



## Human Research Subject Protection Plan (HRSP)

RPCI's mission is to understand, prevent and cure cancer. Research is front and center within that mission. **This plan describes RPCI's integration** of its mission with the protection of research subjects. The primary focus is to assure that research subjects' rights, dignity, welfare and privacy will be protected and that the institution will comply with all applicable state and federal regulations.

**Scope and application of the HRSP:** This HRSP applies to all RPCI activities where RPCI employees or agents are engaged in human subject research under the following guidelines and definitions (Section V. below).

**Engagement in Research:** Roswell Park Cancer Institute (RPCI) becomes "engaged" in human subject research when its employees or agents (i) intervene or interact with living individuals for research purposes; or (ii) obtain individually identifiable private information for research purposes in accordance with the DHHS and FDA definitions of research involving human subjects

### I. Federal Wide Assurance (FWA):

RPCI maintains a Federal Wide Assurance (No. 00006731). This assurance is applicable to all activities which, in whole or in part, involve research with human subjects conducted by or under the direction of any employee, staff, faculty, student, or agent of this institution in connection with that person's institutional responsibilities. Agents are defined as non-employees that perform institutionally designated activities or exercise institutionally delegated authority or responsibility.

The Assurance provides that RPCI will comply with the DHHS and FDA regulations for the protection of human research subjects for all Public Health Service funded research reviewed by the IRB(s). The Assurance also defines other responsibilities of the Institution including: the provision of sufficient institutional support for the RPCI Office of Research Subject Protection (ORSP); the authority of RPCI's IRBs to approve, require modification in, or disapprove human subject research; the maintenance of written procedures describing the IRB's process for the review of research projects; and the reporting to the appropriate oversight agencies, e.g. DHHS/FDA/DOD/OHRP, of certain research outcomes (e.g., unanticipated problems involving risks to subjects or others). This institution acknowledges and accepts its responsibilities for protecting the rights and welfare of human research subjects covered by this assurance.

**II. All research will be guided by ethical principles:**

These guiding ethical principles are embodied in the **Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research** issued by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in 1979, and their revisions. RPCI accepts the **Belmont Report's** principles of *respect for persons*, *beneficence* and *justice* as critical for the ethical conduct of human subject research.

**III. RPCI will be compliant with research regulations:**

All human subject research will be reviewed and, if appropriate, approved by the institutional review board (IRB), except for those categories specifically exempted by 45 CFR 46. Exempt studies will be submitted to and reviewed by the ORSP, and a letter of exemption will be issued if the federal requirements for exemption are met.

This HRSP applies to all research involving human subjects conducted at RPCI as well as to RPCI research conducted, supported, or otherwise subject to regulation by the federal government outside the United States. When research covered by this policy takes place in foreign countries, procedures normally followed in those countries to protect human subjects may differ from those followed in the United States. In these circumstances, if the institution in the foreign country has an FWA or if the DHHS OHRP determines that the procedures prescribed by that institution afford protections that are at least equivalent to those provided for by the US, then RPCI may do research there, following that country's policies.

**SCIENTIFIC MISCONDUCT**

Roswell Park Cancer Institute (RPCI) requires the highest standards of ethical practice and integrity in the conduct of its research. The staff is expected to maintain these standards and to conduct research in a manner that is above reproach and suspicion. All employees are required to report actual or suspected instances of research misconduct.

For purposes hereof, "misconduct" means fabrication, falsification, or plagiarism in proposing, performing, or reviewing research or in reporting research results.

- Fabrication is making up data or results and recording or reporting them.
- Falsification is manipulating research materials, equipment or processes or changing or omitting data or results such that the research is not accurately represented in the research record.
- Plagiarism is the appropriation of another person's ideas, processes, results, or words without giving appropriate credit.

Finding of misconduct requires that:

- There be a significant departure from accepted practices of the relevant research community; and

- The misconduct be committed intentionally, knowingly, or recklessly; and
- The allegation be proven by a preponderance of the evidence (42 CFR Part 93.104)

Misconduct determinations are managed through Roswell Park Cancer Institute Policy 1204.1  
Research Misconduct

Any allegations of undue influence are initially assessed for merit by the Director of ORSP. Alternate individuals are assigned to fulfill these responsibilities in the event of a conflict of interest with the allegation of undue influence. In the event of a conflict of interest, the individual responsible for review must recuse themselves from the review and the next individual responsible for review takes his or her place in the following order:

- ORSP Director;
- IO;
- Referred to RPCI general counsel if necessary..

