to subjects (informed consent forms, recruitment materials, questionnaires, and survey forms). The secondary reviewer should evaluate whether these documents clearly and accurately describe the nature of participation in order to ensure that potential subjects are able to provide truly informed consent. The UPIRB secondary and tertiary reviewers have the same role as a primary reviewer.

All reviewers are asked to upload a written review in iStar. In their written comments, reviewers identify human subjects protection concerns, explain the basis for raising those concerns, request modification to study documents, and ask for clarification or additional information. All assigned reviewers attend the IRB meeting and present their analysis to the Full Board committee. If a reviewer is unable to attend the meeting, another assigned reviewer or the IRB Chair will present the review to the committee. Even if written comments are provided by the assigned reviewers, the board might choose to defer discussion of a protocol until a time when the assigned reviewer can attend the meeting and present concerns in person.

Use of Consultant Reviewers

If the IRB Chair/Director determines that the IRB lacks the expertise necessary to review a particular study, the IRB will seek the services of an external consultant reviewer. An expert will be identified and invited to review the study as a consultant. The consultant will be required to disclose any possible conflict of interest to the IRB using the same
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criteria applied to investigators as outlined in Section 13.6 – Investigator Conflict of Interest. Once it is confirmed that there are no actual or perceived conflicts of interest, a copy of the complete study submission and any reviews posted by the other reviewers will be sent to the consultant. The consultant will provide written comments to the IRB and may be invited to attend the meeting to discuss the protocol. The consultant cannot vote.

Meeting Materials – Full Board

The IRB staff electronically distributes all meeting materials to IRB members or their alternates through iStar. To ensure adequate time for review, the meeting agenda, study documents, and minutes to be approved by the board are sent to members approximately seven days before the meeting. Meeting materials available to IRB members for new study submissions are listed below.

- iStar study application
- Previous correspondence from study team and IRB
- Study protocol
- Grant application (including budget)
- Sponsor’s sample informed consent documents
- Drug and device brochures
- Informed consent documents
- Child assent forms
- Surveys, questionnaires, and other instruments
- Recruitment materials
- HIPAA authorization forms and other documents required for medical research

A list of meeting materials for Continuing Review, amendments, and reportable event submissions are found in their respective sections in Chapter 9 – IRB Considerations after Initial Approval.
Projects Needing Verification from Sources Other than the Investigator

The IRB may determine that verification of required changes as well as study conduct need to be provided by sources other than the investigator. The IRB determines the appropriate sources and makes that part of the contingencies for approval. The criteria used by the IRB to make these determinations could include some or all of the following:

- Complex projects involving increased risk to subjects
- Projects conducted by investigators who previously have failed to comply with the requirements of the Health and Human Services (HHS) regulations or the requirements or determinations of the IRB, and
- Projects where concern about possible material changes occurring without IRB approval have been raised based upon information provided in continuing review reports or from other sources

8.6 Sponsored Research and Ancillary Approvals

Other university approvals may be necessary before a study can begin, depending on the type of funding and the type of study. Funding and contract agreements are negotiated through USC Department of Contracts and Grants, which includes the Clinical Trials Office. The IRB application will inform the reviewer and/or investigator that additional approvals must be obtained. The ancillary approvals, encountered mostly at HSC and less frequently at UPC, are described below.

Funded Research

Department of Contracts and Grants

All research funds received from federal, state, and local government and/or private/foundations must be deposited with the Department of Contracts and Grants (DCG). The DCG:

- Serves as “gatekeeper” for acceptance, oversight and disbursement, and fulfilling government and university requirement
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- Provides training and assistance to faculty and research administration staff
- Assists with proposal development, review, approval and submission
- Negotiates and accepts awards on behalf of the University
- Offers post-award administrative guidance
- Maintains the Sponsored Projects Data Information System (DCG Database)
- Provides support to University offices and committees in matters related to research policy and guidelines

Clinical Trials Office (Industry-funded)

The Clinical Trials Office (CTO) provides budget development and contract negotiation and execution for industry-sponsored research.

Medicare Coverage Analysis (MCA) and Consistency Review

CTO staff prepares the Medicare Coverage Analysis (MCA) for all clinical trials regardless of the funding source or Medicare eligibility. The MCA is used to identify and differentiate between costs that are study-related and those that are routine care. Routine care costs are independent from the study and would therefore be billed to Medicare, another insurer, or the subject. CTO verifies that the terms of “qualifying trials” are met before study costs are allocated.

The IRB staff works closely with CTO to ensure that language in the informed consent document and iStar application is consistent with the sponsor contract or Clinical Trial Agreement. CTO staff will modify and approve the language in the Financial Obligation and Compensation section of the iStar application as needed. This is accomplished using the “Review Consistency” activity.

If the investigator has addressed all the IRB contingencies before the CTO review is final, the IRB will approve the study but will not release the informed consent documents. The investigator cannot begin recruitment and enrollment until the CTO review is completed, the IRB confirms that the cost, injury, and compensation sections of the consent documents match the CTO language, and the IRB uploads the stamped consent documents in iStar. The IRB will notify investigators when the approved consent documents are uploaded and enrollment can begin.
Institutional Contract and Funding Agreements

At USC, the Clinical Trials Office and the Department of Contracts and Grants are responsible for funding agreements. All institutional contract and funding agreements meet established standards and include:

- A written agreement addressing medical care for research participants with a research-related injury, when appropriate

- A written agreement stating that the sponsor promptly reports to USC findings that could affect the safety of participants or influence the conduct of the study (for studies in which sponsors conduct site monitoring visits or conduct monitoring activities remotely)

- A written agreement that addresses provisions for monitoring the data to ensure the safety of participants and for providing data and safety monitoring reports to USC, when the sponsor has the responsibility to conduct data and safety monitoring

- A written agreement, before initiating research, that addresses plans for disseminating findings from the research and the roles that researchers and sponsors will play in the publication or disclosure of results

- A written agreement that the researcher or USC will be notified of the results in order to consider informing participants, when participant safety could be directly affected by study results after the study has ended

Ancillary Committee Reviews

Depending on the study, additional ancillary committee review and approval may be necessary before the study can begin. The IRB submission will trigger certain required approvals; however, some approvals are not linked to iStar and may be required after IRB submission depending on the study. Ancillary committees include:

- Institutional Biosafety Committee (IBC)
- Radiation Safety Committee (RSC)
- Stem Cell Research Oversight Committee (SCRO)
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- Conflict of Interest in Research Committee (CIRC)
- Investigational Drug Pharmacy Services
- Pathology and Laboratory Services
- Clinical Trials Unit (CTU)
- Cancer Center Clinical Investigations Committee (CIC)

8.7 IRB Review and Determinations

**Full Board Review**

At a convened meeting, after all reviewers present their analyses of the study, the discussion is opened to all members. During the discussion, other members note omissions, raise and/or comment on issues, request clarifications, and make suggestions to improve the readability of consent and recruitment documents. When all members have the opportunity to voice their concerns and no further discussion is necessary, the board votes upon the study and makes one of the following determinations:

**Approve**

If the board determines that the study as written provides adequate protection of human subjects, the board will approve the study with no further changes.

**Approve with Contingencies**

The contingencies under Approval with Contingencies are not contingencies that impact the regulatory determination for approval. If the board finds that the application is “approvable” with modifications, clarifications, or verifications, the board will approve the study with contingencies that can be verified by a designated reviewer. The IRB may require the following as conditions of approval:

1) confirmation of specific assumptions or understandings on the part of the IRB regarding how the research will be conducted;
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2) submission of additional documentation;

3) precise language changes to protocol or informed consent documents; or

4) substantive changes to protocol or informed consent documents along with clearly stated parameters that the changes must satisfy.

The IRB may designate the verification of satisfied contingencies to the IRB Chair, Vice Chairs, or an IRB member, without additional review by the Full Board. This process does not constitute an expedited review. Refer to Appendix I - Verification that IRB Contingencies were Satisfied for additional information.

**Defer**

If the board has serious concerns about the study, and/or requires significant modifications directly relevant to the criteria for regulatory determinations under 45 CFR 46.111 and/or 21 CFR 56.111, the board must defer a vote on the approval of the study. The subsequent response to request for significant modifications may not be reviewed using expedited procedures and must be reviewed by the Full Board. Examples of significant modifications include more than minor changes to the risks, research design and methodology, statistical analyses, data safety monitoring plan, provisions for protecting human subjects’ safety and privacy, and informed consent document(s).

**Table**

If the board is unable to initiate a discussion of a study due to a lack of time, loss of quorum, or the absence of a reviewer, the board will table the discussion of the study for review at a subsequent meeting.

**Disapprove**

If the application describes research activities that may pose significant concerns for human subject safety with minimal prospect of benefit, or the risk/benefit ratio is deemed to be unfavorable, the board may disapprove the study.

An IRB member makes a motion for one of the above options; if another member of the IRB seconds the motion, the motion is voted upon. A majority of the members present at the meeting must vote in favor of the motion for passage [45 CFR 46.108(b) and 21 CFR 56.108(c)]. Discussion and/or deliberations of each study on the meeting agenda continues until one of the above motions is passed.
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Expeditied and Exempt Review

The IRB designated reviewer can make one of the following determinations:

- Determine that the study as written provides adequate protection of human subjects and approves the study (with no further changes). The IRB will approve a study only after determining that the proposed application contains sufficient information to address the criteria for IRB approval cited at 45 CFR 46.111 and 21 CFR 56.111.

- Find that the application is “approvable” after modifications, clarifications, or verifications and designate a reviewer (same reviewer, IRB Chair, Vice Chairs, another IRB reviewer, or IRB administrator) to verify that contingencies have been satisfied. Refer to Appendix I - Verification that IRB Contingencies were Satisfied for additional information.

- If the reviewer has serious concerns about the study, and/or requires significant modifications directly relevant to the criteria for regulatory determinations under 45 CFR 46.111 and/or 21 CFR 56.111, the expedited reviewer can refer the study for Full Board review.

Review of Response to Contingencies

When a study is approved with contingencies, the IRB designates a reviewer (same reviewer, IRB Chair, Vice Chairs, another IRB reviewer, or IRB administrator) to verify that contingencies have been satisfied.

- If the designated reviewer determines that the investigator has satisfied all conditions of approval, further IRB review is not necessary.

- If the reviewer determines that the investigator failed to adequately address the modifications requested by the IRB, the investigator’s response may be returned to another member reviewer or to a Full Board meeting. The reviewer may request additional correspondence identifying outstanding concerns to be sent to the investigator by IRB staff.
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- If the reviewer determines that the initial response and/or secondary correspondence from the investigator is inadequate, unacceptable, or raises new concerns, the study will be forwarded to the full IRB for further adjudication at the next possible IRB meeting.

Additionally, the following applies when changes to research are proposed after the IRB has approved the research with contingencies:

- If changes proposed are administrative/editorial in nature, no additional IRB review is needed and the changes can be reviewed as part of the verification process.

- If additional changes/procedures, which are listed in the expedited review categories under 45CFR 46.110, are proposed by the PI or designated reviewer, those changes may be reviewed by the IRB Chair/Vice-Chair/designated reviewer through an expedited review procedure.

- If changes are more than minor, increase risks to subjects, and/or impact any of the approval criteria under 45 CFR 46.111, those changes would require review by the full IRB committee.

This review process is applicable to review of response to contingencies after initial study submission, amendments, continuing review and reportable events.

8.8 IRB Correspondence and Investigator Response

IRB Correspondence

After each IRB meeting (or review by designated reviewer), the IRB staff forwards correspondence to investigators whose protocols were reviewed, notifying them of the action/status of their applications. The nature of the correspondence and the process by which an investigator’s response is reviewed vary according to the decision made for the study.

- When the board (or reviewer) determines that the study as written provides adequate protections, the correspondence indicates the study is approved (with no further changes).
Chapter 8: Process of IRB Submissions

- When the board (or reviewer) finds that the application is “approvable” after modifications, clarifications, or verifications, the correspondence indicates the study is approved with contingencies.

- When a study is approved with contingencies, the IRB staff composes correspondence describing reviewers’ comments and concerns and forwards it to the investigator. The investigator’s response to the correspondence is then reviewed by the Chair/Vice Chair or designee.

- Correspondence indicates when the IRB or reviewer previously agreed that a response may be evaluated by a designated reviewer.

- When the IRB or reviewer has serious concerns about a study, or if significant modifications are required to ensure protection of human subjects, the correspondence indicates that the IRB will defer approval of the study until additional information is obtained from the investigator.

- For Full Board studies, when the board is unable to initiate a discussion of a study due to a lack of time or the absence of a reviewer, the correspondence indicates the board will table the discussion of the study for review at a subsequent meeting.

- When the application describes research activities that may pose significant concerns for human subject safety with minimal prospect of benefit, or the risk/benefit ratio is deemed to be unfavorable, the correspondence indicates the IRB’s decision to disapprove the study. Investigator will have the opportunity to respond to the board in person or in writing [45 CFR 46.109(d) and 21 CFR 56.109(e)].

IRB correspondence includes all the information required by federal regulations and/or guidance. Generally, IRB correspondence for Full Board review studies is approved by the Chair before it is sent to investigators.

IRB correspondence with IRB determinations and the IRB’s action will be sent to the investigator [45 CFR 46.109(d) and 21 CFR 56.109(e)]. When responding to the IRB’s determinations or requests, the investigator may disagree with the board or reviewer, and provide written justification in support of their viewpoint. The IRB will then review the investigator’s justification and make a determination. It should be noted, however, that the IRB has the final authority to approve or disapprove the research.
Investigator Response

During the IRB review process, all requests for modifications or further clarifications from the IRB are documented in a letter and sent to the investigator by IRB staff via iStar. The investigator’s response to the IRB correspondence is evaluated in accordance with the requirement set forth during the initial review (reviewed by the Full Board, reviewed by an expedited reviewer, or verified by an IRB staff member). All correspondence between the IRB and investigators is recorded and stored under the history tab in the iStar application.

If the investigator believes requirements imposed by the IRB are unduly restrictive of the proposed research, the investigator can contest the requirements to the IRB. The investigator can outline the reasons why the proposed research procedures are already in compliance with USC policy and the applicable federal regulations and request that the IRB reconsider the requirement. If the IRB rejects the appeal, the investigator must comply with the IRB’s restrictions or the research will not be approved. No other entities or officials at USC may override the IRB’s decision to disapprove a study.

Other institutional entities or officials may determine that a study approved by the IRB cannot be conducted. Among the reasons for disapproval are issues of inadequate resources or university sensitivities.
8.9 IRB Meeting Schedules and Transfer of Jurisdiction

Meeting Schedule for Health Sciences IRBs

HSIRB 1 meets the first and third Thursday of each month. HSIRB 2 meets the second and fourth Thursday of each month. HSIRB 3 meets on the first and third Tuesday of each month. A calendar for submission and review dates is available on the HSIRB website http://oprs.usc.edu/hsirb/hsirb-deadlines/.

Meeting Schedule for University Park IRB

The full UPIRB meets the second Friday of each month. A calendar for submission and review cut-off dates is available on the University Park IRB (UPIRB) website http://oprs.usc.edu/upirb/upirb-deadlines/.

Transfer of Jurisdiction from UPIRB to HSIRB

Because the University Park faculty is predominantly on nine-month contracts, securing a quorum for the summer months may not always be an option. Additionally, there may be studies requiring biomedical expertise. Under these conditions, the University Park IRB (UPIRB), at their discretion, defers Full Board reviews to the Health Sciences IRB (HSIRB). The UPIRB Director sends a request to the HSIRB Chair to add studies to an HSIRB Full Board agenda. The UPIRB staff completes the staff review and the HSIRB staff adds the study to a HSIRB agenda. The UPIRB Director, UPIRB Chair, and/or UPIRB staff reviewer attend the HSIRB meeting. The HSIRB keeps the study under their jurisdiction until all contingencies (if any) are met or the study obtains final approval. If there is a need for a consultant, or expertise beyond that of the HSIRB members, the HSIRB Chair will secure the appropriate consultants.
8.10 Additional IRB Submissions

In addition to the IRB submissions described earlier in this chapter, there are other IRB submissions applicable to human subjects research. These IRB submissions include Continuing Review, Amendments, Significant New Findings and/or Information (SNIFs), Reportable Events, and Reports. These submissions are not discussed further in this chapter as they are described in Chapter 7 – Types of IRB Submissions and discussed as part of the IRB submission process in Chapter 9 – IRB Considerations after Initial Approval.

Primary Investigator and Self-experimentation

Application of submission for USC IRB review is required for human subjects studies entailing self-experimentation.

USC policy does not distinguish between self-experimentation and research on subjects who are recruited for a specific project. As part of its commitment to the protection of the rights and welfare of individuals participating in research, USC’s Research Protection Program requires investigators who wish to act as participants in their own studies to submit for IRB review and approval - following standard procedures as outlined in the IRB policy. All human subject research must be reviewed to assure safety of those involved and the integrity of the research at the university. While researchers may be aware of the risks of self-experimentation, they may also be more willing to accept risks that are ill-advised. Application for review with the IRB office allows a neutral third party to raise concerns and/or propose measures to promote the welfare of researchers.
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Chapter 9
IRB Considerations after Initial Approval

This chapter describes investigator reporting requirements after a research project is approved. It covers amendments to approved research, continuing review, expiration of IRB approval, adverse events and unanticipated problems, project closure, record keeping, and publications. Only the major reporting responsibilities of investigators are described here. There may be additional responsibilities placed on the Principal Investigator by a sponsor, regulatory agencies, or the IRB. For more in-depth information about investigator reporting requirements, refer to the referenced sections in this manual.

9.1 Amendments – Changes to Research after Approval

The IRB requires investigators to submit modifications to previously approved studies through an amendment in iStar. IRB approval of the amendment must be granted before any changes are implemented in the study. If a change is necessary to eliminate apparent immediate hazards to the research subjects or others, the investigator must promptly (within 30 days) inform the IRB of the change by submitting a reportable event in iStar. The IRB will review the change to determine that it was consistent with ensuring participants’ continued welfare. The IRB approval letter sent to the investigator outlines this responsibility.

Significant New Information/Findings (SNIF) relating to protocol changes should be provided to participants when such information might relate to their willingness to continue to take part in the research. This new information, termed Significant New Information/Findings (SNIF), can be provided to subjects in various ways depending on urgency (refer to Section 10.14 – Providing Significant New Information and/or Findings (SNIF) to Participants for more information).

Investigators should be aware that certain modifications may require changes in the budget or contract agreements with the sponsor or funding agency. Investigators should
contact the Clinical Trials Office and/or the Department of Contracts and Grants to discuss the need for budget or contract changes.

Investigators should also be aware that the original expiration date of a study does not change when an amendment is approved by the IRB. Expiration dates change only at the time of continuing review.

**Materials Available to the IRB for Amendment Reviews**

The electronic IRB application contains the following information that is available to the IRB for review of amendments:

- iStar Amendment Application, including a description of the proposed changes and any revised documents
- Correspondence from study team
- All previously reviewed documents

The entire study history is available to members in the iStar application.

**Levels of Review for Amendments**

Amendment submissions may receive full committee or expedited review, according to the nature of the proposed changes and their effect on the risk/benefit ratio.

**Full Committee Review of Amendments**

If the changes proposed to the protocol are substantial or if the changes alter the risk/benefit ratio of the study, the amendment must be reviewed by the full IRB.

Examples of such changes are an increase in dosage of an investigational drug, a significant increase in the risks to subjects, addition of a procedure that is greater than minimal risk to subjects (such as addition of an x-ray for research purposes), addition of a new subject population (such as adults who are not competent to consent or children), or significant changes in study design.

As in their initial and continuing review, members evaluate the study purpose, procedures, risks, potential benefits, alternatives, subject selection, informed consent, protection of the privacy of subjects and the confidentiality of their data, safety
monitoring procedures, and additional protections for vulnerable populations as set forth in 45 CFR 46.111 and 21 CFR 56.111.

**Expedited Review of Amendments**

If proposed changes to a protocol are minor, an amendment may qualify for expedited review. The IRB defines “minor modifications” as any change in the previously approved protocol that does not deviate significantly from the requirements for approval during the previous IRB review. Modifications are considered minor when all of the following criteria are met:

- the change does not significantly alter the risk/benefit ratio the IRB relied upon to approve the protocol
- the change does not significantly affect the safety of subjects
- the change does not involve the addition of procedures, interactions or interventions that add significant medical, social or psychological risks
- the change does not involve addition of a vulnerable population in research not otherwise eligible for expedited review, and
- the change does not significantly alter the scientific question or the scientific quality of the study

Examples include editorial changes to the protocol or consent form, the addition of an investigator or Faculty Advisor, change in the number of study subjects to be enrolled, and the addition of a procedure that does not pose more than minimal risk to study participants (such as the addition of a small-volume blood draw).

Expedited review is conducted by experienced IRB members designated by the IRB Chair under 45 CFR 46.110 (b)(2). Expedited reviewers evaluate the proposed changes to ensure compliance with review criteria 45 CFR 46.111 and 21 CFR 56.111.

**Changes in Study Personnel**

Study personnel changes (with certain exceptions) can be made to the IRB application without submitting an amendment. To do this, research staff can select the “Edit Study Personnel” activity in the iStar study workspace and add or delete study personnel. Any study personnel added to a study must have current human subjects training. However, an
9.2 Continuing Review

The IRB is required to review all non-exempt research projects at intervals appropriate to the degree of risk, but not less than once a year after the study receives initial IRB approval [45 CFR 46.109(e)]. Subsequent IRB review is called "continuing review."

Objectives of Continuing Review

The IRB performs continuing review to systematically monitor previously approved research and document that the requirements imposed by the IRB during the initial review and approval of the protocol continue to sufficiently protect subject safety and welfare. A second objective of continuing review is to confirm that all information presented to subjects is complete, accurate, and up-to-date. The investigator must submit a continuing review application through iStar which includes:

- The relevant information required to determine whether the proposed research continues to meet the regulatory criteria for approval
- The number of human subjects accrued. If the study has multiple cohorts or phases, subject accrual must be explained in more detail.
- An updated abstract
- A description of adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, protocol deviations/errors, or complaints about the research
- A summary of any recent literature, findings, or other relevant information, especially new information about risks associated with the research that may affect the subjects’ willingness to continue participation
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• A description of interim findings or benefits and the progress of the study

• A current risk-benefit assessment

• Any new information relevant to any subject’s participation since the IRB’s last review

• The current informed consent/assent document(s), information sheet, and/or verbal script, as appropriate (if subject enrollment is open)

• Any relevant multi-center trial reports (Data Safety Monitoring Board, audits,)

• Any investigator/institutional conflict of interest

• Any incidental findings in fMRI studies occurring at the Dornsife Neuroimaging Center

• Verification of funding information, study personnel, and study locations

• If the study is closed to enrollment and the current study status is not data analysis only, the reason for accrual closure must be provided

• If the study status is "Enrolling New Subjects" and no new subjects were enrolled (or fewer than expected) since the last progress report, an explanation must be provided

In addition to the Continuing Review application described above, the IRB has the following materials available to consider for Continuing Review approval:

• Correspondence from study team

• Currently approved iStar study application, including all previously reviewed documents

• Study protocol

• Grant application (including budget)

• Sponsor’s sample informed consent documents

• Drug and device brochures

• Informed consent documents
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- Child assent forms
- Surveys, questionnaires, and other instruments
- Recruitment materials
- HIPAA authorization forms and other documents required for medical research
- All reports of adverse events, including:
  - Protocol deviations/exceptions
  - Participant complaints
  - Unanticipated problems
  - Data Safety Monitoring Board (DSMB) or monitoring/auditing reports, including any relevant multi-center trial reports
  - IDE annual reports from sponsors

As in their initial review, IRB members evaluate the study purpose, procedures, risks, potential benefits, alternatives, subject selection, informed consent, protection of the privacy of subjects and the confidentiality of their data, safety monitoring procedures, and additional protections for vulnerable populations as set forth in 45 CFR 46.111 and 21 CFR 56.111.

To address the criteria for IRB approval, a copy of the currently approved application is maintained in the iStar online submission and tracking system. The iStar application is updated with each approved modification and so represents the current parameters under which IRB approval is granted.

The IRB has developed comprehensive reviewer guidelines/checklists to assist IRB members and IRB staff in performing thorough reviews. These forms can be downloaded from the IRB website in Guidance for Special Types of Research under IRB Reviewer Guidelines/Checklists (also refer to Appendix B).

Finally, the Board determines which projects need verification from sources other than the investigators confirming that no material changes have occurred since previous IRB review [45 CFR 46.103(b)(4)(ii) and 21 CFR 56.108(a)(2)]. The criteria used by the IRB to make these determinations could include some or all of the following:
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- Randomly selected projects
- Complex projects involving unusual levels or types of risk to subjects
- Projects conducted by investigators who previously failed to comply with the requirements of Health and Human Services regulations or the requirements or determinations of the IRB, and
- Projects where concern about possible material changes occurring without IRB approval have been raised based upon information provided in continuing review reports or from other sources

Levels of Continuing Review Submissions

Continuation submissions may receive full committee or expedited review according to the status of the research. For additional guidance, refer to the:

- IRB Continuing Review for Full Board Studies worksheet
- IRB Requirements for Continuing Review after Enrollment and Data Collection are Completed worksheet

Full Committee Review

Studies that do not meet the criteria for expedited review and belong in one of the following categories must undergo full committee review:

- Actively enrolling new subjects and/or providing research-related interventions to previously enrolled subjects.
- Subject accrual is complete and previously enrolled subjects continue to receive research-related treatment/interventions.

Expedited Review

The Chair/Vice Chairs and IRB members designated by the Chair serve as expedited reviewers of the IRB. In this capacity, these members perform expedited review of continuations that fall into one of the following categories:
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- Research permanently closed to the enrollment of new subjects. All subjects have completed all research-related interventions and the research remains active only for the long-term follow-up of subjects.

- Research previously approved by the fully-convened IRB where no subjects have been enrolled and no additional risks have been identified.

- Research in which the remaining activities are limited to data analysis only.

- Research previously reviewed by the IRB via expedited review procedures.

- Research, not conducted under an investigational new drug application or investigational device exemption, where categories (2) through (8) do not apply, but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

### Continuing Review Determinations

**Approved with Contingencies**

A continuing review application is “approved with contingencies” when the IRB requires as a condition of approval that the investigator make specified changes to the application, confirm specific assumptions about the study, or submit additional documents.

If the research expires before the contingencies are reviewed and approved, all research activities must stop until approval is obtained, unless it is determined by the IRB to be in the best interests of already enrolled subjects to continue participating in the research. However, new subjects may only be enrolled after all contingencies are satisfied. For FDA-regulated research, the IRB also permits the study to continue while the investigator addresses outstanding contingencies, consistent with [FDA guidance on continuing review](https://www.fda.gov/regulatoryinformation/guidances/ucm571492.htm).

If a researcher does not submit a continuing review application to the IRB or the IRB has not approved the study by the expiration date, all research activities stop unless it is determined by the IRB to be in the best interests of already enrolled subjects to continue participating in the research. If continuing review contingencies have not been satisfied by the investigator and a subsequent amendment is submitted for review, the IRB may
require that the investigator satisfy continuing review contingencies before the IRB will approve the amendment.

If the review of responsive materials from investigators requires medical, scientific, or other technical expertise, the IRB should designate an individual with the appropriate expertise to review the investigator response. Typically, this would be the IRB Chairperson, another IRB member, or an expert consultant.

If the review of responsive materials from investigators is limited to verification of verbatim changes or submission of a specific document, the IRB could designate an IRB administrator to review the investigator response. This verification process is not equivalent to approval of minor changes under an expedited review procedure.

For additional information and examples, refer to Appendix I – Verification that IRB Contingencies were Satisfied.

*At USC, contingencies and conditions are used interchangeably.

### Approval for Follow-up Only

A research project approved for “follow-up only” occurs when subject accrual and research-related interventions have been completed, although previously enrolled subjects may continue to be monitored for safety and outcomes as detailed in the approved protocol. When “follow-up only” approval is granted, the approved consent form(s) will not be issued.

### Approval for Data Analysis Only

A research project approved for “data analysis only” occurs when subject accrual and all follow-up activities at USC have been completed; however, the protocol remains active for data analysis purposes only. Protocols should remain open for data analysis only when the investigator intends to continually analyze the data for potential dissemination through journal articles or poster presentations related to the stated objectives in the currently approved protocol.

### Investigator Responsibilities

Investigators are required to submit the continuing review application through the IRB Submission Tracking and Review system (iStar). The application should be submitted
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one to two months before the study expiration date to allow for timely continuing review and approval. It is the principal investigator’s responsibility to submit an application for continuing review in sufficient time to permit the IRB to review and approve the application prior to its expiration date.

If the principal investigator does not submit a continuing review application before the expiration date, all research activities must stop.

To assist investigators in fulfilling the requirement for continuing review, the IRB sends expiration notices through iStar to the investigator, faculty advisor, and study contact person at 90, 60, 45, and 30 days prior to expiration. If investigators do not forward a completed application for continuing review at least 30 days before the protocol expiration date, the IRB cannot guarantee that the application will be reviewed before the date of expiration.

It is the investigator’s responsibility to ensure that approval for an active protocol remains current. The IRB expiration date can be found on the main study page of the approved protocol in iStar, in the IRB approval letter, and in the expiration notices.

9.3 Project Closure

When a study ends, is closed, or is canceled for any reason, a final report must be submitted to the IRB through iStar either by submitting a continuing review application or by selecting the “Close Study” button (for selected studies). This report notifies the IRB that continuing review of the study is no longer needed.

A research project is closed when subject accrual, subject follow-up and data analysis are completed at USC. Once the investigator or the IRB has closed a study, no further research activity, including data analysis, may occur. It is permissible for a study to be closed at USC when it is still open to accrual at other sites. In the event that a serious adverse event or an unanticipated problem occurs at a non-USC site after the closure of the study at USC, the USC investigator is required to submit the SAE report via iStar as outlined in Section 20.1 – Adverse Events.

If no subjects have been enrolled in a study for a period of three or more years, the IRB may require the investigator to close the study unless there are extenuating circumstances for keeping a study open (for example, when the study is about a rare condition).
A study that is closed to enrolling new subjects may still be collecting follow-up data on subjects. In this case, the project must remain open and requires continuing review until the collection of all follow-up data has ceased. Once a final progress report is submitted to the IRB, data collection about any of the subjects must stop. Studies that are closed to enrollment but open for “data analysis only” are subject to continuing review.

If a final continuing review application is submitted to the IRB, the following information must be included:

- The total number of subjects entered into the research study.
- Number of subject withdrawals from the research and the reasons for withdrawals.
- Participant complaints submitted since the last IRB review.
- A summary description of adverse events / reactions.
- A summary description of findings or benefits.

If the final report is sent to the IRB using the “Close Study” button, the following information must be included:

- Affirmation that study data will be handled according to USC policy and federal law.
- Affirmation that there are no outstanding Reportable Events.
- Affirmation that the study is complete and that no study activity is continuing (including data analysis or sponsor visits).

### 9.4 Expired Projects

If the investigator does not submit a continuing review application through iStar by the current expiration date, the investigator is notified by e-mail that IRB approval has expired. The email includes a notice that all study-related activities must cease (including recruitment, advertisement, enrollment, interventions, interactions, collection of private identifiable information, and data analysis). After 60 days, the iStar system automatically closes the study.
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If IRB approval expires and stopping research interventions may place study subjects at risk, the investigator may request IRB permission to continue any interventions needed for subject safety. If research-related interventions have been continued with subjects after IRB approval lapses, the IRB must be immediately informed of the circumstances that necessitated this action.

Investigators can notify the IRB and request permission to continue study intervention after IRB expiration using the request for treatment extension activity in iStar. An IRB Chair or Vice Chair will review and acknowledge the request. The investigator will receive an acknowledgment message through iStar. Other research activities (such as recruitment, enrollment, and data analysis) may only be resumed after the IRB approves the continuing review application.

9.5 Data Safety Monitoring Report

A data safety monitoring report is an interim analysis that is conducted by a committee (such as a Data Safety Monitoring Board or a Data Monitoring Committee) independent of the research team and the IRB. The committee looks at data as it is being collected to determine if unexpected risks and safety issues have occurred. The committee may recommend alterations in the protocol, termination of a study for reasons of obvious benefit or harm, or continuing the research without change. Additional information is found in Chapter 21 – Data Safety Monitoring.

At USC, this report is submitted to the IRB through the iStar reportable event application.

9.6 Protocol Deviation or Error

A protocol deviation refers to those occasions when protocol required procedures are accidentally or intentionally not met. These can result when new staff conduct a study, when records may be unavailable, or when an individual subject may require deviations from the procedures of the study. The determination as to which deviations or errors must be reported to the IRB is driven by sponsor/monitor requests or concerns of the principal investigator or research staff. There is no regulatory language that defines which deviations meet the level of required reporting. When the choice is made to report a deviation, it should be submitted through iStar as a reportable event.
9.7 Noncompliance

Potential noncompliance with 45 CFR 46, FDA regulations, or institutional requirements should be reported promptly to the IRB. The IRB will determine whether it is serious and/or continuing noncompliance. For more information, see Section 20.8 – Procedure for Handling Reports of Alleged Noncompliance.

Noncompliance

A failure to follow federal, state or local regulations governing human research, requirements or determinations of the IRB, or institutional policies. This definition may include action of any University employee or agent, such as investigators, research staff, IRB members, IRB staff, employees, or institutional officials.

Serious Noncompliance

An action or omission by an individual (investigator, research staff, IRB member, IRB staff, employee or institutional official) that any other reasonable individual would have foreseen as compromising the rights and welfare of a subject or others.

Continuing Noncompliance

A pattern of repeated actions or omissions by an individual (investigator, research staff, IRB member, IRB staff, employee, or institutional official) that 1) indicates a pattern of deficiency in the ability or willingness of an individual to comply with federal regulations, USC HSPP policy, or determinations or requirements of the USC HSPP; 2) if allowed to continue could reasonably be expected to develop into serious noncompliance; or 3) recurs after a report of the activity has been evaluated and corrective action has been mandated.

9.8 Reportable Events

The reportable events policy is established to comply in part with the regulatory requirement in 45 CFR 46.103(b)(5) which states, “each IRB shall follow written procedures for ensuring prompt reporting to the IRB, appropriate institutional officials,
and the Department or Agency head of any unanticipated problems involving risks to subjects or others.” The Food and Drug Administration regulations include the same requirement [21 CFR 56.108(b)(1)]. For more information, see Chapter 20 – Reportable Events, Noncompliance, Suspensions and Terminations.


**Adverse Events**

The FDA defines adverse event as “any untoward medical occurrence associated with the use of a drug in humans, whether or not considered drug related” in the Investigational New Drug Safety Reporting Requirements for Human Drug and Biological Products and Safety Reporting Requirements for Bioavailability and Bioequivalence Studies in Humans.

OHRP defines adverse events as “any untoward or unfavorable medical occurrence in a human subject, including any abnormal sign (for example, abnormal physical exam or laboratory finding), symptom, or disease, temporally associated with the subject’s participation in the research, whether or not considered related to the subject’s participation in the research” in the “Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events.”

Adverse events that are unexpected, related or possibly related, and are either serious or place subjects or others at a greater risk of harm than was previously known or recognized, must be reported to the IRB through iStar. Reporting to the USC IRB must be done as soon as possible, but not later than 10 working days of the investigator becoming aware of the event.
Unanticipated Problems Involving Risks to Subjects or Others

The term unanticipated problems involving risks to subjects or others (UPX) is found (but not defined) in the HHS regulations at 45 CFR 46.103(b)(5), and is found in the Food and Drug Administration regulations at 21 CFR 56.108(b)(1).

An unanticipated problem involving risks to subjects or others (UPX) includes any incident, experience, or outcome that meets all of the following criteria:

- **unexpected** (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent document; and (b) the characteristics of the subject population being studied

- **related or possibly related** to participation in the research (in this guidance document, possibly related means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research), and

- suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized

Events that meet the definition of UPX (see above) must be reported to the IRB. The method for submitting a UPX report is through the reportable event application in the iStar system.

Adverse Device Effects

The investigational device exemption (IDE) regulations define an unanticipated adverse device effect (UADE) as “any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects” [21 CFR 812.3(s)].
Chapter 9: IRB Considerations after Initial Approval

Investigators are required to submit a report of a UADE to the sponsor and the reviewing IRB as soon as possible, but in no event later than 10 working days after the investigator first learns of the event (§ 812.150(a)(1)).

See the Chapter 20 - Reportable Events, Noncompliance, Suspensions, and Terminations for more information.

Materials Available to the IRB for Reportable Event Reviews

IRB reviewers have access to the entire iStar study file and study history when reviewing reportable events. The iStar Reportable Event application includes:

- Medwatch reports or other supporting documents
- All submitted reports of adverse events

9.9 Participant Complaints

A participant complaint is an expression of dissatisfaction by the participant (or his/her representative) that may or may not involve a breach in human subjects rights or research ethics. Participants may choose to report complaints to the study team, the IRB, or a third party (such as hospital administration). Therefore, it is important that during the consent process, subjects receive consent forms and information sheets that include investigator and IRB contact information so that participants have resources to ask questions about the study and report complaints.

At USC, subject complaints must be reported by the study team in iStar using the “Participant Complaint” form in the “Reportable Events” application. The report should be specific and include: date of the complaint, event description, relation to the study, determination of whether the complaint involves increased risk to study participants, explanation of how a similar event will be prevented in the future and supporting documentation if applicable. Alternatively, the study team can choose to contact the IRB directly to discuss the participant complaint. Complaints reported to OPRS, Office of Compliance (OOC) or third parties will be subsequently reported to the IRB. When the IRB receives a participant complaint from one of these sources or directly from the
participant, the IRB staff or Director will be responsible for documenting the complaint in iStar.

When a subject complaint is received, the IRB, along with OPRS or OOC as applicable, will attempt to substantiate the complaint in a timely manner. Once all the information is received, the IRB will determine if any further action is necessary. The IRB will provide written correspondence to the subject and principal investigator with their determination and justification for actions taken. The determination and outcome of the complaint will be documented in iStar by the IRB.

If the IRB office suspects there may be potential non-compliance, the IRB will initiate the process as outlined in Section 20.8 – Procedure for Handling Reports of Alleged Noncompliance. For additional information regarding subject complaints, refer to Section 22.1 – Participant Complaints.
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Chapter 10
Informed Consent Requirements

Investigators are required to obtain informed consent as a legal and ethical obligation. This chapter discusses the process of consent, the elements of consent, and legal requirements involved when obtaining informed consent from subjects.

No informed consent, whether oral or written, may include any exculpatory language through which the subject or the representative is made to waive or to appear to waive any of the subject's legal rights, or releases or appears to release the investigator, the sponsor, the Institution or its agents from liability for negligence.

10.1 The Process of Consent

Informed consent is more than a form, it is a process. Information must be presented to participants so that they can voluntarily decide whether or not to participate in research. Thus, the informed consent form must be written in “lay language” to ensure participants can understand its content. The amount of information contained in the consent and the manner of presentation is related to the complexity and risk involved in the study. The consent form serves to document the basis for consent and also serves as future reference for study subjects.

While the informed consent process is prospective and takes place prior to any research activity, consent should also be an ongoing interaction between the investigator and the research subject for the duration of the study. Subjects must be informed about significant new information or findings that develop during the course of the study that may affect their willingness to continue participation. Refer to Section 10.14 – Providing Significant New Information/Findings (SNIF) to Participants for more information.

The informed consent form must be signed before any study procedures begin. The investigator or research staff verbally explains the purpose and procedures involved in the study. The research staff answers questions and provides information to allow the subject to make an informed decision with ample time to consider participation. Thus, investigators should consider whether obtaining consent on the same day that study procedures begin provides participants enough time to consider participation.
The consent process must be free of coercion or undue influence. If an investigator has a relationship with potential subjects (physician-patient, instructor-student, employer-employee), care should be taken to avoid recruitment methods that may be seen as coercive due to the special relationship between the parties.

The consent document should be revised when new information becomes available or when changes will improve the consent process. Any proposed changes to an IRB-approved informed consent form must be reviewed and approved by the IRB before changes are implemented (unless the change is necessary to avoid immediate harm to subjects or others). Refer to Section 9.1 – Amendments – Changes to Research after Approval for additional information.

### Consent and Assent

Only competent adults can give legally effective informed consent to participate in research. Minors and those individuals who are not competent to give consent should be asked for their agreement to take part in the research. Assent is a knowledgeable agreement to participate in a research project.

Adequate provisions should be made for soliciting the independent, non-coerced assent from minors/children or cognitively-impaired persons who are capable of knowledgeable agreement. In general, the IRB recommends that children ages seven and older and most cognitively-impaired adults be given the opportunity to assent. In cases where assent is obtained from a minor or cognitively-impaired subject, permission must also be obtained from a legally authorized representative. The legally authorized representative may be a parent, a court-appointed guardian, or the court.

Special attention must be given to state law regarding attaining the age of majority (18 years of age) and situations involving emancipated minor subjects. Refer to Section 10.13 – Child Assent Special Requirements for more information.

For additional information about the consent process, refer to “Tips on Informed Consent” from the Office for Human Research Protections (OHRP).
10.2 Required Elements of Informed Consent

Campus-specific informed consent Templates provide sample language, instructions, and guidance. These templates can be found at: http://oprs.usc.edu/review/forms/.

By following the consent templates, investigators ensure that the basic and additional elements of consent are included as required by federal regulations.

Federal regulations (45 CFR 46.116 and 21 CFR 50.25) specify eight basic elements and six additional elements of informed consent described below.

Purpose and Procedures of the Study

The informed consent form must include “a statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed and the identification of any procedures which are experimental.” This section should clearly identify the procedures that will be followed during the course of the research. The procedures should be presented to the subject in the order of their occurrence and include expected duration of participation. Studies that involve experimental procedures or agents must clearly distinguish procedures or agents that are clinically indicated (standard of care) from experimental interventions.

Potential Risks and Discomforts

The informed consent form must include “a description of any reasonably foreseeable risks or discomforts to the subject.”

The informed consent form must provide subjects with a clear understanding of any risks or discomforts which are reasonably anticipated during their participation in the research.

Risks should not be understated or overstated. If enough data are available, it may be appropriate to state the frequency of potential risks, risk prevention measures, and reversibility and treatment of discomforts and risks.
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**Anticipated Benefits**

The informed consent form must include “a description of any benefits to the subject or to others which may reasonably be expected from the research.”

**Direct Benefits**

The informed consent form should state whether there are any direct benefits to the subject that may reasonably be expected as a result of participation in the research. Examples of direct benefits to the subject may include treatment of an illness or acquiring knowledge of value to the subject (such as results of a cardiac stress test or an educational test). The potential benefits to the subject should not be overstated or guaranteed. Payment for participation in the study cannot be listed as a benefit. If there are no benefits to the subject, this should be clearly stated.

**Benefits to Society**

All research should have some underlying potential benefit to society (such as advancement of knowledge or new treatments for people in the future).

**NOTE:** This section should not include payment as a benefit. Payment is addressed in the Compensation section of the consent form (Refer to Section 10.3 – Additional Elements of Informed Consent).

**Alternatives to Participation**

The informed consent form must include “a disclosure of appropriate alternative procedures or courses of treatment, if any, which might be advantageous to the subject.”

**Therapeutic Alternatives**

In clinical research, all informed consent forms are required to state any therapeutic alternatives available to the subject. Alternatives may include approved treatments, other clinical trials, continuing with current care, or supportive care only. For medical protocols that are not therapeutic in nature, the alternative would be to not participate in the study.
Non-Therapeutic Alternatives

In non-medical research, the informed consent form should state any alternatives that may be advantageous to the subjects. For instance, if the subjects are students who will receive academic credit, the informed consent form should describe the available alternatives to earn equivalent academic credit.

Confidentiality Statement:

The informed consent form must include “a statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained.”

The amount of information provided to subjects about confidentiality will vary greatly depending on the nature of the study. Specific language may be required in certain situations, such as when the research involves an FDA-regulated product, when the research has a Certificate of Confidentiality, or when researchers must report potential abuse, harm, or communicable diseases as mandated reporters.

FDA Regulated Research:

Consent forms used to enroll subjects in FDA-regulated research must contain a statement informing the subjects that the FDA may inspect the research records. Researchers will maintain confidentiality of records identifying the subject, to the extent possible.

ClinicalTrials.gov Registration:

Consent forms for "applicable clinical trials" (see end of this section for definition) must contain the following statement:

“A description of this clinical trial will be available on http://www.ClinicalTrials.gov, as required by US law. This web site will not include information that can identify you. At most, the web site will include a summary of the results. You can search this web site at any time.’’

For additional information regarding ClinicalTrials.gov Registration, refer to Section 18.11 – Registration of Clinical Trials and Other Types of Research.