#### UNDUE INFLUENCE

Reports of undue influence are initially reviewed by an uninvolved IRB Chair to determine if the allegation has merit. If the IRB Chair finds the allegation has merit, the IO forms an investigative committee of uninvolved investigators and/or IRB members to gather and review information related to the allegation.

- Any member of the investigative committee having a conflict of interest with the allegation of undue influence is expected to identify the existence of a conflict and recuse themselves from the committee's discussion of the matter.

Determinations resulting from the appropriate committee's review of the allegations may include the following:

- No response necessary, there was no intent for undue influence and there was no resultant influence on an IRB determination, OPRS staff process, or within the HSPP program; or
- Undue influence occurred; the appropriate committee will develop a corrective action plan, which may include possible sanctions

**A. Conduct of Research:**

The involvement of human subjects in research will not be permitted until the IRB has:

- Determined that RPCI is engaged in research
- Determined that human subject research is being done
- Reviewed and approved the research protocol and consent form or application for waiver or alteration of consent and, HIPAA authorization or waiver, as appropriate.

RPCI conducts or oversees therapeutic and non-therapeutic biomedical and limited social science studies with a primary focus on the understanding, preventing and curing of cancer. The categories of participants who are involved in research include adults with no decision-making impairment, adults with decision-making impairment, children, prisoners, employees, and/or students.

RPCI does not conduct research solely involving certain categories of participants, namely fetuses, prisoners, adults with decision-making impairment, or pregnant women. However, adults with decision-making impairment, prisoners and pregnant women are not excluded from enrollment in an intervention or non-intervention study if they meet the eligibility criteria.

RPCI does not perform planned emergency research involving waiver of informed consent. It does however perform research under Emergency Use provisions of 21CFR 56.102 (d): "Emergency use means the use of a test article on a human subject in a life-threatening situation in which no standard acceptable treatment is available, and in which there is not sufficient time to obtain IRB approval." RPCI has the ability to convene an IRB meeting within 24-72 hours to review and approve single patient IND use in urgent or life-threatening situations.

It is the policy of RPCI that unless informed consent has been waived or altered by the IRB in accordance with 45 CFR 46.116, no research investigator shall involve any human as a subject in research unless the investigator has obtained the legally effective consent of the subject or the subject's legally authorized representative (LAR).

**B. Affiliations:**

RPCI has formal institutional affiliation agreements with regional hospitals, academic institutions, and individual physicians or groups. RPCI's Federal wide Assurance (FWA) designates RPCI IRB(s) as the IRB(s) of record for research carried out in RPCI facilities. The RPCI IRB will rely on the National Cancer Institute Central IRB (NCI CIRB) as the IRB of record for eligible adult and pediatric national cooperative group studies. For non-RPCI

institutions and investigators that are subject to RPCI's IRB and are governed by RPCI's FWA, an Authorization Agreement will be executed and followed.

RPCI is cognizant of its responsibility to assure that collaborative institutions perform required IRB/Ethics Committee reviews and have on file with OHRP appropriate assurance documents. RPCI investigators are required to submit approvals from off site IRBs/Ethics Committees, as well as any required administrative approval(s) for conduct of research at non-RPCI facilities. ORSP staff is responsible for communicating with investigators to assure that documentation is provided before a project may be initiated.

C. Intra-Institutional Relationships:

ORSP coordinates its activities and works collaboratively with other units and individuals within the institution and its affiliates to ensure research activities do not commence until the research has received all required approvals, and to ensure proper monitoring, oversight, and reporting of research activities. The following units collaborate with the IRB:

**1. CRS- Clinical Research Services:**

Clinical Research Services (CRS) is a shared resource critical to the submission and implementation of research studies associated with Roswell Park Cancer Institute (RPCI). CRS staff work in collaboration with RPCI Investigators to provide oversight of the research process, the accrual of participants to research studies and the collection of a complete and accurate dataset. CRS also has collaborative relationships with RPCI Departments involved in the research process including Pharmacy, Radiology, Pathology, Laboratory Medicine, Marketing, Information Technology (IT), Decision Support and Finance.