“Applicable clinical trials” generally include interventional studies (with one or more arms) of drugs, biological products, or devices that are subject to FDA regulation,
meaning that the trial has one or more sites in the U.S, involves a drug, biologic, or device that is manufactured in the US (or its territories), or is conducted under an investigational new drug application (IND) or investigational device exemption (IDE). For more information on definitions of terms, refer to FDA’s draft guidance document “Elaboration of Definitions of Responsible Party and Applicable Clinical Trial”

**Limits to Confidentiality**

Depending on the subject matter of the research, there may be limits to the investigator’s promise of confidentiality to the subject. An example would be if a subject reveals information about possible child or elder abuse or if the investigator and/or the research staff discover the possibility of abuse. See Section 13.13 – Mandatory Reporting for more information.

**Certificates of Confidentiality**

If a Certificate of Confidentiality is requested for a study, the consent must include specific language. See the IRB Informed Consent Template and Instructions. For more information about Certificates of Confidentiality, refer to: http://grants.nih.gov/grants/policy/coc/appl_extramural.htm.

**Mandatory Reporting**

Study subjects must be informed if the investigator is a mandated reporter (as defined by state and federal law) required to report any sexual or physical abuse to the appropriate authorities.

**Injury Statement**

The informed consent form must include “for research involving more than minimal risk, an explanation as to whether any compensation for study-related injury and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained”.

The informed consent form should explain whether medical treatment is available for a research-related injury and who will pay for the treatment. USC may provide treatment at its health care facilities, but the cost of medical treatment is typically paid by the study sponsor or billed to the subject’s health insurance. Specific language is required for studies conducted at the USC Clinical Trials Unit (CTU). For most biomedical studies,
the USC Clinical Trials Office (CTO) will provide injury language that must appear in the consent form.

Compensation is not offered by USC or by study sponsors if a subject is injured.

No informed consent, whether oral or written, may include any exculpatory language through which the subject or the representative is made to waive or to appear to waive any of the subject’s legal rights, or releases or appears to release the investigator, the sponsor, the Institution or its agents from liability for negligence.

**Contact Information**

The informed consent form must include “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 subject.”

The informed consent form must provide phone numbers for subjects to call if they have questions about the research or if they have a research-related injury. For greater than minimal risk studies, the consent form must provide a phone number where the study doctor can be reached **24 hours a day, 7 days a week**.

The informed consent form must also include a statement that subjects may contact the IRB if they would like to speak to someone independent of the research team, obtain answers to questions about the research, learn about their rights as participants, or if they cannot reach the research staff.

**Voluntary Participation and Withdrawal**

The informed consent form must include “a statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled”. The form should also state that gradual withdrawal may be necessary for safety reasons, as applicable.
10.3 Additional Elements of Informed Consent

Six additional elements of informed consent may apply, depending on the nature of the study [45 CFR 46.116(b)]. When appropriate, informed consent forms must also include one or more of the following elements:

**Risks Involving Pregnancy**

For research studies intending to enroll females of child bearing potential, the consent form must include “a statement that the particular treatment or procedure may involve risks to the subject or embryo or fetus if the subject is or may become pregnant, which are currently unforeseeable.”

**Termination of Participation by Investigator**

The informed consent must include “anticipated circumstances under which the subject’s participation may be terminated by the investigator without regard to the subject’s consent.” These circumstances include when the subject fails to follow the investigator’s instructions, if the subject’s disease gets worse, if the subject’s side effects are too severe, or if the sponsor or FDA closes the study.

**Subject’s Withdrawal from Research**

The consent form must include “the consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject.”

For FDA-regulated research, specific data retention requirements must be adhered to and disclosures to the subject must be included in the informed consent form when a subject withdraws from research. Refer to Section 18.10 – Data Retention Requirements Related to Subject Withdrawal from FDA-Regulated Research.

**Additional or Incurred Costs**

The informed consent must note “any additional costs to the subject that may result from participation in the research.” For most biomedical studies, the USC Clinical Trials Office (CTO) will provide language describing the costs of participation.
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Disclosure of New Findings

The informed consent form must include “a statement that significant new findings developed during the course of the research which may relate to the subject's willingness to continue participation will be provided to the subject.” Guidelines for telling subjects about significant new information are provided in Section 10.14 – Providing Significant New Information / Findings (SNIF) to Participants.

Number of Subjects

The informed consent should include “the approximate number of subjects involved in the study.” This additional element is required for research projects submitted to the Health Sciences IRB.

Other Information to be Included in Consent

Compensation

The informed consent form should describe any compensation available to subjects. This may include payment for participation and reimbursement for expenses such as parking fees, travel expenses, and childcare incurred during the study. The consent form should explain how and when subjects will receive payment. In alignment with Food and Drug Administration (FDA) recommendation, USC encourages the adoption of a pro-rated payment system whenever possible. The nature, amount, and method of payment must not constitute undue inducement to participate. The payment alone should not serve as sufficient inducement for the subject to volunteer.

If subjects will receive more than $600 per year for taking part in one or more research studies, the consent form should explain that subjects may receive an Internal Revenue Service (IRS) Form 1099. The $600 per year amount does not include reimbursements for expenses.

Academic Credit

If payment will be in the form of academic credit that will be awarded for research participation, the amount and type of credit should be clearly stated as well as any required conditions for credit.
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Commercial Products

Investigators are required to inform subjects in the informed consent form if their biological human materials (such as tumor tissue, bone marrow, or blood) may be used to establish a commercially useful product (such as a cell line). Subjects should also be informed that they will not receive payment for any commercial product developed from their specimens.

Sponsor or Funding Agency Identification

If applicable, subjects should be told what entity is funding the research (such as the drug company, device manufacturer, federal agency, or foundation). This information should appear in the introductory section of the consent form.

Conflict of Interest

The research team must disclose all financial or other personal considerations that compromise, or have the appearance of compromising, professional judgment in proposing, conducting, supervising, or reporting research. Conflicts include financial, non-financial and institutional interests.

Disclosure of Incidental Findings

The consent form must clarify whether or not subjects will be informed about information obtained but not sought as part of the research project.

Consent of Pregnant Partner

Sponsors of drug studies may provide a sample informed consent for pregnant partners. This consent form is used if a female partner of a male participant becomes pregnant during the study and there are potential risks to the woman or fetus from exposure to the drug. The purpose is to obtain medical information about the partner’s pregnancy and birth outcomes to learn more about the risks of the study drug.

Investigators should not prepare and submit pregnant partner consent forms to the IRB for review. The IRB will not review and approve a pregnant partner consent form unless a pregnancy occurs. If a pregnancy occurs in a partner of a USC participant, the investigator should prepare the pregnant partner consent form and submit it as an amendment at that time.
10.4 Who May Conduct the Informed Consent Process

The federal regulations 45 CFR 46.116 state: “No investigator may involve a human being as a subject in research covered by this policy unless the investigator has obtained the legally effective informed consent of the subject or the subject’s legally authorized representative. An investigator shall seek such consent only under the circumstances that provide the prospective subject or representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence.” Further, a basic element to be included in a consent document is “an explanation of whom to contact for answers to pertinent questions about the research…” Therefore, the following is the USC policy on who can conduct the informed consent process for human research studies:

- Individuals who are knowledgeable about the protocol must obtain consent from subjects for participation in a study. Specifically, they must be able to describe the purpose, procedures, benefits, risks, and alternatives to participation in the study. They must be able to answer subjects’ questions about the protocol and about risks of the research procedures and alternatives.

- For studies involving medical procedures, the person obtaining consent should be licensed and privileged to conduct those procedures. Sometimes more than one person on the research team participates in the consent process. For example, study coordinators may describe the study procedures and a physician investigator may discuss specific issues related to the medical interventions and potential alternative treatments.

- All individuals who participate in the informed consent process must first successfully complete the online USC Human Subjects Education Program through the Collaborative IRB Training Initiative (CITI). More information on CITI is available at the following website http://oprs.usc.edu/education/citi/.

- The PI must identify all individuals who will obtain consent and attest that they fit the above criteria. The PI is ultimately responsible for ensuring that ethically and legally valid consent is obtained from all research subjects.

- The investigator or other person obtaining informed consent must sign the study consent document(s) on the signature line labeled “Person Obtaining Informed Consent”.

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10.5 Legally Authorized Representative

Informed consent may be obtained from a subject’s family member or authorized agent in certain situations. California law specifies who can be the Legally Authorized Representative and provide consent when a subject is not able to provide informed consent.

For studies involving cognitively-impaired adults, consent guidelines and the use of legally authorized representatives are governed by California Health and Safety Code Section 24175. For more information, refer Section 14.4 – Cognitively-Impaired Persons. If studies relate to the subject’s cognitive impairment, lack of capacity, or serious or life-threatening diseases and conditions, consent must be sought from the surrogate decision makers based on the order defined in California Law CA Health and Safety Code 24178.

If the person from whom assent is sought refuses, the person should not be enrolled, even if the parent or authorized representative gives permission. Alternatively, if the person from whom assent is sought agrees to participate, the person may not be enrolled if the parent or authorized representative does not give permission. In rare circumstances, depending on the nature of the study and the age and circumstances of the minor, the IRB may waive the requirement for parental or authorized representative’s permission.

10.6 Documentation of Informed Consent

The purpose of an informed consent form is to provide subjects with a written source of information for future reference and to document the fact that the process of informed consent occurred prior to the subject's participation. The form generally serves as a basis for the initial presentation of the study to the potential subject. Typically, informed consent is documented by using the IRB-approved, written informed consent form which is signed and dated by the subject, or the subject's legally authorized representative, at the time of consent. A copy of the informed consent form must be given to the subject. Unless the investigator has requested a waiver of documentation of consent, the subject's signature on an informed consent form is required prior to beginning any study procedures.

Information given to the subject or the representative must be in a language understandable to the subject or representative.
When deception is used as a technique in research, there should be a prompt and complete debriefing of the subjects. Debriefing may include explaining the research, and if possible, providing the opportunity for withdrawal of personal responses or withdrawal from participation in the study. A debriefing statement for IRB review should be submitted along with the informed consent form.

The informed consent form signed by a study subject, or the subject’s legally authorized representative, must be the version currently approved by the IRB that bears the date stamp of the IRB. One copy must be given to the subject and the original consent with the original signature must be maintained by the investigator. Another copy of the informed consent form must be maintained in the subject’s research chart, medical record, or equivalent file in medical research studies.

If informed consent is obtained using the Short Form method (oral translation of the consent form in a language understood by the participant supplemented with the written Short Form in the participant’s language), the subject, or the subject’s legally authorized representative, and a witness must sign and date the informed consent. If applicable, the subject or (legally authorized representative) must also sign the California Bill of Rights translated into a language understood by the subject. Refer to Section 10.7 – Obtaining Consent from Non-English Speaking Subjects for additional information regarding use of the Short Form.

10.7 Obtaining Consent from Non-English Speaking Subjects

If a study includes non-English-speaking subjects, the investigator must provide methods for assuring the subject or legally authorized representative (LAR) understands the research. When an investigator anticipates enrollment of non-English speaking subjects, the IRB-approved informed consent form must be translated into each anticipated language. If a consent form is not available in a language understood by the subject or LAR, the Short Form process can be used to obtain and document consent for the study.

Guidelines for the Use of the Short Form

If there is occasional and unexpected need to enroll subjects who are not fluent in English, a written short form informed consent must be used in conjunction with the
written IRB-approved English version of the consent. The short form consent includes the basic and possible additional elements of disclosure. The short form is available in English and many languages on the HSIRB and UPIRB websites. Investigators can download the short form and fill in the blanks as appropriate. The language has already been approved by the IRB.

The process for enrolling subjects with the short form is outlined below. Substitute “Legally Authorized Representative (LAR)” for “subject” when an LAR is involved in the process. All of the following requirements must be completed:

- A translator must orally translate the entire IRB-approved English version of the consent form to the subject in a language understandable to him/her, and the subject must be given a copy of the translated "short form" consent document to read
- The entire consent process must include a witness to the oral presentation
- The IRB-approved English version of the consent form must be signed by the individual authorized by the IRB to obtain consent, and signed by the witness to the consent process. The translated short form must be signed by the subject and the witness to the consent process
- The California Bill of Rights must be provided to the subject for studies that involve a “medical experiment” as defined by California law. The Bill of Rights is available in the same languages as the short form. The subject must sign and date the form, AND
- The subject must be given copies of the IRB-approved English version of the consent form and the translated versions of the short form consent document and California Bill of Rights. The original signed English version with the original signed short form attached should be placed in the subject's research record, medical record, or equivalent file as appropriate.

For additional information, refer to “Consent and Short Forms: Who Must Sign?”:
http://oprs.usc.edu/files/2013/01/Consent_and_Short_Forms_Final.pdf.
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Translation of Consent Forms into Languages Other than English

When the study subject population includes people who do not understand English, and the investigator or the IRB anticipates that consent interviews are likely to be conducted in a language other than English, the IRB will require translation of the IRB-approved consent documents into those languages.

Translation Options

If the study population is likely to include subjects whose primary language is Spanish, the consent documents must be translated into Spanish. The HSIRB office will provide Spanish translation of the IRB-approved consent form at no cost to investigators. The HSIRB does not provide translation services in languages other than Spanish, nor does the HSIRB translate study documents other than consent forms. Investigators must request Spanish translation by checking the appropriate box in the iStar application. Once consent forms have been translated, they are uploaded into the iStar application and stamped by the IRB. Investigators will receive email notification that the translated consent form is ready for use.

For languages other than Spanish, it is the responsibility of the investigator or study sponsor to provide translation using a translation service. The investigator must obtain IRB approval of the English version of the forms before providing them to the translator. A consent form translated by a translation service must be submitted to the IRB along with a certificate of translation. The translated consent form will be uploaded into the iStar application and stamped by the IRB. Investigators will receive email notification that the translated consent form is ready for use.

The investigator or study sponsor is also responsible for sending revised consent forms to the translation service. After changes to the English consent form are approved by the IRB, the changes must be made to the translated consent forms as soon as possible and submitted to the IRB for stamping.

For OHRP and FDA guidelines on obtaining consent from subjects who do not speak English, refer to the links below.
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Helpful Links:


10.8 Consent Documentation when Subjects Cannot Read, Hear, or Sign Consent Forms

Additional protections are needed for subjects who cannot see, hear, or speak or who cannot read or sign consent forms. The consent process must be conducted in a language or manner understandable to the subject and must allow the subject to communicate his or her willingness to participate. The study team must ensure that the subject is adequately informed and properly document the consent process.

English-speaking subjects who cannot see or are unable to read and write may have the informed consent form read to them. A witness must be present during the consent process and must sign the consent form. Subjects who are unable to sign the consent form can consent to participate in the research by "making their mark" (providing an alternative form of signature) on the signature line. The name of the subject, date, and time (if applicable) can be completed for the subject by either the witness or the person obtaining consent. A note must be included in the research record stating the method used for communicating with the subject and the means by which the subject communicated agreement.

For non-English speaking subjects who cannot see, read, or write, the process described above should be used. The study team must use a consent form or short form translated into a language the subject understands.

People who can read but cannot physically write can give verbal consent. A witness must be present during the consent process and must sign the consent form. The name of the subject, date, and time (if applicable) can be completed for the subject by either the witness or the person obtaining consent. A note must be included in the research record.
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stating the method used for communicating with the subject and the means by which the subject communicated agreement.

For people who can read and write but cannot hear or speak, sign language or specialized oral interpreters should be used to enhance communication with the study team. A witness must be present during the consent process and must sign the consent form. A note must be included in the research record stating the method used for communicating with the subject and the means by which the subject communicated agreement.

When consent is obtained from a Legally Authorized Representative (LAR), follow the procedures above substituting LAR for subject as applicable.

10.9 Electronic Consent and / or Signatures

The USC IRB will allow use of electronic consents for minimal risk research and full board review clinical research studies. Electronic consents or electronic signatures may be used if the procedures for obtaining them are approved by the IRB and the risk of breech is minimized. The IRB will consider vendor security and issues such as how a copy of the consent document may be provided for review if requested by the subject. As noted by the Office of Human Research Protections (OHRP), “If properly obtained, an electronic signature can be considered ‘original’ for the purposes of recordkeeping.”

OHRP also notes that it “would allow electronic signature of the document if such signatures are legally valid within the jurisdiction where the research is conducted.” The Federal Electronic Signatures in Global and National Commerce Act (eSIGN) and California’s Uniform Electronic Transactions Act (UETA) require that subjects agree to use the electronic format and that subjects be informed about their rights to obtain the electronic consent in non-electronic form and a description of any procedures that must be followed to withdraw their agreement to use an electronic record.

Vendors producing electronic consents will also need to comply with established FDA regulations. “Electronic” documents would be subject to a specialized set of requirements found at 21 CFR Part 11. Compliance with these standards is used to assure that electronic records are “trustworthy, reliable, and generally the equivalent to paper records and handwritten signatures executed on paper.” Investigators are responsible for ensuring compliance with 21 CFR Part 11 requirements.
For studies that involve social media websites, investigators must ensure informed consent language does not conflict with terms of service agreements from those websites (such as Facebook, Twitter).

10.10 Waivers of Informed Consent

Waiver of Documentation of Consent

In some situations, the IRB may waive the requirement for obtaining a signed informed consent 45 CFR 46.117(c). Investigators may request the IRB waive the requirement for a signed, written, informed consent. The IRB may waive the requirement for a signed consent if it finds:

- The only record linking the subject and the research would be the informed consent form and the principal risk would be potential harm resulting from a breach of confidentiality (for example, the subjects would be placed at risk by documents linking them with an illegal or stigmatizing characteristic or behavior), and the research is not subject to FDA regulations. Each subject will be asked whether they want documentation linking them with the research, and the subject’s wishes will govern; or

- The research presents no more than minimal risk of harm to the subjects and involves no procedures for which written consent is normally required outside of the research context (such as surveys without identifying information about compliance with a smoking cessation program).

In some cases, when a waiver of documentation of consent is granted, no written document is provided to the subject. For example, with a random-dial telephone survey study, the telephone interview would begin with a script that includes all of the required elements of consent but the study subjects would receive no written information about the study either before or after the interview. The telephone script containing the elements of consent must be included in the research application and reviewed and approved by the IRB.

In other cases, the waiver of documentation of consent can mean the subject is given a consent document but no signatures are needed. IRB regulations stipulate that the IRB may still require the investigator to provide the subject with a written statement about the
research even when a waiver of documentation is granted. For example, for an Internet-based survey, the IRB may determine that it is reasonable for the investigator to provide the subjects with an information sheet containing all of the basic elements of consent. The information sheet would state that completing the survey constitutes the subject’s consent/agreement to participate in the research study.

OHRP Human Subject Regulations Decision [Chart 10](#) provides more information.

### Waiver of Elements of Consent or Consent Itself

Some research projects would not be possible if obtaining consent from subjects was required. The IRB may consider waiving the requirement for some or all of the elements of informed consent 45 CFR 46.116(d). The regulations state that informed consent may be waived in full or in part if the IRB determines that all 4 conditions below are met:

- The research involves no more than minimal risk to the subjects and
- The waiver or alteration will not adversely affect the rights and welfare of the subjects and
- The research could not practicably* be carried out without the waiver or alteration and
- Whenever appropriate, the subjects will be provided with additional pertinent information after participation and
- The research is not subject to FDA regulation

*For the purposes of this policy, practicably means reasonably capable of being accomplished; feasible. The investigator must provide justification as to why the research cannot "practicably" be carried out without a waiver or alteration of consent. The investigator must document either that it is not possible to obtain consent from most subjects or their legally authorized representatives, or that limiting enrollment to subjects from or for whom consent can be obtained may bias the study results significantly. It is not sufficient to state there is not enough time or resources to obtain consent. Meeting the criteria for “not feasible” will be decided on a case-by-case basis. IRB considerations include: the number of subjects involved, the difficulty involved in obtaining informed consent, the nature of the research, and provisions for protecting the confidentiality of the data (chart reviews, specimen research).
Obtaining informed consent would not be practicable if the investigator will have no direct contact with subjects, will not know their identities or addresses, or subjects are lost to follow-up.

Alternatively, Public Demonstration Projects may obtain waiver of consent if the IRB finds that all criteria below are satisfied:

- The research is to be conducted by or subject to the approval of state or local government officials, and
- The research is 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, and
- The research could not practicably be carried out without the waiver or alteration, and
- The research is not FDA-regulated.

**Examples of Waiver of Consent:**

- Retrospective chart reviews. Example: review of medical records of patients who have undergone abdominal surgery in the past two years to correlate the data with blood chemistry values kept by pathology. Researchers collect limited data that will be assigned a random code number and the link between the subjects’ names and code numbers is known only to the researchers. Results of the research will not affect clinical care of the individuals, because they have already left the hospital and may be lost to follow-up.

- Large population studies such as testing new biometric scanners at busy airports.

- Research on existing pathology specimens (in which all specimens to be studied have already been collected and are "on the shelf" at the time of the IRB application)

**Examples of Waiver of Some Elements of Consent:**

- Certain ethnographic research. For example: when obtaining signed consent is not appropriate or feasible according to the cultural standards of the population being studied and there is minimal risk involved in the study.
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- Studies utilizing deception. For example: in a study that involves playing a computer game to test subjects' responses to differential payoffs or reinforcements, the investigator indicates in the consent form that the purpose of the study is to test reaction time. This deception may be necessary because the study would be compromised if subjects were told the true purpose. In this scenario, one of the basic elements of consent – the purpose of the study – could be waived by the IRB, and not be included in the consent form. Note: studies involving deception require a debriefing statement that is provided to the subjects (written and oral) at the conclusion of the study procedures.

- When there is a possible legal, social or economic risk to the subject by signing the consent form. For example, undocumented immigrants, HIV-positive individuals, and victims of domestic violence might be identified as such by signing the consent form.

In emergency situations, an exception to the informed consent process may be justified. Refer to Section 18.7 – Planned Emergency Research with Exception from Informed Consent.

*OHRP Human Subject Regulations Decision Chart 11 provides more information.

10.11 California Experimental Subject’s Bill of Rights

The California Experimental Subject’s Bill of Rights is legally required for all studies involving a medical experiment. A medical experiment is defined under section 24174 of the California Health and Safety Code as follows: “(a) 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 or 109925, 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 the subject or otherwise directly benefiting the subject; (b) The investigational use of a drug or device as provided in Sections 111590 and 111595; (c) Withholding medical treatment from a human subject for any purpose other than maintenance or improvement of the health of the subject.”

California law requires that the Experimental Subject’s Bill of Rights should remain a separate document from the informed consent form. It must be attached to the front of the informed consent form as illustrated in the Informed Consent Template and
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Instructions available on the HSIRB and UPIRB websites. In addition, the copy is to be dated and signed by the subject or the subject’s legally authorized representative. The subject or subject’s legally authorized representative is given a copy of the Experimental Subject’s Bill of Rights before giving consent to participate in any medical experiment.

The California Experimental Subject’s Bill of Rights must be provided to the subject or subject’s legally authorized representative in his or her language during the consent process. This also applies when a Short Form is used in the consent process. The Bill of Rights is available in various languages on the HSIRB and UPIRB websites.

10.12 HIPAA Research Authorization Form

For research involving protected health information (PHI), a current Health Insurance Portability and Accountability Act (HIPAA) research authorization form must be signed. The subject or legally authorized representative must sign and date the authorization form. If the subject is a minor (under 18 years old), a parent will sign the HIPAA authorization form. HIPAA authorization templates can be downloaded from the following website: http://oprs.usc.edu/rules/hipaa/.

Investigators should refer to “Instructions for Completing HIPAA Research Authorization Forms” provided by the USC Office of Compliance. This instruction sheet explains what sections can and cannot be changed. If additional changes to language in the HIPAA Authorization are required, these changes must be submitted to the Office of Compliance for approval before they are used. For additional information regarding HIPAA Privacy Regulations, refer to the Office of Compliance at http://ooc.usc.edu/hipaa-privacy-regulations.

California Law requires the HIPAA Authorization to remain as a separate document from the informed consent form.

10.13 Child Assent Special Requirements

Special informed consent procedures and forms are required when children participate in research. Children have not attained the legal age to consent to research treatments or procedures. Assent is a child’s affirmative agreement to participate in research. Investigators must obtain permission from parents and agreement (assent) from children.
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Additional information about research involving children is found in Section 14.1 – Protection of Children Involved as Subjects in Research.

**Assent Form Requirements for Permission by Parents**

Subpart D of the federal regulations (45 CFR 46 Subpart D) addresses permissible research with children and consent requirements. Some situations require permission from one parent, while other situations require permission from both parents. In other cases, waiving the requirement to obtain consent may be necessary (See Section 14.1 – Protection of Children Involved as Subjects in Research for more about Subpart D).

**Requirements for Parental Signature and Waiving Consent:**

- **Permission of One Parent**
  
  The IRB may find that the permission of one parent is sufficient for research to be conducted under §46.404 (research not involving greater than minimal risk) or §46.405 (research involving greater than minimal risk but presenting the prospect of direct benefit to the individual subjects).

- **Permission of Both Parents**
  
  Where research is covered by §46.406 and §46.407, permission is to be obtained from both parents, 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.

- **Waiver of Consent Requirements**
  
  If the IRB determines that a research protocol is designed for conditions or for a subject population for which parental or guardian permission is not a reasonable requirement to protect the subjects (for example, neglected or abused children), it may waive the consent requirements in 45 CFR 46 Subpart A and 45 CFR 46.408(b), provided an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and provided further that the waiver is not inconsistent with federal, state or local law.
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Additionally, Public Demonstration Projects may obtain a waiver of parental permission if the IRB finds that all criteria below are satisfied:

- The research is to be conducted by or subject to the approval of state or local government officials, and
- The research is 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, and
- The research could not practicably be carried out without the waiver or alteration, and
- The research is not FDA-regulated.

10.14 Providing Significant New Information/Findings (SNIF) to Participants

Regulations require that participants be provided with significant new information/findings (SNIF) developed during the course of the research that may affect their willingness to continue participating [45 CFR 46.116(b)(5) and 21 CFR 50.25(b)(5)].

Examples of situations that may require the investigator to provide new information to the participants:

- Changes to the procedures that may affect a participant’s willingness to continue in the research
- Identification of new risks or that risks previously described are known to occur with greater frequency or severity than previously reported
- Significant changes in potential costs to participants
- New conflict of interest for an investigator
- Notification of significant findings from this study or related studies
Methods for Providing Significant New Information/Findings to Participants

The regulations do not specify how significant new findings should be provided to participants. The IRB must review the new findings and approve the proposed method of informing participants. It is important that such changes in approved research not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to participants [21 CFR 56.108(a)(4)]. See the Appendix L - Informing Participants about Significant New Information and Findings for more information.

Method for SNIF Involving an Apparent Immediate Hazard

If an apparent, immediate hazard to participants is identified, participants must be notified and corrective actions implemented as soon as possible. This is a rare exception to ensure participant safety. However, the IRB must be informed about these occurrences and the investigator must submit a reportable event (Protocol Change Initiated to Eliminate Immediate Hazard) to the IRB promptly (within 30 days). Subsequently, an amendment with revised study documents (such as an updated consent form, a SNIF form, and updated protocol) must be submitted to the IRB. The Principal Investigator must notify the sponsor as required by the sponsor or FDA.

When investigators must contact participants immediately, notification can be made in writing or verbally. However, study files must document when participants were notified, how they were notified (in person, by phone, or by email or letter), what information was provided to them, and who contacted them.

Methods for SNIF that Do Not Involve an Apparent Immediate Hazard

If significant new information/findings do not warrant immediate notification of participants, the investigator must inform participants of the new information/findings using one or more of the following methods. Each method requires prior IRB review and approval.

- **Signed SNIF Form**
  The most common method is to prepare a brief SNIF form. The purposes of the SNIF form are to: (1) provide information to current and former participants who are affected by the new information and (2) to document that the new information was shared with participants. Use of the SNIF form is not considered “re-
consenting.” Only information that is both new and significant enough for subjects to reconsider their participation should be described in the SNIF form. When appropriate, the form must state that the information in the previously signed consent form is still current and valid. Participants are required to sign a copy of the form, and a copy must be kept in the research records. SNIF form templates are available for each campus:

- For the HSC SNIF template, click: [HSC Significant New Findings](#)
- For the UPC SNIF template, click: [UPC Significant New Findings](#)

- **Verbal, Script, or Information Sheet**
  In certain situations, the IRB may approve alternative methods for telling participants about significant new information. The study staff can tell participants in person or over the phone, using scripts, or send participants an information sheet that provides the same information as the SNIF form but does not request the participant’s signature.

- **Revised Consent Form, New Consent Form, or Consent Form Addendum**
  When the new information affects several elements of informed consent and/or involves extensive changes not easily described in a few pages, the participant may be asked to sign a revised informed consent form, a new informed consent form, or an addendum to the current informed consent form. The chart below compares when a SNIF can be used and when a full informed consent form may be needed. A full consent form or addendum may be necessary to provide sufficient context regarding the new information and to document the participant’s decision to remain in the study (“re-consent”). Occasionally, a study sponsor may insist that participants sign a revised consent form, even if the new information can be shared using a SNIF form. The IRB may require that participants also sign a SNIF form to ensure that changes and new information are clearly identified for participants.

**Translation of SNIF forms**

The HSIRB will provide Spanish translation of SNIF forms. For participants whose language is neither English nor Spanish, an interpreter must be used to read the SNIF form to the participant in the participant’s language. Use of the translator must be documented in the research records.
**SNIF Form versus a Revised Informed Consent Form**

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**Reminder:** If the study is still open to enrollment, the informed consent form must be updated to include the new information. The updated consent form is then used to enroll new participants.

### 10.15 Obtaining Consent for Screening Procedures

Screening procedures to determine eligibility are considered part of the subject selection and recruitment process, and therefore, require IRB oversight. Examples include collecting data directly from subjects through written screening tools, oral responses to questionnaires, accessing private information, and medical testing. Interactions or interventions performed as part of the practice of medicine and which would be done whether or not study entry was contemplated, such as for diagnosis or treatment of a disease or medical condition, may be performed and the results subsequently used for determining study eligibility without first obtaining consent. However, a partial waiver of HIPAA authorization for screening and recruitment is required to access medical records.

Depending on the nature of the research, consent may be required before any screening procedures are performed. There are several potential options for obtaining consent for screening procedures.

Examples of screening procedures that can be performed without consent:
• When no data is kept and no medical or psychological intervention occurs
• When screening activities generally pertain to non-medical minimal risk research
• When screening involves a procedure for which written consent is normally NOT required outside the research context

Screening procedures that require a separate consent form for screening:

• When requested by sponsor / IRB
• When screening involves a medical/psychological interaction or intervention that is greater than minimal risk or involves a procedure for which written consent is normally required
• When screening data are kept
• When impractical or not feasible to enroll a subject immediately after screening
# Chapter 11: Privacy, Confidentiality and HIPAA

## Chapter Contents

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Chapter 11
Privacy, Confidentiality and HIPAA

This chapter describes the importance of privacy and confidentiality protections as required by 45 CFR 46.111, Food and Drug Administration (FDA) regulations 21 CFR 56.111, the Health Insurance Portability and Accountability Act (HIPAA, also known as the Privacy Rule), and state and local laws. The IRBs review each study to ensure that privacy of subjects and confidentiality of data are adequately addressed.

11.1 Privacy and Confidentiality

Privacy is about people. It refers to research participants’ willingness to allow access to themselves and their information. Consideration of privacy includes the time and setting where private information is given, the nature of the information given, and who receives and uses the information.

Confidentiality is about data. It refers to the handling of information that a person has disclosed in a relationship of trust, with the expectation that it will not be divulged to others without permission.

IRBs must consider the protection of privacy and confidentiality as part of their ethical and regulatory duty to protect the rights and welfare of human subjects. Maintaining privacy and confidentiality helps to protect subjects from potential harms that could occur with a breach of confidentiality, such as psychological distress, loss of insurance, loss of employment, or damage to social standing. Often, particularly in behavioral research, the main risk to subjects is the possibility of a breach of privacy or confidentiality. The IRB must consider privacy and confidentiality for the entire duration of the study. The IRB must also consider confidentiality of research data after the study is finished.

Investigators are required to maintain and protect the privacy and confidentiality of all personally identifiable information, except as required by law or released with the written permission of the subject. Subjects, including children, have the right to be protected against invasion of their privacy, to expect that their personal dignity will be maintained, and to be assured that the confidentiality of their information will be maintained. The more sensitive the data, the greater the care investigators must take in obtaining, handling, and storing data.
During the consent process, investigators must explain what information will be collected, how it will be used, who will have access to it, and what will happen to it after the study ends. When applicable, investigators should explain any special precautions they will take to ensure confidentiality of sensitive information. This will allow subjects to understand how their information will be used and decide if potential confidentiality risks are acceptable to them.

**Types of Identifiable Information**

Information through which subjects may be identified include names, student identification numbers, hospital ID numbers, social security numbers, driver’s license numbers, home addresses, photographs, videotapes, and the like. Individuals also may be identified by description, for example, as the personnel manager in a particular company, the sixth grade teacher in a certain school, or the pediatric nurse at a local hospital. If information or data to be collected may be traced back to individual subjects, safeguards (described below) should be provided to ensure confidentiality.

**Guidelines for Protecting Confidentiality**

- Limit recording of personal information to that which is absolutely essential to the research
- Store personally identifiable data securely and limit access to the Principal Investigator (PI) and authorized staff
- Code data as early in the research process as possible, and plan for the ultimate disposition of the code linking the data to individual subjects
- Apply for federal Certificates of Confidentiality in all situations for which certificates are reasonable and available. If a Certificate of Confidentiality is requested for a study, the consent must include specific language. See the IRB Informed Consent Template and Instructions. For more information about Certificates of Confidentiality, refer to: [http://grants.nih.gov/grants/policy/coc/appl_extramural.htm](http://grants.nih.gov/grants/policy/coc/appl_extramural.htm)
- Do not disclose personally identifiable data to anyone other than the research staff without the written consent of the subjects or their legal representative.
(Exceptions may be made in case of emergency need for intervention or as required by regulatory agencies).

Investigators must describe their plans for protecting privacy and confidentiality in the iStar application. The IRB evaluates the investigator’s plans, including:

- The settings in which potential participants will be approached and research procedures will be performed
- The settings in which data will be recorded, reviewed, and stored
- The method for recording data and labeling samples (identifiable, coded, or anonymous)
- The amount and type of data collected (to ensure that only the minimum amount necessary is collected)
- The study staff who have access to data
- Security measures in place to prevent inappropriate access to and disclosure of data
- Release of data or samples to third parties
- Destruction or de-identification of data at the end of the study

The IRB must decide on a study-by-study basis whether there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data. The IRB decision is based on the sensitivity of the information obtained in the research and the protections promised to participants.

**11.2 Limits to Privacy and Confidentiality**

Depending on the subject matter of the research, there may be limits to the investigator’s promise of confidentiality to the subject. An example would be if a subject reveals information about possible child or elder abuse or if the investigator and/or the research
staff discover the possibility of abuse. (See Section 13.13 – Mandatory Reporting for more information.) The informed consent form must explain any limits to confidentiality.

### Mandated Reporting of Abuse

California law requires reporting of abuse or neglect of the elderly, dependent adults, and children to law enforcement and/or protective services agencies. California law also requires reporting of some communicable diseases to public health agencies. California law defines who is a mandated reporter and what agencies receive reports in each of these situations. Mandated reporting limits the confidentiality that can be promised to research participants. As a researcher, mandated reporters who observe or suspect child/elder abusive or neglect must report the incident. Student researchers although not mandated reporters, must inform their faculty advisor of their concern. Additional information is found in Section 13.13 – Mandatory Reporting.

Participants must be informed if the investigator is a mandated reporter. The informed consent form should disclose what types of information must be reported to outside agencies by the research staff.

### Mandated Reporting of Positive Results of Communicable Disease Testing

California law requires health care providers to report certain communicable diseases to local health authorities. For research that includes testing for HIV infection, hepatitis, tuberculosis, sexually transmitted diseases, and other communicable diseases, participants must be told that the investigator is a mandated reporter. The informed consent form should disclose what positive test results will be reported to public health agencies (California Code of Regulations Title 17, Section 2500).

### Sponsor Monitoring of Research Records

In signing the consent and HIPAA form, subjects authorize monitors and auditors from funding agencies, sponsors, and regulatory agencies to access participants’ study files to verify study-related data. Investigators must ensure that only the data described in the protocol and the access agreed to by participants in the informed consent and HIPAA authorization forms is available to external monitors. Research personnel often keep “shadow” research files that contain copies of source documentation for the purpose of
protecting a subject’s entire record accessible to third parties. Investigators must exercise caution to confirm that the privacy or confidentiality promised in the iStar application/informed consent are met regardless of whether records are kept in electronic or paper systems.

11.3 State Laws Addressing Privacy and Confidentiality

IRBs must consider state laws concerning privacy and confidentiality when reviewing research. Federal regulations require the IRB to evaluate the acceptability of proposed research in terms of applicable law, which includes state law. Federal regulations do not affect local and state laws that apply to protection of human research subjects or that require greater protections for subjects than federal regulations. Therefore, investigators must comply with state laws regarding privacy and confidentiality.

Research Related to HIV or AIDS

The California Health and Safety Code (Section 121075-121125) provides additional protections for confidential research records in studies relating to HIV or AIDS. “Confidential research records” includes any data in a personally identifying form (such as name, social security number, address, employer or other information that could, directly or indirectly, lead to the identification of the individual research subject) developed or acquired by any person in the course of conducting research relating to AIDS.

Confidential research records developed or acquired by any person in the course of conducting research, or a research study relating to AIDS, shall be confidential and shall not be disclosed by any person in possession of the research record, nor shall these records be discoverable, nor shall any person produce any confidential research record except in the following situations:

- Confidential research records may be disclosed in accordance with the prior written consent of the research subject to whom the confidential research records relate, but only to the extent, under the circumstances, to the persons and for the purposes the written consent authorizes. Any disclosure made pursuant to such prior written consent shall contain the following statement:
This information has been disclosed to you from a confidential research record the confidentiality of which is protected by state law and any further disclosure of it without specific prior written consent of the person to whom it pertains is prohibited. Violation of these confidentiality guarantees may subject you to civil or criminal liabilities.

- Confidential research records may be disclosed without prior written consent of the research subject to whom the confidential research records relate in the following circumstances:
  
  o To medical personnel to the extent it is necessary to meet a bona fide medical emergency of a research subject, and
  
  o To the California Department of Health Services for the conduct of a special investigation of the sources of morbidity and mortality and the effects of localities, employments, conditions and circumstances on the public health and for other duties as may be required in procuring information for state and federal agencies regarding the effects of those conditions on the public health

The content of any confidential research record shall be disclosed to the research subject, the legal representative of the research subject if the research subject is a minor, or the personal representative of a deceased research subject to whom the record pertains within 30 days after a written request is made for such records by the research subject or the legal representative.

**Hereditary Disorders**

The California Health and Safety Code (Section 124980) addresses confidentiality related to hereditary disorders such as sickle cell anemia, cystic fibrosis, and hemophilia.

All testing results and personal information obtained from any individual related to hereditary disorders, or from specimens from any individual related to hereditary disorders, shall be held confidential and be considered a confidential medical record except for information that the individual, parent, or guardian consents to be released, provided that the individual is first fully informed of the scope of the information requested to be released, of all of the risks, benefits, and purposes for the release, and of the identity of those to whom the information will be released or made available.
Prior consent for the release of such information is not required in the following situations:

- Data compiled without reference to the identity of any individual

- Data compiled for research purposes, so long as the research has been reviewed and approved by an IRB, who must certify its approval of the research to the custodian of the information and further must certify that in its judgment the information is of such potentially substantial public health value that modification of the requirement for legally effective prior informed consent of the individual is ethically justifiable.

NOTE: USC legal opinion interprets this statute to indicate that as long as the IRB certifies that the research is approved and that the information is of a potentially substantial public health benefit, prior consent by the subject need not be obtained in order to obtain the records from the custodian. There is some concern, however, that this may conflict with the HIPAA Privacy Rules, which would require authorization by the subject for the release of his or her medical records, whether related to a hereditary disorder or not. For research where these issues arise, the IRB and/or the Office of Compliance will interpret on a case-by-case basis.

### 11.4 Certificate of Confidentiality

Certificates of Confidentiality (COCs) are documents issued by the National Institutes of Health (NIH) and other federal agencies (such as DOJ, FDA, CDC) to protect against forced disclosure of identifiable research information. They allow investigators and others who have access to research records to refuse to disclose identifying information on research participants in any civil, criminal, administrative, legislative, or other proceeding, whether at the federal, state, or local level. COCs may be granted for studies collecting sensitive information that, if disclosed, could have adverse consequences for subjects or damage their financial standing, employability, insurability, or reputation. NIH will issue a COC for a study that fits the NIH mission regardless if the study has federal funding or not.

Examples of sensitive information that may require a COC include:

- Genetic susceptibility or family pedigree
• Mental illness

• High risk sexual attitudes, preferences, and practices

• Substance abuse or other illegal behaviors

• Participation in exposure effects studies that later become litigious, such as breast implants or environmental or occupational exposures

By protecting investigators and Institutions from being compelled to disclose information that would identify research participants, COCs help the investigator achieve research objectives and promote participation in studies by assuring confidentiality and privacy to participants.

The certificate states the date it becomes effective and the date it expires. A COC protects all information identifiable to any individual research participant during the time certificate is in effect. If the research extends beyond the expiration date, an extension of coverage must be requested. However, the protection afforded by the certificate is permanent. All personally identifiable information obtained about subjects in the project while the certificate is in effect is protected in perpetuity.

While certificates protect against involuntary disclosure, research subjects might voluntarily disclose their own information or authorize (in writing) the investigator to release information to others. In such cases, researchers may not use the certificate to refuse disclosure. Researchers must still comply with mandatory state and local reporting of child or elder abuse, reportable communicable diseases, or a subject's threatened violence to self or others. Additionally, the certificate does not prevent audits of the study by federal agencies such as the Food and Drug Administration (FDA) or the Office for Human Research Protections (OHRP).

The informed consent form must explain that a COC has been obtained for the study. The consent form should explain the protections it affords as well as the limitations of protection. The IRB template informed consent forms contain language that should appear when a COC is obtained.

The IRB understands there is a slight risk that data may be subpoenaed before the certificate is received and would not be protected by the certificate. In these cases, the USC IRB will decide if the risk outweighs the benefit of proceeding with participant recruitment and data collection before the certificate was granted. Data collected before
the certificate is granted are protected by the certificate once it is granted so the risk pertains only to the period of time between data collection and receipt of the certificate

**How to Obtain a Certificate of Confidentiality**

Investigators may choose to apply for a COC, or the IRB may require that an investigator obtain one. The following steps are required to request a COC:

- Investigator indicates in the IRB application that a COC will be requested for the study
- Investigator completes a COC application (online, if available) and drafts and signs a cover letter to be additionally signed by the USC Institutional Official
- Investigator submits a copy of the COC application and the original cover letter to the IRB
- IRB forwards the packet (see below) and IRB cover memo to the USC Office for the Protection of Research Subjects (OPRS)
- OPRS staff verifies packet completion, obtains the signature of the OPRS Executive Director, and forwards the packet to the office of the USC Vice President of Research / Institutional Official (VPR/IO)
- VPR/IO staff obtain VPR/IO signature, distribute electronic copies of signed document(s) to the Principal Investigator, IRB, and OPRS
- Investigator submits the application to NIH (or other agency) according to the agency’s application procedures

A complete USC COC packet will contain these items in the prescribed order:

a) Memorandum signed by IRB Chair or Director requesting VPR/IO signature

b) Principal Investigator letter to NIH and additional documents submitted by PI, if any

c) IRB Study Approval* Letter (may be included in IRB memo – item 1)
Neither the USC IRB nor the VPR/IO will evaluate the content of the Certificate of Confidentiality application. *IRB approval may be granted even though receipt of a COC is pending as long as the consent form(s) indicate the Principal Investigator has applied for a Certificate of Confidentiality from an HHS agency. Once received the PI must upload the certificate of confidentiality into iStar and submit an amendment to update the consent informing participants the data is covered under a COC.

**Helpful Links**

- DHHS Certificate of Confidentiality Kiosk:  

- DHHS Frequently Asked Questions on Certificates of Confidentiality:  

- DHHS Certificate of Confidentiality Contacts:  

- OPRS Essential Elements for a Certificate of Confidentiality:  
  [http://oprs.usc.edu/review/confident/](http://oprs.usc.edu/review/confident/)

### 11.5 Health Insurance Portability and Accountability Act (HIPAA)

The federal HIPAA Privacy Rule went into effect April 14, 2003. The law generally prohibits health care entities such as health care providers, hospitals, nursing facilities, and clinics from using or disclosing protected health information without written authorization from the individual (HIPAA authorization). The Privacy Rule is in Title 45 of the Code of Federal Regulations, in Part 160 and in Subparts A and E of Part 164. More information about the Privacy Rule can be found at the Health Information Privacy site of the Office for Civil Rights (OCR) at: [http://www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa).
Chapter 11: Privacy, Confidentiality and HIPAA

Protected Health Information (PHI)

Protected health information (PHI) is any identifiable health information relating to the individual's past, present, or future physical or mental health condition, including payment for health care. When health information is individually identifiable and held by a “covered entity” it is likely to be PHI. A covered entity is a healthcare provider, healthcare clearinghouse, or health plan that transmits health information electronically. The HIPAA rule governs the use of individually-identifiable health information when it is PHI.

HIPAA and Research

HIPAA regulations apply to research that involves the use and/or creation of protected health information (PHI). Investigators who obtain, use or create PHI must comply with HIPAA requirements during all phases of the research, from the initial identification of potential participants to the storage of data after the research ends. Investigators must limit their use and disclosure of PHI to the minimum necessary to achieve the stated goals of the research.

HIPAA regulations identify 18 elements that could be used to identify an individual

- Patient names
- Dates (except year) directly related to an individual (such as date of birth, death, hospital admission, and discharge)
- Patient postal addresses including city, state, and zip code
- Patient telephone numbers
- Patient fax numbers
- Patient e-mail addresses
- Patient social security numbers
- Patient medical record numbers
- Patient health plan ID numbers
- Account numbers
• Certificate/license numbers belonging to a patient
• Patient vehicle identifiers
• Device identifiers and/or device serial numbers specific to a particular patient
• URLs
• IP address numbers
• Biometric identifiers, including finger and voice prints, belonging to a patient
• Full face photos and other comparable images of a patient
• Any other unique patient-identifying characteristic or code

HIPAA requirements apply when investigators obtain information containing any of these identifiers from a covered entity. If investigators obtain the information directly from the participant or from sources other than a covered entity (such as a research laboratory), the information is not considered PHI and is not subject to HIPAA requirements.

Additionally, creation of PHI may also require that investigators obtain an authorization from subjects.

• If a hospital lab, CLIA-certified lab, or any other facility that is HIPAA-covered is involved in the generation of the health information, HIPAA authorization from subjects is required

• If health information is generated by an investigator’s private laboratory or if it is done outside of the oversight of a HIPAA covered entity, HIPAA is not required

Investigators can obtain and use PHI for research in the following situations:

• When participants sign a written HIPAA research authorization allowing access to their PHI

  Research participants authorize use of their PHI by signing the “USC HIPAA Authorization to Use Health Information for Research” form. Participants sign the HIPAA authorization form at the same time they sign the informed consent. The two forms are separate – the HIPAA authorization form cannot be combined with the informed consent document in California.
The HIPAA authorization form (in English and Spanish) and instructions for completing the form are available at: [http://oprs.usc.edu/hsirb/hsirb-forms](http://oprs.usc.edu/hsirb/hsirb-forms). This form is prepared by the USC Office of Compliance, and the form cannot be modified except as described in the instructions. If a sponsor wishes to change or add language in the form, the investigator must submit the proposed changes to the USC Office of Compliance for review and approval before the form can be used.

State and federal laws limit the disclosure of certain PHI, even with a HIPAA authorization. Under California law, a covered entity cannot release HIV test results to a researcher unless the participant gives specific permission. Release of information about mental health treatment also requires specific permission. Federal law limits the disclosure of information about alcohol and drug treatment from medical records unless the participant gives specific permission. Participants can give specific permission for these disclosures by initialing the applicable section of the USC HIPAA authorization form.

- When the IRB grants a waiver or alteration of HIPAA authorization, allowing PHI to be used in research without written authorization from participants

Under HIPAA regulations, IRBs and Privacy Boards have the authority to grant a partial or full waiver of the requirement for written authorization by research participants. A partial waiver of HIPAA authorization allows investigators to use PHI to identify, screen, and recruit potential participants. A full waiver of HIPAA authorization allows investigators to use PHI for all study activities without getting authorization from participants. Investigators request full or partial HIPAA waivers when they complete the iStar application. Under the Privacy Rule (45 CFR 164.512(i)(1)(i)), the IRB can grant HIPAA waivers if the following criteria are met:

1. The use or disclosure of protected health information involves no more than minimal risk to the individuals or their privacy, based on:
   a. An adequate plan to protect identifiers from improper use and disclosure,
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b. An adequate plan to destroy the identifiers at the earliest opportunity (unless there is a health or research justification for retaining identifiers or such retention is otherwise required by law), and

c. Adequate assurances that the protected health information will not be reused or disclosed to any other person or entity except as required by law, for authorized oversight of the research project, or for other research permitted under this policy.

2. The research could not be practicably be conducted without the alteration or waiver, and

3. The research could not be conducted without access to and use of the protected health information.

If the HIPAA waiver is granted, the IRB correspondence to the investigator will document and explain the waiver.

- When the investigator obtains only de-identified health information

HIPAA regulations allow a covered entity to use or disclose health information that has been de-identified. Health information that has been de-identified is not considered protected health information. De-identification involves removal of the 18 identifiers of the individual or the individual’s relatives, employers, or household members (listed above). When investigators obtain only de-identified health information for research, HIPAA requirements do not apply; no written authorization or waiver is needed to conduct the research.

- When the investigator obtains a limited data set containing only selected identifiers

The Privacy Rule allows investigators to obtain and use a “limited data set” for research without authorization from the participant or a waiver of authorization. In a limited data set, 2 of the 18 HIPAA identifiers remain but the other 16 identifiers are removed. Limited data sets can include the following identifiers of participants and their relatives, household members, or employers:
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- Dates (date of birth, date of death, and dates of service, such as hospital admission and discharge)
- Age
- City, state, and ZIP code

Investigators must sign a Data Use Agreement to obtain and use a limited data set. The Data Use Agreement is an agreement between the covered entity holding the PHI and the investigator who receives the limited data set. The agreement explains how the data will be used and protected and identifies the obligations of the investigator using the limited data set. The USC Data Use Agreement is available at: [http://policy.usc.edu/hipaa](http://policy.usc.edu/hipaa).

- When the investigator obtains information about deceased individuals

  The Privacy Rule protects identifiable health information after an individual dies. An investigator who wishes to obtain PHI of deceased people for research purposes can obtain the PHI only if certain conditions are met. The investigator must certify that the PHI is being sought solely for research on the PHI of decedents, that the PHI is necessary for the research, and that documentation of the death of each individual will be provided if requested by the covered entity. If these conditions are met, the PHI can be used without a written authorization or waiver of authorization. Investigators must complete the form “Researcher Request for Decedents’ Protected Health Information” to obtain the PHI.

NOTE: HIPAA regulations have a “Preparatory to Research” provision that permits researchers to obtain and use PHI to prepare a research proposal. Under this provision, researchers are not allowed to remove PHI from the covered entity. Because Keck Hospital of USC and LAC+USC Medical Center are different covered entities, the preparatory to research provision is not practical for a study conducted at both sites. Investigators should request a partial waiver of HIPAA authorization for recruitment and screening.

### External Monitor Access to Protected Health Information

In signing the consent and HIPAA form, subjects authorize monitors and auditors from funding agencies, sponsors, and regulatory agencies to access participants’ study files to verify study related data. Investigators must ensure that only the data described in the protocol and the access agreed to by participants in the informed consent and HIPAA
authorization forms is available to external monitors. Research personnel often keep “shadow” research files that contain copies of source documentation for the purpose of protecting a subject’s entire record accessible to third parties. Investigators must exercise caution to confirm that the privacy or confidentiality promised in the iStar application/informed consent are met regardless of whether records are kept in electronic or paper systems.

### Role of the USC IRBs Related to HIPAA

The USC IRB acts as the Privacy Board for Keck Medicine of USC and LAC+USC Medical Center. In this capacity, the IRB will consider and make determinations about partial or full waivers of HIPAA authorization. The IRB reviews the HIPAA sections of the iStar application and advises investigators about HIPAA applicability and the need for written authorization. However, the Privacy Officer in the USC Office of Compliance is responsible for the content of HIPAA authorization forms. The USC Office of Compliance is also responsible for HIPAA training and oversight of HIPAA compliance at USC.

For more detailed information regarding HIPAA policies, forms, procedures, and training, please go to the Office of Compliance website: [http://ooc.usc.edu/health-information](http://ooc.usc.edu/health-information). HIPAA authorization forms for non-research activities such as fundraising, marketing, and public relations are also available at this website.
Chapter 12: Subject Compensation and Recruitment

Chapter Contents

12.1 – Compensation
12.2 – Recruitment
12.3 – Payments for Referrals (Finder’s Fees) Are Not Permitted
Subject compensation and recruitment issues are significant concerns of the IRB. Compensation must not be excessive or coercive. Recruitment materials must reflect the true nature of the research and not mislead potential participants. This chapter explores these issues and discusses criteria for recruitment and subject compensation including industry sponsored studies.

12.1 Compensation

Compensation for participation in research remains a contentious issue with no regulatory guidelines. However, many papers have been written about subject compensation and guidelines have been suggested. Compensation takes many forms such as school supplies, gift certificates, parking reimbursements, meal coupons, nominal gifts, lotteries or cash.

The plan for compensating subjects must be submitted to the IRB in the study application. In addition, the form of compensation must be described in the informed consent document (such as cash, gift card, or chance to win a gift) as well as a description of the conditions under which a subject would receive partial or no payment.

For participation in an FDA regulated, sponsored trial, compensation may not be offered in the form of a discount coupon on the purchase price of the product after it has been approved for marketing.

Guidelines for Compensating Research Participants:

- Payment for participation in research should not be offered as a means of coercion. Rather, it should be a form of recognition for the investment of the subject's time, loss of wages, or other inconvenience incurred. Compensation may not be withheld contingent on the subject's completion of the study.

- In cases involving ongoing participation, compensation should be given on a reasonable, prompt, and prorated basis to avoid possible coercion. The payment should be made throughout the course of the study, contingent on participation as described in the protocol.
Chapter 12: Subject Compensation and Recruitment

- The Principal Investigator and IRB should consider the risk, duration of participation, effort required, and local economy when determining appropriate compensation for a study population. Additional caution should be exercised when establishing compensation for greater than minimal risk studies. Economically disadvantaged subjects are especially vulnerable to undue influence from excessively high levels of compensation.

- It is acceptable to provide a chance to receive a gift as a form of compensation in lieu of providing cash or other remuneration. The “thank you” gift is commonly used by student investigators with limited funds. Examples of gifts include a chance to win a “thank you” item such as an MP3 player, cellular phone, or gift-card.

**Compensation for U.S. Military Personnel for Department of Defense (DOD) Sponsored Research**

When Department of Defense-sponsored research is conducted on US military personnel, the following limitations on dual compensation for US military personnel apply:

- Prohibits an individual from receiving pay from more than one position for more than 40 hours of work in one calendar week.

- Includes temporary, part-time and intermittent appointments.

Being a research subject is generally not a part-time job nor is it an intermittent appointment. There are some situations where active duty can be compensated. The Army allows this when military personnel are 'off-duty' or on 'official leave'. If the research is greater than minimal risk the Commanding Officer must give permission for the military personnel to enroll. DOD allows compensation for military personnel up to $50 per blood draws whether on or off duty.

**12.2 Recruitment**

Recruitment of subjects is considered to be the beginning of the informed consent process. Recruitment is one of the most challenging aspects of research involving human subjects. Recruitment is often conducted through newspapers, email, posters, brochures,
by internet, radio or television announcements, or by soliciting volunteers in public spaces, hospitals, clinics and laboratories.

The pressure to enroll subjects raises ethical challenges for investigators and research staff. Recruitment of subjects must be equitable and include racial, ethnic, educational, socioeconomic, and gender diversity appropriate to the condition being studied. All recruitment efforts must respect personal rights to privacy and confidentiality and be compliant with FDA, OHRP, and HIPAA regulations, as applicable.

For additional information, refer to FDA Information Sheet “Recruiting Study Subjects”.

**Recruitment Materials**

When a project requires IRB review, all recruitment materials under local control including advertising and marketing materials must be reviewed as part of the study. Any recruitment materials generated by USC investigators or research personnel must be submitted to the IRB for review and approval before they can be used.

The following information should be included in recruitment materials:

- Accurate description of the research purpose
- Name and address of the investigator or facility (including university affiliation and/or department)
- Condition under study or purpose of the research
- Eligibility criteria
- Time commitments required
- Location of the research
- Person to contact for further information

The following information should NOT be used in recruitment materials:

- Coercive language
- Claims that a device or drug is safe and effective
Chapter 12: Subject Compensation and Recruitment

- The words “new treatment,” “new medication,” or “new drug” if the test article is investigational
- Promises of “free medical treatment”
- Amount of payment, dollar signs, or the words “free” in large or bold face type
- Compensation should not be excessive relative to the nature of the project
- Statements or implications assuring favorable outcome or other benefits beyond what is outlined in the consent document and protocol
- Claims, either explicitly or implicitly, that the test article is known to be equivalent or superior to any other drug, biologic, or device
- Exculpatory language

Note: content allowed in recruitment materials may differ between the University Park and Health Sciences Campuses. If you have questions, contact your local IRB for more information.

National Recruitment Materials Not Reviewed by the IRB

Industry sponsors often produce recruitment materials that are used on a national basis and that cannot be modified by local sites. Examples include websites, radio or television advertisements, and call center scripts. Recruitment materials that cannot be modified by USC investigators will not be reviewed, approved, or acknowledged by the USC IRB. These materials should not be attached in the iStar application.

Recruitment Materials Used in Exempt Research

Recruitment plans, materials and advertisements should be submitted with the initial study submission to the IRB. However, when a study receives an exempt determination by the University Park IRB, if the researcher subsequently wants to use advertisement materials that were not included in the original IRB submission, or alters the recruitment plan, the investigator does not need to submit these changes for IRB review (note: only for exempt research reviewed by the UPIRB) unless the materials change the level of risk or IRB determination. Exempt study advertising and recruitment materials should follow the guidelines suggested.
12.3 Payment for Referrals (Finder’s Fees) Are Not Permitted

USC policy does not allow any finder’s fees. Investigators, or any other member of the research team, may not offer payment to subjects (prospective, previously enrolled, or currently enrolled) for referring their friends, family member, or other individuals. Finder’s fees may not be offered to other investigators, clinicians, researchers, or any other individual or group for referring potential subjects.
# Chapter 13: Investigator’s Role and Responsibilities

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Chapter 13
Investigator’s Role and Responsibilities

This chapter defines the role of Principal Investigator, co-investigator, and student investigator. It identifies the specific responsibilities, qualifications, and interactions an investigator has when conducting human subjects research.

13.1 Definition and Role of Principal Investigator (PI)

The term Principal Investigator (PI) implies specific responsibilities and interactions for conducting research. Investigators have a responsibility to protect the rights and welfare of participants. In addition to following applicable federal, state, and local regulations, investigators are expected to follow ethical principles and standards appropriate for their discipline and research. Investigators must also follow Good Clinical Practice (GCP) guidelines in designing and conducting clinical trials. USC policies, procedures, and education programs are provided to help investigators carry out research studies ethically.

The PI bears ultimate responsibility for the scientific, technical, and administrative aspects of the research project, even when certain tasks have been delegated to or co-investigators, sub-investigators, staff, or students.

Who may be a Principal Investigator on an IRB application

At USC the following may be listed as Principal Investigator on iStar:

- USC faculty and staff (excluding temporary personnel)
- Students including undergraduates, master and doctoral students, medical students, residents/interns, clinical, research and postdoctoral fellows. Student investigators must designate a Faculty Advisor on the IRB application. Faculty Advisors are responsible for the scientific and ethical quality of student research projects. For more information, see Section 13.7 – Faculty Advisor’s Assurance for Student Investigators
For research conducted by PIs who are not USC faculty, PI requirement should be consistent with local policy (such as faculty from Cedars-Sinai Medical Center)

In contrast, for grants management principal investigators can only include:

All tenured, tenure track, and non-tenure track faculty, and research scientists (with the exception of lecturers, adjunct, and part-time clinical faculty) may act as Principal Investigators. Postdoctoral, Research Associates and Postdoctoral Teaching Associates, as defined by USC’s Postdoctoral Scholars Policy, may act as co-principal investigators on sponsored projects, but may not be principal investigators unless a specific waiver and approval is granted upon recommendation by the Department and approval of the appropriate Dean. The signature of the Dean/Department designee on a Proposal Approval Record (PAR) is equivalent to departmental authorization that the person may act as a principal investigator.

For additional information refer to the Guide to Research at USC and the Postdoctoral Scholars Policy.

**IRB Review of Investigator Qualifications**

One of the responsibilities of the IRB is to determine that the investigator is appropriately qualified to conduct and supervise the proposed research. In many cases, previous experience with an investigator allows the IRB to readily determine an investigator’s qualification. However, if the IRB has no knowledge about an investigator, the IRB may request additional documentation to evaluate an investigator’s qualifications (such as curriculum vitae, medical licensure or relevant publication). The IRB may also need to assess an investigator’s training specific to the proposed study, particularly if the research involves higher risk, vulnerable subjects or novel technologies.

**Principal Investigator Responsibilities**

The PI initiates the research proposal, defines the scope of the work, controls the conduct of research, and directly supervises any others (faculty, staff, or students) involved in the research. The PI specifies and participates in the selection of supplies, equipment, and subcontractors (if applicable). The PI certifies the percentage of effort for other faculty and staff working on the project, certifies the accuracy of charges, notifies and
communicates with sponsor personnel and collaborating organizations as needed, and manages the orderly execution and close out of the project.

**Investigator Responsibilities to IRB**

PIs are responsible for ensuring that research is conducted according to valid research design and methods. PIs must adhere to an IRB approved study plan (protocol) and terms of the grant, contract and/or signed funding agreements as well as applicable laws, regulations, and institutional policies.

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**Initial Study Responsibilities**

Prior to commencing research PIs must:

- Obtain approval from the appropriate department, institute and Dean or designee of the school for any proposal to be submitted to the Health Sciences IRB (HSIRB). Some schools (such as the Keck School of Medicine) require additional approvals, for example, from a Division Chief.

- Ensure appropriate research compliance committee (Institutional Animal Care and Use Committee review and approval of a sponsored project’s protocol in accordance with those committees' policies and procedures. Studies submitted to the University Park (UPIRB) may require school or department approvals as determined by the particular school or department or other committees as deemed necessary.

- Submit an application for IRB review and approval. All IRB applications must be submitted through the iStar system.

**Note:** If research initiated at another Institution will be continued at that Institution and/or transferred to USC, the investigator must contact the USC IRB for information and submission requirements. Refer to Appendix J – IRB Requirements for Research with Other Sites for guidance.

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**Ongoing Study Responsibilities**

PIs must keep the IRB informed about their study and are required to:
Chapter 13: Investigator’s Role and Responsibilities

- Submit annual progress reports to the IRB for expedited and Full Board review studies unless the study is expedited and has a 2 year approval (see Section 9.2 – Continuing Review)

- Submit an amendment to the IRB if a change to an IRB-approved study is necessary. The IRB must review and approve the changes before these are implemented unless the change to the study is initiated to prevent an immediate hazard to subjects (see Section 9.1 – Amendments – Changes to Research after Approval)

- Submit reportable events and reports to the IRB as applicable. Reportable events and reports include adverse events, unanticipated problems involving risks to subjects, protocol deviations, data safety monitoring reports, and protocol changes initiated to eliminate immediate hazard to subjects (see Section 7.13 – Reportable Events and Section 7.14 - Reports)

Close Out Study Responsibilities

PIs must submit a final progress report to close out a study when a study is completed or terminated (see Section 9.3 - Project Closure). PIs who plan to leave USC and have active studies are required to:

- Close the study/ies: investigators must submit a final progress report (Continuing Review in iStar) or complete the “Close Study” activity in iStar

- Transfer the study to another USC investigator: submit an amendment to change the Principal Investigator

- Transfer the study to another Institution: investigators must close the study at USC by submitting a final progress report (Continuing Review in iStar) or complete the “Close Study” activity in iStar

- Continue study at USC and at another site: investigator should contact the USC IRB for more information and guidance.
13.2 Investigator-Initiated Research and Sponsor-Investigators

Investigator-Initiated research has many different meanings. The National Institute of Health (NIH) uses the term “investigator-initiated research” to describe an investigator submitting an application to the NIH on a topic of his or her choice. Investigator-initiated research differs from targeted research in which investigators respond to an institute's call for applications in research topics specified in requests for applications (RFA) or requests for proposals (RFP).

Investigator-initiated research, in the context of clinical trials with an IND or IDE, is when an investigator is also considered the sponsor (sponsor-investigator) and must fulfill all regulatory requirements, FDA expectations, and monitoring expectations of a sponsor. This differs from studies initiated and funded by a sponsor in which the sponsor provides the protocol. In addition to FDA regulations, sponsor-investigators must comply with California laws that affect research sponsors, such as manufacturing regulations for experimental drugs and devices. For additional information, refer to the California Health and Safety Code Sections 111515-111545 and 111550-111610.

The iStar application requires investigators to indicate when the IND/IDE is held by USC faculty or investigator. Sponsor-investigators must also complete the Sponsor-Investigator attestation in iStar when submitting their study to the IRB. Investigators who plan to conduct sponsor-investigator research should contact the HSIRB Chair for assistance. For more information refer to Section 18.4 – Sponsor-Investigators.

13.3 Educational Requirements

Human Subjects Protections Course

For an application to be approved by the USC IRBs, all study personnel must complete human subjects training. The online course used is provided by the Collaborative Institutional Training Initiative (CITI) at www.citiprogram.org, providing a certificate of completion valid for three years.
Prior to a certificate expiring, a notification is sent from iStar to the researcher. Study personnel who have completed the human subjects basic course must renew their certification every three years. A refresher course is provided on www.citiprogram.org.

For exempt research projects a shorter human subjects training is required. If human subjects certification expires and the key personnel are only conducting Exempt research, recertification is not necessary. Human subjects training is not required for studies that are considered Not Human Subjects Research (NHSR).

Proof of human subjects training from outside Institutions are accepted in lieu of CITI certification. For CITI educational requirements, refer to the OPRS website at: http://oprs.usc.edu/citi.

**Good Clinical Practice (GCP) Course**

GCP training has been required since 2009 for study PIs and personnel conducting full board clinical trials. In 2015, the requirement will be expanded to PIs and staff conducting clinical trials, not just those trials that require full board review. Effective January 26, 2015, PIs and staff on new studies and any new staff on ongoing studies meeting the NIH definition of a clinical trial are required to satisfy the GCP requirement.

A clinical trial is a “research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes”.

Although GCP training is primarily intended for study staff who collect data through intervention or interaction with a subject, or have access to private identifiable information anyone on the study team may be asked to take it at the request of the IRB.

USC offers GCP online training program through CITI. For more information, contact the OPRS at (213) 821-1154 or visit the OPRS website: http://oprs.usc.edu/citi.

**HIPAA Course**

The “Privacy Rule” also known as the Health Insurance Portability and Accountability Act establishes minimum Federal standards for safeguarding the privacy of individual’s identifiable health information. For more information, refer to Section 11.5 – Health Insurance and Portability Accountability Act (HIPAA).
USC researchers who use/access protected health information are required to complete USC’s HIPAA online educational program. For detailed information regarding HIPAA policies, forms, procedures, and to access the online educational program, visit the Office of Compliance’s website: http://ooc.usc.edu/hipaa-privacy-regulations.

13.4 Professional Qualifications of PIs

No person is allowed to perform medical procedures at USC without being properly credentialed/licensed and have the required hospital privileges. Persons with a foreign medical degree/license are not credentialed/licensed to perform medical procedures in California.

Credentialing for licensure is the responsibility of the Office of Compliance.

The HSIRBs may require new PIs (first time submitters) to provide a copy of their curriculum vitae and medical license, and if necessary, additional supporting information to document that the investigator is qualified to conduct the research activity.

13.5 USC Investigators Conducting Multi-Site Research

Procedures for USC Investigators conducting multi-site, research at non-USC sites or acting as the designated coordinating center are described below. This only applies to full board and expedited studies.

For additional information, refer to Section 4.3 – Responsibilities Defined under the FWA.

The following procedures are for review and oversight of multi-site, non-exempt research.
Non-USC / Non-Engaged Research Sites in Multi-Site Research

USC investigators who conduct non-exempt research at non-USC sites are required to obtain permission to conduct the study when the site itself is not “engaged” (refer to Section 4.5 – Engagement in Research).

A permission letter is necessary to ensure that relevant information regarding the proposed research has been shared with, and agreed to, by the appropriate agency/institutional authority. The institutional authority is someone who has signatory authority (such as a Principal, clinic Director, school board Chair, or superintendent) for the organization. The site contact information in addition to the permission letter must be uploaded to the USC IRB application. A template letter is available on the IRB website: Research Site Permission Template.

Waivers may be granted for minimal risk research and certain social behavioral studies.

**Common Reasons for Waiving the Site Permission Requirement:**

- Obtaining site permission is not practicable
- The research is being conducted at a large number of sites
- The data being collected is anonymous
- The behavior studied is not related to site/place
- The study involves less than minimal risk

**Common Reasons for NOT Waiving the Site Permission Requirement:**

- Research involves greater than minimal risk
- Safety concerns for participants or researchers
- Permission is required by the site (such as LAUSD, health clinics, hospitals)
- Amount of time and effort required to obtain permission is minimal, and a courtesy
Subjects are vulnerable and permission letters are usually required (children, cognitively impaired populations) (See Chapter 14 – Vulnerable Subject Populations)

USC as Coordinating Center for Multi-Site Research

If a USC PI is the lead investigator /coordinating center for a multi-site study and USC is the coordinating center, an adequate plan for the management of information from all sites relevant to the protection of participants is required. This plan should include:

- A description of the types of events to be reported (such as unanticipated problems involving risks to subjects or others, adverse events, noncompliance, significant new information or findings, required protocol modifications)
  - When the reports must be made and sent to the coordinating center
  - How to make the reports to the coordinating center (specific forms, IRB forms)
  - To whom the reports should be made (such as lead investigator, other)
  - The process for disseminating these reports to the non-USC sites

- A description of how the coordinating center will ensure that each participating non-USC site has obtained IRB approval before initiating research activities

It is the Lead PI’s responsibility to submit an adequate management and communication plan in iStar for research being conducted at multiple sites.

Helpful Links

  http://www.hhs.gov/ohrp/policy/engage08.html

- Individual Investigator Agreement – Sample
  http://www.hhs.gov/ohrp/policy/unaflsup.rtf
13.6 Investigator Conflict of Interest

The term “conflict of interest” in this policy refers to situations in which financial, or other personal considerations compromise, or have the appearance of compromising, an individual’s professional judgments in proposing, conducting, supervising or reporting research. Conflicts of interest include non-financial as well as financial.

(See “Responsibility of Applicants for Promoting Objectivity in Research for which PHS Funding is Sought”)

Conflicts of Interest may include but are not limited to the following:

- Equity (stocks or options, do not include mutual funds)
- Recruitment incentives, bonus payments, (these are prohibited)
- Consulting Fees
- Speaking Fees
- Travel Reimbursement
- Gifts
- Corporate Officer or Board of Directors
- Other Employment Relationship
- Trademarks/Copyrights
- Licensing Agreements
- Royalty Payments
- Patent Holdings

Conflicts of interest must be declared in the IRB application when the study investigators, research personnel, or their immediate family/domestic partner have a financial interest, and/or intellectual property interest in the sponsor or products used with the project, equal to or exceeding $5,000 per year. Investigators must also inform the IRB of relationships with the sponsor or party with economic interests in the research such as
consultation agreements, speaker services or management roles. When these relationships exist, the potential conflict of interest is reviewed by the Office of Compliance.

Researchers who are proposing or have received HHS (including NIH, CDC, HRSA, and AHRQ) support must also make an annual disclosure of all financial interests related to their institutional responsibilities to USC, regardless of whether any of these interests give rise to a conflict of interest related to their research. The annual disclosure must be completed before a proposal can be submitted to HHS, and any identified conflicts must be managed before an account can be established. In addition, all HHS-funded investigators must complete training on conflicts of interest once every four years.

All potential or actual conflicts of interest must be disclosed online using the diSClose system.

The Conflict of Interest in Research Committee (CIRC) evaluates disclosed (or knowingly withheld) conflicts of interest.

For additional information regarding Conflict of Interest, refer to:

- USC Office of Compliance website: http://ooc.usc.edu/
- USC Conflict of Interest in Research Policy: http://policies.usc.edu/p4acad_stud/conflic_interest_research.html
- USC Relationships with Industry Policy: http://ooc.usc.edu/relationships-industry
- diSClose website: https://disclose.usc.edu/
- diSClose Training Videos: http://ooc.usc.edu/diSClose-training-videos
13.7 Faculty Advisor’s Assurance for Student Investigators

When a student investigator is listed as the PI on the IRB application, a faculty member must also be listed as the faculty advisor. The faculty advisor electronically approves/signs-off on the IRB application to indicate they have reviewed the submission, it is ready for IRB review, and the faculty advisor assumes responsibility for oversight of the student's research.

The faculty advisor certifies that the student investigator is knowledgeable about IRB policies, and applicable federal regulations governing research with human subjects, and has sufficient training and experience to conduct the study in accordance with the approved protocol.

The Human Subjects Protection Program (HSPP) has implemented a mandatory human subjects education program (CITI) for all investigators, including students. Faculty advisors are considered key personnel and are required to complete CITI (see the IRB/OPRS websites for more information). Faculty advisors must ensure that student investigators and all other key personnel have completed the Human Subjects and the Health Insurance Portability and Accountability Act (HIPAA) Programs when required. The faculty member is also responsible for the scientific quality of the student research project submitted to the IRB.

13.8 Student Investigator’s Assurance

A student investigator must electronically sign the IRB application. This means they agree to meet with their faculty sponsor on a regular basis to monitor study progress. If the faculty advisor is away, the student investigator will meet with the arranged alternate faculty advisor who will assume responsibilities.

The student investigator is expected to be familiar with the policies contained in USC’s Federalwide Assurance(s). Prior to initiating research activities, student investigators must complete the Human Subjects Education Program (CITI).
### 13.9 Failure to Submit a Project for IRB Review

There are significant implications to engaging in human subjects research activities subject to IRB review, without first obtaining IRB review and approval. USC policy requires investigators to have obtained IRB approval prior to the initiation of any research activities. If an investigator begins a project not intending to contribute to generalizable knowledge but later finds that the study results could be published or presented, IRB approval must be obtained before publishing or presenting the data. Undergraduate honors papers, Masters theses, and dissertations that are human subjects research require IRB review.

The IRB may not approve applications where an investigator circumvents IRB policies and procedures by collecting data as a “non-research” activity, and then subsequently applying for IRB approval to analyze the data as existing data. It is in the investigator’s best interest to carefully consider the likelihood of the data being used for future research purposes, and err on the side of caution in seeking IRB approval prior to commencing the work.

### 13.10 Scientific / Research Misconduct

The University of Southern California is committed to maintaining an environment that promotes high ethical standards in the conduct of research. The University does not tolerate misconduct in any aspect of research and will deal with misconduct associated with research forthrightly in accordance with academic due process, and with respect for practices commonly accepted within the scientific community.

At USC, allegations of research misconduct, involving human subjects, are reported by the IRB to the Vice President of Research, the Executive Director of the Office for the Protection of Research Subjects (OPRS), and the Senior Associate Vice President of the Office of Compliance, and General Counsel Office for further action (scientific misconduct is not necessarily under the sole purview of the IRB).

If a USC investigator does not conduct research responsibly, according to federal regulations or University policy, the investigator is subject to both federal and USC consequences. USC is committed to fairly and uniformly investigating and reporting all instances of alleged or apparent misconduct involving research by members of the
University community, regardless of the funding source. For information on how these issues are handled by the University, refer to the USC “Policy on Scientific Misconduct.”

The Responsible Conduct of Research section of the HSPP websites contains links to information on the responsible conduct of research and tutorials on how to conduct research responsibly and ethically [http://oprs.usc.edu/education/rcr/].

Scientific misconduct is defined by the federal government for all research and all federal agencies is defined as the fabrication, falsification, or plagiarism in proposing, performing, or reviewing research, or in reporting research results.

Human subjects review does not include evaluation of possible scientific misconduct. Other university committees make these determinations. If there is reason to believe scientific misconduct has occurred in a human subject research project, the IRB will report it to the appropriate official.

Helpful Links:

- ORI Federal Research Misconduct Policy
  http://ori.dhhs.gov/policies/fed_research_misconduct.shtml

- NSF Research Misconduct Policy

- NIH Research Misconduct Policy
  http://grants.nih.gov/grants/research_integrity/research_misconduct.htm

- DHHS Public Health Service Policies on Research Misconduct

13.11 Resource Allocation and Ancillary Approvals

Prior to submission of a new IRB application, it is the investigator’s responsibility to identify all departments and organizational units that will be involved in the conduct of the research. The PI is required to document adequate resources have been allocated for the research and that approval has been obtained from ancillary entities. The IRB may not grant approval of the research until this documentation is complete.
Ancillary approvals are authorizations from units/departments/committees whose services are critical to implementation of the research. Ancillary entities include the Institutional Biosafety Committee (IBC). For ancillary approvals that are not coordinated through the iStar system; investigators must obtain written approval and attach it to the iStar application.

The Health Sciences Campus IRB requires the investigator to prepare a form for pathology and clinical laboratories indicating the impact the research will have on those departments. The Laboratory Agreement is required for research conducted at LAC+USC medical center. Any issues raised by the pathology review will be communicated by the IRB as contingencies to be resolved by the PI.

**IRB Review of Resource Adequacy**

Once an investigator submits a new IRB application, it undergoes an administrative review by an IRB staff reviewer to ensure the application is complete. Upon initial review of the application, the staff reviewer ensures that the PI has listed any organizational units/departments/committees that are involved in the conduct of the research and that the investigator has secured approval from each department. If there are any organizational units that have not been listed, or the PI has not secured appropriate approval, the staff reviewer will send correspondence via iStar to the PI informing them that approval from the organizational units/departments/committee must be obtained prior to IRB approval.

Once a new study is submitted to the Full Board for review, it is the IRB committee’s responsibility to ensure that the Investigator has listed the organizational units/departments/committees that are involved in the conduct of the research in the IRB application and that the investigator has secured approval from each organizational unit/department/committee. If during the IRB’s consideration of the study the investigator has not obtained approval, the IRB must stipulate that such approval be obtained prior to IRB approval. Additionally, the IRB considers whether resources are adequate to conduct proposed research. For example, if the research involves specialized medical equipment or staff, the IRB may ask the investigator to confirm that such resources are available to conduct the research.
13.12 Intent to Publish Expectations

All investigators who intend to publish in an International Committee of Medical Journal Editors (ICMJE) journal must register their study in clinicaltrials.gov. The registration requirement applies to “any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes.”

Health-related interventions include any intervention used to modify a biomedical or health-related outcome (for example, drugs, surgical procedures, devices, behavioral treatments, dietary interventions, and process-of-care changes). Health outcomes include any biomedical or health-related measures obtained in patients or participants, including pharmacokinetic measures and adverse events.”

The FDA / NIH and CMS require study registration for all “applicable clinical trials”.

You must register in clinicaltrials.gov before study begins. All researchers doing health outcome studies must register in clinicaltrials.gov. For additional information about study registration for clinical trials, refer to Section 18.11 – Registration of Clinical Trials and Other Types of Research.

Helpful Links:

- Memorandum from USC Vice President of Research “ICMJE Journals Require Advanced Registration of Human Studies”
  https://oprs.usc.edu/files/2014/04/Registration-of-Human-Studies_4-7-14.pdf

- List of Journals Following the ICMJE Recommendations
  http://www.icmje.org/journals-following-the-icmje-recommendations/

- OPRS webpage “Intend to Publish your Human Subjects Research Findings?”
  http://oprs.usc.edu/review/publication/

13.13 Mandatory Reporting

Mandated reporters are individuals who are obligated by law to report suspected cases of child and/or elder abuse and neglect. In general, any person who has contact with children or the elderly in a professional capacity is a mandated reporter, although laws
vary from state to state, as does the legal entity to which reports must be made. For the California Penal Code definition of mandated reporter see Elder Abuse and Dependent Adult Civil Protection Act Section 15630 (a) and Child Abuse and Neglect Reporting Act Section 11165.7.

Only “mandated reporters” are required to make mandatory reports of child and elder abuse. If one is not a mandated reporter, he or she need not make a mandated report.

**Abuse Disclosure Notification in Consent Documents**

Disclosing the obligation to report certain types of neglect and abuse in the informed consent process is only required for research projects involving mandated reporters. However, even though the requirement to report only applies to mandated reporters, **Section 11166.05** broadens the scope of possible reporting beyond the mandated areas by allowing (not requiring) mandated reporters to make reports regarding children suffering from “serious emotional damage or... at a substantial risk of suffering serious emotional damage, evidenced by states of being or behavior, including, but not limited to, severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others”. This should be addressed in the informed consent process.

**Elder Abuse and Dependent Adult Civil Protection Act**

If a physician researcher, while conducting human subjects research, discovers or reasonably suspects that a study subject: (1) Has been the victim of a wound or other physical injury caused by a firearm (either self-inflicted or inflicted by another); or (2) Is suffering from any wound or other physical injury inflicted upon the study subject where the injury is the result of assaultive or abusive conduct, has a legal obligation to make two reports to the local law enforcement agency.

The first report must be made immediately by telephone or as soon as practically possible. The second report must be made in writing within two working days on a "Suspicious Injury Report" Form published by California's Office of Emergency Services (Form OES-920). Both the oral and written report must include the name of the injured person, if known; the injured person's whereabouts; the character and extent of the person's injuries; and the identity of any person the injured person alleges inflicted the assaultive or abusive conduct.
In the event a physician researcher becomes aware of or reasonably suspects that a study subject has been the victim of any of the injuries set forth in this policy, the physician researcher should immediately notify the IRB, the Office of General Counsel, or the Office of Compliance to ensure that the proper reports are made (California Welfare and Institutions Code 15601).

**Reporting of Positive Results of Communicable Disease Testing**

It shall be the duty of every health care provider, knowing of, or in attendance on, a case, or suspected case, of any of the diseases or conditions listed (click the link to Title 17, Section 2500 above) to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions (click the link to Title 17, Section 2500 above) may make such a report to the local health officer for the jurisdiction where the patient resides.

The administrator of each health facility, clinic or other setting where more than one health care provider may know of – a case, a suspected case, or an outbreak of, disease within the facility – shall establish and be responsible for administrative procedures to assure that reports are made to the local health officer.

“Health care provider” means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

The manner and timing of reporting obligations varies depending on the communicable disease to be reported. In the event a report may be necessary, the investigator must immediately contact the IRB or the Office of Compliance for further guidance.

**Reporting Observed/Suspected Injuries in Research**

This link provides information on reporting observed/suspected injuries in research: California Penal Code 11160


**Child Abuse and Neglect Reporting Act**

This link provides information on the child abuse and neglect reporting act: [California Penal Code 11165](https://www.ca.gov/pdfs/oag/policies/child_abuse_and_neglect_reporting_act.pdf)

### 13.14 Investigator and Staff Safety

Investigators are ultimately responsible for the conduct and safety of their research staff (including themselves). Faculty members are also responsible for safety of student researchers. Therefore guidance for what constitutes appropriate and professional behavior must be provided before research begins. To reduce the likelihood of risks to their research team, investigators should provide training and a written management plan for research in high risk situations or where subjects may be unpredictable (HIV/AIDS research, gang violence research, former prisoner research). A good safety plan will include rules for behavior, safety and emergency situations.

Investigators are required by regulation to report “unanticipated problems involving risks to subjects or others” to the IRB (see [Section 20.2 – Unanticipated Problems Involving Risks to Subjects or Others](https://www.usc.edu/research/institutional-review-board/institutional-review-board-policies-and-procedures/index.html)). “Others” is widely interpreted to include members of the research team, thus IRBs must evaluate risks to study staff as well as to subjects when approving a study.

The IRB may also require safety plans/guidelines be submitted and will review the adequacy of such plans before approving the research.
Chapter 14: Vulnerable Subject Populations

Chapter Contents

14.1 – Protection of Children Involved as Subjects in Research
14.2 – Pregnant Women, Fetuses and Neonates in Research (45 CFR 46 Subpart B)
14.3 – Prisoners in Research (45 CFR Subpart C)
14.4 – Cognitively-Impaired Persons
Chapter 14
Vulnerable Subject Populations

This chapter addresses additional protection required when “vulnerable subjects” participate in research. Children, pregnant women, fetuses, neonates, and prisoners are vulnerable subjects as stated in the federal regulations (45 CFR 46 Subparts B, C, and D).

IRBs and researchers must be aware of “vulnerability” beyond the regulatory definitions. Individuals and classes of subjects may also be vulnerable depending on the research, the situation, their condition and susceptibility to coercion. Researchers are expected to take special precautions when including individuals who have a compromised ability to understand and/or are vulnerable to coercion.

14.1 Protection of Children Involved as Subjects in Research (45 CFR 46 Subpart D)

State and federal regulations use different terms to describe individuals below the age of consent. Federal human research regulations refer to “children”. California laws use both “minor” and “child” to refer to people under 18.

Definitions Related to Children as Research Subjects

<table>
<thead>
<tr>
<th>Children</th>
<th>Individuals who have not attained the legal age to consent to research treatments or procedures. In California the legal age is 18 years of age but there are exceptions which allow individuals under the age of 18 to consent to research and some medical procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minors</td>
<td>Individuals under 18 years of age (CFC 6500)</td>
</tr>
<tr>
<td>Assent</td>
<td>A child's affirmative agreement to participate in research. Failure to object should not be construed as assent (45 CFR Part 46.402)</td>
</tr>
<tr>
<td>Guardian</td>
<td>An individual who is authorized under applicable state or local law to consent on behalf of a child to general medical care (45 CFR Part 46.402). 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</td>
</tr>
</tbody>
</table>
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 care of the child

<table>
<thead>
<tr>
<th>Parent</th>
<th>A child's biological or adoptive guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permission</td>
<td>The authorization of parent(s) or guardian(s) to the participation of their child or ward in research</td>
</tr>
<tr>
<td>Ward</td>
<td>An individual (usually a minor) who the court has appointed a guardian to care for and take responsibility for that individual. If the minor is suffering from parental neglect or abuse, or has been involved in trouble with the law, a government agency may take temporary custody of the minor for their protection. If the custody is court-ordered, the child is a &quot;ward of the court&quot; or a &quot;ward of the state.&quot;</td>
</tr>
<tr>
<td>Legally Authorized Representative</td>
<td>An individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research</td>
</tr>
</tbody>
</table>

### Permissible Research with Children

To involve children in research, direct or indirect benefit must justify the risk level. The disease or condition to be studied must be related to a research need in children that cannot be satisfied in an adult population. The information below describes the four permitted categories of research with minors defined by federal regulation (45 CFR 46, Subpart D). If research is supported by or conducted in collaboration with the Department of Defense (DOD), refer to the end of the section for additional DOD regulations.

### Permitted Categories for Research with Children

<table>
<thead>
<tr>
<th>Category</th>
<th>Risk-benefit</th>
<th>Parental Permission Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1&lt;br&gt;(45 CFR 46.404, 21 CFR 50.51)</td>
<td>Minimal Risk&lt;br&gt;• Research not involving greater than minimal risk&lt;br&gt;• Permission from ONE parent/legal guardian may be sufficient. Assent may be required if</td>
<td>One parent/legal guardian may be sufficient</td>
</tr>
<tr>
<td>Category 2 (45 CFR 46.405, 21 CFR 50.52)</td>
<td>Greater than Minimal Risk, Direct Benefit to Subject</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>- Research involving greater than minimal risk, but presenting the prospect of direct benefit to the individual subjects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Permission from ONE parent/legal guardian <em>may be sufficient</em> and assent may be required if child is 7 years of age or older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Usually subject to Full Board review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Example: A Phase II study using an experimental chemotherapeutic regimen for children with malignant brain tumors for whom standard therapy has failed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 3 (45 CFR 46.406, 21 CFR 50.53)</th>
<th>Greater than Minimal Risk, No Direct Benefit to Subject, but Likely to Yield Generalizable Knowledge about Subject’s Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Research involving minor increase over minimal risk greater than minimal risk and no prospect of direct benefit to individual subjects, but likely to yield generalizable knowledge about subject’s disorder or condition</td>
<td></td>
</tr>
<tr>
<td>- Permission of BOTH parents/legal guardians, unless one parent is deceased, unknown, incompetent, not reasonably available, or does not have legal responsibility for the custody of the minor. Assent may be required if child is 7 years of age or older</td>
<td></td>
</tr>
<tr>
<td>- Subject to Full Board review</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>One parent/legal guardian <em>may be sufficient</em></th>
</tr>
</thead>
</table>

|  | Both parents/legal guardians, unless one parent is deceased, unknown, incompetent, not reasonably available, or does not have legal responsibility for the custody of the child. |

- child is 7 years of age or older
- Usually subject to Expedited level of review
- Example: A study involving one venipuncture (no more than the lesser of 50 ml or 3 ml per kg in an 8 week period) in healthy 10-year-old subjects
### Category 4 – (45 CFR 46.407, 21 CFR 50.54)

**Example:** A study testing new biomarkers of disease progression that involves 2 extra samples of cerebrospinal fluid over a year of therapy (beyond the 5-6 that would be done as part of the child’s routine care.)