CRS audits protocols for compliance and reports on a monthly basis to the IRB. Any significant protocol deviations or instances of non-compliance are monitored regularly this way.

**2. IDS: Investigational Drug Service:**

IDS is a shared clinical research resource managed in collaboration with Clinical Research Services and the Department of Pharmacy. IDS is responsible for all aspects of drug accountability and inventory maintenance including maintaining an accurate dispensing log and ordering, receiving, storing and returning investigational agents. All investigational agents are dispensed in accordance with the study documents and all applicable State and Federal laws. IDS collaborates with RPCI principal investigators and the assigned clinical research coordinators to

prepare study specific pre-printed orders. IDS also works with RPCI investigators to assure that drug sections of the study are accurate and complete and that related implementation issues are resolved prior to study implementation.

**3. Phase I Committee:**

The RPCI Phase 1 Committee is comprised of a multi-disciplinary team involved in the development and implementation of Phase I studies. The Committee meets to assess adverse events reported for patients enrolled in Phase I studies with the goal of ensuring patient safety and study integrity. Adverse events (AE's) meeting criteria for dose-limiting toxicity (DLT) are closely monitored for patient accrual purposes and protocol compliance. AE information and meeting minutes are submitted to the IRB for further review and action in a continuous review process.

**4. DSMB: Data Safety Monitoring Board:**

RPCI has a Data Safety Monitoring Board (DSMB) that reviews Pilot, Phase II and Phase III investigator initiated intervention studies annually or more frequently if indicated. The DSMB submits its recommendations and reports to the IRB for consideration and action.

**5. HRI – Grant Administration Services:**

The HRI Office is responsible for assisting faculty in the preparation and submission of research grant proposals and management of post award activities. RPCI's IRB provides for grant and protocol review to assure that there is an approved protocol to cover work proposed in the grant. HRI will be notified of any suspensions, terminations or closures of funded research projects.

**6. Conflicts of Interest Committee:**

The IRBs review disclosures of financial conflicts-of-interest on a per study basis and also reviews recommendations from the Institutional Conflict of Interest Committee. Final approval of a study by the IRB is contingent upon lack of a financial conflict-of-interest or satisfactory management of the conflict.

**7. HIPAA Compliance:**

The IRBs review research protocols for HIPAA compliance. HIPAA forms and guidance are available to all researchers and are updated in collaboration with the RPCI Privacy Officer, who is responsible for Institutional compliance with HIPAA

regulations. IRB specialists consult with the Privacy Officer regarding any HIPAA research issues.