**Note:** A category 4 study is very rarely approved.

**Greater than Minimal Risk, No Direct Benefit to Subject, but Results May Alleviate Serious Problems of Children’s Health or Welfare**

- Research not otherwise approvable which presents opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children
- The Secretary of the U. S. Department of Health and Human Services, after consultation with a panel of experts and following an opportunity for public review and comment, must either approve or deny approval of the study.
- Permission of BOTH parents/legal guardians is required, unless one parent is deceased, unknown, incompetent, not reasonably available, or does not have legal responsibility for the custody of the minor. Assent of child (if child is 7 years of age or older).
- Subject to Full Board review and DHHS review as described above
- Example: A study examining sleep mechanisms in children to better understand sleep-related diseases. Involves 13- to 17-year-old adolescents undergoing 3 hospital visits for IV infusion of acetate and glucose followed by MRI, in normal and sleep-deprived groups. [See OHRP’s “Special Protections for Children as Research Participants” for more information about the above and other examples of the handful of

**Both parents/legal guardians, unless one parent is deceased, unknown, incompetent, not reasonably available, or does not have legal responsibility for the custody of the child.**
Permission from Parents and Assent from Children

The term permission refers to legally binding authorization granted by parents or guardians. In most cases, permission from one or both parents/guardians must be obtained for their child/ward to participate in a research study. Circumstances in which parental permission may be unnecessary or inappropriate are discussed below under Waiver of Parental Permission.

For children/subjects, the term used is assent. Typically, children do not have the legal capacity to consent to participate in research, but children should be involved in the process if they are able to assent (capable of having a study explained to them and/or reading a simple form about it, and giving verbal or written agreement if they decide to participate in the study.) Circumstances in which a child's assent may be unnecessary or inappropriate are discussed below under Waiver of Child’s Assent.

Consent Guidelines for Children by Age Group

<table>
<thead>
<tr>
<th>Age of Participant</th>
<th>Assent Form Recommended</th>
<th>Parental Permission Form Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant-6 years old</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>7-13 years old</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>14-17 years old</td>
<td>Yes</td>
<td>No (add signature line to adolescent assent form for parent(s) to sign)</td>
</tr>
<tr>
<td>13-17 years old</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

When One Parent’s Permission Is Sufficient
For research that falls into risk-benefit category 1 or 2, the IRB may determine that permission from only one parent is sufficient. The IRB will find that permission of one parent is sufficient unless the nature of the study seems likely to provoke disagreements about participation among two parents, in which case permission from two parents may be required unless one parent is deceased, unknown, incompetent, not reasonably available, or does not have legal responsibility for the custody of the minor.

Research that falls into Category 3 or 4 requires permission from both parents, unless one parent is deceased, unknown, incompetent, not reasonably available, or does not have legal responsibility for the custody of the child [45 CFR 46.406, 45 CFR 46.407, 21 CFR 50.55(e)].

When there is only one living parent or guardian or one parent has sole custody after a divorce, the PI may determine that single-parent or single-guardian permission is sufficient.

**When Parents Disagree**

If parents disagree about allowing their child to participate in the study, the child may not be enrolled unless that disagreement can be resolved. Even if only one parent’s signature is required, when both parents are involved in the decision, they must agree for the child to be enrolled.

**Waiver of Parental Permission**

In certain cases, parental permission is not a reasonable requirement to protect subjects (neglected or abused children); more detailed examples are given below. The IRB will consider requests for waiver of parental permission on a case-by-case basis. For non-FDA-regulated studies, the IRB may waive parental/guardian permission provided “an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and provided further that the waiver is not inconsistent with Federal, State, or local law” (45 CFR 46.408).

Additionally, Public Demonstration Projects may obtain a waiver of parental permission if the IRB finds that all criteria below are satisfied:

- The research is to be conducted by or subject to the approval of state or local government officials, and
• The research is 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, and
• The research could not practicably be carried out without the waiver or alteration, and
• The research is not FDA-regulated.

NOTE: Parental Permission for children’s enrollment cannot be waived for FDA-regulated studies except for the use of an FDA test article meeting the emergency exception. The FDA regulations do not contain a provision for waiver of parental permission.

Examples where parental permission may be waived:

• Research on child abuse or neglect, or research that is reasonably likely to elicit information identifying child abuse or neglect, where there is serious doubt as to whether the parents’ interests reflect the child’s interests \[45\text{ CFR 46.408(c)}\].
  ○ The Federal Regulations specifically refer to “research on neglected or abused children” as an instance where “parental or guardian permission is not a reasonable requirement to protect the subjects,” the IRB would be likely to waive parental permission in such a case, provided the other requirements of the regulations \[45\text{ CFR 46.408(c)}\] are met.

• Research on people under age 18 who are in circumstances where they are clearly outside of parental influence or control.
  ○ Researchers also should be aware that some people under 18 who are living independently may not fit the federal definition of “children” and are able to consent for themselves without a waiver of parental permission. See California Exceptions Permitting Certain Minors to Consent below.

Examples where parental permission may not be waived:

• Research on parental political affiliations or beliefs

• Research on mental or psychological problems, sexual behavior or attitudes, illegal, antisocial, or self-incriminating behavior; religious affiliations or beliefs
Research on appraisals of other individuals with whom the minor has a familial relationship

Research on relationships legally recognized as privileged (lawyers, doctors, clergy)

**Waiver of Child Assent**

In certain cases the IRB may waive the requirement to obtain children’s assent, for example:

- The capability of some or all of the children is so limited that they cannot reasonably be consulted, or
- 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 (45 CFR 46.408, 21 CFR 50.55)

The parents’ right to make medical decisions for their child may come into conflict with the child’s right to give or withhold assent. In this situation, assent may not be mandatory, though it always should be sought.

The IRB’s decision about waiver of assent will depend on the specifics of the study. For example, assent would likely be waived for a trial of primary induction therapy for a new malignancy where there is a real prospect of direct benefit to subjects. Waiver of assent would be less likely for a recurrent brain tumor study if direct benefit is not probable. The IRB would want to ensure that the child could refuse to participate.

If the child is considered capable of being involved in the informational process, a simple verbal explanation of what will happen to him/her and the opportunity for questions and discussion should always be provided. Even if the requirement for assent is waived, it is always preferable to seek the child’s assent if possible. There must be documentation on the parental permission form or in the study records that the child was appropriately informed about the study.

**Children under Guardian Care**

In California, a guardian normally has the same authority with respect to the child as a parent having legal custody, except as limited by statute or court order (the legal
document establishing the guardianship). This includes the authority to consent on behalf of the child to general medical care.

For research that involves medical care, however, a guardian’s authority to consent or require is restricted, in the absence of an affirmative court order, in the following circumstances:

- By the terms of any letters of guardianship issued by a court (a certified copy of which should be obtained and placed in the medical record)
- For surgery on a child 14 years or older, unless:
  - The child also consents;
  - The guardian obtains a court order, or
  - The guardian has determined based on medical advice that an emergency exists in which the child faces loss of life or serious bodily injury if the surgery is not performed.
- From administering an “experimental drug” (defined in Health & Safety Code Section 111515; FDA investigational drug), unless a 7 years or older child also consents and the drug is related to maintaining or improving health or obtaining information about a pathological condition of the child
- From authorizing electro-convulsive treatment (defined in Welfare & Institutions Code Section 5325)
- From admitting the child to a “mental health treatment facility” [defined in Probate Code 2356(a)] without the child’s consent
- From authorizing antipsychotic drugs except under certain circumstances
- From authorizing an elective procedure performed primarily for the purpose of rendering the child sterile (not treatment which secondarily results in sterilization)
- From authorizing psychosurgery under any circumstances

For additional information regarding informed consent considerations, refer to “Informed Consent for Children Not in Parental Custody” below.
Children under the Jurisdiction of Dependency Court / Court Appointee

Parental permission and consent for a child’s participation in research is not required when the juvenile dependency court has explicitly removed the individual parents’ power to make such a decision. In cases where the parent has lost parental rights, the IRB can accept consent from whomever the court appoints as authorized under applicable state or local law to consent on behalf of a child to general medical care.

NOTE: The court cannot issue “blanket consents” even if the court rules allow the court to issue an order allowing the conduct of research including access to juvenile records. To the extent that a court order has been interpreted as “blanket consent,” the IRB should not accept it as such because this mechanism does not adequately protect child subjects.

Special considerations apply to research involving children who are wards of the state. Investigators should contact the IRB staff or the Office of Compliance if they need further guidance.

The IRB may approve a protocol that involves wards and research involving greater than minimal risk but presenting the prospect of participant direct benefit (under 45 CFR 46.406 or 21 CFR 50.53) or not otherwise approvable which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children (under 45 CFR 46.407 or 21 CFR 50.54) only if:

- The research is:
  - Related to their status as wards, or
  - Conducted in schools, camps, hospitals, Institutions, or similar settings in which the majority of the participating children are not wards, and

- The research appoints an advocate for each child, who:
  - May be the same individual for all of the children
  - Has the background and experience to act in (and agrees to act in) the best interest of the child for the duration of the research, and
  - Is not associated in any way with the research (except as an advocate), the investigators, or any guardian association
Additionally, for research involving medical care for wards of a court, often an order from the judge is required, in addition to permission from the person charged with the care of the child.

Before waiving the parental consent requirement, the IRB should require a court order that clearly and specifically provides that the children may participate in research without parental consent. According to California Welfare and Institutions Code Section 361 (a) there is no limitation of parents’ right to consent to research that was not “necessary to protect the child.”

**Informed Consent for Children Not in Parental Custody**

Investigators are required to obtain a court order permitting the participation of the individual subjects in the research without parental consent, and should be required to follow the procedure in Los Angeles County Superior Court Rule 17.2(d) (if research and the children are within Los Angeles County) or other applicable court procedures.

The investigators are required, if possible, to obtain written permission from each parent unless it meets the requirements for waiver of parental consent, then from each subject’s guardian unless the IRB determines that such permission need not be obtained in accordance with federal human subjects regulations.

The investigators are required to obtain the assent of subjects unless the IRB determines that assent should not be obtained in accordance with federal human subjects regulations.

If the study is more than minimal risk, each individual subject must have a court appointed advocate according to 45 CFR 46.405 and 45 CFR 46.406.

**California Exceptions Permitting Certain Minors to Consent**

In California, minors (those under 18 years of age) generally may not consent to medical care or treatment, or research involving medical care or treatment, without a parent or legal guardian’s consent. Federal regulations when interpreted with California legal exceptions allow minors, as described below, to consent as adults to research or treatment:

- **Emancipated minors:**
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- married or divorced, or
- on active duty in the U.S. armed forces
- emancipated by a court
- have the legal right to consent on their own behalf to medical, dental, or mental health treatment. They also have extensive other rights to enter into legal and business arrangements, and so can consent to be included in other research (such as surveys or interviews) (Section 7000-7143)

The IRB interprets California law relating to emancipated minors as authorizing an emancipated minor to give consent to participation in any type of research, even if the research does not involve treatment.

- Self-Sufficient minors:
  - 15 years of age or older, and
  - living separate from their parents/guardians, and
  - managing their own financial affairs
  - may consent to the minor’s own medical or dental care (Section 6922)

- Care related to the prevention or treatment of pregnancy

- Minors, 12 years or older, seeking care for:
  - Out-patient mental health treatment or counseling, excluding drugs
  - Care related to the diagnosis or treatment of reportable infectious, contagious, or communicable/sexually transmitted diseases
  - Care provided to the victims of sexual assault or rape
  - Medical care and counseling relating to the diagnosis and treatment of drug or alcohol abuse (only if treating physician deems and documents that parental involvement is inappropriate), excluding narcotic replacement drugs.

With IRB approval, for the above categories a minor must provide consent and sign the consent form just as an adult would, unless the IRB approves a waiver or alteration of the
usual consent standards for adults. The IRB requires that any investigator that is not familiar with these laws and proposes to enroll a minor without parental permission to contact the IRB staff for further guidance. The IRB always retains the option to exclude minors that may otherwise consent in light of risks or the nature of the trial.

Researchers enrolling participants in other states or countries must comply with local law. In all cases, if the prospective subjects cannot legally consent for the treatments or procedures involved in the study because they are too young, they are considered "children" by federal regulations. If they can consent for the treatments or procedures, they are not "children" by federal regulations (therefore if they are not “children” 45CFR46 subpart D does not apply).

**Discovery and Disclosure of Sensitive Information**

In the course of research investigators may discover sensitive information about subjects that is not directly related to the study aims.

Examples of such information include sexual activity, STDs, use of illegal substances, HIV status, cancer, and child abuse. Investigators need to consider how they will handle disclosure of such situations should they arise. The permission and/or assent form should describe plans for disclosure—or non-disclosure—of such information to parents, legal authorities, and the subjects themselves.

In some cases, it may be appropriate for the PI to seek an NIH Certificate of Confidentiality (refer to Section 11.4 – Certificate of Confidentiality).

Also visit [http://grants.nih.gov/grants/policy/coc/background.htm](http://grants.nih.gov/grants/policy/coc/background.htm) for information as to whether a certificate is applicable for a particular study.

**Mandatory Reporting**

Discovery of child abuse initiates certain ethical and legal obligations. In most cases, the same reporting expectations pertain in research settings as in clinical settings. University researchers may be health professionals or other “mandated reporters” under the California Child Abuse and Neglect Reporting Act ([California Penal Code 11164-11174.3](https://www.leginfo.ca.gov/billtext20142015/a_bill/ab_11164-11174.3_bill.html)). Even if the mandated reporter status is not clear, the investigator can make a voluntary report to the appropriate agency.
If an investigator is planning a study that is designed or likely to elicit information about sexual or physical abuse of a child, the application and consent/assent forms must indicate how discovery of such information will be handled.

If such information is discovered unexpectedly (not anticipated given the study design or subject population), the PI should seek advice from his/her department Chair or dean or from the Director of the IRB, who may refer the question to Legal Counsel.

**Enrolling Children in Long-Term Studies**

Long-term research studies may involve subjects who are children at the time of enrollment but reach the age of consenting (18 years old, in California) while study procedures or follow-up are still ongoing. The IRB will consider on a study-by-study basis whether obtaining new consent from such subjects is required.

If there is continued interaction with subjects who were first enrolled as children, “re-consenting” when a subject’s legal status changes will usually be required. If the only continuing study procedures are follow-up activities such as review of records or examination of biological specimens, the original consent may suffice.

**Research Involving Children in Educational Settings**

When planning studies involving children in educational settings, investigators should consider the following issues:

The first step for investigators is to obtain support from the school principal or administration. This may include contacting school district officials, the local PTA, and/or the principal of a particular school. School officials and/or teachers may approve recruitment for a study, but they do not have authority to give permission for participation of individual children in research—only a parent or guardian, with the child’s assent, can do so.

If the study will be conducted during school hours, an equivalent alternative activity should be offered for students who do not wish to participate.

Additionally, according to California Education Code 51513, generally speaking, no test, questionnaire, survey, or examination containing any questions about the pupil's personal beliefs or practices in sex, family life, morality, and religion, or any questions about the pupil's parents' or guardians' beliefs and practices in sex, family life, morality, and
religion, shall be administered to any pupil in kindergarten or grades 1 to 12, inclusive, unless the parent or guardian of the pupil is notified in writing that this test, questionnaire, survey, or examination is to be administered and the parent or guardian of the pupil gives written permission for the pupil to take this test, questionnaire, survey, or examination.

FERPA Rules and Research with Education Records

The Family Educational Rights and Privacy Act (FERPA) (34 CFR 99) sets limits on the conditions under which education records can be accessed for research purposes.

Education records are generally defined in FERPA as personally identifiable information regarding a student in a K-12 or higher education setting that receives federal funding. More specifically, FERPA states that education records may include any of the following items:

- records, files, documents, and other materials, such as films, tapes, or photographs, containing information directly related to a student that an educational agency maintains on students in report cards, surveys, and assessments, health unit records, special education records, and correspondence between the school and other entities regarding students (34 CFR 99.3(d))

It is the holder of the records (e.g., a school authority, university registrar) – not the researcher – who carries the legal responsibility for abiding by FERPA. Therefore, it is the holder of the records – not the researcher – who is in violation of FERPA if education records are released inappropriately or illegally.

It is not the responsibility of the IRB to ensure that researchers access personally identifiable student level data in compliance with FERPA. It is incumbent upon the holder of the records to ensure that the personally identifiable information was released pursuant to the conditions imposed by FERPA. Moreover, it is up to the researcher to ensure that the personally identifiable information from an education record will not be disclosed to any other party without prior consent of the parent or eligible student. If a researcher improperly discloses personally identifiable information from an education record, the researcher may not be allowed to access information from education records for five years (34 CFR 99.33(e)). Please see FERPA for more information regarding researcher responsibilities: http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html.
FERPA requires that the holder of the records ensure written consent is obtained from a parent or eligible student in order to release personally identifiable student information. The holder of the record only obtains consent from parents and eligible students under limited circumstances (see the Directory Information Policy exception below). Consequently, record holders do not have consents on file for the release of most information contained in the education record. This means that a researcher who is interested in obtaining personally identifiable information from a student’s education record must obtain written consent from the parent or the eligible student if he/she wants to access personally identifiable student information from a record holder (K-12 school or district and institutions of higher education).

There are two exceptions to FERPA that might also enable a researcher to access personally identifiable student information without obtaining consent from the parent or eligible student. The holder of the record may release the records to the researcher under the following conditions:

- The researcher is conducting studies for or on behalf of the school or district (34 CFR 99.31(a)(6))

- The information is identified by the school within its Directory Information policy (34 CFR 99.31(a)(11))

If a researcher has entered into a formal agreement with the holder of the record(s) to conduct research on the record holder’s behalf, consent is not required in order for personally identifiable information to be shared with the researcher.

If the researcher is requesting personally identifiable information that has been designated by the holder of the record as “Directory Information,” the holder of the record may decide to release this information without obtaining additional consents. Directory Information is information that has been deemed under FERPA to not pose a risk to the student if released. Consent is obtained by the record holder on a yearly basis for the release of this information. Information that is usually considered directory information includes the student’s name, date of birth, dates of attendance, and other information that has been deemed harmless pursuant to FERPA (see each school’s Directory Information policy for more information). Although the record holder may release this information under the Directory Information exception, the record holder does not have to do so.
Finally, consent is not required if the information requested for release is not personally identifiable (therefore has been stripped of any identifying information.

Individuals who are employed by schools or universities in one role (e.g., teacher, administrator, superintendent, academic advisor) and who are conducting research as part of their graduate level coursework (e.g., masters thesis or dissertation) must abide by FERPA when seeking to access personally identifiable student information. In other words, for the purposes of accessing student information as a researcher, they must ensure that they seek parent or eligible student consent or that they are able to access the information as the result of one of the aforementioned exceptions. They may not use their access through their employment in order to obtain personally identifiable information.

**PPRA Role in Research Supported by Department of Education**

USC Office of Compliance and outside legal counsel have determined that there is no IRB role in applying PPRA to human subjects research. Complying with PPRA is the responsibility of the school system/district (per internal communication dated 3/20/14).

It is the responsibility of the researcher/school that research funded by the Department of Education complies with additional protections under the Protection of Pupil Rights Amendment (PPRA) (34 CFR Part 98).

Schools and contractors must obtain prior written parental consent before minor students are required to participate in any survey, analysis, or evaluation funded by the Department of Education.

**Research Supported by the Department of Defense (DOD)**

Research supported by or in collaboration with the Department of Defense (DOD) is subject to additional regulations. The DOD has adopted 45 CFR 46, Subpart D with the following modification:

- The DOD does not apply Subpart D to active duty personnel under the age of 18 as it considers all active duty military to be adults with legal capacity to participate in DOD supported research.
14.2 Pregnant Women, Fetuses and Neonates in Research (45 CFR 46 Subpart B)

Federal regulations mandate that IRBs require additional safeguards before approving research involving pregnant women, human fetuses, neonates of uncertain viability, or non-viable neonates. If research is supported by or conducted in collaboration with the Department of Defense (DOD), refer to the end of this section for additional DOD regulations.

Research Involving Pregnant Women or Fetuses

Pregnant women or fetuses may be involved in research if all of the following conditions are met (45 CFR 46.204):

a) Where scientifically appropriate, preclinical studies, including studies on pregnant animals, and clinical studies, including studies on nonpregnant 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, if there is no such prospect of benefit, the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means

c) Any risk is the least possible for achieving the 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, or no prospect of benefit for the woman nor the fetus when risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means, her consent is obtained in accord with the informed consent provisions of subpart A

e) If the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accord with the informed consent provisions of subpart A, 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 as defined in §46.402(a) who are pregnant, assent and permission are obtained in accord with the provisions of subpart D

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

**Research Involving Neonates**

a) Neonates of uncertain viability and nonviable neonates may be involved in research if all of the following conditions are met (45 CFR 46.205):

1. Where scientifically appropriate, preclinical and clinical studies have been conducted and provide data for assessing potential risks to neonates.

2. Each individual providing consent under paragraph (b)(2) or (c)(5) of this section is fully informed regarding the reasonably foreseeable impact of the research on the neonate.

3. Individuals engaged in the research will have no part in determining the viability of a neonate.

4. The requirements of paragraph (b) or (c) of this section have been met as applicable.

b) **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:
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1. The IRB determines that:

   i. 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

   ii. 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

2. 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 subpart A, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.

c) Nonviable Neonates

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

   1. Vital functions of the neonate will not be artificially maintained

   2. The research will not terminate the heartbeat or respiration of the neonate

   3. There will be no added risk to the neonate resulting from the research

   4. The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means

   5. The legally effective informed consent of both parents of the neonate is obtained in accord with subpart A, except that the waiver and alteration provisions of §46.116(c) and (d) do not apply. However, if either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the informed consent of one parent of a nonviable neonate will suffice to meet the requirements of this paragraph (c)(5), 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 (c)(5).

**Viable Neonates**

d) 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 subparts A and D.

§46.206 Research involving, after delivery, the placenta, the dead fetus or fetal material.

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

b) If information associated with material described in paragraph (a) of 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 subparts of 45 CFR 46 are applicable.

§46.207 Research not otherwise approvable which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of pregnant women, fetuses, or neonates.

DHHS will conduct or fund research that the IRB does not believe meets the requirements of §46.204 or §46.205 only if:

a) 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

b) The Secretary of HHS, after consultation with a panel of experts in pertinent disciplines (for example: science, medicine, ethics, law) and following opportunity for public review and comment, including a public meeting announced in the FEDERAL REGISTER, has determined either:

1. That the research in fact satisfies the conditions of §46.204, 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 informed consent provisions of subpart A and other applicable subparts.

**Newborn Dried Bloodspots**

The Newborn Screening Saves Lives Reauthorization Act of 2014 explicitly states that the use of newborn dried bloodspots for research is considered to involve human subjects if the research is federally supported and the bloodspots are collected on or after March 18, 2015. The identifiability (or not) of the bloodspots is irrelevant. In other words, if a researcher is receiving de-identified or anonymous bloodspots for research, the research is considered to involve human subjects. A detailed summary of recommendations is provided by the U.S. Department of Health and Human Services, Secretary’s Advisory Committee on Human Research Protection (SACHRP). The goal of this recommendation is to provide thoughtful consideration of this act and allow for important research to take place. Refer to: https://oprs.usc.edu/files/2016/05/SACHRP-Newborn-Dried-Bloodspots.docx

**Research Supported by the Department of Defense (DOD)**

Research supported by or in collaboration with the Department of Defense (DOD) is subject to additional regulations. The DOD has adopted 45 CFR 46, Subpart B with limitations and modifications:

- For the purposes of applying Subpart B risk-benefit analysis, DOD replaces the phrase “biomedical knowledge” with “generalizable knowledge”

- The DOD limits the applicability of Subpart B to research involving:
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- Pregnant women as participants in research that is more than minimal risk and includes interventions or invasive procedures to the woman or fetus; or
- Fetuses or neonates as participants

- Fetal research must comply with the US Code Title 42, Chapter 6A, Subchapter III, Part H, 289g

Refer to Section 3.2 – Research Supported by the Department of Defense for additional DOD requirements.

14.3 Prisoners in Research (45 CFR 46 Subpart C)

Because incarceration affects a person's ability to make a truly voluntary decision whether or not to participate in a research project, state and federal regulations provide additional safeguards for the protection of prisoners in research. If research is supported by or conducted in collaboration with the Department of Defense (DOD), refer to the end of this section for additional DOD regulations.

Research involving prisoners is never exempt from IRB review. Any study that recruits prisoners that does not qualify for expedited review must be reviewed at a fully-convened IRB meeting with a prisoner representative present for the discussion and vote of that study protocol. The IRB Chair and/or IRB Director, and/or IRB Staff ensure a prisoner representative and/or consultant will be present at the meeting.

Apart from their membership on the IRB, the majority of the IRB members (exclusive of prisoner representative) shall have no association with the prison(s) involved in the research being reviewed.

If research activities under the jurisdiction of the USC IRB involve prisoners held outside of the state of California the investigator is responsible for identifying and ensuring compliance with the laws of that state.
Federal Regulations Permit 5 Categories of Research with Prisoners (45 CFR 46.306)

The 5 permitted categories are:

i. Studies 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

ii. Studies 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

iii. Research on conditions particularly affecting prisoners as a class (for example, vaccine trials and other research on hepatitis which is much more prevalent in prisons than elsewhere; and research on social and psychological problems such as alcoholism, drug addiction, and sexual assaults) provided that the study may proceed only after the Secretary of HHS (through OHRP) has consulted with appropriate experts, including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of their intent to approve such research.

iv. Research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subject. In cases in which those studies require the assignment of prisoners in a manner consistent with protocols approved by the IRB to control groups which may not benefit from the research, the study may proceed only after the Secretary (through OHRP) has consulted with appropriate experts including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of his intent to approve such research.

v. Waiving the applicability of 45 CFR 46.305(a)(1) and 45 CFR 46.306(a)(2) for certain research conducted or supported by HHS. This is referred to as the Epidemiology Waiver. In specific, for HHS conducted or supported research involving epidemiologic studies: (1) In which the sole purposes are (i) To describe the prevalence or incidence of a disease by identifying all cases, or (ii) To study potential risk factor associations for a disease, and (2) Where the Institution responsible for the conduct of the research certifies to OHRP, acting on behalf of the Secretary, that the IRB approved the research and fulfilled its duties under 45 CFR 46.305(a)(2)-(7) and determined and documented that (i) The
research presents no more than minimal risk and no more than inconvenience to the prisoner-subjects, and (ii) Prisoners are not a particular focus of the research. (For more information, refer to: [http://www.gpo.gov/fdsys/pkg/FR-2003-06-20/html/03-15580.htm](http://www.gpo.gov/fdsys/pkg/FR-2003-06-20/html/03-15580.htm))

The informed consent form must include additional information for potential subjects regarding the fact that participation or non-participation will have no effect on their duration of incarceration or terms of parole. The IRB must determine whether assent is a requirement for research pertaining to prisoners that are children.

**IRB Considerations for Prisoner Subjects (45 CFR 46.305)**

When a prisoner is a subject, in addition to the usual criteria for approval, the IRB must find:

1. The research under review represents one of the categories of research permissible under 45 CFR 46.306(a)(2).

2. Any possible advantages accruing to the prisoner through their 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 their ability to weigh the risks of the research against the value of such advantages in the limited choice environment of the prison is impaired.

3. The risks involved in the research are commensurate with risks that would be accepted by non-prisoner volunteers.

4. 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 to 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.

5. The consent information is presented in language which is understandable to the subject population.
6. Adequate assurance exists that parole boards will not take into account a prisoner's participation in the research in making decisions regarding parole, and each prisoner is clearly informed in advance that participation in the research will have no effect on their parole.

7. 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. Subjects must be adequately informed of this fact.

If the research is conducted or supported by HHS, the University must certify to the HHS Secretary (through OHRP) that the IRB has approved the research under the HHS regulations for research that involves prisoners as participants. Additionally, the HHS Secretary (through OHRP) must determine that the research meets one of the approvable categories before the research can be initiated. This determination is known as the “OHRP Prisoner Research Certification”.

Helpful Links

- OHRP Frequently Asked Questions – Prisoner Research: http://answers.hhs.gov/ohrp/categories/1568

Definitions Related to Prisoners as Research Subjects

<table>
<thead>
<tr>
<th>Prisoner</th>
<th>Any individual involuntarily confined or detained in a penal Institution; 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisoner Representative</td>
<td>Any individual who can represent the concerns that prisoners might have about research, who has a working knowledge of prison conditions and the life of prisoners, such as an individual employed at a prison, a prisoner chaplain, a social worker who deals with prisoners, or a prisoner advocate</td>
</tr>
<tr>
<td>Penal Institution</td>
<td>Any place of confinement for convicted criminals. Penal Institutions include local and county jails and workhouses, reformatories,</td>
</tr>
</tbody>
</table>
Chapter 14: Vulnerable Subject Populations

institutions, prison camps and farms, as well as the modern correctional

Subjects Who Later Become Incarcerated

If a study was not initially approved to recruit prisoners, the investigator may not enroll
prisoners. A prisoner, who is brought to USC for treatment and happens to be eligible
for a research study, may not be enrolled in a study unless: the study was approved to
include prisoners, and a prisoner representative was present during the discussion and
vote of the study.

The regulations for research with prisoners apply to any subject who becomes a prisoner
after enrolling in research. It is unlikely that the IRB contemplated the constraints
imposed by incarceration during their review therefore, if an investigator determines that
a subject has become a prisoner after enrollment, and the study involves additional
research interventions or interactions with that subject, the subject must either be dropped
from follow-up, or an amendment request must be submitted for the inclusion of
prisoners as subjects. With the exception of special circumstances, all research
interactions and interventions with, and collection of identifiable private information
about, the now-incarcerated subject must cease until all the requirements of Subpart C
have been satisfied. The Office for Human Research Protections (OHRP) guidance
allows in special circumstances, for which the Principal Investigator (PI) asserts that it is
in the best interest of the subject to remain in the research study while incarcerated; the
IRB Chair may determine that the subject can continue to participate in the research until
the requirements of Subpart C are satisfied.

Limits under California Penal Code

Under the California Penal Code, competent adult prisoners are permitted to decide
whether or not to participate in behavioral research, but no biomedical research can be
conducted on any prisoner in the state. See Cal. Penal Code §§ 3501, 3502 (also, see
definitions for “biomedical” and “behavioral research” at § 3500). Prisoners may,
however, obtain investigational drugs or treatments – under a protocol or treatment
Investigational New Drug (IND) application – if a physician determines that the drug or
treatment is in the best interest of the patient/prisoner and the prisoner gives consent id. §
3502.5. With regard to behavioral research, generally, informed consent must be
obtained, but can be waived if it is determined that it would be unnecessary or would significantly inhibit the research id. § 3505. There are specific state law requirements with regard to consent for prisoners, see id. §3521. Additional federal guidelines that pertain to prisoners in research are outlined below. Note, however, that in some instances the federal guidelines conflict with California law.

For more information, review the California Penal Code and guidance links below.

**Helpful Links**

- CA Penal Code 3501-3509.5:  
  [http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=03001-04000&file=3501-3509.5](http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=03001-04000&file=3501-3509.5)

- CA Penal Code 3515-3520:  
  [http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=03001-04000&file=3515-3520](http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=03001-04000&file=3515-3520)

- CA Penal Code 3521-3523:  
  [http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=03001-04000&file=3521-3523](http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=03001-04000&file=3521-3523)

- CA Penal Code 3524  
  [http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=03001-04000&file=3524](http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=03001-04000&file=3524)

- CA Code of Regulations, Title 15, Article 9.1 “Research of Inmates/Parolees” (see page 203)  

- CA Department of Corrections and Rehabilitation (CDCR) guidance “Research Involving Wards, Inmates or Staff”  
  [http://www.cdcr.ca.gov/Reports_Research/researchWIS.html](http://www.cdcr.ca.gov/Reports_Research/researchWIS.html)

- CA CDCR guidance: “Research Project Approval Guidelines”  
  [http://www.cdcr.ca.gov/Reports_Research/rpaguide.html](http://www.cdcr.ca.gov/Reports_Research/rpaguide.html)
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Research Supported by the Department of Defense (DOD)

Research supported by or in collaboration with the Department of Defense (DOD) is subject to additional regulations. The DOD has adopted 45 CFR 46, Subpart C with limitations and modifications:

- For research intended to enroll prisoners, the DOD does not allow review by expedited mechanism.

- If a PI attests that it is in the best interest of a subject who becomes a prisoner to continue participation in the research, the DOD allows the IRB Chair to make a preliminary determination until the convened IRB (and DOD Component, if applicable) can review the request. Otherwise, the IRB may require that all research interactions and interventions with the prisoner-subject (including obtaining identifiable private information) cease until the convened IRB with consultation from the prisoner representative, can review this request to ensure that the rights and well-being of the human subject, now a prisoner, are not in jeopardy.

If the prisoner-participant can continue to consent to participate and is capable of meeting the research protocol requirements, the terms of the prisoner-participant’s confinement does not inhibit the ethical conduct of the research, and there are no other significant issues preventing the research involving human participants from continuing as approved, the convened IRB may approve a change in the study to allow this prisoner-participant to continue.

Refer to Section 3.2 – Research Supported by the Department of Defense for additional DOD requirements.

14.4 Cognitively-Impaired Persons

Individuals in a wide variety of situations may have impaired decision-making capacity. For example, impairment may occur during situations associated with high levels of stress (death of a family member). Impaired capacity is not limited to individuals with neurologic, psychiatric, or substance abuse problems; conversely, individuals with neurologic, psychiatric, or substance abuse problems should not be presumed to be
decisionally-impaired. Some research questions may be answered only by research that involves persons with impaired decision-making capacity.

Unlike research involving children, prisoners, pregnant women, and fetuses, HHS regulations do not specifically address research involving persons who are cognitively-impaired. While limited decision-making capacity should not always prevent participation in research, it is important to keep in mind that additional scrutiny is warranted for research involving this population. Subjects with permanent or transient cognitive impairments may find it difficult to understand the difference between research and treatment, and to differentiate between investigators’ multiple roles and interests (practitioner and researcher).

**IRB Criteria for Reviewing Research with Cognitively-Impaired Persons**

The IRB uses the following criteria for reviewing studies that involve Cognitively-Impaired Persons:

- Research not involving greater than minimal risk
- Research involving greater than minimal risk but presenting the prospect of direct benefit to the individual subjects
- The risk is justified by the anticipated benefit to the subjects
- The relation of the anticipated benefit to the risk is at least as favorable to the subjects as that presented by available alternative approaches
- Adequate provisions are made for soliciting the assent of the subject and permission of their legally authorized representative

The IRB uses the following criteria for reviewing studies that involve Cognitively-Impaired Persons when the research is greater than minimal risk, there is no prospect of direct benefit to individual subjects, but is likely to yield generalizable knowledge about the subject's disorder or condition:

- The risk represents a minor increase over minimal risk
• The intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations

• The intervention or procedure is likely to yield generalizable knowledge about the subjects' disorder or condition which is of vital importance for the understanding or amelioration of the subjects' disorder or condition

• Adequate provisions are made for soliciting assent of the subject and permission of their legally authorized representative

Assessing Capacity to Consent

A key factor in subjects' decision-making is their appreciation of how the risks, benefits, and alternatives to participation in the study apply to them personally. Assessment is complex and there are no standard criteria for determining capacity to consent to research. Individual capacities, impairments, and needs must be taken into account in order to develop practical and ethical approaches to enable them to participate in research. IRB applications for the proposed involvement of cognitively impaired subjects should propose a plan to screen for incapacity in subjects who are likely to be incapable of providing consent. Assessments should be timed to avoid periods of heightened vulnerability when individuals may not be able to provide valid informed consent.

Limited decision-making capacity covers a broad spectrum. Researchers should be sensitive to the differing levels of capacity and use assessment methods tailored to the specific situation and population. A healthy person in shock may be temporarily decisionally-impaired, another may have been severely mentally retarded since birth, while a person with schizophrenia may experience fluctuating capacity. Fluctuations in decision-making capacity may require ongoing assessment during the course of research.

Consenting Cognitively-Impaired Subjects

In developing the consenting process, the investigator is obligated to incorporate any special accommodations necessary to assure that the subject population or their surrogates comprehend the nature and purpose of the study. Useful techniques may include simplified consent documents, supplemental summary sheets, formal Q&A sessions for the subject and family or friends, and waiting periods after the initial discussion before the prospective subject actually enrolls.
The consent process should be ongoing to ensure subjects’ ability understand and follow the protocol. The IRB, at its discretion, may observe the consent process or require an outside witness to observe the consent process.


**Voluntariness, Consent, and Assent**

In addition to determining subjects’ ability to consent, investigators must also ensure subjects’ participation is completely voluntary. Some knowledge and assessment of the subject's competence is relevant to a determination of whether voluntary participation is evidenced by a written consent, or in the case of persons lacking legal capacity to consent, their assent. Research should not be conducted against the wishes of the subject.

In conclusion, varied degrees of research risk and decisional impairment call for varied levels of scrutiny and safeguards; additional protections may be necessary in certain circumstances. Treating all individuals who have cognitive deficits as capable, at times, of understanding research is respectful of their autonomy. It also exemplifies the principle of “respect for persons” in The Belmont Report. Many individuals, adequately informed, may be willing to undertake certain risks so that they, or others, may benefit in the future. Researchers and IRBs must strive for a balance that maximizes potential benefits and opportunities, recognizes and extends individual autonomy, and minimizes risks associated with scientific inquiry.

**Surrogate Consent**

If a potential subject is found to be incapable, the federal regulations allow a “Legally Authorized Representative” to consent on their behalf. The federal regulations leave it to the states to define this term. In California, the selection of an appropriate representative to consent on behalf of those unable to consent for themselves is clearly delineated. The IRB has determined that the individuals defined in the state of California Health and Safety Code, Section 24178 (c) and (d), as legally authorized representative meet the HHS and FDA definitions of legally authorized representative. These rules only apply to
medical experiments that relate to the cognitive impairment, lack of capacity or serious or 
life threatening disease or conditions of research subjects.

Cognitively-Impaired in Non-Emergency Room 
Environments

The research covered is that of medical experiments that “relate to the cognitive 
impairment, lack of capacity, or serious life-threatening diseases and conditions of 
research subjects.” If a person is unable to consent and does not express dissent or 
resistance to participation in such research, surrogate informed consent may be obtained 
from a surrogate decision-maker with reasonable knowledge of the subject. The proxy 
decision maker is to use a “substituted judgment” standard if possible; if not, a “best 
interests” standard. The proxy shall include any of the following persons, in the 
following descending order of priority:

a) The person’s agent pursuant to an advance health care directive

b) The conservator or guardian of the person having the authority to make health 
care decisions for the person

c) The spouse of the person

d) An individual as defined in Section 297 of the Family Code (a “domestic 
partner”)

e) An adult son or daughter of the person

f) A custodial parent of the person

g) Any adult brother or sister of the person

h) Any adult grandchild of the person

i) An available adult relative with the closest degree of kinship to the person

When there are two or more available persons who may give surrogate informed consent 
and who are in the same order of priority, if any of those persons objects to have the 
subject participate in the medical experiment, consent shall not be considered as having 
been given. Also, consent of a person who is in lower priority cannot supersede the 
refusal to consent by a person who is a higher priority surrogate.
Cognitively-Impaired in Emergency Room Environments

Surrogate informed consent may be obtained from a surrogate decision maker who is any of the following persons:

- The person’s agent pursuant to an advance health care directive
- The conservator or guardian of the person having the authority to make health care decisions for the person
- The spouse of the person
- An individual defined in Section 297 of the Family Code (a “domestic partner”)
- An adult son or daughter of the person
- A custodial parent of the person
- Any adult brother or sister of the person

When there are two or more available persons described in the above list, refusal to consent by one person shall not be superseded by any other of those persons.

Note that the rules on proxy consent in this statute do not apply to subjects who lack capacity to give informed consent and are involuntarily committed, voluntarily admitted, or admitted on conservator-request to a psychiatric hospital. Investigators should consult the IRB for guidance when the potential subjects are in one of the above categories.
Chapter 15: Biomedical Research

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15.2 – Specimens (Human Biological Materials)
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Chapter 15
Biomedical Research

This chapter discusses special types of biomedical research and additional requirements for investigators conducting these types of research.

15.1 Chart Reviews / Case Studies

Chart Reviews

Reviewing medical charts or records for research purposes requires IRB review and approval. This is true even if all the medical records are from patients of the investigator. The IRB will review chart review research under the exempt or expedited review categories. The level of IRB review depends on the nature of the data collected, if any identifying information is recorded, and whether study data already exist (retrospective) or will be created in the future (prospective). In the iStar application, investigators are asked to provide the range of dates for the data and a list of the specific data fields that will be extracted from medical records.

The IRB may authorize a waiver of informed consent for chart review research when the following criteria are met:

- The study involves no more than minimal risk to participants
- The waiver will not adversely affect the rights and welfare of participants
- The research could not practicably be carried out without the waiver
- When applicable, participants are provided with additional pertinent information after participation.

The IRB may also waive the requirement for a Health Insurance Portability and Accountability Act (HIPAA) authorization for chart review research if the following criteria are met:
1. The use or disclosure of protected health information involves no more than minimal risk to the privacy of individuals, based on, at least, the presence of the following:

   a. An adequate plan to protect the identifiers from improper use and disclosure
   
   b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or retention is required by law
   
   c. Adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of protected health information is permitted
   
2. The research could not practicably be conducted without the alteration or waiver or alteration
   
3. The research could not practicably be conducted without access to and use of the protected health information.

HIV test results cannot be recorded for chart review research conducted under a waiver of HIPAA authorization. For more information, refer to Section 11.5 – Health Insurance Portability and Accountability Act (HIPAA).

Case Studies

In socio-behavioral research, case studies are reports about experiences or observations associated with up to three individuals. Medical case studies involve reports of up to three patients identified in the course of clinical care. Reports from individuals receiving investigational drugs or devices or other situations that require FDA oversight cannot be included in case studies.

Case studies normally do not require IRB review because they do not meet the definition of research (they are not generalizable). However, if a series of subject observations are collected to allow possible extrapolation of the results to a larger population, the case
studies may be generalizable. At USC, the collection of data from more than three individuals is considered to be human subjects research and must be submitted to the IRB.

HIPAA regulations apply to collection of protected health information for the purpose of a case study, even though the case study does not require IRB review. A HIPAA authorization form specifically for case studies is available at http://oprs.usc.edu/files/2013/01/USC_HIPAA__Case_Report.pdf. Additional information on HIPAA is available in Section 11.5 – Health Insurance Portability and Accountability Act (HIPAA).

15.2 Specimens (Human Biological Materials)

Human biological materials include blood, urine, saliva, hair, nails, cells, tissue samples (fresh, frozen, or paraffin blocks), other body fluids or tissues, and molecules derived from these materials. Common sources of specimens used in research include:

- Specimens to be collected specifically for a research project
- Specimens collected during previous research projects
- Stored (archived) tissue from diagnostic testing or surgery
- Tissue that is discarded during routine medical care
- Specimens obtained from repositories at USC or outside Institutions
- Specimens purchased from commercial tissue banks

The use of human biological materials in research requires review by the IRB. The level of review depends on the potential risks to participants, how the specimens were collected or will be collected, and what information is associated with the specimens. Some specimen research may require Full Board review, other research may qualify for expedited review, and some research may be granted exempt status. Refer to Chapter 7 – Types of IRB Submissions for the expedited and exempt review categories that specifically refer to specimens. The IRB makes the determination about the appropriate review type, not the investigator.
Specimen research involves the potential risk of loss of confidentiality. The level of risk is determined by the type of information obtained with the specimen. Specimens are generally labeled in one of three ways:

- **Identified**: The specimen is directly labeled with personal identifying information (such as a name, patient number, or medical record number)

- **Coded**: The specimen is labeled with a code that researchers can link to personal identifying information

- **Anonymous**: The specimens are not labeled with direct identifiers or a code; researchers cannot retrieve any personal identifying information

Specimens that are truly anonymous carry no risk of loss of confidentiality. Specimens that have direct identifiers carry the greatest risk of loss of confidentiality. Whenever possible, investigators should obtain anonymous or coded specimens to minimize potential risks.

Investigators who obtain coded specimens but do not hold the link to identifiers and cannot obtain identifiable information about the participants are not conducting human subjects research. At USC, investigators are still required to submit this type of research to the IRB using the “Coded Specimens/Data” review category in the iStar application. More information on research involving coded specimens is available in the OHRP Guidance on Research Involving Coded Private Information or Biological Specimens.

Research that uses only cadaver specimens is not considered human subjects research under federal regulations. Research that uses only anonymous specimens is also not considered human subjects research. Investigators conducting research on these types of specimens do not need to submit the research to the IRB.