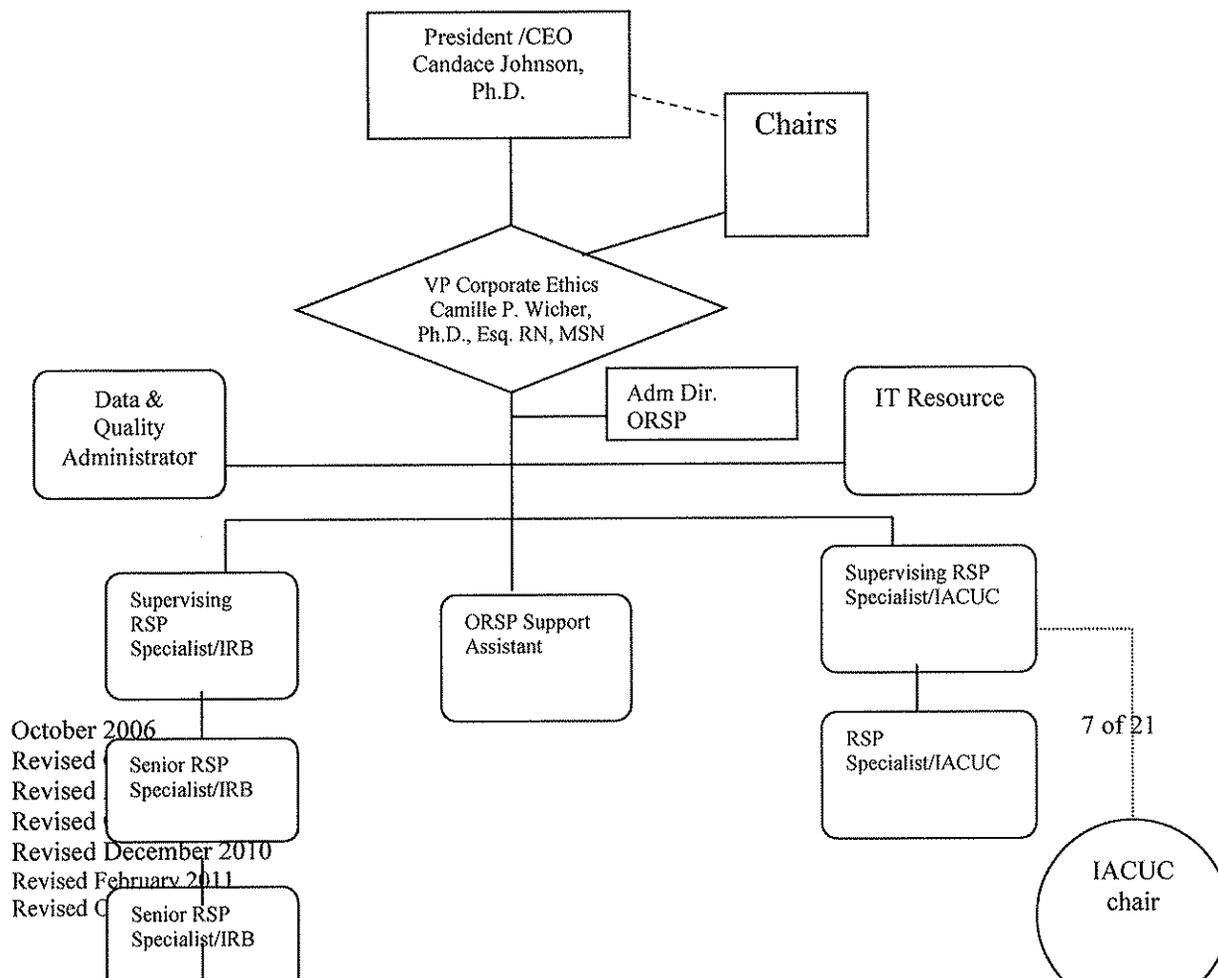
**8. RPCI Biosafety Committee:**

The RPCI Biosafety Committee (IBC) is responsible for ensuring that research involving recombinant DNA (rDNA), infectious agents, or other biohazardous materials is conducted in a manner that minimizes hazards and/or risks to participants, laboratory workers, the RPCI community and the community at large. The IRBs collaborate with the IBC on any human subject research involving rDNA. The IRBs will release the study contingent upon approval by the IBC approval, where necessary.

**9. Corporate Compliance Department:**

RPCI maintains a corporate compliance office that is responsible for enhancing overall organizational compliance with regulations. The Vice President (VP) of Corporate Ethics & ORSP, Institute Official (IO) or designee works with the compliance office on any compliance issues that are other than protocol compliance related. Although the ORSP has an open door policy to address concerns or suggestions, these may also be communicated to the compliance officer.

**IV. IRB Organization: ORGANIZATIONAL CHART**



- A. Institutional Official (IO): The CEO/President of RPCI has designated the responsibility of Institute Official to the Vice President of Corporate Ethics & Research Subject Protections. The Institutional Official (IO) has the specific responsibility and authority for overseeing the Office of Research Subject Protections (ORSP) and the human research subject protection program (HRSP). The IO, in collaboration with the CEO, has the authority to establish the Institution's IRBs as well as to dissolve the operations of the IRBs.
- B. Vice President for Corporate Ethics & Research Subject Protections (RSP): The ORSP provides administrative oversight for the protection of research subjects. The VP for Corporate Ethics & RSP reports directly to the President/CEO. Responsibilities include but are not limited to: Keeping the CEO/President informed regarding issues related to the ORSP & IRB; Creating, establishing, and maintaining the policies and procedures for the ORSP in collaboration with the IRB Chairs and others as appropriate; Providing interpretation and application of federal regulations and institutional policies and procedures; Interacting with federal authorities (OHRP, FDA) concerning research subject protection issues; Assessing the ORSP's human resource needs and capabilities including the creation of new positions, support for ongoing staff development and annual evaluations of ORSP personnel; Setting standards for human subject research education requirements in collaboration with the IRB Chairs, IRB staff, and others, as appropriate; Ensuring the independence of the IRB, including the authority to act without undue influence; Preparing documents necessary to fulfill certain federal and/or State reporting requirements, as mandated in 45 CFR 46.103 and 21 CFR 56.113.
- C. Administrative Director for the Office of Research Subject Protections: The Administrative Director for the Office of Research Subject Protections reports directly to the VP for Corporate Ethics and Research Subject Protections. Responsibilities include but are not limited to: Keeping the VP informed regarding issues related to the ORSP & IRB; Assisting in creating, establishing, and maintaining the policies and procedures for the ORSP in collaboration with the VP, IRB Chairs and others as appropriate; Providing interpretation and application of federal regulations and institutional policies and procedures; Interacting with federal authorities (OHRP, FDA) concerning research subject protection issues; Assisting in assessing the ORSP's human resource needs and capabilities including the creation of new positions, support for ongoing staff development and annual evaluations of ORSP personnel; Setting standards for human subject research education requirements in collaboration with the VP, IRB Chairs, IRB staff, and others, as appropriate; Assuring the independence of the IRB, including the authority to act without undue influence; Responsible for the day-to-day operations of the department and oversight of the staff; Preparing documents necessary to fulfill certain Federal and/or State reporting requirements, as mandated in 45 CFR 46.103 and 21 CFR 56.113.

- D. **IRB Chairs:** The IRB Chairs/Co-chairs are responsible for assuring that the IRB operates in accordance with federal and state regulatory requirements governing IRB functions. The Chairs work with IRB members, the ORSP, and investigators to ensure that the rights and welfare of research participants are adequately and appropriately protected. The IRB Chairs routinely report to the ORSP but have direct access to the CEO as needed.

IRB Co-Chairs: The Co-Chair assumes the responsibility of the Chair in the Chair's absence, in instances when the Chair has a conflict of interest, or at the discretion of the Chair.

- E. **IRB Specialists:** The primary administrative responsibility for the day-to-day operation of the IRB is with the individual IRB specialists. The IRB specialists work in collaboration with the Administrative Director and/or the VP of Corporate Ethics & ORSP or designee and IRB Chair(s) to manage the institutional review and approval process for all proposed research activities involving human subjects in order to protect their safety, rights, and welfare. The IRB specialists report to the VP of Corporate Ethics & ORSP or designee and IRB Chairs.

## V. **Definitions:**

### A. **Federal**

**"Research Involving human subjects"** - means any activity that either:

- Meets the DHHS definition of "research" and involves "human subjects" as defined by DHHS; or
- Meets the FDA definition of "research" and involves "human subjects" as defined by the FDA.

**Research** - as defined by **DHHS (45 CFR 46.102)**: "Research" means a systematic investigation design to develop or contribute to generalizable knowledge.

**Research – as defined by FDA (21 CFR 50.3(c))**- means 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 Food and Drug Administration under section 505(i) or 520(g) of the act, or is not subject to requirements for prior submission to the Food and Drug Administration under these sections of the act, but the results of which are intended to be submitted later to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit. The terms research, clinical research, clinical study, study, and clinical investigation are deemed to be synonymous for purposes of FDA regulated research. (21 CFR 50.3(c) and 21 CFR 56.102(c)) (Note: Activities are subject to requirements for prior submission to the Food and Drug

Administration under section 505(i) or 520(g) of the FDC act when they involve any use of a drug or medical device other than the use of an approved drug or device in the course of medical practice)

**Human Subject** - as defined by **DHHS**: a living individual about whom an investigator ... conducting research obtains (1) data through interventions or interactions with the individual, or (2) identifiable private information.

**"Human Subject"** - as defined by **FDA** regulations means an individual who is or becomes a subject 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. [21 CFR 50.3(g), 21 CFR 56.102(e)] A human subject includes an individual on whose specimen a medical device is used. [21 CFR 812.3(p)]

#### **B. New York State:**

In addition to the federal regulations regarding human subject research, RPCI will also be compliant with NYS Public Health Law ARTICLE 24-A: "PROTECTION OF HUMAN SUBJECTS" Sec. 2440 et. seq., which provides the following:

**"Human subject"** shall mean any individual who may be exposed to the possibility of injury, including physical, psychological or social injury, as a consequence of participation as a subject in any research, development, or related activity which departs from the application of those established and accepted methods necessary to meet his needs or which increases the ordinary risk of daily life including the recognized risks inherent in a chosen occupation or field of service.