### Newborn Dried Bloodspots

The Newborn Screening Saves Lives Reauthorization Act of 2014 explicitly states that the use of newborn dried bloodspots for research is considered to involve human subjects if the research is federally supported and the bloodspots are collected on or after March 18, 2015. The identifiability (or not) of the bloodspots is irrelevant. In other words, if a researcher is receiving de-identified or anonymous bloodspots for research, the research is considered to involve human subjects. A detailed summary of recommendations is provided by the U.S. Department of Health and Human Services, Secretary’s Advisory Committee on Human Research Protection (SACHRP). The goal of this recommendation
is to provide thoughtful consideration of this act and allow for important research to take
place. Refer to: https://oprs.usc.edu/files/2016/05/SACHRP-Newborn-Dried-Bloodspots.docx

Retaining Specimens for Future Research

If specimens obtained in a study will be retained for future use in other studies, the
informed consent form must disclose this to participants. The consent form should
describe who might have access to specimens and information in the future, the potential
purposes of the future specimen research, how participants can request destruction or
removal of their specimens from future research use, and whether there are plans to
compensate participants if a commercial product is developed from use of their
specimens. Participants should be given the opportunity to opt out of storing samples for
future research.

Material Transfer Agreements (MTAs)

Transfer of materials among collaborators requires the use of Material Transfer
Agreements (MTAs). MTAs ensure USC’s rights are protected when specimens or
reagents are shared with colleagues or private entities.

An MTA is a research contract between a provider and recipient of research materials
which governs the terms and conditions under which the material may be used. An MTA
protects the intellectual and other property rights of the provider and generally addresses:

- Limits on the use of the research materials, inventions, and results
- Prohibitions on the redistribution of the material
- Conditions of use, including prohibitions of use in animals or humans
- Conditions for publication, usually with provisions that the manuscript must be
  seen by the donor before submission for publication
- A hold-harmless cause, meaning that the donor has no liability resulting from the
  use of the material
- The return of unused materials
There are two main types of MTAs: incoming and outgoing. MTAs at academic Institutions fall into these categories:

- Transfers between academic or non-profit research Institutions
- Transfers from industry to academia
- Transfers from academia to industry

USC is a member of the Uniform Biological Material Transfer Agreement which was developed by the NIH to encourage the signatory Institutions to share research materials.

MTAs need to be reviewed to ensure compliance with USC policies, principles and guidelines, and all MTAs must be signed by an authorized representative of USC.

Review and approval of MTAs is conducted by the Senior MTA Administrator of the USC Stevens Institute (https://stevens.usc.edu/researchers/mta-cda/).

Additionally, IRB review and HIPAA consideration may apply when human specimens that contain identifiable subject information are transferred among Institutions.

15.3 Repositories: Banking of Specimens / Data

The banking of specimens/data refers to the creation of tissue banks and/or databases (repositories) to collect, store, and distribute human specimens and data for future research purposes. Repository activities involve three components:

- **Collection** of specimens/data
- **Storage and management** of the specimens/data
- **Distribution** of specimens/data to “recipient” investigators for use in future research projects

**Research Repositories**

If specimens or data were collected for research purposes, it is a research repository. Collection of specimens/data, repository storage or data management, and use of
specimens or data are all considered research activities and require IRB review and approval.

**Non-Research Repositories**

If specimens or data were originally collected for non-research purposes AND were added to the repository/database without any identifiers or links to identifiable private information, it is a “non-research” repository/database. Studies using specimens/data from non-research repositories or databases are considered Not Human Subjects Research (NHSR) (Refer to Section 7.1 - What Is Not Human Subjects Research).

Specimen/data repositories may include two kinds of specimens/data: (1) those collected with the expressed purpose of distribution to other investigators, and (2) those collected by individual investigators with no original intent to share with others, but which are later shared as part of a repository. Any collection which contains specimens/data that are potentially identifiable, either directly or indirectly with a code, and are distributed to someone other than the named investigator(s) making the collection, regardless of the original intent, is considered to be a repository requiring IRB oversight.

**Collecting Specimens/Data for a Repository**

Investigators who collect directly or indirectly identifiable specimens/data require IRB review at the site of collection (even if different from the site of the repository). Under most circumstances, written informed consent from the subject is required and HIPAA authorization may be required. The informed consent form should include information about the repository and the conditions under which the specimens/data will be shared with others. Some consent forms give participants choices about what types of specimens/data can or cannot be shared.

**Establishing a Repository at USC**

Investigators who wish to establish and operate a repository at USC must create Standard Operating Procedures (SOPs) for operating and managing the repository. The USC IRB must review and approve the SOPs. The following documents must be included in the iStar application:

- Standard Operating Procedures for the repository. The operating procedures and policies should include, but are not limited to, the following elements:
Chapter 15: Biomedical Research

- Purpose of the repository
- Specimen and data collection procedures
- Specimen and data storage/retention
- Specimen derivation and processing
- Specimen and data distribution
- Obtaining informed consent and HIPAA authorization
- Procedures for protecting privacy and confidentiality (for example, anonymizing specimens/data, coding of specimens/data, encryption of data, limiting access/secure storage)
- Employee confidentiality measures and confidentiality agreement
- Procedures for return of research results (if and under what conditions)
- Repository oversight

- Sample informed consents for subjects contributing to the repository

- Sample agreements for investigators collecting tissues for the repository and for investigators receiving tissues from the repository. These agreements should address use of specimens/data, human subject protections, sharing of specimens with third parties, commercial use of specimens, biohazards, and indemnification.

- A Certificate of Confidentiality, if needed. Certificates of Confidentiality are issued by the National Institutes of Health and other federal agencies to protect identifiable research information from forced disclosure. 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. Additional information is available at the NIH Certificate of Confidentiality Kiosk web site.
Confidentiality Considerations

Whenever possible, all identifiers should be stripped from the stored samples or data, such that they can never be traced to the individual. If the experimental design requires that the specimens/data be traced back to an individual subject, this creates a lasting confidentiality risk that must be both controlled and disclosed. If the need to link data to the individual is time limited, the data should be stripped of identifiers (rendering the samples truly anonymous) as soon as the time window has closed. Storage with easily traceable identifiers such as patient names, initials, social security numbers, or medical record numbers is almost never appropriate. An additional safeguard for maintaining confidentiality while retaining a link is to use a code in place of identifiers.

Risks of research participation extend beyond the duration of the subject’s direct participation in research when records or samples are stored with identifiers. Loss of confidentiality leads to potential risks such as denial of insurance or employment, or disclosure that some members of a family are not genetic relatives. In addition, the ability to re-test samples containing extractable DNA has made it possible that retained samples will later provide sensitive or medically relevant information that was not anticipated at the time of initial collection.

Distribution of Specimens/ Data from a USC Biorepository

Investigators must follow the operating procedures and distribution conditions described in the approved IRB application. These conditions must consider the privacy of the individuals from whom the specimens/data came, the sharing options dictated by participants in the informed consent, and the intent of the person to whom the specimens/data are sent. The recipient of the specimens/data must abide by the conditions specified.

A biorepository committee, established under the IRB guidelines and pursuant to the IRB approval for the repository, should evaluate each request for samples to see if the request is consistent with the IRB’s conditions for sharing samples and with the informed consent forms signed by participants. See USC Biorepository Policy
http://policy.usc.edu/biorepositories/
Storing Specimens / Data Outside of USC

If a USC investigator wishes to send specimens/data to a repository located at an external Institution or organization, the investigator must include a copy of the external site’s IRB approval letter for operation of the repository in the USC IRB submission.

The IRB at the external site where the repository is located must approve and maintain oversight of a protocol that: (a) specifies the conditions under which data and specimens may be accepted and shared with other researchers and (b) ensures adequate privacy protections for subjects contributing to the repository.

Helpful Links

- USC Biorepository Policy: http://policy.usc.edu/biorepositories/

- USC Biobanks Initiative: http://oprs.usc.edu/initiatives/biobanks/

- OHRP “Issues to Consider in the Research Use of Stored Data or Tissues” http://www.hhs.gov/ohrp/policy/reposit.html

15.4 NIH Genomic Data Sharing Policy (GDS) (Formerly GWAS)

The purpose of the National Institutes of Health (NIH) Genomic Data Sharing (GDS) Policy is to ensure the broad and responsible sharing of genomic research data. NIH has longstanding policies to make data publicly available in a timely manner from the research activities that it funds.

The GDS Policy applies to all NIH-funded research that generates large-scale human or non-human genomic data as well as the use of these data for subsequent research. Large-scale data include genome-wide association studies (GWAS), single nucleotide polymorphisms (SNP) arrays, and genome sequence, transcriptomic, metagenomic, epigenomic, and gene expression data, irrespective of funding level and funding mechanism (e.g., grant, contract, cooperative agreement, or intramural support).
NIH expects all funded investigators to adhere to the GDS Policy, and compliance with this Policy will become a special term and condition in the Notice of Award or the Contract Award.

This Policy applies to:

- Competing grant applications that are submitted to NIH for the January 25, 2015, receipt date or subsequent receipt dates;
- Proposals for contracts that are submitted to NIH on or after January 25, 2015; and
- NIH intramural research projects generating genomic data on or after January 25, 2015.

The NIH GDS policy http://gds.nih.gov/pdf/supplemental_info_GDS_Policy.pdf provides detailed requirements for GDS data submission and GDS data access. The process for data submission and data access differ substantially and requirements for each are summarized below.

### GDS Data Submission and Access

#### Overview of Differences in Submission and Access to the GDS database

- **Data Submission**: Requires IRB approval and Institutional Official (IO) signature

- **Data Access (general process applicable to majority of requests)**: Data access requires signature of USC Institutional Official (IO) and application to (and approval from) NIH Data Access Committee

- **Data Access (for selected datasets requiring IRB approval)**: Data access for selected datasets requires IRB approval, USC IO signature and application to (and approval from) NIH Data Access Committee

### GDS Data Submission Process of Genomic Data at USC

NIH expects investigators and their institutions to provide basic plans for following the Policy in the “Genomic Data Sharing Plan” located in the Resource Sharing Plan section
of funding applications and proposals. Any resources that may be needed to support a proposed genomic data sharing plan (e.g., preparation of data for submission) should be included in the project's budget. A more detailed genomic data sharing plan is requested by the funding agency prior to award. The Institutional Certification (for sharing human data), should also be provided to the funding agency prior to award, along with any other Just-in-Time information. NIH expects intramural investigators to address compliance with genomic data sharing plans with their funding agency scientific leadership prior to initiating applicable research and encouraged to contact their funding agency leadership or the Office of Intramural Research for guidance. The funding agency will typically review compliance with genomic data sharing plans at the time of annual progress reports or other appropriate scientific project reviews, or at other times, depending on the reporting requirements specified by the funding agency for specific programs or projects.

**Investigator Responsibilities**

*Data Submission Expectations and Timeline*

Investigators should submit large-scale human genomic data as well as relevant associated data (e.g., phenotype and exposure data) to an NIH-designated data repository in a timely manner. Investigators should also submit any information necessary to interpret the submitted genomic data, such as study protocols, data instruments, and survey tools.

Genomic data undergo different levels of data processing, which provides the basis for NIH’s expectations for data submission and timelines for the release of the data for access by investigators. These expectations and timelines are provided in the Supplemental Information. In general, NIH will release data submitted to NIH-designated data repositories no later than six months after the initial data submission begins, or at the time of acceptance of the first publication, whichever occurs first, without restrictions on publication or other dissemination.

Investigators should de-identify human genomic data that they submit to NIH-designated data repositories according to the standards set forth in the HHS Regulations for the Protection of Human Subjects to ensure that the identities of research subjects cannot be readily ascertained with the data. Investigators should also strip the data of identifiers according to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. The de-identified data should be assigned random, unique codes by the investigator, and the key to other study identifiers held by the submitting institution.
NIH encourages investigators and institutions submitting large-scale human genomic datasets to NIH-designated data repositories to seek a Certificate of Confidentiality as an additional safeguard to prevent compelled disclosure of any personally identifiable information they may hold.

Data Repositories

Investigators should register all studies with human genomic data that fall within the scope of the GDS Policy in dbGaP by the time that data cleaning and quality control measures begin, regardless of which NIH-designated data repository will receive the data. After registration in dbGaP, investigators should submit the data to the relevant NIH-designated data repository (e.g., dbGaP, GEO, SRA, the Cancer Genomics Hub). NIH-designated data repositories need not be the exclusive source for facilitating the sharing of genomic data, that is, investigators may also elect to submit data to a non-NIH-designated data repository in addition to an NIH-designated data repository. However, investigators should ensure that appropriate data security measures and that confidentiality, privacy, and data use measures are consistent with the GDS Policy.

To obtain IO certification, investigators must provide complete information in the IRB application (iStar sections 9.4 and 9.4.1) which will trigger a request for IO certification. If the IO certification is requested after a study has been approved by the IRB (including legacy studies), investigators should submit a study amendment to obtain IO certification.

For multi-center data submission to the GDS repository by a USC investigator: the investigator must provide the IRB GDS certifications from each institution. Each participating institution is responsible for conducting the GDS analysis of their submission based on applicable local standards. In these cases, the USC Institutional Official approval memo will note that GDS certification for study data includes appropriate institutional approvals from collaborating sites. There are 3 options for Institutional Certifications:

- For Studies Using Data Generated from Cell Lines Created or Clinical Specimens Collected AFTER January 25, 2015

- For Studies Using Data Generated from Cell Lines Created or Clinical Specimens Collected BEFORE January 25, 2015
  - That Lack Consent
For Studies Using Data Generated From Cell Lines Created or Clinical Specimens Collected BEFORE January 25, 2015
  o That Have Consent

**IRB Responsibilities**

For research that falls within the scope of the GDS Policy, submitting institutions, through their Institutional Review Boards (IRBs), privacy boards, or equivalent bodies, are to review the informed consent materials to determine whether it is appropriate for data to be shared for secondary research use. NIH provides additional information on issues related to the respect for research participant interests in its *Points to Consider for IRBs and Institutions in their Review of Data Submission Plans for Institutional Certifications*.

For studies initiated after the effective date of the GDS Policy, NIH expects investigators to obtain participants’ consent for their genomic and phenotypic data to be used for future research purposes and to be shared broadly. The consent should include an explanation about whether participants’ individual-level data will be shared through unrestricted- or controlled-access repositories.

For studies proposing to use genomic data from cell lines or clinical specimens that were created or collected after the effective date of the Policy, NIH expects that informed consent for future research use and broad data sharing will have been obtained even if the cell lines or clinical specimens are de-identified. If there are compelling scientific reasons that necessitate the use of genomic data from cell lines or clinical specimens that were created or collected after the effective date of the GDS Policy and that lack consent for research use and data sharing, investigators should provide a justification in the funding request for their use.

For studies using data from specimens collected before the effective date of the GDS Policy, there may be considerable variation in the extent to which future genomic research and broad sharing were addressed in the informed consent materials for the primary research. In these cases, an assessment by an IRB, privacy board, or equivalent body is needed to ensure that data submission is not inconsistent with the informed consent provided by the research participant. NIH will accept data derived from de-identified cell lines or clinical specimens lacking consent for research use that were created or collected before the effective date of this Policy.
NIH recognizes that in some circumstances broad sharing may not be consistent with the informed consent of the research participants whose data are included in the dataset. In such circumstances, institutions planning to submit aggregate or individual-level data to NIH for controlled access should note any data use limitations in the data sharing plan submitted as part of the funding request. These data use limitations should be specified in the Institutional Certification submitted to NIH prior to award.

**Institutional Official Approval Memo**

Once a GDS study is approved by the IRB and the informed consent declarations are made, the IRB forwards the information request to the USC Office for the Protection of Research Subjects (OPRS). The OPRS Executive Director assures the approval memo is complete and that the informed consent information has been included and forwards it to the IO for review, signature, and distribution. The IO approval memo is mailed directly to the NIH Program Officer identified in the iStar application. At minimum, electronic copies of the approval will be sent to the investigator, HSIRB Director, IRB administrator and OPRS office. HSIRB staff will upload the IO approval memo(s) in iStar.

**Institutional Official Responsibilities**

The responsible Institutional Official of the submitting institution should provide an Institutional Certification to the funding agency prior to award consistent with the genomic data sharing plan submitted with the request for funding. The Institutional Certification should state whether the data will be submitted to an unrestricted- or controlled-access database. For submissions to controlled access and, as appropriate for unrestricted access, the Institutional Certification should assure that:

- The data submission is consistent, as appropriate, with applicable national, tribal, and state laws and regulations as well as relevant institutional policies;
- Any limitations on the research use of the data, as expressed in the informed consent documents, are delineated;
- The identities of research participants will not be disclosed to NIH-designated data repositories; and
- An IRB, privacy board, and/or equivalent body, as applicable, has reviewed the investigator’s proposal for data submission and assures that:
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- The protocol for the collection of genomic and phenotypic data is consistent with 45 CFR Part 46

### USC Data Accessing Process

Investigators and Institutions seeking data from the NIH GDS data repository will be required to meet data security measures (such as physical security, information technology security, and user training) and will be asked to submit a data access request, including a Data Use Certification agreement, that is co-signed by the investigator and the designated Signing Official through the Data Access Request application (see below).

To access data in the GDS repository in connection with research you are conducting or intending to conduct, please contact the [Office of Compliance](#) as soon as feasible by clicking on the attached link or by calling (213) 740-2500.

### Investigator Responsibilities

Access to human data is through a tiered model involving unrestricted- and controlled-data access mechanisms. Requests for controlled-access data are reviewed by NIH Data Access Committees (DACs) [http://gwas.nih.gov/04po2_1DAC.html]. NIH DACs will accept requests for proposed research uses beginning one month prior to the anticipated data release date. The access period for all controlled-access data is one year; at the end of each approved period, data users can request an additional year of access or close out the project. A Certificate of Confidentiality could serve as an additional safeguard to prevent compelled disclosure of any genomic data.

### Terms and Conditions for Research Use of Controlled-Access Data

Investigators approved to download controlled-access data from NIH-designated data repositories and their institutions are expected to abide by the NIH Genomic Data User Code of Conduct. The Data Use Certification, co-signed by the investigators requesting the data and their Institutional Signing Official, specifies the conditions for the secondary research use of controlled-access data, including:

- Using the data only for the approved research;
- Protecting data confidentiality;
- Following, as appropriate, all applicable national, tribal, and state laws and regulations, as well as relevant institutional policies and procedures for handling genomic data;

- Not attempting to identify individual participants from whom the data were obtained;

- Not selling any of the data obtained from NIH-designated data repositories;

- Not sharing any of the data obtained from controlled-access NIH-designated data repositories with individuals other than those listed in the data access request;

- Agreeing to the listing of a summary of approved research uses in dbGaP along with the investigator’s name and organizational affiliation;

- Agreeing to report any violation of the GDS Policy to the appropriate DAC(s) as soon as it is discovered;

- Reporting research progress using controlled-access datasets through annual access renewal requests or project close-out reports;

- Acknowledging in all oral or written presentations, disclosures, or publications the contributing investigator(s) who conducted the original study, the funding organization(s) that supported the work, the specific dataset(s) and applicable accession number(s), and the NIH-designated data repositories through which the investigator accessed any data.

NIH expects that investigators who are approved to use controlled-access data will follow guidance on security best practices and expected data security protections.

If investigators violate the terms and conditions for secondary research use, NIH will take appropriate action. Further information is available in the Data Use Certification [https://gds.nih.gov/pdf/Model_DUC.pdf].

**Data Access Request**

To submit a Data Access Request (DAR), investigators must complete the NIH SF 424 (R&R) form. To complete the form, investigators must have an NIH eRA Commons account which is the same account used to apply for NIH grants (refer to the end of this section for links to the NIH SF 424 form and eRA Commons).
Completion of the DAR application involves designating a Signing Official (SO). To do this, investigators must select USC’s SO, Contracts and Grant Executive Director Jerry Muniz, from the propagated list in DAR section 19.

**IRB Responsibilities**

Generally, access to GDS data does not require IRB approval. However, some data sets specifically require IRB approval (such as the Framingham SHARe study). Investigators can verify if IRB approval is required for a study by checking the study description in the GDS database, dbGaP. If access to data requires IRB approval, investigators must submit a coded specimens/data application through iStar. Furthermore, if a Full Board or expedited IRB review is required, investigators should contact the IRB.

**Institutional Official Responsibilities**

After the PI completes the data access request, the Institutional Official (IO) will be notified by email. The IO will review the request and will have the option to edit the application, return the form to the PI for revision, or sign off and validate the submitted application.

The data access request is then reviewed by the appropriate Data Access Committee at NIH, and both the PI and IO will be notified by email of approval or disapproval.

**GDS Publication Rights**

The NIH expects that investigators who contribute data to the NIH GDS data repository will retain the exclusive right to publish analyses of the dataset for a defined period of time following the release of a given genotype-phenotype dataset through the NIH GDS data repository (including the precomputed analyses of the data). During this period of exclusivity, the NIH will grant access through the DACs to other investigators, who may analyze the data, but are expected not to submit their analyses or conclusions for publication during the exclusivity period. The maximum period of exclusivity is twelve months from the date that the GDS dataset is made available for access through the NIH GDS data repository, although a shorter period of exclusivity may be determined by the NIH funding institute or center.
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The NIH expects all investigators who access GDS datasets to acknowledge the Contributing Investigator(s) who conducted the original study, the funding organization(s) that supported the work, and the NIH GDS data repository in all resulting oral or written presentations, disclosures, or publications of the analyses.

**Helpful Links**

Additional GDS guidance can be accessed in the following links:

- NIH Genomic Data Sharing (GDS) website:

- Policy for Sharing of Data in NIH Supported or Conducted GWAS:

- Database of Genotypes and Phenotypes (dbGaP) Website:

- Form SF 424 (R&R) Application and Electronic Submission Information

- dbGaP FAQ Archive

- National Human Genome Research Institute Consent Form Examples and Model Consent Language
  http://www.genome.gov/27526660

### 15.5 Genetic Research

Genetic information is uniquely personal information. Disclosure of genetic information has the potential to influence employment, insurance, finances, education, family relationships, and possibly self-perception. Therefore, genetic information collected during research must be carefully managed to protect individuals or groups from stigmatization, discrimination, or psychological harm.
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Research involving analysis of genetic material can be broadly categorized as genetic testing or genetic research.

- Genetic Testing: The gene has a known association with a human trait or medical condition and the results will be disclosed to the participant and/or their health care providers. Genetic testing must be performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory. A geneticist or genetic counselor should disclose results to participants or be available to answer participants’ questions about the implications of the results.

- Genetic Research: The genes being studied have no known associations with human traits or medical conditions. The research does not provide meaningful information about participants’ health. Genetic research is not performed in a CLIA-certified laboratory and results are not typically shared with participants or their health care providers.

Investigators who are conducting genetic research must pay special attention to the following topics in the iStar application and informed consent form:

- Type(s) of genetic testing or genetic research to be conducted
- Confidentiality measures to protect genetic information
- Risks related to loss of confidentiality
- Disclosure of results to participants and their doctors
- Availability of a geneticist or genetic counselor to counsel participants who receive results of genetic testing
- Participants’ rights to opt out of genetic research, to opt out of future research on their genetic specimens, and to request destruction of genetic specimens

Minors and Family Members

Before involving minors in genetic research, the parent(s) or legal guardian(s) must review and sign the informed consent form and HIPAA authorization form (if applicable). The minor subject’s assent should also be solicited when appropriate. Investigators should follow the recommendations of a genetic counselor or professional associations when incorporating genetic testing of minors into research protocols. Most
recommend that genetic testing for adult-onset diseases be postponed until individuals can decide for themselves and consent as an adult (American Academy of Pediatrics and National Society of Genetic Counselors).

In rare cases, it may be possible for investigators to learn that some members of the family are not biological relatives. Investigators may learn that the father is not the child’s biological father or that a child was adopted and the child or other family members are not aware of this information. Investigators conducting genetic research in families must plan ahead for this situation and state whether or not the information will be revealed to participants.

Genetic research may involve gathering information about family members of the participant. Family members who are not enrolled as participants but about whom information is collected are called “secondary subjects”. Participants may be asked to describe the age, gender, health information, social history, and relationship of family members. The privacy of these secondary subjects must be protected, even though they are not enrolled as participants. The IRB may require informed consent from secondary subjects or may grant a waiver of informed consent for secondary subjects.

**Genetic Information Nondiscrimination Act (GINA)**

The Genetic Information Nondiscrimination Act (GINA) of 2008 is a federal law that prohibits discrimination in health coverage and employment based on genetic information. GINA generally prohibits health insurers or health plan administrators from requesting or requiring genetic information of an individual or the individual’s family members, or using it for decisions regarding coverage, rates, or preexisting conditions. The law also prohibits most employers from using genetic information for hiring, firing, or promotion decisions, and for any decisions regarding terms of employment.

GINA applies to genetic information, including utilization of genetic testing and counseling services, by an individual or family member participating in research. The informed consent form should describe this protection against genetic discrimination when it applies to the research. Additional information on GINA protections and limitations is available at:

The HSIRB Informed Consent Template contains suggested language for genetic research, storing specimens for future use, and GINA protections (see http://oprs.usc.edu/hsirb/hsirb-forms/).

Return of Results

Genetic testing is a diagnostic tool prescribed by health care provider and results are provided to patients. Genetic research, however, involves testing of genes that have no known associations with human traits or medical conditions. Test results may not provide meaningful information about participants’ health, thus, results are not typically shared with participants or their health care providers. As a best practice, results should be returned to subjects when the test results have analytical validity (accurately and reliably measures the property or characteristic of interest), clinical validity (consistently and accurately detects or predicts the intermediate or final outcome of interest), and utility/action-ability (such as instances when a medical intervention can change the course of a serious condition).

15.6 Human Gene Transfer Research (“Gene Therapy”)

Human gene transfer, often called “gene therapy,” refers to the process of transferring specially engineered genetic material (recombinant DNA or RNA derived from recombinant DNA) into a person. To avoid the misconception that this technology is therapeutic, the term “human gene transfer research” is preferred to “gene therapy.” Gene transfer research has additional reviewing, reporting, and consent form requirements. Research involving human gene transfer must be reviewed by the USC Institutional Biosafety Committee (IBC) as well as the IRB. For additional information on research involving recombinant DNA, see the USC IBC web site [http://capsnet.usc.edu/department/environmental-health-safety/uscs-institutional-biosafety-committee-ibc].

The Food and Drug (FDA) and NIH have oversight of human gene transfer research and oversee mandatory safeguards.
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**FDA**

The FDA’s role is to determine whether or not a sponsor may initiate study of a gene transfer product and, ultimately, whether it is safe and effective for human use. This process of review and authorization of gene transfer research is conducted by FDA’s Center for Biologics Evaluation and Research (CBER). Sponsors of gene transfer products must test their products extensively and meet FDA requirements for safety, purity, and potency before they can be administered to humans or sold in the United States.

**NIH**


The NIH Guidelines articulate standards for investigators and Institutions to follow to ensure the safe handling and containment of recombinant DNA and products derived from recombinant DNA. These guidelines outline requirements for institutional oversight. Appendix M of the NIH Guidelines describes points to consider in the design and submission of human gene transfer trials, including the registration of protocols with NIH, the review procedures of the Recombinant DNA Advisory Committee (RAC), the conduct of informed consent, and annual and expedited reporting requirements.

Institutions that receive NIH funding for basic and clinical recombinant DNA research must assure to NIH that all research conducted at or sponsored by the Institution complies with NIH Guidelines.

Investigators have an ongoing responsibility to monitor human gene transfer trials and to keep the NIH Office of Biotechnology Activities (OBA), as well as the IRB, the IBC, FDA, and any sponsoring NIH institutes or centers, informed of any adverse events that occur in a gene transfer trial. If a serious adverse event occurs that is unexpected and could be possibly associated with the gene transfer product, a sponsor is required by regulation to notify FDA within 15 days of the event, and investigators should notify OBA of the problem within 15 days of their notification to the sponsor. Serious adverse events that are fatal or life threatening must be reported within seven days. If warranted by the nature of these events, the FDA may mandate changes to the human study and
require more preclinical studies, put the clinical study on hold, or stop the study altogether.

The NIH and FDA have developed a national database for gene transfer clinical research, the Genetic Modification Clinical Research Information System (GeMCRIS) to enable systematic analysis of data across all human gene transfer trials and to enhance communication and application of knowledge gained from the studies. The system provides a standardized means for reporting, organizing, and analyzing data related to adverse events in a format accepted by both the NIH and FDA.

In some cases, the potential risks associated with gene transfer may weigh against the involvement of human subjects in such trials. The IRB will consider the risks and benefits of a human gene transfer study carefully, and, if a protocol is approved, ensure that participants are thoroughly informed of the risks and benefits involved in the trial.

Because gene transfer is innovative and its long-term risks are not well understood, the NIH Guidelines require investigators to inform prospective participants that they will be asked to participate in long-term follow-up that extends beyond the active phase of the study. Investigators need to explain the rationale for long-term follow-up, the specific follow-up activities planned, how long follow-up will continue, and what, if any, procedures participants will be asked to undergo.

The NIH Guidelines state that investigators should inform subjects that an autopsy will be requested at the time of death, no matter what the cause, to obtain vital information about the safety and efficacy of gene transfer. Subjects should be asked to advise their families of the request and of its scientific and medical importance. During the informed consent process, the investigator should explain that the subject is not being asked at this time to consent to autopsy, nor is it required for study participation. However, subjects should be encouraged to express their wishes about an autopsy to their families so that family members are prepared to consider it at the time of the subject’s death.

The NIH Guidelines require that investigators describe in the protocol any potential benefits and hazards of the proposed gene transfer to persons other than the human subjects receiving the experimental intervention. Specifically, investigators must address whether there is a significant possibility that the inserted DNA will spread from the human subject to other persons or to the environment and what measures will be undertaken to mitigate any public health risks. The IBC should be involved in assessment of community health risks.
15.7 Research Involving HIV Testing and AIDS

Confidentiality is the most sensitive aspect of AIDS research from the perspective of the rights and welfare of the subjects. Improper disclosure could have severe consequences for research participants, by threatening family relationships, job security, employability, or ability to obtain credit or insurance. In light of these risks, special precautions should be taken to preserve confidentiality. Limits to confidentiality should be carefully explained to potential subjects so they can make fully informed decision about participating.

Each study must be designed with administrative, management, and technical safeguards to control authorized use and disclosure of information and to protect against unauthorized disclosure. Where identifiers are not required by the design of the study, they are not to be recorded. If identifiers are recorded, they should be separated, if possible, from data and stored securely, with linkage restored only when necessary to conduct the research. No lists should be retained identifying those who elected not to participate.

As a general principle, information is not to be disclosed without the subject's consent. The protocol must clearly state who is entitled to see records with identifiers, both within and outside the project. This statement must take into account the possibility of a review of records by the funding agency and by FDA officials if the research is subject to FDA regulations 21 CFR 50. The informed consent form must disclose that positive HIV tests will be reported to public health agencies.

California Law and HIV Research

The California Health and Safety Code (Section 121075-121125) provides additional protections for research records in studies relating to HIV or AIDS.

“Confidential research records” includes any data in a personally identifying form (such as name, social security number, address, employer or other information that could, directly or indirectly, lead to the identification of the individual research subject) developed or acquired by any person in the course of conducting research relating to AIDS.

Confidential research records developed or acquired by any person in the course of conducting research, or a research study relating to AIDS, shall be confidential and shall
not be disclosed by any person in possession of the research record, nor shall these records be discoverable, nor shall any person produce any confidential research record except in the following situations:

- Confidential research records may be disclosed in accordance with the prior written consent of the research subject to whom the confidential research records relate, but only to the extent, under the circumstances, to the persons and for the purposes the written consent authorizes. Any disclosure made pursuant to such prior written consent shall contain the following statement:

  This information has been disclosed to you from a confidential research record the confidentiality of which is protected by state law and any further disclosure of it without specific prior written consent of the person to whom it pertains is prohibited. Violation of these confidentiality guarantees may subject you to civil or criminal liabilities.

- Confidential research records may be disclosed without prior written consent of the research subject to whom the confidential research records relate in the following circumstances:
  
  o To medical personnel to the extent it is necessary to meet a bona fide medical emergency of a research subject, and

  o To the California Department of Health Services for the conduct of a special investigation of the sources of morbidity and mortality and the effects of localities, employments, conditions and circumstances on the public health and for other duties as may be required in procuring information for state and federal agencies regarding the effects of those conditions on the public health

The content of any confidential research record shall be disclosed to the research subject, the legal representative of the research subject if the research subject is a minor, or the personal representative of a deceased research subject to whom the record pertains within 30 days after a written request is made for such records by the research subject or the legal representative.

Policy on Informing Subjects about HIV Serostatus

It is the policy of the IRB, as required by the Public Health Service (PHS), that when HIV testing is conducted as part of a research project, individuals whose test results are associated with personal identifiers must be informed of their test results and be provided with the opportunity to receive appropriate counseling. Individuals may not be given the option to "not know" the results, either at the time of consenting to be tested or thereafter. This policy does not apply to testing situations in which subjects consent to be tested and where results cannot be linked to individual subjects by anyone other than the subjects themselves.

Counseling

Any person tested for HIV infection should receive the results of their tests and counseling in a timely fashion from an individual qualified to provide test counseling and partner notification services.

Exceptions to Informing Subjects about HIV Serostatus

Individual Subjects

When there are compelling and immediate reasons that justify not informing an individual of their positive HIV test results (for example, indications that an individual would attempt suicide), the individual need not be informed of HIV test results. When this exception is made, the details of the exception shall be documented by the responsible individual(s). The investigator must promptly report the exception to the IRB without identifying the individual.

Protocol Design

Because circumstances may exist in which extremely valuable knowledge might be gained from research involving subjects who would be expected to refuse to learn their HIV antibody results, an exception included in the protocol design may be proposed to the appropriate IRB. The IRB will consider the circumstances of the research study, the characteristics of the subjects, and any other factors; and may approve a testing procedure that would allow subjects to participate without being informed of their results. The investigator must demonstrate that research subjects will be informed of their risk of
infection and will receive counseling whether they receive their test results or not. The investigator must show there is good reason to believe that requiring test result notification would significantly impair the collection of study data that could not be obtained by other means; and the risk/benefit ratio to individuals, their partners, and society will be periodically re-evaluated by the IRB. The re-evaluation by the IRB will consider whether the study should be revised or terminated if it is no longer justifiable to allow subjects to continue to participate without receiving their HIV test results.

### Foreign Sites

Research conducted at foreign sites should be carefully evaluated to account for cultural norms, health resource capabilities, and official health policies of the host country. The reviewing IRB must consider if any modifications to this policy must be significantly justified by the risk/benefit evaluation of the research. The IRB may seek expert advice (such as local public health experts) in evaluation of these projects.
### Chapter 16: Student Research

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Chapter 16
Student Research

This chapter describes the responsibilities of faculty advisors and students who conduct human subjects research. Additionally, other topics specific to student research are discussed including assistance provided by the IRB Student Mentor, international research considerations, mandatory reporting responsibilities, and subject pool policies.

16.1 Introduction to Student Research

In accordance with federal regulations, the IRB requires that all human subjects’ research be prospectively reviewed by an IRB including master’s theses, doctoral dissertations, and all student research projects involving human subjects. Under IRB policy, no UPC student research will be approved with a study design that includes administration of medications. For unique situations, this prohibition may be discussed with the UPIRB.

16.2 Classroom Assignments Involving Human Subjects

The University recognizes that some student projects are conducted to fulfill course requirements, and involve activities that might appear to be human subjects research. Classroom assignments do not require IRB approval. These projects typically fulfill a course requirement, are often completed in one semester, and are designed to teach research methods. Faculty members design these assignments to engage students in interaction with individuals, gather data about individuals, and/or illustrate concepts covered in the course. For the most part, they are not intended to create new knowledge or to lead to scholarly publication. The publication of classroom study results or poster sessions at a professional meeting does not make the project human subjects research. These classroom assignments do not meet the federal definition of human subjects research. Additionally, library research or content analysis of public documents is not human subjects research. If students or faculty are uncertain if a classroom project must be reviewed by the IRB, they should contact the IRB.
For projects that do not require IRB review, faculty may direct students to a practice IRB application through the iStar Sandbox Training application. This site allows students to familiarize themselves with iStar, the online application used for IRB submissions, and work on mock IRB submissions.

Additionally, it is recommended that students working on classroom projects complete the Collaborative IRB Training Initiative (CITI), the online human subjects education program. This training is not optional for projects required to undergo IRB review.

At USC, students involved in classroom assignments are encouraged to follow the University’s Code of Ethics and policies when designing and conducting projects with human volunteers.

Faculty members assigning projects in research methods classes are expected to help students understand ethical obligations toward anyone with whom they interact to complete their assignments.

### 16.3 Requirements of Faculty Who Supervise Student Research

Faculty should determine whether an assigned project involving human subjects is defined as a course-related student project. Faculty is strongly encouraged to contact the IRB office for assistance in making this determination and for education on how to mentor students through the IRB and human subjects research process. Faculty should discuss general principles of research ethics with the class prior to the initiation of any project involving human subjects. It may be possible to bundle similar studies conducted under one faculty advisor, decreasing the number of submissions that need to be submitted to the IRB (please contact the UPIRB for further information). No IRB approval may be given after a classroom-assigned study is begun or completed.

### Faculty Responsibilities for the Protection of Human Subjects

Faculty who supervise student research are responsible for the protection of human subjects and are required to:
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- Determine whether projects require IRB review and assist students with the process.
- Discuss research ethics with the students.
- Familiarize themselves and students with ethical and regulatory mandates for human subjects research
- Approving the student’s IRB application and signing a Faculty Advisor Assurance outlining their responsibilities.
- Monitor student projects focusing on maintaining confidentiality, privacy, the level of risk, voluntary participation and withdrawal, and informed consent.
- Assure prompt reporting to the IRB of any event that requires reporting in accordance with the IRB policies and procedures for Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events (refer to Section 20.2 – Unanticipated Problems Involving Risks to Subjects or Others).
- Complete CITI (On-line human subject protection training)

16.4 IRB Student Mentor

The IRB student mentor is a graduate assistant at the Office for the Protection of Research Subjects (OPRS). The IRB student mentor, like other graduate assistants at USC, contributes to the research and teaching activities of the University while pursuing academic degrees.

As a peer mentor, the IRB student mentor counsels USC student investigators on issues related to human subjects protection and the IRB application process through individual advising and group workshops. The IRB student mentor also works closely with the Executive Director of OPRS, the UPIRB office, and individual schools and departments on the University Park campus to continuously plan and implement outreach programs for the USC community. These programs educate faculty, students, and staff on important issues pertaining to human subjects protection in research activities.

The IRB student mentor serves as a liaison between USC students and OPRS, through whom OPRS develops a better understanding of students’ needs and concerns as they relate to protecting research subjects.
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For more information visit http://oprs.usc.edu/education/mentor/

16.5 International Research Conducted by Students

The following policy is specific to international research conducted by USC students and is not applicable to funded clinical trials.

International research involves projects that are conducted outside of the United States. Federal regulations acknowledge that local customs, norms, and laws where the research will take place may differ from U.S. regulations governing research. Funded student research is required to meet U.S. standards wherever it is conducted. For unfunded student research, USC IRBs may accept comparable standards depending on the risk level. It is the expectation that there will be a local contact and/or consultant for the student researcher who will provide information on local laws and cultural norms.

IRB Considerations

If an unfunded study involves less than minimal risk to participants, domestic IRB approval may be sufficient. Examples include surveys that compare use of social media in U.S. adults versus adults in another country or other questionnaires that do not collect sensitive information. Students and/or faculty should contact the UPIRB for additional information.

If a study involves more than minimal risk to participants, USC requires protocol review and approval by an outside IRB/Ethical Review Committee (EC), equivalent organization in the country where the research will occur or approval letter from local entity (refer to Section 13.5 – USC Investigators Conducting Multi-Site Research) in addition to USC IRB review, if applicable. Examples of these studies include surveys about high-risk behavior or questionnaires that ask questions about HIV status.

International studies will follow the same criteria for IRB review and approval as domestic studies. For example, a less than minimal risk study can receive an expedited review, whether the study is conducted within the US or abroad.

Research policies for studies conducted within the U.S. apply to international research wherever possible. In addition, international research protocols often include:
• Explanations of cultural differences that influenced the study design and the consent process

• Rationale for conducting the study with an international population

• Information regarding the host country’s IRB, Ethical Review Committee or equivalent organization and documentation of its approval of the research, if applicable

• A copy of the letter(s) of agreement on letterhead stationery with signatures from the local host Institution(s), and from government officials, as necessary, to cooperate in the proposed research

• A copy of the informed consent form, if used, in English, and a copy in the appropriate native language(s)

• Information regarding the literacy level of the expected subjects and how this may affect the informed consent process

• A description of the informed consent process, including methods for minimizing the possibility of coercion or undue influence in seeking consent and safeguards to protect the rights and welfare of vulnerable subjects

• A description of the processes for assuring anonymity and/or confidentiality of all data, and a description of the methods of transport and security of data to the United States, if applicable

• If data will be collected by someone other than the researcher, the curriculum vitae of the individual and letters of agreement should be included on letterhead stationery and with original signatures from the research collaborators

• If compensation is to be given to subjects, justification for the amount of money or goods should be provided and an explanation as to how this compensation is proportionate to the average annual income of people in the host country should be examined

**Faculty Advisor Responsibilities**

Faculty Advisors are expected to remain in contact with students conducting research at any foreign site to ensure safety and welfare of the participants and student. Faculty must
also prepare students for cultural differences they will encounter in an international setting. Faculty who supervise student researchers must be aware of their responsibilities and their role in the protection of human subjects. Refer to Section 16.3 – Requirements of Faculty Who Supervise Student Research for more information.

16.6 Students as Research Subjects

Consistent with an overall concern that no research subject should be coerced, researchers must take precautions to avoid the unintentional or subliminal coercion that can occur when potential research subjects are also students. For this reason, researchers should avoid using their own students as research subjects. Researchers who wish to use their own students must be able to provide a good scientific reason, rather than convenience, for selecting their own students as research subjects.

In instances where investigators can provide justification for using their own students in their research, the IRB generally requires that someone other than the investigator (instructor) obtain informed consent and collect the data. When this is not possible, the IRB will consider other methods for obtaining consent and collecting data that would not reveal to the instructor, whether or not a student participated in the research project until after final grades have been determined. The students should be informed of these procedures in the informed consent form. In addition, it is generally recommended that the investigator/professor provide a recruitment flyer or letter to the students, so that the students may be the initiators and contact the investigator/professor regarding the research study.

16.7 Student Researchers’ Abuse Reporting Obligations

Mandated reporters are individuals who are obligated by law to report suspected cases of child and/or elder abuse and neglect. In general, any person who has contact with children or the elderly in a professional capacity is a mandated reporter, although laws vary from state to state, as does the legal entity to which reports must be made. For the California Penal Code definition of mandated reporter see Elder Abuse and Dependent Adult Civil Protection Act Section 15630 (a) and Child Abuse and Neglect Reporting Act Section 11165.7.
Only “mandated reporters” are required to make mandatory reports of child and elder abuse. If one is not a mandated reporter, he or she is not required to file.

**Student Researchers’ Abuse Reporting Obligations**

Although child or elder abuse may be disclosed or suspected in many research disciplines, research conducted in certain schools or departments (gerontology, psychology and social work) often provide situations in which evidence or disclosure of such abuse is more likely to be encountered. Abuse is defined as “non-accidental injury inflicted by others; sexual abuse; unjustifiable mental suffering (as in a young child witnessing domestic violence); neglect; cruelty; statutory rape (minor under 16 and other 21 or older, even if consensual); lewd and lascivious conduct (minor under 16 and other 10 years older, even if consensual); consensual sexual contact between minors (where one is 14 years of age and the other is under 14 years of age)”. In the event that a student researcher becomes aware of, or reasonably suspects, that a study subject has been the victim of child or elder abuse, the student should follow these procedures:

If student researcher’s faculty advisor is a mandated reporter, the student researcher should notify that mandated reporter of the suspected abuse. A mandated reporter is legally obligated to follow up.

Even when the student’s faculty advisor is not a mandated reporter, the student researcher should notify the faculty advisor and/or the department of their concerns.

If one is not a mandated reporter, he or she need not make a mandated report however, students have an ethical obligation to report their suspicion to a faculty member for further action. Guidance for student researchers who are not mandated reporters who encounter or suspect child/elder abuse may be found at [http://oprs.usc.edu/files/2013/01/ChildElder_Abuse_FAQ_2.15.pdf](http://oprs.usc.edu/files/2013/01/ChildElder_Abuse_FAQ_2.15.pdf).

**Abuse Disclosure Notification in Consent Documents**

Disclosing the obligation to report certain types of neglect and abuse in the informed consent process is required for research projects involving mandated reporters. However, even though the requirement to report only applies to mandated reporters, Section 11166.05 broadens the scope of possible reporting beyond the mandated areas by allowing (not requiring) mandated reporters to make reports regarding children suffering from “serious emotional damage or... at a substantial risk of suffering serious emotional
damage, evidenced by states of being or behavior, including, but not limited to, severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others”. This should be addressed in the informed consent process.

### 16.8 Student Subject Pools

A Subject Pool is a research resource used by some departments and schools in academic settings to enroll a large number of “available” subjects as potential volunteers. These volunteers are used in studies for that school or department. Subject Pools serve several roles: to provide researchers a pool from which to recruit primarily student participants for their studies and to familiarize students with the research process as subjects and researchers.

Participants in subject pools may be compensated for their time through course credit, extra credit or other means. These uses make subject pools commonplace in Social and Behavioral Studies.