**"Human research"** means any medical experiments, research, or scientific or psychological investigation, which utilizes human subjects and which involves physical or psychological intervention by the researcher upon the body of the subject and which is not required for the purposes of obtaining information for the diagnosis, prevention, or treatment of disease or the assessment of medical condition for the direct benefit of the subject. Human research shall not, however, be construed to mean the conduct of biological studies exclusively utilizing tissue or fluids after their removal or withdrawal from a human subject in the course of standard medical practice, or to include epidemiological investigations. No one except a researcher shall conduct human research in this state.

**VI. SCOPE and AUTHORITY of the IRB:**

As stated in the Federal Wide Assurance on file with OHRP, RPCI is guided by the ethical principles stated in the Belmont report and codified by the Department of Health and Human Services (DHHS) regulations at 45 CFR 46, and the FDA regulations in 21 CFR 50 and 56. RPCI adheres to the guidance provided by the Office of Human Research Protection (OHRP) and by the FDA as part of that commitment. Additionally, the Institutional Review Boards follow the organization policies that provide additional protections to studies involving vulnerable populations, (e.g. students, employees, decisionally impaired). This fundamental commitment to the protection of human subjects applies to all human subject research conducted by RPCI faculty members or staff. All projects which meet the definition of research and that involve human subjects will be reviewed by the IRB.

**A. Determination of Human Subject Research:**

The determination whether a project qualifies as human subject research rests with the ORSP, in coordination with the IRB. The decision is based on whether the activity represents "research" and involves "humans" as participants (as defined in DHHS 45 CFR 46) and, when applicable, whether the activity represents a clinical investigation of a test article involving one or more humans as participants (as defined in FDA 21 CFR 50).

**B. Determination of Human Subject Involvement:**

Individual researchers shall not make a determination as to whether research will involve human subjects as defined in 45 CFR 46.102, 21 CFR 50, 21 CFR 56, and/or New York State Law. The ORSP in coordination with the IRB will review each project to determine if the research involves human subjects. When it is not clear whether the research involves human subjects, assistance will be sought from the IRB chair in making this determination. If it cannot be determined after review by the chair, then the research will be taken to the full board for a determination.

**1. Definition of Research As It Applies to RPCI staff:**

Research is defined by DHHS and FDA regulations as above and institute policy.

When an activity is research, or a clinical investigation as defined by the FDA, it is subject to review and approval by the RPCI Institutional Review Board (IRB) before the research may be undertaken. Investigators must seek IRB review for any human subject research, but RPCI does not require them to seek IRB approval for clinical practice activities, quality improvement activities or public health interventions.

## 2. Clinical Practice vs. Clinical Investigation

RPCI is aware that research conducted in an academic setting can often result in an overlap between clinical practice designed to take care of a specific patient's medical needs and clinical investigation designed to collect generalizable knowledge to advance standards of care. This distinction can be particularly confusing in clinic-based research where contact with patients and clinical investigators may extend over long periods of time.

The Belmont Report is used as a reference. In that Report, the section entitled "Boundaries Between Practice and Research" makes the distinction between practice and research/clinical investigation clearer. All researchers are urged to review this document carefully.

## 3. Public Health Activities:

RPCI recognizes that surveillance, emergency responses, and program evaluations do not meet the DHHS definition of research. These activities constitute public health activities the primary intent of which is to prevent disease in a particular population, to improve a public health program, or to provide emergency disaster relief. Therefore, these activities do not need IRB review.

## 4. Quality Improvement Projects:

Data collection and analysis activities that are not intended to generate scientific knowledge, but rather are used as a management tool to improve the provision of services to a specific health care population are generally not considered research. These activities are not intended to have any application beyond the specific organization in which they are conducted. These activities are generally referred to as program evaluation, performance improvement or quality improvement.

When the purpose of an activity is to assess the success of an established program in achieving its objectives and the information gained from the evaluation will be used to provide feedback to improve that program, the activity is **not** research. The evaluation is a management tool for monitoring and improving the program. Information learned has immediate benefit for the program and/or clients receiving the program or services. When the quality improvement involving human participants is undertaken to test a new, modified, or previously untested intervention, service, or program to determine whether it is effective and can be used elsewhere, the activity may be research. The systematic comparison of standard or non-standard interventions involving human participants is research.