**Note**: students must be provided an alternative to participation in the subject pool. The alternative assignment must not coerce subjects to participate in the subject pool. To prevent undue influence, the assignment should require approximately the same commitment of time and effort to complete as would participation in the subject pool.

At the University of Southern California, subject pools are found in the Department of Psychology in the College of Letters, Arts, and Sciences and the Marshall School of Business.

### Extra Credit

The IRB can approve projects that give extra credit to student subjects for participating in a research project only when alternative means of obtaining equivalent extra credit with an equivalent effort is available for students who decide not participate in the research. The IRB carefully reviews the alternatives to participation to ensure that students are not being coerced.

The informed consent form should detail the consequences of withdrawing from a project prior to completing the research activities (extra credit should be given despite withdrawal). In general, the IRB favors giving extra credit even if a subject withdraws,
unless the student withdraws immediately or there is clear evidence of bad faith on the part of the student.

**Marshall School of Business Subject Pools**

The Marshall School of Business has an unpaid student subject pool conducted by the Department of Management and Organization and a paid subject pool open to the general public conducted by the Department of Marketing. Links to the Marshall School subject pools and to additional information from Marshall are listed below.

- Policy for Behavioral Studies at Marshall School of Business
- Department of Management and Organization Consent Procedures
  [http://www.uscresearch.org/consentprocedures.html](http://www.uscresearch.org/consentprocedures.html)
- Department of Management and Organization Subject Pool Access
- Department of Marketing Consent Procedures
  [http://www.uscresearch.org/mktconsentprocedures.html](http://www.uscresearch.org/mktconsentprocedures.html)
- Department of Marketing Paid Subject Pool Access

**Department of Psychology Subject Pool**

The Department of Psychology subject pool is only open to USC students. To access the Psychology Subject Pool Webpage click on link below.

- Department of Psychology Subject Pool Webpage

**Recent Federal Guidance on Subject Pool and Penalties for “No Shows”**

Penalties for no-shows may not be assessed in subject pools
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The Office for Human Research Protections (OHRP) posted on its website a letter stating that imposing penalty credits on students who fail to show up for scheduled appointments with investigators without canceling by a specified deadline violates the requirement of Department of Health and Human Services (DHHS) regulation 45 CFR part 46.116(a)(8). The letter can be viewed by clicking here. At USC, the OHRP position is upheld for all research and no such penalty credits may be imposed on subject pool participants.

Correspondence with OHRP has indicated that in subject pool policies, penalties may be assessed when students:

- Sign up for a study for which they are not eligible
- Sign up for the same study for multiple different times
- Sign up for a study in which they have already participate
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Chapter 17
Special Research Topics

This chapter focuses on special research topics. Some topics discussed in this chapter are not subject to IRB review, other topics that are of misconstrued as human subjects research.

17.1 Secondary Data Analysis

Any research that involves secondary use of data where individual identifiable subject records are involved requires IRB review. For example, an investigator who plans to analyze an existing data set obtained from another source should submit an application for IRB review if the data set contains records on individual human subjects. If the data set contains no identifiers (either direct or linked code numbers), the project is not human subjects research (refer to Section 7.1 - Human Subjects Research: What is and What is Not for definitions of “human subject”).

If the data set contains identifiers, and does not contain private information, the project is not human subjects research. Otherwise, the project may be eligible for expedited review. The IRB may waive informed consent if research is minimal risk, the rights and welfare of the subjects are not adversely affected, the research could not practicably be carried out without the waiver, and, when appropriate, subjects are provided with pertinent information after participation.

17.2 Survey Research

Survey research is a research method that obtains data through the use of surveys, questionnaires, interviews, and focus groups. Because of the methodology, it is often assumed that all survey research is minimal risk. However, survey research may involve greater than minimal risk. For example, a survey or interview that asks questions about sensitive topics (childhood abuse, sexual functioning, immigration status) are not minimal risk. These questions may cause emotional stress, discomfort, or may have legal or social implications, and therefore may require full IRB review.
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The term anonymous is sometimes confused with the term confidential. In human subjects research, anonymous means that there is no link or identifier to the subject. If a link exists elsewhere, but is not available to the researcher, the IRB must determine the category of risk, and/or difficulty of discovery of the subject’s identity, the IRB cannot consider the information anonymous.

Survey research may be classified as exempt from the regulations if the information obtained is recorded in a way that the subject cannot be identified (either directly or through a code number or link), in other words, if the research data is anonymous.

A survey or interview study may also be considered exempt from the regulations even when the data is not anonymous if the information being gathered could not reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing, employability, or reputation.

If a study is not anonymous and contains information that, if known, could be damaging as described above, but it does not rise to the level of more than minimal risk, it may be given expedited approval. Although the IRB application gives the investigator the opportunity to indicate a classification, the IRB makes the final determination as to the classification of exempt or expedited.

For minimal risk surveys (mail-out or web-based), it may be appropriate to request the IRB to waive the requirement for the subject's signature on an informed consent form. When the subject's signature requirement is waived, generally the investigator provides all of the required elements of consent in an Information Sheet, with a statement that returning the survey or questionnaire will constitute voluntary agreement/consent to participate in the research study. For additional information, refer to Section 10.10 – Waivers of Informed Consent.

If survey research is supported by or conducted in collaboration with the Department of Defense (DOD), follow DOD requirements for additional review (refer to Section 3.2 - Research Supported by the Department of Defense).

17.3 Internet Research

Research conducted over the internet creates new challenges for those charged with maintaining protections for human subjects participating in such research. Internet research is has two distinct differences; one is collecting data online, the other is studying
internet/social media itself. Internet-based research is no different than other human subjects research in terms of regulatory oversight and requirements. As investigators design research protocols, particular issues must be addressed in order to maintain protections (violation of privacy, legal risks, and psychosocial stress). Human subjects research that is designed to recruit participants or collect data through the internet must be reviewed by the USC IRB.

Internet Research that may require IRB review includes studies with:

- questionnaires completed online via the Internet
- questionnaires downloaded from the Internet and returned by mail
- questionnaires incorporated into an e-mail and returned the same way
- qualitative interviews or discussions conducted over the Internet
- experiments conducted over the Internet
- use or housing of large public use databases
- recruiting volunteers over the Internet
- observation of individual behaviors via the Internet (such as “chat rooms”)
- taking part in a measurement system which tracks web usage using specialist software installed on the user’s computer
- a study that analyzes the age group correlation to Facebook addiction

**The following are options to consider when conducting research over the Internet**

Regulatory requirements and institutional oversight for human subjects research must be followed.

- Internet consent should include all the elements of the regular signed consent. The consent line should read, “By completing the survey you are agreeing to participate in the research”. Internet-based surveys should include “I agree” or “I do not agree” buttons on the website for participants to click their choice of whether they consent to participate or not.
- If a subject completes an anonymous survey and sends it to the researcher, the
researcher will be unable to extract identifiable data from the researcher’s
database and the participant may not have it withdrawn.

- If the IRB approves research and requires documented consent and the PI does
  not plan to maintain the anonymity of participants, the researcher may email the
  consent form to participants who may type their name and date into the spaces
  provided on the consent form, and return it to the researcher via email.

Privacy and Confidentiality in Internet Research

Privacy and confidentiality raise a particular challenge in Internet Research. The
challenges relate to the “unseen-ness” of the researcher as well as the subject. In some
cases, the subjects will not know they are being observed, and in other cases they are
being recruited and are willfully participating. The researcher must consider in which
situation his/her research will be taking place and address the risks to the subject, to the
security of the collected data, and to the validity of data gathered from unseen subjects.

Interactions and activities occurring in public chat rooms or public message boards are
considered public behaviors while some chat rooms and message boards have restricted
access. Interactions in restricted chat rooms and message boards are considered private
behaviors.

Recruitment and Compensation in Internet Research

The text of the recruitment script, the context in which the recruitment takes place
(posting a message on a newsgroup, mass e-mailings, and websites created for
recruitment of participants) must be reviewed and approved by the IRB.

When providing compensation, the following are recommended to maintain anonymity:

- electronic gift cards or certificates sent via email
- cash/gift card sent through the postal service (note: using the subject’s mailing
  address prohibits research being anonymous)
- do not link compensation to contact information
Vulnerable Subject Populations in Internet Research

- Vulnerability pertains to how identified data is protected, whether subjects are knowing participants, and class of subjects.

- The researcher should address subject vulnerability issues in order for the IRB to determine protections are adequate.

- Age of participant: On the Internet age is difficult to verify. To exclude minors, the researcher may state the minimum age of participants on a web page, information sheet, and/or consent document at the outset of the study. Individuals should be able to press a “not eligible, please discontinue” button (give the location) if they are not yet 18 years old, or an “I agree to participate and certify that I am 18 years of age or older” button.

- The researcher must provide a plan for obtaining parental permission when applicable.

- If the study population includes minors, the IRB may waive assent from the minors and/or parental permission from the parents depending on the level of risk in the research. Generally, if the study involves a high level of risk, assent and parental permission is required. If the study involves minimal risk, assent and/or parental permission can be waived. The IRB may require the use of information sheets when child assent and/or parental permission are waived.

Online Survey Options

There are a variety of ways to conduct online surveys. One way is for the researcher to create a survey themselves using a program such as Word, and then sending it through email. Another option is to use an online survey provider such as Survey Monkey. The researcher must consider confidentiality of the data obtained.

Online survey providers offer different options to researchers for maintaining confidentiality. When subjects are told the survey will be anonymous, the online survey must be configured so that identifiers (IP address, email address) are made unavailable to the researchers. Each survey company will have their own method for accomplishing this. Contact the survey provider for information on how to maintain confidentiality. If a survey provider routinely supplies identifiers and the researcher has described the survey as anonymous, the identifiers/IP addresses should be deleted immediately.
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Data being collected through the internet should be in an encrypted format. This helps to ensure that any data intercepted during transmission cannot be decoded, and that individual responses cannot be traced back to an individual respondent. All databases storing sensitive and identifiable information must be protected, regardless of whether they are created and maintained by commercial firms or by individuals.

Researchers are cautioned that encryption standards vary from country to country and that there are legal restrictions regarding the export of certain encryption software outside US boundaries.

Each communication below carries the risk of a breach of confidentiality. Email is not secure.

- Communication between the researcher and the subject
- Communication between the subject and the web server
- Communication between the web server and the researcher

### Additional Recommendations

Researchers should inform subjects that the researcher is available to discuss the questionnaire before starting the study. The researchers must provide email addresses or contact information.

Researchers should design interactive consent/survey/participation processes that are tailored to potential subjects- for example, by identifying the subject’s primary language and/or offering the consent/survey in that language.

When using an online survey vendor (survey monkey) to administer an online anonymous survey, the researchers should ask the vendor to withhold the IP addresses of the participants.

Given the nature of the study, consider the following: what information is being collected, how will it be transmitted, how long will the information be kept, the population being targeted, and are there any additional protections needed to protect participants’ privacy or data confidentiality?

Researchers should convey to subjects:
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- sites with URL's that begin with “https” or that display a small padlock are considered secure
- participants should completely log off the computer when finished to help maintain privacy
- Internet temporary files and cookies should be deleted so that subsequent users cannot “see” what sites were visited

Some online surveys are designed so that subjects cannot proceed without answering every question. Researchers must add the option of “no response” to all questions.

17.4 Incidental Findings in Research

Incidental Findings in research are results obtained/uncovered about an individual research subject, for which there is a potential health importance but is beyond the aims of the study. It may arise in collecting or analyzing research data/images or part of establishing eligibility or for purposes of the study itself (samples, eligibility, screening).

The research proposal should delineate how incidental findings will be managed in the research. The informed consent should be consistent with this plan. In general, it is contemplated that the health care provider/investigator will disclose the relevant information and ensure appropriate referral or care are recommended or provided.

Incidental Findings give rise to a wide range of practical and ethical challenges for recipients and practitioners.

Emerging medical technologies, changing cost structures, and evolving medical practice have increased remarkably the likelihood of discovering incidental findings in the clinical, research, and commercial direct-to-consumer contexts.

Current guidance in the biomedical community includes these recommendations for Incidental Findings

- Researchers should develop a plan to manage anticipatable incidental findings, including but not limited to those findings known to be significant and clinically actionable (and, when relevant, analytically valid and clinically valid). The plan should be reviewed and approved by an Institutional Review Board.
Researchers should develop a process for evaluating and managing unanticipatable findings. The plan should be reviewed and approved by an Institutional Review Board. During the informed consent process, researchers should notify participants about the possibility of unanticipatable incidental findings, including lifesaving incidental findings, and the plan for their management. Researchers who discover an unanticipatable incidental finding of concern should assess its significance, consulting with experts as appropriate.

Researchers should consider carefully the decision to actively look for secondary findings. In certain circumstances, with approval from an Institutional Review Board, researchers can justifiably adopt a plan that includes looking for selected clinically significant and actionable secondary findings. Approved plans should be disclosed to prospective participants during the informed consent process.

**Researchers should consider that:**

- Certain procedures have a higher rate of false positives and that should be considered when sharing incidental findings with research subjects (such as CT scans)
- Data should only be collected and disclosed as necessary for achieving research aims
- Findings that are not actionable may have health, emotional, and well-being impacts

**USC David and Dana Dornsife Imaging Center (DNI) Policy: A progressive policy and process for handling incidental findings**

The David and Dana Dornsife Imaging Center (DNI) is a research facility that is part of the College of Letters, Arts & Sciences and is **not** affiliated with the Keck School of Medicine or the University Hospital.

This DNI policy does not apply to biomedical researchers who conduct research at HSC. They are subject to additional internal policies established by their home division/department.
Researchers using or planning to use DNI services must familiarize themselves with the David and Dana Dornsife Imaging Center policies. The policies are accessible online:

http://brainimaging.usc.edu/index.php?topic=policies

Researchers utilizing the Dana and David Dornsife Imaging Center must follow the DNI policy as described above. Additionally, subject eligibility for Dornsife studies requires agreement to the mandatory neuroradiology scan per Dornsife policy.

**DNI IRB Requirements**

All human research protocols undertaken at the DNI must be submitted to the IRB for review and approval before conducting study activities. The IRB iStar application and the informed consent document must include an explicit description of the procedure for handling incidental findings (see “Mandatory Informed Consent Language” below). Additionally, the Principal Investigator is responsible for adhering to current Dornsife policy and for training and informing research personnel involved in the study of any changes to the policy.

Note: Clinical intervention studies utilizing the Dornsife Imaging Center should be submitted to the HSC IRB.

**Mandatory Informed Consent Language**

Investigators conducting human subjects research at the Dornsife Imaging Center must include specific mandatory language in the informed consent document.

Refer to Section 10.2 – Required Elements of Informed Consent to access the UPIRB informed consent Template which includes DNI mandatory language information.

**17.5 Difference between Human Subjects Research and Quality Assurance Research**

The term “quality assurance” is used for the specific instance of the process of reviewing, analyzing, or evaluating patient and/or provider specific data that may indicate (the need for) changes in systems or procedures that would improve the quality of care.
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The distinction between quality assurance and human subjects research is intent. When an activity is specifically initiated with a goal of evaluating and possible improving the performance of institutional practice in relationship to an established standard, the activity is called quality assurance.

If a project is originally initiated as a quality assurance project but the findings may be of interest beyond the Institution, publishing the findings to benefit other systems does not make it human subjects research. However, if the individual who conducted a quality assurance project chooses to expand the findings into a research study, IRB review is required at that time.

In order to distinguish research from quality assurance, use the following criteria:

- **Intent** - the intent should be clear in the purpose/aim statement for the specific project. In general, quality assurance projects are aimed at improving local systems of care (nongeneralizable). If the intent is to promote “betterment” of a process of care or a clinical outcome, then the project is quality assurance.

If any of the following criteria are met, the study may require IRB review:

- **Generalizability** - if the primary intent of the study is to generate generalizable results
- **Additional risk or burden** - if the study will imposes risks or burdens on the subject/patient beyond the standard of practice it may be human subjects research
- **Design** - if a study involves randomization or an element that may be considered less that standard of care the IRB must evaluate

Studies that do not neatly fall into one of these categories are always challenging to evaluate.

Additional Notes:

- Federal regulators have made it clear that any publication describing a study as “research” and having an interaction or intervention with human subjects must have received prior IRB review and approval. Therefore, projects determined to be quality assurance initiatives ought not to be published as “research”. Refer to [OHRP Quality Improvement Activities - FAQs](#).
- Studies considered quality assurance must also maintain the highest integrity of confidentiality possible.
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- Characterizing a study as quality assurance does not necessarily negate the need for informed consent.

### 17.6 Institutional Research

USC’s approach for institutional research that is conducted for internal use, or to evaluate programs or to inform management practice and decision-making, falls outside the federal definition [45 Part 46] of “research” and hence does not need to undergo review by the IRB.

Institutional research involves data collection, analysis, or reporting about educational, administrative, or other aspects of a college or university for either institutional self-improvement or external reporting. In most universities, institutional research informs such issues as enrollment management; program evaluation; student outcomes assessment; space planning and utilization; financial analysis; and faculty or staff planning. Data most often include institutional databases, surveys, focus groups, interviews, tests, work samples, and archival materials.

These activities do not meet the definition of human subjects research as they are designed to provide data/information about the Institution itself and improving education and services. They are not gathering information about the individual (human subject).

Institutional research is specific and applied. It is not intended to generate theory, provide results that will be generalized beyond USC, or advance knowledge. It is intended to be of direct, practical value. While the term “institutional research” is most often used in an academic setting, the function is found in a wide array of educational, service, and other organizations. For example, many health care providers and service organizations have offices of Quality Assurance, Organizational Effectiveness, Planning and Assessment, or Evaluation.

### 17.7 Oral History Research

Oral history is not considered research as defined by the U.S. Department of Health and Human Services (DHHS) regulations. The DHHS Office for Human Research Protection does not consider oral history to meet the regulatory definition of “research” and therefore is excluded entirely from IRB review, without seeking formal exemption. If oral history projects do not meet the regulatory definition of research they do not require
IRB review. However, oral historians are encouraged to consult the IRB if they have questions.

Oral historians are encouraged to act in accordance with ethical and legal standards appropriate to oral history, not biomedical or behavioral research. For decades, oral historians have promulgated high ethical and professional standards, including their ethical requirement to gain informed consent prior to conducting an interview, and a signed legal release at the conclusion of the interview.

Simply talking with someone for background is not oral history. Oral history involves interviews for the record, explicitly intended for preservation as a historical document. Informed consent means that those being interviewed fully understand the purposes and potential uses of the interview, as well as their freedom not to answer some questions, and their identification in research and writing drawn from the interview.

Legal releases are linked to issues of evidence and copyright. If a researcher makes explicit use of an interview in written work (both in direct quotation and paraphrase), a citation in a footnote should be included so that others can identify and locate the information within the framework of the extant evidence. Recorded interviews involve copyright, and interviewees must sign an agreement that establishes access for those who use the interview in any way. If the interviews are deposited in a library or archives, legal releases will establish ownership of the copyright and the terms of access and reproduction. If the interviews are published, legal releases will satisfy publishers’ concerns over copyright. For further information, see John A. Neuenschwander, *Oral History and the Law*.

### 17.8 Feasibility Studies

A pilot study is a preliminary investigation of the feasibility of a study, usually done on a small scale and exploratory in nature. It is designed to help the investigator refine data collection procedures and instruments or prepare a better, more precise research design. Sometimes pilot studies are conducted to collect initial data in support of or preparation for a grant submission.

Pilot studies, sometimes called feasibility studies, involving human subjects require the same scrutiny as full-scale research projects and therefore, must be submitted for IRB review and approval. It is recommended to explicitly identify in an IRB submission when a study is intended as a pilot or feasibility study, because it helps the committee to contextualize the research, particularly when it comes to justification for the sample size
or research design. In regard to sample size, in particular instead of requiring a formal power calculation for the sample size, the IRB may be satisfied with a rationale as to why the proposed number of subjects was chosen (for example, "15 is the number of available subjects and is expected to provide enough data to determine whether the questionnaires are understandable").

Data from pilot/feasibility studies may be used in a future expanded study and have IRB approval.

Pilot testing to validate questionnaires and survey instruments before implementation in a study does not constitute feasibility/pilot studies and IRB approval is not required.

### 17.9 Research Using Deception

Deception is a technique that may be used in some research despite a general ethical concern about fully informed consent. For certain kinds of less than fully informed consent, exceptions to this prohibition are allowed primarily because there is not expectation of harm that will result. Examples of deception include studies in which the investigator does not disclose the true purpose of the research to subjects, does not explain the ultimate use of the subjects’ data, or uses a “confederate” acting on behalf of the study team, unbeknownst to the subject. Studies using deception routinely receive expedited or Full Board review when the conditions of deception would be problematic for the subjects and pose risk of physical or emotional stress.

#### Deception Qualifying for Exempt Review

- The omission of minor facts is not equivalent to deception.
- Exempt studies using deception in surveys/games/focus groups where the deception is of no risk can receive the Exempt determination.
- Psychological research often justifies a need for use of deception to reduce biased responses that subjects may feel will reflect poorly on them. Study findings suggest that such deception is not harmful to subjects.
17.10 Management of Suicidal Ideation in Research

If there is an established risk of suicidal ideation there is need for identification and management of the potential for suicide. Study participants who express suicidal intentions present a delicate situation that requires sensitive attention and referral to a qualified clinician. The wellbeing and best interests of the research participant must always be maintained throughout a study.

Participants and the Potential for Suicidal Risk

The possibility of suicidal ideation or risk for suicide in an individual participant may not always be known in advance. For this reason, guidance is offered for assuring safety for both unexpected suicide risk and suspected suicide risk among research participants.

Standard mental health measures used in research to evaluate suicide risk include the following:

- Beck Depression Inventory (BDI)
- Columbia-Suicide Severity Scale – Screen Version (CSSR-S)

These evaluations include questions with regard to depression, hopelessness and suicidal ideation. They are commonly used in studies involving adolescents and adults.

If one of these measures is included in a research test battery, the research team may receive information that suggests that a participant might be suicidal. If a participant reports that he/she is considering suicide, the research team is then responsible for timely and appropriate follow-up to assure the safety of that participant. It is essential that a plan to ensure that timely and appropriate follow-up of research participants who are at increased risk for potential suicide is included in the research protocol and or IRB application. Researchers are encouraged to develop procedures, using the general guidelines, applicable to their particular research protocols.

Protocols that include the following elements require a management plan in the event suicidal ideation is identified:

- Questions regarding suicide as part of the testing, interview, or assessment protocol.
Chapter 17: Special Research Topics

- Subject sample or research procedures that involve elements of depression or suicide risk, such as research on mood disorders, severe mental disorders, self-mutilation, debilitating illnesses, or use of a chemotherapy agent that is known to be associated with an increase of depression.

**Assessment of Suicidal Ideation**

- **Intentional assessment of suicidal ideation**, through questions posed during an interview, assessment, or administration of a measurement instrument, such as the Beck Depression Inventory, due to the nature of the research. If the question is posed, either by interview or questionnaire item, be prepared to quickly review and further evaluate a positive response. The suicide question or positive response should be reviewed immediately or as soon as possible, rather than weeks or months after the data collection. This is not applicable in cases of collecting anonymous data when there is no direct subject contact, such as anonymous web based questionnaires or questionnaires returned by mail without identifying information.

- **Unintentional assessment of suicidal ideation** may be revealed through disclosure on the part of subjects in those research projects involving subject populations or procedures that may be associated with mood disorders or debilitating mental or physical illnesses. In these instances a quick review and further evaluation of the disclosure would be necessary.

**Elements of Assessment**

Have clinicians or trained interview/data collection staff gather additional information\(^1\) to evaluate lethality or imminent danger to self and guide intervention.

- **If the person collecting the data or conducting the interview is a trained clinician**, that is, a psychologist, nurse practitioner, psychiatrist, clinical social worker, or the like, then the clinician gathers his or her own information and can act on the information as clinically indicated, (assuming the clinician has experience with managing suicide risk).
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- If the person is not a clinician or is not familiar with suicide risk management, then a system should be in place to gather the necessary information about lethality and/or contact the appropriate clinician or make an appropriate referral for further evaluation and treatment. For example, procedures for non-clinicians may include a list of questions to ask in the event of a subject endorsing current suicidal ideation, and the direct contact information for a research clinician or other agreed upon clinician to review the responses to those questions. The clinician can then direct or advise the non-clinician regarding the safety procedure to follow. The procedures would have to include a clinician being readily available in person, or by phone or pager, ordinarily within an hour, for direct consult.

An adequate assessment of lethality or imminent danger to self should, at minimum, include gathering information about the specific thoughts of suicide, whether or not the person has a plan, determine if the person has the means to carry out the plan, history of suicide attempts, family history of suicide; the person's mental health history, history of use of medication, alcohol or illicit substances that may lead to lowering of inhibitions, and the person's family or community support system.234

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1 Information collected to evaluate lethality or imminent danger should not be included in research records.


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**Intervention**

- All staff should be trained on how to assess for suicide risk and the emergency procedures to follow in the event someone is deemed at imminent risk of suicide. Ordinarily, giving research subjects a list of referrals or telling the subject to go to a hospital after disclosure or endorsement of seriously thinking about suicide would not be considered sufficient standards.
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- **Clinical research staff should be readily available** if the interview or data collection is conducted by non-clinicians or research assistants, either in person, by phone, or pager response, ordinarily within an hour.

- If the person is evaluated as high risk for suicide, the research staff should **act quickly to protect the safety of the subject**. This may mean staying with the subject until assistance arrives or the person is transported to a hospital.

*For non-clinicians, the emergency system should outline procedures for contacting research clinicians for guidance, or in the event that clinicians are not available or cannot be contacted, the services of LAC+USC Medical Center Emergency Psychiatric Evaluation - 24 hour clinic and 911 are both available for response.*

- **For any results less than imminent risk**, research clinicians should be available to assist in developing a plan for safety with the subject. The plan for safety will depend on the level of risk and available resources.

  It may include contacting the person's personal physician, making sure the subject has appropriate referrals with a plan to contact subjects as a means to evaluate the subject following through with the referrals, encouraging the person to talk to trusted family members or other community support resources, or giving the subject suicide hotline information.

- For example, the clinician decides that although the subject has endorsed suicide ideation, there is no intent or plan, nor history of suicide attempts, but the subject does have bouts of depression. The clinician or clinician representative may provide the subject with referrals for treatment and the Suicide Prevention Hotline number, or discuss contacting the subject's primary physician or trusted family member to garner support or assistance.

  Documentation of the assessment and procedures ultimately followed is important.
**Informed Consent Language**

Inform the subjects about what will happen if they endorse suicidal ideation and, in particular, if they are deemed to be an imminent danger to self by way of the research informed consent process. This information would ordinarily go in the confidentiality section of the consent form or information sheet. Below is sample wording regarding the issue.

*The research team may not be able to keep confidential any disclosure or endorsement of thoughts to harm yourself. In the event that you tell the research staff that you are thinking about killing yourself or you answer yes to a question about having thoughts about suicide, the research staff will ask you more questions about the thoughts. Depending on how intense your thoughts are or how much you feel like hurting yourself, the research staff may provide you with referrals for treatment, work with you to contact your personal physician, trusted family member, or therapist to discuss your thoughts of harming yourself; or work with you on a plan that may include getting you to a hospital for safety.*

**Adverse Event Reporting and suicidal ideation**

Adverse event reporting in research on suicide or depressed individuals needs to be tailored to the individual study. If the study involves individuals with a high risk of suicide, then a suicide would not be an “unexpected” event. Other criteria may exist, such as a hospitalization - which may require the need for IRB submission in such a case. In a study without inherent need for monitoring for depression or mood changes, a suicidal event would be unexpected, and therefore potentially reportable. Do not hesitate to contact the IRB for guidance on this issue.
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Chapter 18
FDA-Regulated Research

This chapter covers research involving products regulated by the Food and Drug Administration (FDA), including investigational and approved drugs, biologics, and devices. This chapter also describes procedures for emergency use of investigational drugs, biologics, and devices, and other regulations unique to FDA-regulated products. Research involving FDA-regulated products may also be subject to 45 CFR 46, California regulations, and institutional policies.

18.1 FDA-Regulated Research

The FDA regulations for drugs are outlined in 21 CFR 312, devices are in 21 CFR 812, and biologics are in 21 CFR 600. FDA regulations for informed consent (21 CFR 50) and Institutional Review Boards (21 CFR 56) also apply. For a comparison of FDA and HHS regulations on human subject protection, click here. Reporting of adverse events and unanticipated problems related to research on FDA-regulated products is covered in Chapter 20 - Reportable Events, Noncompliance, Suspensions, and Terminations.

The USC IRBs are registered with both the Office for Human Research Protections (OHRP) and FDA in the OHRP database.

Definitions for FDA Regulated Research

<table>
<thead>
<tr>
<th>Biological Product</th>
<th>A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound) applicable to the prevention, treatment, or cure of a disease or condition of human beings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Investigation</td>
<td>Any experiment that involves a test article and one or more human subjects.</td>
</tr>
</tbody>
</table>
Device | An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory that is intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease; or intended to affect the structure or any function of the body; AND which does not achieve its primary intended purposes through chemical action within or on the body and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.

Drug | Articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease and articles (other than food) intended to affect the structure or any function of the body.

Test Article | Any drug, biological product, medical device, electronic product, or other product regulated by the FDA.

### 18.2 Investigational Drugs

An Investigational New Drug (IND) application is the FDA regulatory mechanism by which a sponsor can ship an unapproved drug or biologic to study sites and initiate clinical research on the drug. The FDA assigns an IND number and allows the investigation to begin after it determines that research participants will not be exposed to unreasonable risk. An IND application is required for:

- Testing of unapproved drugs
- Testing of approved drugs that involves new indications or significant labeling changes


Investigators must describe the regulatory status of each study drug in the iStar application as well as rationale for determining whether or not an IND is required for the study. If a drug is covered by an IND, the IND number and documentation of the IND number must be provided. Documentation may include FDA correspondence to the sponsor that provides the IND number, or a clinical protocol or investigator’s brochure that identifies the IND number. The IRB staff verifies that there is an IND number and
that the number provided in the iStar application is correct. The study will not be approved until the IND number is verified.

Certain drug investigations may be exempt from the requirement for an IND. A clinical investigation of a *marketed* drug is exempt from the IND requirements if *all* of the criteria are met:

- The drug product is lawfully marketed in the United States
- The investigation is not intended to be reported to FDA as a well-controlled study in support of a new indication and there is no intent to use it to support any other significant change in the labeling of the drug
- In the case of a prescription drug, the investigation is not intended to support a significant change in the advertising for the drug
- The investigation does not involve a route of administration, dose, patient population, or other factor that significantly increases the risk (or decreases the acceptability of the risk) associated with the use of the drug product
- The investigation is conducted in compliance with the requirements for review by an IRB (21 CFR 56) and with the requirements for informed consent (21 CFR 50)
- The investigation is conducted in compliance with the requirements of 21 CFR 312.7 (the investigation is not intended to promote or commercialize the drug product)

Investigations of marketed drugs or biologics must have an IND if none of the exemptions described above apply. When the principal intent of the investigation is to develop information about an approved product’s safety or efficacy, IRB approval and an IND are required.

Additional information about exemptions from IND requirements is found in the FDA guidance document “Investigational New Drug Applications (INDs) - Determining Whether Human Research Studies Can Be Conducted Without an IND.”

The IRB will determine if the IND exemption proposed in the iStar application is consistent with FDA regulations and guidance. The committee determination will be recorded in the meeting minutes. If there is no IND and the study does not meet any of the FDA exemption categories, the IRB will not approve the study. The investigator may
re-submit the iStar application after obtaining an IND number from the FDA or obtaining a written determination from the FDA that no IND is needed.

When there is a question as to whether the use of a marketed drug or biologic for an unapproved indication requires an IND, the investigator should contact the FDA directly for a determination. The IRB may require that an investigator contact the FDA if this has not been done at the time of IRB review. If the FDA indicates that an IND is not required, documentation of contact with the FDA is required. This may be either a written notification from the FDA, or documentation of contact with the FDA, including who was contacted, the phone number, the time of the call, and a summary of the information provided by the FDA.

### Off-Label Use

An IND is not required when a health care provider prescribes a marketed drug to treat an individual patient for an unlabeled indication. This is referred to as “off-label use.” An IND is not required because this use falls within the scope of medical practice and it is not research.

### Expanded Access of Investigational Drugs

The use of investigational drugs and biologics is usually limited to subjects enrolled in clinical trials under an IND. However, investigational products may show some promise before the trials are completed. When there is no satisfactory standard treatment for a serious, life-threatening, or debilitating condition, the FDA has a mechanism that allows expanded access to investigational drugs before the clinical trials are complete. When no satisfactory alternative treatment exists, subjects are generally willing to accept greater risks from investigational drugs that have potential benefits.

Expanded access to investigational drugs requires an IND and prospective IRB approval. In some cases, the sponsor will have an expanded access protocol under an existing IND. In other cases, an investigator may have to obtain a new IND for expanded access to an investigational drug. A new IND is needed if there is no existing IND or if the sponsor does not want to amend an existing IND to include expanded access. The following mechanisms expand access to promising therapeutic agents without compromising the protection afforded to human subjects or the thoroughness and scientific integrity of product development and marketing approval.
Treatment IND

A treatment protocol added to an existing IND is called a "treatment IND." The treatment IND 21 CFR 312.34 and 312.35 is a mechanism for providing eligible subjects with investigational drugs for the treatment of serious and life-threatening illnesses for which there are no satisfactory alternative treatments. A treatment IND may be granted after sufficient data have been collected to show that the drug may be effective and does not have unreasonable risks. Because data related to safety and side effects are collected, treatment INDs also serve to expand the body of knowledge about the drug.

There are four requirements that must be met before a treatment IND can be issued:

- The drug is intended to treat a serious or immediately life-threatening disease
- There is no satisfactory alternative treatment available
- The drug is already under investigation, or trials have been completed
- The trial sponsor is actively pursuing marketing approval

Treatment IND studies require prospective IRB review and informed consent.

Open Label Protocol or Open Protocol IND

These protocols are usually uncontrolled studies, carried out to obtain additional safety data (Phase 3 studies). They are typically used when the controlled trial has ended and treatment is continued to enable the subjects and the controls to continue to receive the benefits of the investigational drug until marketing approval is obtained. These studies require prospective IRB review of the protocol and informed consent.

Parallel Track

The FDA’s Parallel Track policy 57 FR 13250 permits wider access to promising new drugs for AIDS/HIV-related diseases under a separate "expanded access" protocol that "parallels" the controlled clinical trials that are essential to establishing the safety and effectiveness of new drugs. It does so by providing an administrative system that expands the availability of drugs for treating AIDS/HIV. These studies require prospective IRB review and informed consent.
## 18.3 Investigational Medical Devices

### Definitions Related to Investigational Medical Devices

<table>
<thead>
<tr>
<th>Medical Device</th>
<th>A medical device is any health care product that does not achieve its primary intended purposes by chemical action or by being metabolized. Medical devices also include reagents and test kits for in vitro diagnosis of disease and other medical conditions such as pregnancy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Risk Device</td>
<td>A device that presents a potential for serious risk to the health, safety, or welfare of a subject, and 1) Is intended as an implant; 2) Is used in supporting or sustaining human life; 3) Is of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise prevents impairment of human health; or 4) Otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.</td>
</tr>
<tr>
<td>Non-Significant Risk Device</td>
<td>A device that does not meet the definition of a significant risk study. (A nonsignificant device should not be confused with the concept of &quot;minimal risk&quot; used in IRB regulations under 45 CFR 46.)</td>
</tr>
<tr>
<td>510(k) Device</td>
<td>A new device determined by the FDA to be substantially equivalent to an approved device. 510(k) devices are “cleared” by the FDA and may be marketed immediately.</td>
</tr>
<tr>
<td>Investigational Device Exemption (IDE)</td>
<td>An approved IDE permits an investigational device to be shipped lawfully for the purpose of conducting investigations of that device.</td>
</tr>
</tbody>
</table>

Medical devices range from simple products such as bandages and tongue depressors to complex products such as cardiac pacemakers, surgical lasers, orthopedic implants, and imaging systems and software. Medical devices also include diagnostic products such as pregnancy test kits. When medical device research involves in vitro diagnostics and unidentified tissue specimens, the FDA defines the unidentified tissue specimens as human subjects.

The FDA has several regulatory mechanisms for studying and approving new devices and modifications to existing devices. These regulatory mechanisms are based on the level of risk to participants. Investigators who are studying devices must provide the IRB with
complete and accurate information about the regulatory status and risk level of each device.

An Investigational Device Exemption (IDE) permits an investigational device to be shipped lawfully for the purpose of conducting investigations of that device. Investigational use also includes clinical evaluation of new intended uses of legally marketed devices. The IDE regulations found at 21 CFR 812 describe three types of device studies:

### Significant Risk Device Studies

A significant risk device is an investigational device that:

- Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject
- Is 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 diagnosing, 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

Significant risk device studies must follow all the IDE regulations. An IDE application must be approved by the FDA and the IRB before the study can begin.

### Nonsignificant Risk Device Studies

A nonsignificant risk device is one that does not meet the definition of a significant risk device. Studies of nonsignificant risk devices must follow the abbreviated IDE requirements at 21 CFR 812.2(b). An IDE application is not required.

### IDE Exempt Studies

Certain device studies are exempt from IDE requirements, including studies using:

- A legally marketed device when used in accordance with its labeling (including 510(k) devices)
• A diagnostic device if it complies with the labeling requirements in §809.10(c) and, if the testing is noninvasive, does not require an invasive sampling procedure that presents significant risk; does not by design or intention introduce energy into a subject; and is not used as a diagnostic procedure without confirmation by another medically established diagnostic product or procedure

• A device used for consumer preference testing, testing of a modification, or testing of a combination of devices if the device(s) are legally marketed device(s) AND if the testing is not for the purpose of determining safety or effectiveness and does not put subjects at risk

• The device is a custom device as defined in 21 CFR 812.3(b) unless the device is being used to determine safety or effectiveness for commercial distribution

### Determination of Risk Level

The study sponsor is responsible for the initial determination that a device poses significant or nonsignificant risk to subjects. If there is no industry sponsor, the Principal Investigator is considered to be the sponsor and must make the initial risk determination. The IRB must review the initial determination for each device study and make an independent risk determination. The FDA guidance document [Significant Risk and Nonsignificant Risk Medical Device Studies](#) is available to help distinguish significant from nonsignificant risk studies. This guidance document provides many examples of significant and nonsignificant risk devices. Sponsors, investigators, and IRBs may need to request additional assistance from the FDA to make the risk determination.

### Significant Risk Devices

The sponsor makes the initial determination that a device presents significant risk to subjects. If the sponsor determines it to be a significant risk device, the sponsor must submit an IDE application to the FDA. The study cannot begin until the FDA approves the IDE application. When the FDA receives an IDE application, FDA notifies the sponsor in writing that the application was received and that an IDE number was assigned. The IDE application is considered approved 30 days after it was received by FDA, unless the FDA informs the sponsor within 30 days that the IDE application was not approved or that it must be modified.
The IRB must make an independent determination of device risk when reviewing the study. Because significant risk devices present more than minimal risk to subjects, all significant risk device studies will be reviewed by the full committee. In deciding if a study poses a significant risk, the committee will consider the nature of the harm that may result from use of the device in the investigation, and not the risks of the device alone. For example, if subjects must undergo a surgical procedure as part of the study, the IRB will consider the potential risks of the surgery in addition to the potential risks of the device.

The investigator cannot begin a significant risk device study until the IDE is approved and the USC IRB approves the study. The sponsor and investigators must comply with IDE regulations in conducting the study.

**Nonsignificant Risk Devices**

The sponsor makes the initial determination that the device presents nonsignificant risks to subjects. The proposed study can then be submitted directly to the IRB for review, without an IDE application and without FDA notification or approval. The IRB reviews the study and makes an independent determination about the risk level.

The IRB determination is based on information provided by the sponsor. In deciding if a device presents nonsignificant risks, the committee will consider the nature of the harm that may result from use of the device in the investigation, and not the risks of the device alone. The sponsor must provide a statement that the study involves nonsignificant risk to subjects and an explanation why the study does not involve significant risks to subjects. The IRB may require additional information from the sponsor or investigator, including: a description of the device, reports of prior investigations with the device, the proposed investigational plan, a description of subject selection criteria and monitoring procedures, any other information the IRB finds necessary to make a risk determination, whether other IRBs have reviewed the study and the determinations that were made, and the FDA’s assessment of the device's risk (if the FDA has made such an assessment).

If the IRB agrees with the nonsignificant risk determination, the study can begin after the investigator receives IRB approval. The FDA does not have to be notified of IRB approval of a nonsignificant risk device study.

If the IRB does not agree with the sponsor’s nonsignificant risk determination and instead finds that the study involves significant risk, the IRB will notify the investigator, and where appropriate, notify the sponsor. The sponsor must notify the FDA in writing (21
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CFR 812.150(b)(9)) of the IRB determination. The IRB can review the study as a significant risk device study, but the study may not begin until FDA approves an IDE application or makes its own nonsignificant risk determination.

**Abbreviated IDE Requirements**

Nonsignificant risk device studies must follow the abbreviated IDE requirements under 21 CFR 812.2(b). These requirements address labeling of the device, IRB approval, informed consent, monitoring, and records and reports.

**IRB Responsibilities**

The IRB must review the initial risk determination for each device study and make an independent determination of the risk. The determination is based on information provided in the device section of the iStar application. If the device information is incomplete or inaccurate, the IRB will not approve the study until the investigator provides additional information.

Investigators must describe the regulatory status of each study device in the iStar application as well as rationale for determining whether or not an IDE is required for the study. If the study requires an IDE, the IRB staff will verify that the IDE number provided in the iStar application matches the number provided in the sponsor’s protocol or in FDA correspondence. The committee will discuss the study risks and make a determination about the device. This determination will be recorded in the meeting minutes. If an IDE number is not provided, the study will not be approved. The investigator will be asked to re-submit the application after obtaining the IDE number.

If the study is proposed as a nonsignificant risk device study, the committee will discuss the study risks and make a determination about the device. This determination will be recorded in the meeting minutes. The minutes will instruct the investigator to comply with the abbreviated IDE requirements.

If the study is proposed to be exempt from IDE requirements, the committee or expedited reviewer will confirm the exemption type proposed by the investigator. The IRB determination will be recorded in the meeting minutes or expedited review correspondence. For studies involving 510(k) devices, the IRB staff will check the FDA database to verify the regulatory status of the device. The IRB may require that the investigator obtain written documentation of 510(k) clearance and attach this
documentation in the iStar application. A device with 510(k) clearance is a legally marketed device when used in accordance with its labeling.

**Off-Label Use of Devices (Treatment)**

An IDE is not required when a health care provider uses an approved device to treat an individual patient for an unlabeled indication. This is referred to as “off-label use.” An IDE is not required because this use falls within the scope of medical practice and it is not research.

### 18.4 Sponsor-Investigators

USC investigators who initiate and submit IND or IDE applications to the FDA assume the responsibilities of both the investigator and the sponsor. Sponsor-Investigators must provide FDA documentation of their IND or IDE in the iStar application.

Sponsor-Investigators are required to complete and sign the USC Sponsor-Investigator Agreement form (found in the Forms pages of the HSIRB and UPIRB websites) and attach it in the iStar application. This agreement serves as an assurance that the investigator will review, be cognizant of, and comply with regulatory requirements of sponsor-investigators. The IRB may require the PI to receive training / education from the HSIRB Chair, an experienced HSIRB member, or other designee before beginning the research.

A sponsor-investigator for an IDE protocol must follow the FDA regulations in 21 CFR 812 applicable to sponsor responsibilities. This includes:

- The record keeping requirements of 21 CFR 812.140(b)
- The reporting requirements of 21 CFR 812.150(b) including annual IDE progress report to the IRB (and annual progress report to FDA if the IDE is for a significant risk device)
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- The required notification under 21 CFR 812.150(b)(1) to the FDA and all participating investigators of any evaluation of an unanticipated adverse device effect within 10 working days of first receiving notice of the effect. Unanticipated adverse device effects are described in Section 7.13 Reportable Events.

A sponsor-investigator for an IND protocol must follow the FDA regulations in 21 CFR 312 applicable to sponsor responsibilities, particularly Subpart D. This includes:

- The recordkeeping and record retention requirements of 21 CFR 312.57
- The annual report requirements of 21 CFR 312.33 and safety reporting of 312.32 and
- Prompt reporting as required in 21 CFR 312.55(b) to the FDA and all participating investigators of significant new adverse effects or risks with respect to the drug or biologic

The IND or IDE product must be stored, secured, dispensed, and documented in accordance with policies of the Institution where the test article will be used, such as Keck Hospital of USC, USC Norris Comprehensive Cancer Center and Hospital, Keck Medicine clinics, LAC+USC Medical Center, and other USC locations.

If the sponsor-investigator holding the IND or IDE leaves USC or transfers to USC, the sponsor-investigator is responsible for notifying FDA about the change in Institution and address.

For additional information, refer to Section 13.2 – Investigator-Initiated Research and Sponsor-Investigators. Additionally, refer to the OPRS booklet “Are You the Holder of an IND or IDE?”

18.5 Compassionate Use of Medical Device

The FDA compassionate use provision allows patients who do not meet eligibility criteria for a clinical trial to have access to an investigational device. This provision applies to an individual patient or a small number of patients for whom the treating physician believes the device may provide a benefit in treating and/or diagnosing their disease or condition. Patients must have a serious disease or condition and have no acceptable alternatives for treatment.
This provision is unlike those that provide for Emergency Use of Test Article or Humanitarian Use Devices (HUD). Prior FDA approval and IRB approval are needed before compassionate use occurs. The sponsor must submit an IDE supplement and request approval for a compassionate use under section §812.35(a) in order to treat the patient(s). The IDE supplement should include:

- A description of the patient's condition and the circumstances requiring treatment
- A discussion of why alternatives therapies are unsatisfactory and why the probable risk of using the investigational device is no greater than the probable risk from the disease or condition
- An identification of any deviations in the approved clinical protocol that may be needed in order to treat the patient
- The patient protection measures that will be followed (including informed consent, concurrence of IRB Chair, clearance from the Institution, independent assessment from uninvolved physician, and authorization from IDE sponsor)

**Physicians Responsibilities**

The physician should not treat the patient until FDA and the manufacturer approves the specific compassionate use of the device under the proposed circumstances. If the request is approved, the physician should submit an Emergency Use/Compassionate Use application in iStar to obtain concurrence of the IRB Chair. The physician must devise an appropriate schedule for monitoring the patient, taking into consideration the investigational nature of the device and the specific needs of the patient. The patient should be monitored to detect any possible problems arising from the use of the device.

Following the compassionate use of the device, a follow-up report should be submitted to FDA as an IDE Report in which summary information regarding patient outcome is presented. If any problems occurred as a result of device use, these should be discussed in the IDE Report and reported to the reviewing IRB as soon as possible.

**IRB Responsibilities**

The IRB will acknowledge and evaluate the submission to determine whether the compassionate use met the eligibility criteria and complied with the regulatory requirements. Compassionate use is a clinical care activity, not research. Data obtained from compassionate use cannot be used for research purposes.

**Compassionate Use for Multiple Patients**
Compassionate use is typically approved by the FDA for individual patients but may be approved to treat a small group. Clinician may treat multiple patients rather than an individual patient suffering from a serious disease or condition for which no adequate alternative therapy meets the medical need. In this case, the clinician should request access to the investigational device through the IDE sponsor. The sponsor should submit to the FDA an IDE supplement that includes the information identified above and indicates the number of patients to be treated. Such a supplement should include the protocol to be followed or identify deviations from the approved clinical protocol. As with single patient compassionate use, a monitoring schedule should be designed to meet the needs of the patients while recognizing the investigational nature of the device. Follow-up information on the use of the device should be submitted to the FDA in an IDE supplement after all compassionate use patients have been treated.

More information can be found on the FDA website:

http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/HowtoMarketYourDevice/InvestigationalDeviceExemptionIDE/ucm051345.htm#compassionateuse

### 18.6 Humanitarian Use Devices (HUD)

**Definitions Related to Humanitarian Use Devices (21 CFR 814)**

<table>
<thead>
<tr>
<th>Humanitarian Use Device (HUD)</th>
<th>A device that is intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 4,000 individuals in the United States per year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humanitarian Device Exemption (HDE)</td>
<td>An authorization from the FDA to market an HUD; indicates the device does not pose unreasonable risk of injury to patient. The probable benefit outweighs risk of injury from use. Exempt from “effectiveness” requirements.</td>
</tr>
</tbody>
</table>

A special type of medical device, the Humanitarian Use Device (HUD), is intended to benefit patients with rare conditions or diseases (affecting fewer than 4,000 people in the United States per year) and that is exempt from the effectiveness requirements. The Office of Orphan Products Development determines if a device can be designated as an HUD. The FDA must approve a Humanitarian Device Exemption (HDE) application
before the device can be marketed. The HDE authorization clears the HUD for marketing.

The use of the device does NOT constitute research; however, federal regulations require the local IRB approve the use of an HUD before it is administered to local patients. USC clinicians who wish to use an HUD must submit an iStar application and select “Use of Humanitarian Use Device (Not Research)” as the submission type. Initial IRB review is conducted at a Full Board meeting, but annual continuing review is conducted by an expedited reviewer.

The clinician submitting the IRB application must provide documentation to the IRB that the device’s sponsor has obtained an HDE. The device’s sponsor must document the following information in writing:

- The generic and trade name of the device
- The FDA HDE number (a six-digit number preceded by the letter H)
- The date of the HUD designation
- Indications for use of the device
- A description of the device
- Contraindications, warnings, and precautions for use of the device
- Adverse effects of the device on health
- Alternative practices and procedures
- Marketing history
- Summary of studies using the device

FDA regulations do not require an informed consent form for clinical use of an HUD (i.e., 21 CFR 50: see reference 7.5). However, sponsors often provide a sample consent form and the IRB or the Institution may require the investigator to use the template informed consent form specific for HUDs with all references to research eliminated.

The USC clinician must verify in the iStar application that the HUD is not being tested as part of a research study. The IRB is not required to determine whether the device is “significant risk” or “non-significant risk”. Investigators who intend to study the efficacy
and safety of an HUD in research require an IDE. Clinicians will also be asked about intended off-label use of the HUD.

18.7 Emergency Use of a Test Article (Investigational Drug, Biologic or Device)

Emergency use is defined as the use of a test article in a human subject in a life-threatening situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval (21 CFR 56.102(d)). The emergency use provision in the FDA regulations 21 CFR 56.104(c) provides an exemption from prior review and approval by the IRB. The exemption allows for one emergency use of a test article without prospective IRB review for a subject in a life-threatening or severely debilitating situation in which no standard treatment is available.

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

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

FDA regulations require that any subsequent use of the test article at the Institution must have prospective IRB review and approval. Subsequent use includes a second use in the first subject or the use in another subject. An IRB application must be submitted immediately after the first emergency use if additional uses of the test article are anticipated. However, the FDA acknowledges that it would be inappropriate to deny emergency treatment to a second individual if the only obstacle is that the IRB has not had sufficient time to convene a meeting to review the proposed use.

When there is time for prospective IRB approval before the test article is used, the investigator must complete an IRB application. The proposal will be scheduled for review at the next convened meeting. FDA regulations do not provide for expedited IRB
approval by an expedited reviewer. Treatment cannot be initiated until IRB approval is obtained.

**Procedures for IRB Notification of Emergency Use**

The treating physician must notify the IRB of any intended emergency use of a test article before the use occurs. This is done through the “New Emergency Use Application” activity in iStar. The physician must provide assurances that the proposed use of the test article meets the emergency use criteria and that an IND, IDE, or HDE will be obtained. The physician must submit the first part of the application to the IRB as notification of the intended use. If the physician proceeds with emergency use of the test article, the physician is required to notify the IRB within 5 working days of the use. This is done by completing and submitting the second part of the Emergency Use Application to the IRB. The IRB will acknowledge the emergency use at the next convened meeting. In the acknowledgment letter, the physician is reminded that subsequent uses of the test article require prior IRB approval.

Some manufacturers will not ship the test article to the physician without written agreement from the IRB. The physician will receive an acknowledgement notice from the IRB when the emergency use application is submitted. If this acknowledgement notice is not sufficient documentation for the sponsor to ship the test article, the physician should contact the IRB immediately for additional documentation.

**Emergency Use of an Investigational Drug or Biologic**

The emergency use of an unapproved investigational drug or biologic requires an IND. The treating physician must contact the manufacturer to find out if the manufacturer will ship the drug or biologic for emergency use under the manufacturer’s IND.

The need for an investigational drug or biologic may arise in an emergency situation that does not allow time for submission of an IND. In such a case, FDA may authorize shipment of the test article in advance of the IND submission. Requests for such authorization may be made by telephone or other rapid communication means.

**Informed Consent**

The treating physician is required to obtain informed consent of the subject or the subject's legally authorized representative for emergency use of a drug or biologic, unless
both the treating physician and a physician who is not otherwise participating in the clinical investigation certify in writing all of the following:

- The subject is confronted by a life-threatening situation necessitating the use of the test article

- Informed consent cannot be obtained because of an inability to communicate with, or obtain legally effective consent from the subject

- Time is not sufficient to obtain consent from the subject's legal representative

- No alternative method of approved or generally recognized therapy is available that provides an equal or greater likelihood of saving the subject's life

If the treating physician believes that immediate use of the test article is required to preserve the subject's life and if time is not sufficient to obtain an independent physician's assessment, the treating physician should make the determination and, within 5 working days after the use of the article, have the determination reviewed and evaluated in writing by a physician who is not participating in the clinical investigation.

**Emergency Use of an Investigational Device**

Unapproved devices are normally used only in approved clinical studies conducted under an IDE. Emergency situations may arise in which there is a need to use an investigational device in a manner inconsistent with the clinical study or by a treating physician who is not part of the clinical study.

Emergency use of an unapproved device may occur before an IDE is approved if all the following criteria are met:

- The subject has a life-threatening disease or serious condition requiring immediate use

- There are no generally accepted alternative treatments

- There is no time to obtain FDA approval of an IDE
If an IDE exists, authorization from the IDE sponsor should be obtained. The sponsor is responsible for reporting the emergency use to the FDA within 5 working days. If no IDE exists, the treating physician is responsible for reporting the emergency use to the FDA.

The treating physician has the following responsibilities:

- Obtain an independent assessment by a physician who is not participating in the investigation

- Obtain institutional clearance according to institutional policy (if required by the healthcare facility)

- Obtain concurrence from the IRB Chair

- Obtain authorization from the sponsor if an IDE exists

- Obtain informed consent for the emergency use

### Informed Consent

The treating physician is required to obtain informed consent of the subject or the subject's legally authorized representative unless both the treating physician and a physician who is not otherwise participating in the clinical investigation certify in writing all of the following (21 CFR 50.23):

- The subject is confronted by a life-threatening situation necessitating the use of the device

- Informed consent cannot be obtained because of an inability to communicate with, or obtain legally effective consent from, the subject

- Time is not sufficient to obtain consent from the subject's legal representative

- No alternative method of approved or generally recognized therapy is available that provides an equal or greater likelihood of saving the subject's life
**Independent Physician Assessment**

If the treating physician believes immediate use of the test article is required to preserve the subject's life, and if time is not sufficient to obtain an independent physician's assessment, the treating physician should make the determination. Within 5 working days after the use of the article, the treating physician must have the determination reviewed and evaluated in writing by a physician who is not participating in the clinical investigation. The investigator must notify the IRB within 5 working days after the use of the test article (21 CFR 50.23).

**18.8 Planned Emergency Research with Exception from Informed Consent**

Planned emergency research is a rare type of research that allows participants to be enrolled without prior informed consent. It differs from emergency use of a test article described above. Investigators who wish to conduct planned emergency research should consult with IRB staff prior to submission of the protocol to the IRB. All of the following conditions must be present for emergency research with an exception from informed consent requirements, as described in 21 CFR 50.24:

- The human subjects are in a life-threatening situation that necessitates urgent intervention
- Available treatments are unproven or unsatisfactory
- Collection of valid scientific evidence is necessary to determine the safety and effectiveness of the intervention
- Obtaining informed consent is not feasible because the subjects are not able to give their informed consent as a result of their medical condition
- The intervention must be administered before consent can be obtained from the subject’s legally authorized representative
- There is no reasonable way to identify prospectively individuals likely to become eligible for participation
- Participation in the research holds out the prospect of direct benefit to the subjects
The clinical investigation could not practicably be carried out without the waiver.

Planned emergency research refers to research planned to occur in emergency settings, and it requires prospective IRB approval. Studies meeting the criteria for an exception from informed consent for emergency research must be approved by the FDA and have a separate IND or IDE.

Before the research is approved, investigators must consult with representatives of the communities where the research will be conducted and from which participants will be drawn and publicly disclose the research plan and potential risks and benefits to the communities. Investigators must also publicly disclose the results of the trial to the community after the trial is completed. An independent data monitoring committee must be established to exercise oversight of the research.

The IRB must ensure that there are appropriate procedures in place to inform subjects, their legally authorized representative, or their family members of their inclusion in the study, details about the study, the subject’s right to discontinue participation, and other information contained in the informed consent form. This must be done at the earliest feasible opportunity.

The IRB and/or the investigator will only provide advance notice of these protocols to the Office for Human Research Protections (OHRP) when the research is not subject to FDA regulations.

Additional responsibilities of investigators, the IRBs, and the sponsors are described in the FDA’s Guidance for Institutional Review Boards, Clinical Investigators, and Sponsors – Exception from Informed Consent Requirements for Emergency Research.

### Research Supported by the Department of Defense (DOD)

Research supported by or in collaboration with the Department of Defense (DOD) is subject to additional regulations. The USC IRBs do not approve exceptions from consent in emergency medicine research funded by DOD unless a waiver is approved by the Secretary of Defense.
18.9 Dietary Supplements

Dietary supplements are regulated by the FDA under the Dietary Supplement Health and Education Act of 1994 (DSHEA). Dietary supplements include vitamins, minerals, herbs, botanicals, amino acids, and other dietary substances intended to supplement the diet.

Investigators who wish to use dietary supplements in clinical studies will be asked to add information about each dietary supplement product to the iStar application. This should include the composition of the product and whenever possible, information about previous human use, testing, and safety.

Although dietary supplements are not subject to the same FDA regulations as drugs, clinical testing of a dietary supplement may still require an Investigational New Drug (IND) application. If the intent of the study is to evaluate a dietary supplement’s effects on the normal structure or function of the body, no IND is required. If the intent of the study is to evaluate the dietary supplement’s ability to diagnose, cure, mitigate, treat, or prevent a disease, an IND is required before the IRB will approve the study. Investigators should review the FDA guidance document “Investigational New Drug Applications (INDs) – Determining Whether Human Research Studies Can Be Conducted Without an IND” when planning a clinical study using a dietary supplement. The IRB may ask investigators to contact the FDA for a written opinion about the need for an IND for clinical studies of dietary supplements. Additional information is available in the FDA guidance document “Botanical Drug Products.”

18.10 Screening Procedures and Consent for FDA Research

The following is excerpted from the FDA Information Sheet “Screening Tests Prior to Study Enrollment”: http://www.fda.gov/RegulatoryInformation/Guidances/ucm126430.htm

In general, for some studies, the use of screening tests to assess whether prospective subjects are appropriate candidates for inclusion in studies is an appropriate pre-entry activity. While an investigator may discuss availability of studies and the possibility of entry into a study with a prospective subject without first obtaining consent, informed consent must be obtained prior to initiation of any screening procedures that are performed solely for the purpose of determining eligibility for research.
Screening may qualify as a minimal risk procedure [21 CFR 56.102(i)] and the IRB may choose to use expedited review procedures [21 CFR 56.110] to approve such screening. The IRB should receive a written outline of the screening procedure to be followed and how consent for screening will be obtained. The IRB may find it appropriate to limit the scope of the screening consent to a description of the screening tests and to the reasons for performing the tests including a brief summary description of the study in which they may be asked to participate.

Unless the screening tests involve more than minimal risk or involve a procedure for which written consent is normally required outside the research context, the IRB may decide that prospective study subjects need not sign a screening consent document [21 CFR 56.109(c)]. If the screening indicates that the prospective subject is eligible, the informed consent procedures for the study, as approved by the IRB, would be followed.

**HIPAA Waiver for Screening Medical Records**

HIPAA regulations apply to the screening process if it involves review of medical records. Investigators must obtain prospective HIPAA authorization from participants or apply for a partial waiver of HIPAA authorization for recruitment and screening. Refer to [Section 11.5 – Health Insurance Portability and Accountability Act (HIPAA)] for additional information.

**18.11 Data Retention Requirements Related to Subject Withdrawal from FDA-Regulated Research**

In FDA-regulated research, specific data retention requirements and disclosure to subjects apply, as described below:

- When a participant withdraws from a study, the data collected on the participant to the point of withdrawal remains part of the study database and may not be removed. The consent document cannot give the participant the option of having data removed.
- A researcher may ask a participant who is withdrawing whether the participant wishes to provide continued follow-up and further data collection subsequent to their withdrawal from the interventional portion of the study. Under this
circumstance, the discussion with the participant distinguishes between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through non-invasive chart review, and address the maintenance of privacy and confidentiality of the participant's information.

- The researcher must obtain the participant’s consent for this limited participation in the study (assuming such a situation was not described in the original consent document). The IRB must approve the consent document.
- If a participant withdraws from the interventional portion of a study and does not consent to continued follow-up of associated clinical outcome information, the researcher must not access for purposes related to the study the participant's medical record or other confidential records requiring the participant's consent. However, a researcher may review study data related to the participant collected prior to the participant's withdrawal from the study, and may consult public records, such as those establishing survival status.

**18.12 Registration of Clinical Trials and Other Types of Research**

FDA regulations under section 801 of the Food and Drug Administration Amendments Act (FDAAA 801) require that all “applicable clinical trials” be registered in the ClinicalTrials.gov clinical trials data bank. ClinicalTrials.gov was developed by NIH in collaboration with the FDA. It is a public registry and results database of clinical trials supported by public or private funds. The “Responsible Party” (the sponsor or the principal investigator designated by the sponsor) must register and report results of applicable clinical trials involving:

- Drugs and Biologics: controlled, clinical investigations, other than Phase 1 investigations, of a product subject to FDA regulation or
- Devices: controlled trials with health outcomes, other than small feasibility studies, and pediatric post market surveillance

"Applicable clinical trials" generally include interventional studies (with one or more arms) of FDA-regulated drugs, biological products, or devices that meet one of the following conditions:
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- Have one or more sites in the U.S
- Involve a drug, biologic, or device that is manufactured in the US (or its territories) and is exported for research
- Be conducted under an investigational new drug application (IND) or investigational device exemption (IDE).

For more information on definitions of terms, refer to FDA’s draft guidance document “Elaboration of Definitions of Responsible Party and Applicable Clinical Trial.” It is important to note that FDA and HHS regulations are inconsistent in the use of the terms “clinical trials” and “clinical investigation”. For more information, refer to 21 CFR 50, 56, 312 and 812.

Registration and results reporting are required for applicable clinical trials; however, ClinicalTrials.gov allows voluntary reporting of other studies that:

- Are in conformance with any applicable human subject or ethics review regulations (or equivalent) and
- Are in conformance with any applicable regulations of the national (or regional) health authority (or equivalent)

Investigators may choose to register a study that is not an applicable clinical trial as a condition to publish study results in a journal.

FDA regulations require reporting of results from registered trials. The Responsible Party must generally report results no later than 12 months after the trial completion date. Results must include participant baseline characteristics, participant flow diagram, outcomes, and adverse events. Instructions for submitting results are available at ClinicalTrials.gov. FDA also requires sponsors or investigators to certify compliance with ClinicalTrials.gov registration when submitting certain applications to the FDA. Form FDA 3674 is used to certify compliance.

Mandatory Informed Consent Language

FDA regulations require that informed consent forms contain specific language about clinical trial registration. Informed consent documents for applicable clinical trials or any study that will be registered in ClinicalTrials.gov must contain the following language in the Confidentiality section:
“A description of this clinical trial will be available on http://www.ClinicalTrials.gov, as required by U.S. Law. This web site will not include information that can identify you. At most, the web site will include a summary of the results. You can search this web site at any time.”

**Federal Enforcement**

Investigators who fail to comply with registration or reporting of results on ClinicalTrials.gov can be penalized. Penalties include civil monetary fines and withholding of grant funds if the study is federally funded.

**Other Registration Requirements**

**National Institutes of Health**

NIH requires all grantees, regardless of whether or not they are the Responsible Party, to certify that they are complying with FDAAA 801 in grant applications and progress reports. Grantees must certify that the responsible party has made all required submissions to ClinicalTrials.gov for applicable clinical trials funded in whole or in part by the NIH. Click here for more details about [Certifying Compliance with FDAAA in NIH Applications and Progress Reports](#). NIH certification is different from the FDA certification described above.

**Centers for Medicare & Medicaid Services (CMS)**

CMS now requires providers and suppliers to report an 8-digit clinical trial number (NCT number) assigned by ClinicalTrials.gov on claims for items/services furnished pursuant to clinical trials that qualify for coverage as set forth in the Medicare National Coverage Determination Manual. This requirement became effective 1/1/2014. Any qualifying clinical trial that bills tests and procedures to Medicare must be registered to receive payments from CMS. Claims submitted without the NCT number will be returned to providers for reprocessing and addition of the NCT trial number.

**Journals**

Journals may require registration of clinical trials and other types of health-related interventions in order to publish manuscripts. The International Committee of Medical Journal Editors (ICMJE) policy requires, and recommends that all medical journal editors
require, registration of clinical trials in a public trials registry prior to enrollment of the first subject. Investigators should carefully review registration requirements at ICMJE Clinical Trials Registration.

How to Register a USC Study

For industry-sponsored research:

The industry sponsor is responsible for registration of the research on ClinicalTrials.gov. USC Clinical Trials Office (CTO) will verify that the sponsor has registered the trial and provided the NCT number.

For investigator-initiated research:

Investigators in the Cancer Center should contact the Clinical Investigations Support Office (CISO) for assistance in registering their research on ClinicalTrials.gov.

Investigators who are not in the Cancer Center should contact the Associate Director of HSC Department of Contracts and Grants to request a user account for ClinicalTrials.gov:

Email: jeanbcha@usc.edu

Telephone: 323-442-2825

Webpage: https://research.usc.edu/clinical-trials-at-usc/9309-2/

For more information on registration of research on ClinicalTrials.gov, see the links below.

Helpful Links

- FDA “Guidance for Industry: Information Program on Clinical Trials for Serious or Life-Threatening Diseases and Conditions”

- Clinicaltrials.Gov Protocol Registration System
  http://prsinfo.clinicaltrials.gov/index.html
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- USC Vice President of Research Memorandum “ICMJE Journals Require Advanced Registration of Human Studies”
  https://oprs.usc.edu/files/2014/04/Registration-of-Human-Studies_4-7-14.pdf

- ICMJE List of Journals Following the ICMJE Recommendations
  http://www.icmje.org/journals-following-the-icmje-recommendations/

- OPRS “Intend to Publish Your Human Subjects Research Findings?”
  http://oprs.usc.edu/review/publication/
Chapter 19: Continuous Quality Improvement (CQI)

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Chapter 19
Continuous Quality Improvement (CQI)

This chapter describes the USC Continuous Quality Improvement Program objectives, activities, and components. A detailed list of quality improvement activities outlines major components of the Program. The chapter concludes with an overview of investigator and IRB assessments and audits.

19.1 The Continuous Quality Improvement (CQI) Program

The Human Subjects Protection Program (HSPP) conducts Continuous Quality Improvement (CQI) activities to measure and improve HSPP effectiveness, quality, and compliance with IRB policies and procedures, and applicable federal, state, and local laws. Outcomes of CQI activities are fed back into the process, resulting in improved protections for human subjects and increased efficiency. The CQI Program:

- develops and maintains USC Human Research Protection Program (HSPP) according to national best practices, regulations and guidelines
- keeps investigators cognizant of rules, corrects procedural errors, and
- increase protections for human research participants
- auditing and assessing investigator compliance with the HSPP policies and procedures and IRB requirements
In addition to developing and maintaining policies, the HSPP creates resources to facilitate compliance in the USC research community. Below is a list of initiatives that make up and support CQI activities:

**Human Subjects Teleconferences**

Each month OPRS hosts a teleconference for the Health Sciences and University Park IRB Directors and Chairs to share ideas and discuss human subjects protections developments and their impact on the Program.

**HSPP Executive Committee**

Monthly meetings are held amongst OPRS Executive Director and IRB Chairs and Directors from both campuses to discuss updates to regulations, implementation of new procedures, and best research practices.

**Education Sessions**
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OPRS and the IRB offer educational sessions on introduction to human subjects training, use of the electronic IRB application system and informed consent documentation to the USC research community.

**Classroom Education Sessions**

OPRS and IRB Student Mentors offer classroom education as guest lecturers to discuss human subjects protections with students (incoming PhD students, medical students, undergrad scholars).

**Booklets**

OPRS creates many booklets (available in hard copy and online) to educate student and researchers on a range of topics including students and research, conducting research using human subjects, mentoring USC student researchers, informed consent in human subjects research.

**OPRS and IRB Website**

The website provides the latest information to the USC research community including guidance, consent templates, policies, educational resources, and contact information. Website analytics are reviewed periodically to determine web traffic, reader interest and improve site content.

**Listerv Newsletter**

OPRS distributes a periodic newsletter to keep the USC research community informed of updates in regulations, policies, best practices, and relevant research news.

**Research Coordinator Bulletin**

Information specific for coordinators and research support staff is communicated through a coordinator bulletin. Featured topics include educational sessions, coordinator events and networking opportunities, coordinator FAQs, national coordinator resources and articles of interest.

**IRB Student Mentor**

The OPRS graduate assistant serves as UPIRB liaisons by meeting with student researchers and providing one-on-one assistance and training. The student mentor is a full voting IRB member and represents USC students in IRB deliberations. Student mentors
bring student concerns to policy meetings and also review OPRS documents for student perspective.

**Annual IRB Survey**

Each year, users of the IRB application system are invited to complete an online anonymous survey to provide feedback about the IRB system and offer suggestions on how to improve the review process. The surveys show trends over time and identify problems and issues. A summary of the survey results is publicly disseminated to the research community on the listserv and HSPP website; detailed results are provided to the Institutional Official and the IRBs. Feedback often results in educational opportunities, policy changes and iStar system process changes.

**iStar Development Meetings**

Representatives from OPRS, University Park IRB, Health Sciences IRB and Children’s Los Angeles IRB meet with iStar personnel twice per month to address iStar upgrades, problems, glitches and solutions. Also, iStar issues and suggestions identified at various stages of the CQI process are addressed and discussed at these meetings.

**Policies and Procedures Review and Updates**

HSPP Policies and Procedures are regulatory updated by the Human Subjects Working Group (OPRS, HSIRB, and UPIRB). Changes to Policies and Procedures are communicated to the IRB members, IRB staff, investigators, and research staff via the Human Subjects Newsletter. The Policies are available on the HSPP website.

**IRB Member and Administration Education**

OPRS arranges monthly educational sessions for IRB members as well as periodic IRB administration educational lunches to discuss best practices, upcoming policy changes and other topics.

**IRB Community Member Outreach**

OPRS hosts annual meetings and teleconferences with community IRB members from many Southern California Institutions to discuss emerging issues and share information. Additionally, OPRS created and regularly updates the “What It Takes to be an IRB Community Member” handbook ([https://oprs.usc.edu/files/2013/05/Community-Member-Booklet-5.1.13.pdf](https://oprs.usc.edu/files/2013/05/Community-Member-Booklet-5.1.13.pdf)). The handbook is nationally praised and has been adapted by various Institutions to supplement community member training.
Collaboration and Networking with Other Institutions

The HSPP collaborates and networks with other Institutions regularly to discuss best practices in policy and guidance development. Additionally, collaborative efforts with local partner Institutions reduce duplicative review of studies conducted at USC and either partner Institution (Children’s Hospital Los Angeles and Cedars-Sinai Medical Center).

Flexibility Coalition

The Coalition was originally established to discuss reducing the administrative burden on non-federally funded, no more than minimal risk projects. Teleconferences and in-person meetings are regularly scheduled to share, discuss and brainstorm ideas related to flexibility in the IRB review process. The Coalition is now more than 170 members strong.

Audits

Not-for-cause audits of research studies are conducted by ORPS; for-cause audits are conducted by the HSIRB. OPRS and IRB personnel also conduct assessments of IRB operations and the iStar system to identify trends and issues related to study approval times, IRB and investigator response time, IRB workload, and changes or deficiencies in policy implementation or process. Refer to the rest of this chapter for additional information.

For a list of more CQI activities at USC, visit: https://oprs.usc.edu/files/2013/01/CQI-Efforts-7.2013.pdf

19.3 Audits and Assessments

Audits For-Cause

For-cause audits are reactive, direct, and aimed to investigate or substantiate an allegation or complaint received by the Human Subjects Protection Program (HSPP). Allegations or complaints may be submitted to the HSPP through written correspondence, anonymous phone call, or other avenues. Information received from a sponsor, the FDA, a whistleblower, the IRB, IRB Chair, OPRS, an investigator, or a subject may all lead to a for-cause audit. Audits may also be initiated in response to protocol amendments,
continuing reviews, and other submissions or communications with the IRB. Additionally, funding agencies may request a for-cause audit due to allegations of noncompliance, adverse events, or other causes of concern.

Low-risk/ non-clinical studies rarely warrant a for-cause audit. A main goal of for-cause audits is to collect sufficient information for the IRB to determine a course of action on serious or continuing non-compliance, or reported allegations and complaints. For-cause audits are conducted by HSIRB and OPRS personnel.

### Audit Procedures

The IRB Chair or Vice-Chair initiates for-cause audits based on an allegation, complaint, deficiencies found by IRB review activities, and/or information from media or scholarly reports.

The IRB discussion of the allegation and subsequent determination are documented in the IRB meeting minutes.

The following items/processes may be inspected:

#### IRB (iStar) Application

- Initial applications including the protocol
- Amendment and revisions to the protocol
- Adverse events, unanticipated problems involving risks to subjects or others, protocol deviations, DSMB reports, as applicable
- Continuing Review Progress Reports
- Informed consents and/or other consent/assent documents
- Questionnaires, recruitment materials and other materials used in the study
- Correspondence from the investigator and the IRB
- IRB action letters (approved, approved with contingencies, deferred)
Researcher Files

- Copies of documents submitted to the IRB
- IRB action letters (approval notices)
- Case report forms
- Monitoring logs, enrollment and screening logs
- Correspondence between sponsor and investigators, and/or governmental correspondence
- PI/Staff education certifications/licensure/CVs
- Accrual information including the number of subjects enrolled to date; subjects not meeting eligibility criteria; subjects who either dropped out or were discontinued
- Approvals from other agencies or groups on or off campus (collaborating Institutions or organizations and University Safety Committees such as IBC, Radiation, other)

If the investigator is a student researcher, the IRB may request to have the file inspected in the faculty advisor’s office.

Research Case Report Forms (CRF)

These forms are kept in the research staff offices or investigator’s office. In most cases the subject’s medical records, as a source document, will be reviewed to verify the information on the CRF.

Informed Consent (IC) Documents

- Protocol status (active, closed)
- Version date of the informed consent
- Language version of the informed consent (English, Spanish)
- IRB approval stamp
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- Signatures (subject, investigator, witness, legally authorized representative and translator, as applicable)
- Date and time of the signature
- Copy given to the subject
- Short Form Documentation

**Observing the Consent Process**

Members of the USC HSPP are authorized to observe, or have a third party observe, the consent process and/or the conduct of the research for various reasons. Observation may be required by the IRB for projects requiring additional oversight, or projects that have been reported to have a problem related to the consent process or the conduct of the research.

After an audit/inspection, the auditor will summarize the findings and submit it to the Chair, and/or the IRB. The IRB will make recommendations to address any issues of noncompliance. See Section 20.8 – Procedure for Handling Reports of Noncompliance for more information.

**Quality Assessments (Not For-Cause)**

Quality assessments are not-for-cause assessments conducted by designees of the HSPP. The assessment team performs up to 10 assessments/re-assessments annually. In some cases, a follow-up assessment may be conducted to ensure compliance has been effected. Results of these assessments are educational and not routinely submitted to the IRB unless deemed necessary by OPRS. Research studies are chosen for quality assessment by OPRS/IRB staff using the following criteria:

- Schools and/or departments that submit high volumes of studies to the IRBs
- Investigators who have a high volume of active protocols
- Investigator-initiated protocols
- Studies including vulnerable subjects
- Studies conducted outside of the United States
• Recommendation by IRB staff

**Procedures for Investigator Visit Assessment**

**OPRS Program Director**
- Select audit candidates
- Review/approve audit report and PI response to report
- Conduct education session, if necessary
- Maintain ongoing log of audit findings to identify areas for improvement and trends

**CQI Team (HSIRB and UPIRB Administrators)**
- Set up assessment with PI and Research Team
- Conduct not for-cause audit: visit site and review study files
- Explain CQI process to the PI and Research Team
- Document findings in audit report and suggest recommendations

**PI and Research Team**
- Meet with CQI team to update CQI team on status of studies, discuss communication among the research team, answer questions about the studies and provide feedback regarding the IRB process
- Make study-related documentation available to CQI team
- Respond to audit report, if required

OPRS notifies the Principal Investigator in writing of being selected for the CQI assessment. The CQI team schedules the assessment with the Principal Investigator (PI) and/or research team. The CQI team may request updated subject enrollment numbers for each IRB approved study to guide the assessment.

During the site visit, the CQI team conducts some of the following activities:

- Interviews the PI/research team to assess their knowledge of the study procedures
- Solicits feedback from researchers on the IRB process
- Inspects documentation that subjects met inclusion criteria


- Inspects study records and storage facilities
- Inspects documents and coding mechanisms used to protect confidentiality
- Reviews documentation of adverse events and unanticipated problems

After the assessment, the CQI team prepares a report summarizing findings or recommendations. Once reviewed and approved by the OPRS Program Director, the final report is forwarded to the PI. If findings are identified, the Principal Investigator must submit a response addressing each deficiency and include an action plan to prevent similar deficiencies in the future. In some cases, a follow-up assessment and/or training session(s) may be required.

If serious and/or continuing non-compliance is found, the CQI assessment report will be submitted to the IRB Chair and/or the IRB. The IRB will make recommendations to correct any issues of serious and/or continuing noncompliance. Refer to Section 20.8 - Procedure for Handling Reports of Noncompliance for more information.

The CQI team maintains a record of audit findings which is also used to identify trends and areas that are difficult or confusing for investigators. OPRS reviews audit findings to determine if improvements to the IRB process, electronic submission system or educational materials can be made to promote investigator compliance. When improvements to the system are identified, OPRS works with the IRB and/or iStar team to implement such changes.

Audits by External Entities

External audits may be conducted by regulatory agencies (FDA, OHRP), a sponsor, or other entities external to USC (AAHRPP). External audits may be conducted for-cause or not for-cause.

For-cause

For-cause audits by entities external to USC may arise from an anonymous complaint, an unanticipated problem reported by the investigator to a sponsor or federal agency (FDA), noncompliance reports, or other. For-cause audits may arise from a self-report or be complaint-driven.
Routine, not for-cause audits maybe conducted by entities external to USC. Investigators or sponsors may hire consultants to review a protocol, clinical practices, or other aspects of research. Clinical trial sponsors frequently send trial monitors to verify data integrity and adherence to regulatory requirements.

19.4 Assessments of IRB Processes

OPRS assesses internal IRB processes on an ongoing basis. These are primarily done through iStar-generated reports.

Assessment of the IRB process includes:

- Review of IRB minutes and Full Board meeting agendas, paying particular attention to subject complaints, adverse events, and ad hoc agenda items (miscellaneous problems/issues/suspensions/audits)
- Examination of IRB staff pre-reviews for accuracy, especially for exempt studies approved by the UPIRB staff
- Review of official IRB letters for accuracy, correct regulatory citations, and clarity
- Review of researcher feedback/complaints
- Review of the various forms and guidance documents found on the IRB websites, functionality of the website and hyperlinked documents
- Analysis of IRB processes (Not Human Subjects Research / Coded Data short application, other) to identify process issues
- Monitoring of new IRB staff members for accuracy, and the proper application of regulations and USC policies
- Review of ad hoc items as necessary
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Chapter 20
Reportable Events, Noncompliance, Suspensions, and Terminations

This chapter contains regulatory requirements* for reportable events for both the investigator and the IRB. The following outline provides the contents of the chapter.

*Written policies for ensuring prompt reporting to the IRB, appropriate Institutional Officials, and the Department or Agency head of any unanticipated problems involving risks to subjects or others are required by 45 CFR 46.103(b)(5), 21 CFR 56.108(b)(1) and 21CFR 812.3 and 812.150(a).


Part One: Investigator Sections

- Adverse Events
- Unanticipated Problems Involving Risks to Subjects or Others
- Adverse Events that are Unanticipated Problems
- Adverse Device Effects

Part Two: IRB and Institutional Sections

- IRB Procedure for Handling Reports of Adverse Events
- IRB Reporting of Adverse Events that are Unanticipated Problems
- IRB Procedure for Handling Reports of Unanticipated Problems Involving Risk to Subjects or Others (UPX)
- Procedure for Handling Reports of Alleged Noncompliance
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- Suspension or Termination of IRB Approval
- IRB Reporting Requirements to Federal Agencies, Institutional Committees, or Others

PART I – INVESTIGATOR PERSPECTIVE

20.1 Adverse Events

The FDA defines adverse event as “any untoward medical occurrence associated with the use of a drug in humans, whether or not considered drug related” in the Investigational New Drug Safety Reporting Requirements for Human Drug and Biological Products and Safety Reporting Requirements for Bioavailability and Bioequivalence Studies in Humans.

OHRP defines adverse events as “any untoward or unfavorable medical occurrence in a human subject, including any abnormal sign (for example, abnormal physical exam or laboratory finding), symptom, or disease, temporally associated with the subject’s participation in the research, whether or not considered related to the subject’s participation in the research.” (See Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events)

Adverse events (AEs) encompass both physical and psychological harms. Adverse events occur most commonly in the context of biomedical research, although on occasion, they can occur in the context of social and behavioral research. A small number of AEs are also unanticipated problems involving risks to subjects or others (UPX).

Internal and External Adverse Events in Multicenter Clinical Trials

In the context of multicenter clinical trials, AEs are characterized as either Internal AEs or External AEs. When USC participates in a multicenter clinical trial, Internal AEs are those AEs experienced by subjects enrolled by the USC investigator(s), whereas External AEs are those AEs experienced by subjects enrolled by investigators at other Institutions engaged in the clinical trial. In the context of a single-center clinical trial conducted at USC, all AEs would be considered Internal AEs.
Internal Adverse Events at USC

The USC investigator typically becomes aware of an Internal Adverse Event directly from the subject, another collaborating USC investigator, or the subject’s healthcare provider. Upon becoming aware of an Internal AE, the investigator should evaluate whether the AE should be reported. If it is **unexpected; related or possibly related** to the study; and is either **serious** or suggests that the research places subjects or others at a **greater risk of harm** (physical or psychological) than was previously known or recognized, it should be reported to the IRB. The investigator must also ensure that the AE is reported to a monitoring entity (such as the research sponsor, a coordinating or statistical center, an independent research monitor, or a DSMB/DMC) as required under the monitoring provisions described in the IRB-approved protocol.

If the investigator determines that an AE is not reportable, but the monitoring entity subsequently determines that the AE does in fact represent a UPX (for example, due to an unexpectedly higher frequency of the event), the monitoring entity should report this determination to the investigator, and such reports must be promptly submitted by the investigator to the IRB.

Investigator Evaluation of Internal Adverse Events

Internal adverse events must be evaluated to determine whether they are:

**Unexpected**

Any adverse event occurring in one or more subjects participating in a research protocol for which the nature, severity, or frequency are **not** consistent with either:

- the known or foreseeable risk of AEs associated with the procedures involved in the research that are described in:
  - the protocol-related documents, such as the IRB-approved research protocol, any applicable investigator brochure, and the current IRB-approved informed consent document, and
  - other relevant sources of information, such as product labeling and package inserts, or
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- the expected natural progression of any underlying disease, disorder, or condition of the subject(s) experiencing the adverse event and the subject’s predisposing risk factor profile for the adverse event

The vast majority of AEs occurring in the context of research are expected in light of:

- the known toxicities and side effects of the research procedures

- the expected natural progression of subjects’ underlying diseases, disorders, and conditions, and

- subjects’ predisposing risk factor profiles for the AEs. Thus, most individual AEs do not meet the first criterion and do not need to be reported because they are “expected”

Related

Related or possibly related to participation in the research (in this document, possibly related means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research). Adverse events may be caused by one or more of the following:

- the procedures involved in the research including the drug, biological, device, or other intervention

- an underlying disease, disorder, or condition of the subject, or

- other circumstances unrelated to the research or any underlying disease, disorder, or condition of the subject

In general, AEs that are determined to be at least partially caused by (a) would be considered related to participation in the research, whereas AEs determined to be solely caused by (b) or (c) would be considered unrelated to participation in the research.

Serious

An event is defined as being serious if the event adversely alters the relationship between risks and benefits. Serious events include:

- Inpatient hospitalization or prolongation of hospitalization
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- Life-threatening reactions
- Persistent or significant disability/incapacity or permanent harm or disability (either physical or psychological)
- A congenital anomaly/birth defect in the offspring of the subject
- Jeopardizes the subject’s health and may require medical or surgical intervention to prevent one of the other outcomes listed in this definition
- A breach of confidentiality that may have a negative consequence
- Results in death or places subject in immediate risk of death

The investigator’s evaluation of the event is critical. Events that are unexpected, related to study participation, and serious must be submitted to the IRB for review. Events that do not meet these criteria do not have to be submitted to the IRB. If they are submitted, the event is auto-acknowledged and filed electronically.

Investigator Reporting of Internal Adverse Events to the USC IRB

Time-frame and mechanism of reporting:

AEs that are unexpected, related or possibly related, and are either serious or place subjects or others at a greater risk of harm than was previously known or recognized, must be reported to the IRB through iStar, using the Reportable Event application. Reporting to the USC IRB must be as soon as possible, but not later than 10 working days after the investigator becomes aware of the event.

For submission of an adverse event, include:

- A detailed description of the adverse event, incident, experience, or outcome
- A description of any changes to the protocol or other corrective actions that have been taken or are proposed in response to the event. Protocol changes and informed consent changes must be submitted through an iStar amendment application which may accompany (but more often follows) the submission of the event.
External Adverse Events

External AEs are events experienced by subjects enrolled at non-USC Institutions. Very few External AEs need to be reported to the IRB. An External AE should be submitted only when it meets the criteria for reporting (the AE is unexpected, related to the research, and serious) AND it meets the following additional criteria: (a) it occurred at a non-USC site in the same trial that the USC investigator is conducting OR (b) it occurred with the same drug that is being used at USC, but under a different protocol and/or different trial, and the event resulted in a change to the risk/benefit ratio, protocol, and/or informed consent. External AEs are submitted to the IRB through iStar, using the Reportable Event application. These external adverse events are auto acknowledged and filed electronically. They are available for review at the time of continuing review.

20.2 Unanticipated Problems Involving Risks to Subjects or Others

Defining Unanticipated Problems Involving Risks to Subjects or Others (UPX)

The term unanticipated problems involving risks to subjects or others (UPX) is found (but not defined) in the HHS regulations at 45 CFR 46.103(b)(5), and is found in the Food and Drug Administration regulations at 21 CFR 56.108(b)(1).

An incident, experience, or outcome that meets the criteria for a UPX (below), generally is significant enough to warrant consideration of changes in the research protocol, informed consent process, informed consent document, or corrective actions to protect the safety, welfare, or rights of subjects or others.

A UPX includes any incident, experience, or outcome that meets all of the following criteria:

- unexpected (in terms of nature, severity, or frequency) given:
  - the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent document, and
  - the characteristics of the subject population being studied
related or possibly related to participation in the research (in this document, possibly related means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research), and

suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized

### Examples of Unanticipated Problems Involving Risks to Subjects or Others

- A breach in confidentiality that involves risk to that individual or others, such as a PI’s laptop is stolen, and it contains identifiable medical information and research data about subjects (if laptop is encrypted, data is not considered “identifiable”)
- Subject complaints that cannot be resolved by the research team or which indicate increased or unexpected risks
- Any accidental or unintentional change to the IRB-approved protocol that increases risk or decreases benefit, affects the subject’s rights, safety, welfare, or affects the integrity of the resultant data
- Any publication in the literature, safety monitoring report including a Data and Safety Monitoring Board report, interim result, or other finding that indicates an unexpected change to the risk/benefit profile of the research

Adverse events are a larger and all-inclusive category of events in comparison to unanticipated problems. Only a small subset of adverse events will also meet the definitions/criteria “involving risks to subjects or others” (UPX) and require reporting to the FDA and OHRP. See the flow chart below to determine if an adverse event is a UPX and must be reported. For additional information, refer to Section 7.13 – Unanticipated Problems Involving Risk to Subjects or Others.
20.3 Adverse Events that are Unanticipated Problems

When adverse events should be considered unanticipated problems (UPX) that merit reporting to the IRB is a critical question. In the years since the IRB and IND regulations were issued, changes in the conduct of clinical trials (for example, increased use of multi-center studies and international trials) have complicated the reporting pathways for adverse event information described in the regulations.

For clinical investigations of drug and biological products conducted under an investigational new drug (IND) application, information about adverse events must be communicated among investigators, sponsors, and IRBs as follows:

- Investigators are required to report promptly “to the sponsor any adverse effect that may reasonably be regarded as caused by, or probably caused by, the drug. If the adverse effect is alarming, the investigator shall report the adverse effect immediately” (§ 312.64(b)).

- Sponsors are specifically required to notify all participating investigators (and FDA) in a written report of:
  - any adverse experience associated with the use of the drug that is both serious and unexpected
  - any finding from tests in laboratory animals that suggests a significant risk for human subjects, and
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- new observations discovered by or reported to the sponsor on the drug, particularly with respect to adverse effects and safe use

- Investigators are required to report promptly “to the IRB... all unanticipated problems involving risks to human subjects or others,” including adverse events that should be considered unanticipated problems (§§ 56.108(b)(1), 312.53(c)(1)(vii), and 312.66).

The practice of local investigators reporting individual, unanalyzed events to IRBs, including reports of events from other study sites that the investigator receives from the sponsor of a multi-center study—often with limited information and no explanation of how the event represents an unanticipated problem—has led to the submission of large numbers of reports to IRBs that are uninformative. Reports of individual External AEs often lack sufficient information to allow investigators or the IRB at each Institution engaged in a multicenter clinical trial to make meaningful judgments about whether AEs are unexpected, are related or possibly related to participation in the research, are serious or suggest that the research places subjects or others at a greater risk of physical or psychological harm than was previously known or recognized.

For multicenter research protocols, when a local investigator at one Institution engaged in the research independently proposes changes to the protocol or informed consent document in response to an AE or UPX, the investigator should consult with the study sponsor or coordinating center regarding the proposed changes because changes at one site could have significant implications for the entire research study.

Accordingly, to satisfy the investigator’s obligation to notify the IRB of unanticipated problems, an investigator participating in a multicenter study may rely on the sponsor’s assessment and provide to the IRB a report of the unanticipated problem prepared by the sponsor. In addition, if the investigator knows that the sponsor has reported the unanticipated problem directly to the IRB, because the investigator, sponsor, and IRB made an explicit agreement for the sponsor to report directly to the IRB, and because the investigator was copied on the report from the sponsor to the IRB, FDA would not expect an investigator to provide the IRB with a duplicate copy of the report received from the sponsor.

## Coordinating Center Reporting Responsibilities

A coordinating center in multicenter research is the Institution responsible for collecting all reports of adverse events and UPXs for all study sites. Coordinating centers should only report individual AEs to investigators and IRBs at all Institutions when a
determination has been made that the events meet the criteria for a UPX. Ideally, AEs occurring in subjects enrolled in a multicenter study should be submitted for review and analysis to a monitoring entity (the research sponsor, a coordinating or statistical center, or a DSMB/DMC) in accordance with the monitoring plan described in the IRB-approved protocol.

**Sponsor Determination of Adverse Events that Are Unanticipated Problems**

In a multicenter study, it is clear that individual investigators must rely on the sponsor to provide them information about AEs occurring at other study sites. It is also clear that the sponsor receives AE information from all study sites and typically has more experience and expertise with the study drug than an investigator. Accordingly, the sponsor is in a better position to process and analyze the significance of AE information from multiple sites and—when the determination relies on information from multiple study sites or other information not readily accessible to the individual investigators—to make a determination about whether an AE is an unanticipated problem. Furthermore, the regulations require the sponsor of an IND to promptly review all information relevant to the safety of the drug and to consider the significance of the report within the context of other reports (§ 312.32).

For multicenter studies, the sponsor is in a better position to process and analyze adverse event information for the entire study and to assess whether an adverse event occurrence is both unanticipated and a problem for the study.

**FDA Examples of Adverse Events that are Unanticipated Problems:**

- A single occurrence of a serious, unexpected event that is uncommon and strongly associated with drug exposure (such as angioedema, agranulocytosis, hepatic injury, or Stevens-Johnson syndrome)

- A single occurrence, or more often a small number of occurrences, of a serious, unexpected event that is not commonly associated with drug exposure, but uncommon in the study population (such as tendon rupture, progressive multifocal leukoencephalopathy)

- Multiple occurrences of an AE that, based on an aggregate analysis, is determined to be an unanticipated problem. There should be a determination that the series of AEs represents a signal that the AEs were not just isolated occurrences and involve risk to human subjects (for example, a comparison of rates across treatment groups reveals higher rate in the drug treatment arm versus a control). The FDA
recommends that a summary and analyses supporting the determination accompany the report.

- An AE that is described or addressed in the investigator’s brochure, protocol, or informed consent documents, but occurs at a specificity or severity that is inconsistent with prior observations. For example, if transaminase elevation is listed in the investigator’s brochure and hepatic necrosis is observed in study subjects, hepatic necrosis would be considered an unanticipated problem involving risk to human subjects. The FDA recommends that a discussion of the divergence from the expected specificity or severity accompany the report.

- A serious AE that is described or addressed in the investigator’s brochure, protocol, or informed consent documents, but for which the rate of occurrence in the study represents a clinically significant increase in the expected rate of occurrence (ordinarily, reporting would only be triggered if there were a credible baseline rate for comparison). The FDA recommends that a discussion of the divergence from the expected rate accompany the report.

- Any other AE or safety finding (such as that based on animal or epidemiologic data) that would cause the sponsor to modify the investigator’s brochure, study protocol, or informed consent documents, or would prompt other action by the IRB to ensure the protection of human subjects. The FDA recommends that an explanation of the conclusion accompany the report.
Is an Adverse Event an Unanticipated Problem that Must Be Reported?

http://www.hhs.gov/ohrp/policy/advevntguid.html

Investigator Reporting of Unanticipated Problems to the IRB

Events that the investigator believes might meet the definition of UPX (see above) must be reported to the IRB. The method for submitting a UPX report is through the Reportable Event application in the iStar system.

The investigator’s evaluation of the event is critical. Events that do not meet the definition of unanticipated problems involving risks to subjects or others do not have to be submitted to the IRB. If submitted, events that do not meet the UPX definition are auto-acknowledged and filed electronically.

**Report contents must include:**

- A detailed description of the event, incident, experience, and or outcome and
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- A description of corrective actions that have been taken or are proposed in response to the possible UPX

**Time frame for reporting to the IRB:**

UPXs should be reported to the IRB as soon as possible, but not later than 10 working days after the investigator becomes aware of the event.

For sponsored research, the terms of the contract may define a shorter reporting timeframe.

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### 20.4 Adverse Device Effects

The investigational device exemption (IDE) regulations define an unanticipated adverse device effect (UADE) as “any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects” (21 CFR 812.3(s)). UADEs must be reported by the clinical investigator to the sponsor and the reviewing IRB, as described below:

- Investigators are required to submit a report of a UADE to the sponsor and the reviewing IRB as soon as possible, but in no event later than 10 working days after the investigator first learns of the event (§ 812.150(a)(1)).

UADEs must be reported to the IRB through the Reportable Event application in the iStar system.

**Report contents must include:**

- A detailed description of the event, incident, experience, and or outcome

- A description of corrective actions that have been taken or are proposed in response to the possible UADE.

Sponsors must immediately conduct an evaluation of a UADE and must report the results of the evaluation to FDA, all reviewing IRBs, and participating investigators within 10 working days after the sponsor first receives notice of the effect (§§ 812.46(b), 812.150(b)(1)).

The IDE regulations, therefore, require sponsors to submit reports to IRBs in a manner consistent with the reporting of unanticipated problems.
PART II – IRB AND INSTITUTIONAL PERSPECTIVE

20.5 IRB Procedure for Handling Reports of Adverse Events

Adverse events may be either internal or external. **Internal Adverse Events** are events experienced by subjects enrolled by USC investigators. **External Adverse Events** are events experienced by subjects enrolled at non-USC Institutions.

Adverse Event reports are submitted by researchers through the iStar system. When the criteria for IRB Chair/Designee review is met*, the adverse event report is automatically routed to an IRB Chair or Designee. When the criteria for IRB Chair/Designee review are not met, the report is auto-acknowledged by the iStar system. Auto-acknowledged reports are “electronically filed” and are not reviewed by the IRB Chair/Designee.

**IRB Chair / Designee Review**

The IRB Chair/Designee reviews all adverse event reports when the reportable event application indicates the event is (all criteria below must apply):

- Unexpected
- Reasonably related (definitely, probably, or possibly)
- Suggests that the research places subjects or others at a greater risk of harm (physical or psychological) than was previously known or recognized
- Serious

The IRB Chair / Designee reviews the application and either:

- **Acknowledges the Adverse Event**
  
  If the Chair/Designee determines the event does **not** affect the risk/benefit ratio, study protocol, or informed consent, he or she will issue an IRB acknowledgment letter.

- **Forwards the Adverse Event to Full Board for Review**
  
  If the Chair/Designee determines the event affects the risk/benefit ratio, study protocol, or informed consent, or is unsure of a determination, the Chair/Designee
forwards the report to the Full Board for review. If subjects are at immediate risk of harm and there is insufficient time to wait for review by the convened IRB, the Chair/Designee may immediately halt further enrollment and/or suspend activities for currently enrolled subjects.

When Full Board review is required, the IRB staff assigns the item to the next Full Board agenda. All board members have access to:

- The adverse event report
- The Data Safety Monitoring Board (DSMB) or safety report, if applicable
- Any attached supplemental material submitted with the report
- An amendment request, if applicable
- The current IRB approved application, which may include the informed consent documents, sponsor’s protocol, investigator’s brochure and any other pertinent materials such as advertisements or questionnaires

**IRB Committee Review**

The Full Board reviews adverse event reports that were previously evaluated and forwarded from the IRB Chair/Designee. The Full Board reviews the adverse event report and any supporting documents and considers the following actions:

- Accept the report with no changes
- Accept the report with changes to the risk/benefit ratio, the protocol, or the informed consent documents
- Require modification of the protocol or consent(s), modification of the information disclosed during consenting, and/or re-consent of all subjects with the new information
- Defer the reportable event if significant modifications directly related to the approval criteria at 45CFR46.111 and/or 21CFR56.111 are required. The investigator’s response must be reviewed and approved by a convened IRB.
- Require minor modifications that meet criteria for expedited review (45CFR46.110 and 21CFR56.110) or are explicit changes verifiable by the Chair and/or IRB designee
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- Request further information from the investigator or the DSMB
- Increase the frequency of continuing review
- Impose additional monitoring by the Office of Compliance, IRB, Office for the Protection of Research Subjects (OPRS), or an independent monitor
- Halt enrollment pending receipt of further information
- Determine that the adverse event is an unanticipated problem involving risks to subjects or others and report findings as appropriate depending on the nature of the event
- Suspend any of the following activities:
  - Screening and enrollment
  - Recruitment
  - Intervention and interaction
  - Follow up activities
- Terminate IRB approval of the study according to IRB policy
- Consider whether the event represents serious or continuing noncompliance

### 20.6 IRB Procedure for Handling Reports of Unanticipated Problems Involving Risk to Subjects or Others (UPX)

Unanticipated problem reports may come to the IRB through iStar or “offline” from subjects, study staff, or others. Unanticipated problem reports from researchers are submitted through the iStar system. The iStar system either forwards the report to an IRB Chair or Designee for review, or auto-acknowledges the report. When the criteria for IRB review is met the unanticipated problem report is automatically routed to an IRB Chair/Designee. If the reviewer determines the event meets the criteria of a UPX, the event is forwarded to the Full Board for review and verification. The Full Board determines whether proposed changes to the protocol, consent, or other corrective actions are required. Once a UPX determination is made by the Full Board, the UPX will be reported to the appropriate entities according to the reporting policy (refer to Section 7.13).
Unanticipated Problems Involving Risk to Subjects or Others). The determination will be documented in the meeting minutes. When the criteria for IRB review are not met, the unanticipated problem report is auto-acknowledged by the iStar system. Auto-acknowledged reports are “electronically filed” and are not reviewed by the IRB Chair/Designee.

IRB Chair / Designee Review

The IRB Chair/Designee reviews unanticipated problem reports when the reportable event application indicates the event is (all criteria below must apply):

- Unexpected
- Reasonably related (definitely, probably, or possibly)
- Suggests that the research places subjects or others at a greater risk of harm (physical or psychological) than was previously known or recognized

The IRB Chair/Designee reviews the application and either:

- Acknowledges the Unanticipated Problem
  
  If the Chair/Designee determines the reported event does not meet the definition of a UPX (also refer to Section 7.13 – Unanticipated Problems Involving Risk to Subjects or Others), and/or the event does not affect the risk/benefit ratio, study protocol or informed consent, he or she will issue an IRB acknowledgment letter.

- Forwards the Unanticipated Problem to the Full Board for Review
  
  If the Chair/Designee determines the report is a possible UPX, and/or the event affects the risk/benefit ratio, study protocol, or informed consent, or is unsure of a determination, the Chair/Designee forwards the report to the Full Board for committee review. If subjects are at immediate risk of harm and there is insufficient time to wait for review by the Full Board, the Chair/Designee may immediately halt further enrollment and/or suspend activities for currently enrolled subjects. At the same time, the IRB staff assigns the item to the Full Board agenda.

When the report is forwarded to the Full Board, all board members have access to:

- The report of unanticipated problem
- The Data Safety Monitoring Board (DSMB) or safety report, if applicable
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- Any attached supplemental materials submitted with the report
- An amendment request (if there is one)
- The current IRB approved application, which includes (if applicable) the informed consent documents, sponsor’s protocol, and investigator’s brochure
- Any other pertinent materials such as advertisements or questionnaires

**IRB Committee Review**

The Full Board IRB reviews unanticipated problem reports that were previously reviewed by the IRB Chair/Designee. The Full Board makes the final determination as to whether the event meets the definition of a UPX (unexpected, related or possibly related, and suggests that the research places subjects or others at a greater risk of harm than was previously recognized). The Full Board considers the following actions:

- Accept the report with no changes
- Accept the report with changes to the risk/benefit ratio, the protocol, or the informed consent documents
- Require modification of the protocol or consent(s), modification of the information disclosed during consenting, and/or re-consenting all subjects with the new information
- Defer the reportable event if significant modifications directly related to the approval criteria 45CFR46.111 and/or 21CFR56.111 are required. The investigator’s response must be reviewed and approved by the Full Board.
- Require minor modifications that meet criteria for expedited review (45CFR46.110 and 21CFR56.110), or are explicit changes verifiable by the Chair and/or IRB designee
- Request further information from the investigator and/or the DSMB
- Increase the frequency of continuing review
- Impose additional monitoring by the Office of Compliance, IRB, Office for the Protection of Research Subjects (OPRS), or an independent monitor
- Halt enrollment pending receipt of further information
Chapter 20: Reportable Events, Noncompliance, Suspensions and Terminations

- Report findings as appropriate depending on the nature of the event
- Suspend any or all of the following activities:
  - Screening and enrollment
  - Recruitment
  - Intervention and interaction
  - Follow up activities
- Terminate IRB approval of the study according to IRB policy
- Consider whether the event represents serious and/or continuing noncompliance

20.7 IRB Reporting of Adverse Events that are Unanticipated Problems

When applicable, the IRB must report adverse events that are unanticipated problems to:

- OHRP (if federally funded)
- FDA (if subject to FDA regulations)
- Sponsor
- Funding agency (if federal agency)
- Institutional Official
- Principal Investigator
- Department Chair / Director / Principal Investigator's supervisor
- Office of Compliance
- Department of Contracts and Grants
- Other institutional committees (such as Institutional Biosafety Committee)

When the investigator provides documentation that the appropriate federal agency (-ies) and/or study sponsor have already been notified of the event, the IRB will not submit a duplicate report.
20.8 Procedure for Handling Reports of Alleged Noncompliance

Noncompliance is a generic term that is used to describe behavior that is not expected or acceptable and may or may not be intentional. Noncompliance may require action by the IRB or the Institution. The following definitions are provided to help with this determination.

**Definitions Related to Noncompliance**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncompliance</td>
<td>Failure to follow federal, state or local regulations governing human research, requirements or determinations of the IRB, or institutional policies. This definition may include action of any University employee or agent, such as investigators, research staff, IRB members, IRB staff, employees, or Institutional Officials.</td>
</tr>
<tr>
<td>Serious Noncompliance</td>
<td>An action or omission by an individual (investigator, research staff, IRB member, IRB staff, employee, or Institutional Official) that any other reasonable individual would have foreseen as compromising the rights and welfare of a subject or others.</td>
</tr>
<tr>
<td>Continuing Noncompliance</td>
<td>A pattern of repeated actions or omissions by an individual (investigator, research staff, IRB member, IRB staff, employee, or Institutional Official) that 1) indicates a pattern of deficiency in the ability or willingness of an individual to comply with federal regulations, USC HSPP policy, or determinations or requirements of the USC HSPP; 2) if allowed to continue could reasonably be expected to develop into serious noncompliance; or 3) recurs after a report of the activity has been evaluated and corrective action has been mandated.</td>
</tr>
</tbody>
</table>

Reports of alleged noncompliance or inappropriate involvement of human subjects in research may come to the attention of the IRB from different sources and by various means. For example, alleged noncompliance may come from an IRB member, an investigator, a subject or their family members, institutional personnel, institutional committees, the Clinical Trials Unit (CTU), the USC Office of Compliance, the media, anonymous sources, or the public. All reports of alleged noncompliance or inappropriate involvement of humans in research are investigated by OPRS, IRB, or both, when appropriate.

Allegations of noncompliance are different from and not considered protocol deviations that occur during the course of clinical research. Very rarely, a protocol deviation may be
considered noncompliance when the deviation compromises the rights and welfare of subjects.

When investigating allegations of noncompliance, the process should include:

- Assuring the safety of human participants
- Developing action plans to prevent reoccurrence, and promote future compliance
- Educating research staff on federal guidelines, regulations, and USC IRB policy
- Reporting serious or continuing noncompliance

Handling Reports of Noncompliance

Reports of IRB or institutional noncompliance will be dealt with on a case-by-case basis.

IRB Review

When the IRB receives a verbal or written report of alleged noncompliance, a preliminary review is conducted and forwarded to the IRB Chair. The materials the IRB Chair reviews to make the determination of serious and/or continuing noncompliance may include a description of the allegation, the entire research file, medical/research charts, interviews with research personnel/PI, and any subject complaints. If the IRB Chair determines the allegation has no merit, the matter will be closed.

If the Chair determines there is merit the matter is scheduled for review by the Full Board.

If more information is needed, the Chair requests an investigation by the IRB staff. The investigator is notified in writing of the directed investigation (audit). The completed audit report is presented to the IRB Chair and reviewed at the next Full Board meeting.

The IRB staff prepares the following documents for Full Board review:

Audit report (investigation report)

- Notification of noncompliance, if applicable
- Pertinent IRB correspondence (such as IRB applications, IRB approval letters, IRB approved informed consent)

The IRB committee reviews the materials at a convened meeting. The discussion, actions, and determinations are noted in the minutes. Upon review, the IRB determines:
Chapter 20: Reportable Events, Noncompliance, Suspensions and Terminations

- There is noncompliance that is neither serious nor continuing. The Full Board will formulate a corrective action plan, forward it to the investigator, and require a response from the investigator.

- There is serious or continuing noncompliance. The IRB office will report this determination to appropriate agencies, officials, and sponsors.

- There is insufficient information to make a determination. In this case, the board will request additional information to be gathered by the IRB staff and defer a determination to a later convened IRB meeting.

The Full Board determines the following **corrective actions**, if applicable:

- Require modification of the protocol or consent(s), modification of the information disclosed during consenting, and/or re-consenting all subjects with the new information.

- Defer the report if significant modifications directly related to the approval criteria 45CFR46.111 and/or 21CFR56.111 are required. The investigator’s response must be reviewed and approved by the Full Board.

- Require minor modifications that meet criteria for expedited review (45CFR46.110 and 21CFR56.110), or are explicit changes verifiable by the Chair and/or IRB designee.

- Verification that subject selection is appropriate.

- Observation of the informed consent process by the IRB staff.

- An increase in monitoring of the research activity via a data safety monitoring board and continuing evaluation of the site by the staff.

- Request a directed audit of targeted areas of concern.

- Request a status report after a specified number of subjects receive intervention.

- Shorten the continuing review cycle.

- Request additional investigator and staff education focused on human research protections given by the IRB staff or using other sources (such as Institutional Biosafety Committee (IBC), Radiation Safety Committee (RSC), OHRP conferences, National Institutes of Health (NIH) tutorial, or human research protection seminars).
Chapter 20: Reportable Events, Noncompliance, Suspensions and Terminations

- Require notification to current and/or past subjects, if information about the noncompliance might affect subjects’ willingness to continue participation
- Suspend the study
- Terminate the study
- If the event involves research misconduct, the IRB Chair will report this to the Dean of the investigator’s school and the USC Scientific Misconduct Committee

20.9 Suspension or Termination of IRB Approval

The IRB may suspend or terminate research on any study approved by the IRB when the IRB has an indication that circumstances warrant and there is cause (such as serious and continuing noncompliance, increased or undue risk, or unexpected serious harm to subjects).

Examples of actions that may cause suspensions or terminations include: inappropriate involvement of human subjects in research; impairment of the rights or welfare of participants; serious or continuing noncompliance with federal regulations or IRB policies; and new information indicating increased risk to human participants.

There is a regulatory difference between suspensions and terminations. It is:

Suspension of IRB Approval for Research Study

A suspension exists when the IRB temporarily or permanently withdraws approval of some or all research activities in a protocol. While suspended, the research remains under the jurisdiction of the IRB.

Termination of IRB Approval for Research Study

Termination takes place when the IRB permanently withdraws approval of ALL research activities in a protocol. Terminated research is no longer required to undergo continuing review and does not remain under the jurisdiction of the IRB.
IRB Committee Responsibilities

Before suspending IRB approval, the IRB or individual requesting the suspension must consider whether actions are necessary to protect the rights and welfare of currently enrolled subjects (such as allowing subjects to continue in the research, transferring subjects to other investigators, transferring subjects to physicians who will provide clinical care off the protocol, and monitoring of current or former subjects). The IRB may request an ad hoc review from an independent source with expertise in the type of research being conducted or expertise in the specific area of concern. The IRB may request the development of an education plan and/or the completion of a directed audit by the appropriate IRB staff.

The full IRB reviews the study and determines whether circumstances warrant suspension of IRB approval. Some examples of situations that may warrant suspension are:

- Falsification of study safety data
- Failure to comply with prior conditions imposed in writing by the IRB
- Repeated or deliberate failure to obtain or document informed consent from human subjects, which may include:
  - Repeated or deliberate omission of a description of serious risks of the research intervention when obtaining informed consent
  - Repeated or deliberate failure to provide informed consent in a language understandable to the subject
- Repeated or deliberate failure to comply with conditions placed on the study by the University, IRB, sponsor, FDA, or other governmental agency
- Repeated or deliberate failure to obtain prior review and approval of new protocols and on-going human subjects research by the IRB
- Repeated or deliberate failure to follow the signed Investigator statement or protocol; for example, by enrolling subjects who do not meet inclusion criteria
- Repeated or deliberate failure to maintain accurate study records or submit required adverse event reports to the IRB
- Repeated or deliberate falsification, fabrication, or concealment of study records; for example, by substituting the results of biological samples from subjects who
met the inclusion criteria for samples of subjects who do not meet the inclusion criteria, or by fabricating participants.

The Institution may determine that suspensions or terminations associated with a particular study or an investigator are repetitive and warrant action for issues of serious and continuing noncompliance.

Reinstatement of Suspended Research

Reinstatement of suspended research studies occur after corrective actions are completed to the IRB’s satisfaction. The Full Board may approve the study with or without additional restrictions (such as mandating a data and safety monitoring committee to oversee the research at designated intervals, increasing the frequency of IRB review, or observing the consent process).

The convened IRB, IRB Chair, and IRB Vice Chairs are all authorized to suspend or terminate research. If there is an urgent situation requiring suspension or termination of a study, the IRB Chair or Vice Chair may make this determination. If the IRB Chair or Vice Chair terminates or suspends a study, the IRB committee may be notified of the action at the next IRB meeting.

The IRB promptly notifies the investigator, in writing, of all suspensions or terminations of IRB approval. The notification letter includes the following:

- Identifies the suspended or terminated research
- Includes a statement of the reasons for the IRB’s action
- Requires the investigator to submit proposed procedures for withdrawal of currently enrolled subjects with consideration of subject rights and welfare. The IRB reviews the proposed procedures. The IRB may transfer this responsibility to another investigator to ensure implementation of these procedures
- Requires the investigator to submit a proposed script or letter notifying all currently enrolled subjects that are impacted by the suspension or termination. The IRB reviews the proposed script or letter. If follow up with subjects for safety reasons is permitted/required by the IRB, subjects should be so informed. The IRB may directly contact subjects to effect this notification
- As a condition of ending suspension or termination, the IRB may require oversight by an IRB Director, designee, or other, and/or require the study to be transferred to another USC investigator who will serve as the Principal
Chapter 20: Reportable Events, Noncompliance, Suspensions and Terminations

Investigator. The new investigator will ensure that IRB requirements are being implemented and followed.

Investigators who fail to comply with IRB directives or federal or state law or regulations may be subject to administrative and/or legal action by the University.

The iStar system automatically notifies the PI in writing of IRB suspensions.

The IRB staff, USC Office of Compliance, and OPRS staff communicate corrective actions to be taken by the investigator as applicable. The IRB staff completes a directed audit and/or develops an education plan as deemed appropriate by the IRB.

Research activities must cease as specified in the suspension criteria, until the IRB has granted approval for the study to resume. Suspensions are within the authority of the IRB and remain in effect until the investigator complies with all corrective actions required by the IRB.

Investigator Responsibilities

When the USC IRB has suspended, terminated, or reinstated a project, the investigator must notify the sponsor. The investigator is responsible for notifying all affected subjects of the suspension, termination, or reinstatement of the research project (by phone, letter, or in person). The subject letter or script must be submitted by the investigator to the IRB for review and approval. The investigator must continue to report adverse events, unanticipated problems involving risks to subjects or others, and serious or continuing noncompliance with federal regulations to the IRB during the period of suspension or termination.

20.10 IRB Reporting Requirements to Federal Agencies, Institutional Committees or Others

This section describes IRB reporting requirements for unanticipated problems involving risks to subjects or others (UPX), serious or continuing noncompliance, suspensions, and terminations.

The following events will be reported as appropriate to institutional personnel and/or committees in accordance with this policy and procedure:

- Any unanticipated problem involving risks to subjects or others (UPX)
• Any serious or continuing noncompliance with federal regulations or the requirements or determinations of the IRB

• Any suspension or termination of IRB approval

Additionally, reporting to the appropriate federal agency will also take place if one of the above events require an action such as, but not limited to:

• Changes to the research protocol initiated by the investigator prior to obtaining IRB approval to eliminate apparent immediate hazard to subjects

• Modification of inclusion or exclusion criteria to mitigate the newly identified risks

• Implementation of additional procedures for monitoring subjects

• Suspension of enrollment of new subjects

• Suspension of research procedures in currently enrolled subjects

• Modification of informed consent procedures to include a description of newly recognized risks

• Provision of additional information about newly recognized risks to previously enrolled subjects

When the investigator provides documentation that the appropriate federal agency(-ies) and/or study sponsor has already been notified of the event, the IRB will not submit a duplicate report.

Report Contents and Routing of Report

If the report is related to IRB or institutional serious or continuing noncompliance, the report is generated by the Office of Compliance and distributed to the Vice President of Research and the Office for the Protection of Research Subjects.

If the report is related to investigator or research personnel noncompliance, the IRB staff will generate a report of unanticipated problems involving risks to subjects or others, serious or continuing noncompliance, and suspension or terminations. The report is forwarded to the IRB Chair. The report includes the following information:

• Title of the research project and/or grant proposal that was suspended or terminated
Chapter 20: Reportable Events, Noncompliance, Suspensions and Terminations

- Name of the principal investigator
- The study number assigned by the IRB, and the number of any applicable federal award(s) (grant, contract, or cooperative agreement)
- A detailed description of the reason for the suspension or termination
- The actions the Institution is taking or plans to take to address the problem, noncompliance or suspension or termination

**Distribution of Report and Timeline**

Reports regarding determinations of investigator or research personnel serious or continuing noncompliance, unanticipated problems involving risks to subjects or others, as well as suspension or termination of IRB approval will be submitted by the IRB Chair or Designee as appropriate, to:

- OHRP, if federally funded
- FDA, when the research is subject to FDA regulations
- DOD (Human Research Protection Official), when research is subject to DOD regulations
- Funding agency, when the research is funded by a federal agency
- Institutional Official (if federally funded or not)
- Principal Investigator
- Department Chair, institute Director, and/or PI’s supervisor
- Department of Contract and Grants (only if the report involves suspension or termination of research or is otherwise determined by the IRB leadership to merit reporting to Contract and Grants)
- Non-federal study sponsor (only if the report involves suspension or termination of research or is otherwise determined by the IRB leadership to merit reporting to the sponsor)
- Leadership of any other institutional committee or entity involved in the oversight of the research (such as IBC, Office of Compliance, OPRS)
Reports are to be distributed to the parties described above within 30 days from the
determination that the event is reportable. For more serious incidents, reports may be
distributed within days from the time at which the determination is made.

When the investigator provides documentation that the appropriate federal agency(-ies)
and/or study sponsor has been notified of the event, the IRB will not submit a duplicate
report.

**Record Retention**

Copies of all reports made in accordance with this policy and corresponding responses
are maintained in the iStar study record indefinitely.
Chapter 21: Data Safety Monitoring (DSM)

Chapter Contents

21.1 – Data Safety Monitoring (DSM)
21.2 – Data Safety Monitoring Board (DSMB)
21.3 – The Relationship between DSMBs and IRBs
Chapter 21
Data Safety Monitoring (DSM)

The USC IRBs follow the Department of Health and Human Services (HHS) and the U.S. Food & Drug Administration (FDA) regulations regarding the monitoring of research for the safety of human subjects. This chapter describes situations in which a plan for the monitoring of research is required, the roles of Data Safety Monitoring Boards (DSMB) and the relationship between DSMBs and IRBs.

21.1 Data Safety Monitoring (DSM)

The IRB criteria for approval, as listed in the FDA and OHRP regulations, requires in part that “when appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects” 45 CFR 46.111[a][6], 21 CFR 56.111[a][6]. The IRB is responsible for determining when a study needs ongoing monitoring by a data safety monitoring (DSM) plan or the establishment of a data safety monitoring board to ensure protection for research subjects. However, the USC IRBs do not act as data safety monitoring boards.

The regulations do not discuss data and safety monitoring committees or boards. However, in 1998, the NIH created a requirement for data and safety monitoring boards for some of the studies it funds. The data and safety monitoring functions and oversight of such activities are distinct from the requirement for study review and approval by an Institutional Review Board (IRB). The NIH Policy for Data and Safety Monitoring is available at: http://grants.nih.gov/grants/guide/notice-files/not98-084.html.

The FDA has created guidance for the establishment and operation of clinical trial data monitoring committees. This policy highlights the FDA guidance. To review the FDA guidance in its entirety, visit the website at: http://www.fda.gov/downloads/RegulatoryInformation/Guidances/ucm127073.pdf

Every clinical trial conducted at USC must include a plan for data and safety monitoring. Specific plans should be based on:

- The amount of risk involved for participating subjects
- The size and complexity of the clinical trial
- The nature of the investigational agent
Chapter 21: Data Safety Monitoring (DSM)

- The study sponsor requirements
- The phase of the clinical trial

DSM plans may be required for non-clinical trials and for studies involving more than minimal risk as determined by the IRB.

During the initial IRB approval process and annual review, the IRB will review all proposed protocols for scientific relevance, protocol completeness, and the presence of an appropriate DSM plan.

Investigators will develop a DSM plan based upon the characteristics of the individual study. Investigators must describe how the study will be monitored for the safety of subjects and for the validity and integrity of the data. Sponsor-investigators who act as both the investigator and the study sponsor for drug/biologic/device studies must perform the sponsor data safety monitoring requirements from FDA, HHS, and the funding agency.

Appointment of a Research Monitor for Department of Defense (DOD) Sponsored Research

The following pertain to the appointment of a research monitor for DOD-sponsored research:

- Required for research involving greater than minimal risk, although IRBs can require a research monitor for a portion of the project or for studies involving no more than minimal risk studies if appropriate
- The independent research monitor must be appointed by name
- The research monitor has the authority to:
  - Stop a research study in progress
  - Remove individuals from study
  - Observe group recruitment
  - Take whatever steps are necessary to protect the safety and well-being of participants
21.2 Data Safety Monitoring Board (DSMB)

A DSMB is an independent committee set up specifically to monitor data throughout the duration of a study to determine if continuing the study is scientifically and ethically appropriate. DSMB’s are also known as Data Monitoring Committees (DMCs) or Data and Safety Monitoring Committees (DSMCs).

Factors that Suggest a DSMB Is Needed

- A large study population
- Multiple study sites (it is more difficult to recognize a pattern of increased or unusual problems when one site enrolls only a small percentage of the study population)
- The study is blinded
- The study employs high-risk interventions that may include highly toxic therapies or dangerous procedures, expected high rates of morbidity or mortality in the study population, or high chance of early termination of the study
- The study includes vulnerable populations, such as minors, prisoners, and/or pregnant women

FDA Guidance on Data and Safety Monitoring Boards, Committees, and Plans

FDA regulations (21 CFR 56) specifically require a Data Monitoring Committee (DMC) only for research conducted in emergency settings with an exception from informed consent requirements (21 CFR 50.24). However, all clinical trials require safety monitoring, and sponsors of trials evaluating new drugs, biologics, and devices are required to ensure proper monitoring of the trial.

FDA guidance defines a DMC as a group of individuals with pertinent expertise that regularly reviews accumulating data from an ongoing clinical trial. The DMC advises the sponsor regarding the continuing safety of study subjects as well as the continuing validity and scientific merit of the trial. The FDA recommends that sponsors establish a DMC in studies where safety concerns may be unusually high, such as when:
Chapter 21: Data Safety Monitoring (DSM)

- There are *a priori* reasons for a particular safety concern; for example, the procedure for administering the treatment is particularly invasive

- There is prior information suggesting the possibility of serious toxicity with the study treatment

- The study is being performed in a potentially fragile population such as children, pregnant women, the elderly, or other vulnerable populations such as those who are terminally ill or of diminished mental capacity

- The study is being performed in a population at elevated risk of death or other serious outcomes, even when the study objective addresses a lesser endpoint

- The study is large, of long duration, and multi-center

- The study endpoint is such that a highly favorable or unfavorable result, or even a finding of futility, at an interim analysis might ethically require termination of the study before its planned completion

**Data Monitoring Committee for Investigator-Initiated Research**

The FDA recommends that when the investigator is also the product manufacturer or IND/IDE sponsor and thereby subject to potentially strong influences related to financial and/or intellectual incentives, a DMC would provide additional, independent oversight that would enhance safety of study subjects and the credibility of the product development. DMCs should be considered in such settings.

**IRBs and DMCs**

In order to determine that risks are being minimized “by using procedures that are consistent with sound research design”, the IRB may appropriately ask for information about the approach to trial monitoring, including the statistical basis for early termination (when relevant) and what steps the sponsor is taking to minimize risks to subjects.

Since multi-site clinical trials generally have many IRBs and only one DMC, the DMC often has more information about the data, including interim efficacy and safety data than any single IRB. IRBs may want to appropriately take advantage of this situation and request information about the latest meeting and recommendations from the DMCs, even when those reports and recommendations show that no problems have been identified.
DMC Charters

DMCs typically operate under a written charter that includes their operating procedures. These procedures generally include the schedule and format of meetings, format for presentation of data, specification of who will have access to interim data and who may attend all or part of DMC meetings, procedures for assessing conflicts of interest of the DMC members, the method of providing interim reports to the DMC, and other issues relevant to committee operations.

Frequency of DMC meetings may depend on the expected rate of accrual and event occurrence at the time the trial is designed as well as the perceived risk of the experimental or control interventions. Annual meetings maybe adequate for some studies; other trials will require more frequent review. The study protocol will generally describe the schedule of interim analyses or other considerations that will determine meetings.

The IRB may ask for the DMC charter during initial review of the study.

Independence of the DMC

Independence of the DMC will depend upon the relations of its members to those sponsoring, organizing, conducting, and regulating the trial. Independence is greatest when members have no involvement in the design and/or conduct of the trial except through their role on the DMC, and have no financial or other important connection to the sponsor (other than compensation for serving on the DMC). However, DMCs are rarely totally independent since the sponsor usually selects members, gives them their charge, and pays them for their services.

21.3 The Relationship between DSMBs and IRBs

The National Institutes of Health (NIH) explicitly identifies required communication that must occur between DSMBs and IRBs when multicenter trials are supported by the NIH (see policy at [http://grants.nih.gov/grants/guide/notice-files/not99-107.html](http://grants.nih.gov/grants/guide/notice-files/not99-107.html)). Generally, the DSMB provides feedback at regular and defined intervals to IRBs. After each meeting of the DSMB, the DSMB Executive Secretary or Chair should send a brief summary report to each investigator. The report should document that a review of data and outcomes across all centers took place on a given date. It should summarize the DSMB members' review of the cumulative toxicities reported from all participating sites without specific disclosure by treatment arm. It should also inform study investigators of
the DSMB members' conclusions with respect to progress or need for modification of the protocol. Investigators are required to transmit the report to their local IRBs.

Chapter 22: Complaints Regarding Human Subjects Research

Chapter Contents

22.1 – Handling Complaints Regarding Human Subjects Research
Chapter 22
Complaints Regarding Human Subjects Research

A well run and well documented HSPP has mechanisms in place to receive and address complaints from any concerned party. This chapter contains information about participant complaints, undue influence, and the IRB/HSPP.

22.1 Handling Complaints Regarding Human Subjects Research

Participant Complaints

A participant complaint is an expression of dissatisfaction by the participant (or his/her representative) that may or may not involve a breach in human subjects rights or research ethics. Participants may choose to report complaints to the study team or to a third party. Therefore, it is important that during the consent process, subjects receive consent forms and information sheets that include investigator and IRB contact information so that participants have resources to ask questions about the study and report complaints.

At USC, participants can also address their complaints to the Office for the Protection of Research Subjects (OPRS) and the Office of Compliance (OOC).

OPRS Resources for Participant Complaints

The OPRS website contains contact information for OPRS, IRBs, and OOC, a webpage specific to participant complaints and a brochure for participants considering study participation with contact information for questions or complaints.

- OPRS and IRB contact information: http://oprs.usc.edu/about/complaints/

- Participant brochure: Should I Participate in Research?
OOC Resources for Participant Complaints

The USC Office of Compliance Help and Hotline can be utilized by participants to report complaints or ask questions about applicable laws, regulations and USC policies. Complaints may be made anonymously by calling the OOC Help and Hotline at (213)740-2500.

- OOC contact information:
  http://ooc.usc.edu/contact-us

- OOC Help and Hotline:
  http://ooc.usc.edu/help-hotline

At USC, subject complaints should be reported by the study team in iStar using the “Participant Complaint” form in the “Reportable Events” application. The report should be specific and include: date of the complaint, event description, relation to the study, determination of whether the complaint involves increased risk to study participants, explanation of how a similar event will be prevented in the future and supporting documentation if applicable. Alternatively, the study team can choose to contact the IRB directly to discuss the participant complaint. Additionally, complaints reported to OPRS, OOC or third parties will be subsequently reported to the IRB. When the IRB receives a participant complaint, the IRB staff or Director will be responsible for documenting the complaint in iStar.

Once a subject complaint is received, the IRB, along with OPRS or OOC as applicable, will attempt to substantiate the complaint in a timely manner. This process involves reviewing the study in which the subject is enrolled to ensure that the study has received and maintains active IRB approval and ensure compliance with pertinent federal and state regulations. The IRB office may contact the Principal Investigator (PI) and/or research staff for additional information to assist with the validation and/or dismissal of the complaint. Once all the information is received, the IRB will determine if any further action is necessary. The IRB will then provide written correspondence to the subject and PI with their determination and justification for actions taken. The determination and outcome of the complaint will be documented in iStar by the IRB.

If the IRB/OPRS office suspects there may be potential non-compliance, the IRB will initiate the process as outlined in the policy on handling allegations of non-compliance. Refer to Section 20.8 – Procedure for Handling Reports of Noncompliance for more information.
Complaints Regarding Undue Influence

Undue influence is a situation in which one person takes advantage of a position of power over another person. Any IRB staff member, IRB member, or other individual involved in the review of research, who believes they have been the target of undue influence by an investigator or other individual should report the incident to the IRB Director, Chair, or call the Office of the Compliance Help and Hotline (**213)**740-2500.

If the IRB is contacted, the Director or Chair will attempt to get all available information and, if warranted, forward the validated allegation to the Office of Compliance, where corrective action will be undertaken.

Complaints Regarding the IRB or HSPP

Subjects/participants, researchers, IRB members, and others who have human subjects research related complaints, concerns, recommendations, or reports of violations are encouraged to contact one of the following offices listed below. Aspects of the HSPP unrelated to the IRB may also be directed to these offices. All inquiries are taken seriously and will be directed to the appropriate personnel. When a complaint, concern, recommendation, or report of violation made to any one of the offices listed below reveals the need to consider modifying any aspect of USC’s Human Subjects Research Protection Program, due consideration will be given and changes made as appropriate.

Complaints regarding the IRB or aspects of the non-IRB HSPP should be made to the nearest organization entity independent of the IRB. This could be the OPRS, Office of Compliance, or the Vice President of Research (Institutional Official). Attempts to get adequate information to validate the circumstances of the complaint will be sought by one or all of these entities. The contact information for these entities is found at [http://oprs.usc.edu/about/complaints/](http://oprs.usc.edu/about/complaints/). Complaints may be made anonymously by calling the OOC Help and Hotline at **213**740-2500.
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Appendices

A. Federalwide Assurances (FWAs)

The University of Southern California maintains assurances of compliance with the Office for Human Research Protections (OHRP) to comply with the requirements set forth in 45 CFR Part 46, as well as the Terms of Assurance. USC’s assurances can be accessed at: oprs.usc.edu/review/fwa

B. IRB Reviewer Checklists / Guidelines

The checklists provide insight into how applications are initially assessed by the IRB. Topics include new applications, informed consent, research with pregnant women, research with prisoners, research with children and more. The checklists can be accessed at: oprs.usc.edu/review/tipsheets#guides

C. UPIRB Forms and Instructions

Methods of consent and documentation will vary according to the level of review and nature of the research. Templates containing the required elements of consent can be accessed at: oprs.usc.edu/upirb-forms

D. HSIRB Forms and Instructions

Methods of consent and documentation will vary according to the level of review and nature of the research. Templates containing the required elements of consent and common biomedical research procedure can be accessed at: oprs.usc.edu/hsirb-forms

E. USC Human Subjects Research Booklets

The USC Human Subjects Protection Program has developed booklets available to users online or in hard copy by request. Topics and titles include Responsible Conduct of Research, Making Sense of Human Subjects Research, Informed Consent and More. The booklets are available at: oprs.usc.edu/booklets
F. Ceded Review Agreements and Memorandum of Understanding

USC has established agreements to simplify the IRB review process for projects taking place between USC and a partner site. Under the Memoranda of Understanding (MOU), one Institution will cede the IRB review process and the other Institution will provide the IRB review. USC’s agreements with CHLA, Hebrew Union College, Rancho, Rand Cooperation, and Cedars may be found at oprs.usc.edu/initiatives/agreements

G. Glossary of Medical Terms

A compilation of common medical terms used in healthcare and research is available at: oprs.usc.edu/education/glossary

H. USC Flexibility Policy and Coalition

The Flex Policy permits extended IRB approval and new exempt and expedited review categories for non-federally funded research. The Flexibility Coalition consists of Institutions that have developed similar policies. Information about the policy and coalition is available at: oprs.usc.edu/flex

I. Verification that IRB Contingencies were Satisfied

Contingencies are modifications requested or required by the IRB that must be satisfied before final IRB approval is granted. Designated IRB reviewers can verify that contingencies were satisfied depending on the level of expertise required. Explanation of contingency types and designated reviewer examples are available at: oprs.usc.edu/files/2013/01/Verification-of-IRB-Contingencies.pdf

J. IRB Requirements for Research with Other Sites

Research conducted at non-USC sites (or transferred to USC) may be subject to additional IRB requirements/documentation. A summary of requirement is available at: oprs.usc.edu/files/2013/02/IRB-Required-Documents-for-Research-with-Other-Sites.pdf
K. Requirements for Department of Defense (DOD) Supported Research and Reviewer Checklist

Research supported by the Department of Defense (DOD) is subject to additional IRB requirements/documentation depending on study specifics. Summary requirements are available at: oprs.usc.edu/files/2013/01/DOD-Summary-Requirements.pdf. DOD Reviewer Checklist available at: http://oprs.usc.edu/files/2013/03/DoD_Checklist.doc

L. Informing Participants about Significant New Information and Findings (SNIFs)

SNIFs must be provided to participants when the new information may affect their willingness to continue in a study. A flowchart to determine when a SNIF form, consent form or both are required is available at: https://oprs.usc.edu/files/2013/02/SNIF-consent-chart-6.30.14.pdf

M. USC Research Sponsored by Federal Agencies

USC complies with requirements stipulated by other federal agencies when they serve as sponsors or have oversight of research conducted at USC. A chart with specific federal agency regulations is available at: https://oprs.usc.edu/files/2013/01/USC-Research-Sponsored-by-Federal-Agencies.pdf