It is often difficult to distinguish QA/QI activities and research activities, especially when data analysis after implementation of a QA/QI activity will occur. It is possible that the same project may have both QA/QI and research components.

Prospective collection of identifiable patient or subject-level data for future research is considered human subjects research, regardless of whether the institution that collects the data will de-identify the data before analysis at RPCI. Such projects must be submitted to the IRB for review. Funding applications submitted to support QA/QI activities with a subsequent research component will be reviewed by the ORSP to assure that participating sites have an OHRP approved assurance on file.

5. **Determination of exemption eligibility:**  
Using exemption criteria specified 45 CFR 46.101, the Vice President for Corporate Ethics, Administrative Director or designee shall determine whether research that does involve human subjects is exempted from IRB review and oversight under DHHS regulations. When it is not clear whether the research is exempt, assistance will be sought from the IRB chair in making this determination. If a determination cannot be reached, the protocol will be reviewed at the full board for a determination.

## VII. INSTITUTIONAL REVIEW BOARD (IRB):

- A. **Establishment of IRB** RPCI's IRB(s) has been established to review all research involving the use of human subjects. IRB members are appointed by the CEO, in consultation with or delegated to the Vice President for Corporate Ethics/Research Subject Protection with input from the IRB chairs. Appointments and reappointments are generally for three-year staggered terms. The CEO shall also designate a faculty/staff member as chair. If possible, the chair shall be an experienced member of IRB.
- B. **IRB membership requirements:** The IRB shall be comprised of members from diverse backgrounds, such as humanities, science, medicine, other health care disciplines as well as lay people, to promote complete and adequate review of research activities covered by this assurance; and it shall include the range of professional competence necessary to review the specific research activities that will be assigned to it. In appointment of members to IRB, consideration will be given to individuals who have an understanding of and sensitivity to research, to the research process, and to ethical considerations in research.

The IRB shall be sufficiently qualified through the experience and expertise of its members, the diversity of their backgrounds, and their sensitivity to community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of

human subjects. The IRB shall include both male and female members, members representing a variety of professions, and at least one member whose primary expertise is in a non-scientific area; for example: lawyers, ethicists, and members of the clergy.

The IRB shall include at least one member who is neither affiliated with the institution nor part of the immediate family of a person affiliated with the institution. The IRB shall include, whenever possible, members who have as a special concern the welfare of vulnerable subjects (e.g., prisoners, children, individuals institutionalized as mentally disabled, etc.). When such expertise is not held by board members, appropriate consultants will be invited to participate in the research review as needed. Names and qualifications of the members of IRB are kept in accordance with 45 CFR 46.103 (b) (3).

- C. Education** IRB Staff, Members and Chairs are required to complete IRB member training through Citi every three years (beginning 2016). Compliance with this requirement is verified at the time of annual IRB member self- assessment. IRB staff member training is monitored at the time of annual evaluations. Members failing to complete training may be removed.

The Office of Research Subject Protection has a variety of materials and publications and conducts intermittent education programs dedicated to help RPCI Staff and volunteers

Upon joining the IRB members are given a copy of the OHRP Guidebook, the Belmont Report, IRB member Handbook, (Robert Andur, MD). ,The RPCI, Internal IRB Website to access policies and procedures, forms and other information pertinent to the IRB

**D. IRB review and approval of research:**

The IRBs have the authority to:

1. Approve, require modifications to secure approval, or disapprove, all human subjects research activities overseen and conducted by the organization.
2. Suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to participants.
3. Observe, or have a third party observe, the consent process.
4. Observe, or have a third party observe, the conduct of the research.

Officials of RPCI may not approve research if it has not been approved by the IRB.  
Officials of RPCI may disapprove research that has been approved by the IRB.

**Conflict of Interest:** IRB members cannot participate in the review of any protocol where the member has a conflict of interest.

RPCI may rely on other organizations to provide IRB review. Such reliance shall be documented in written IRB review agreements, and the terms of the agreements shall be reflected in the Organization's assurance documents, as applicable.

**E. Informed Consent:**

It is the policy of the Organization that no one may involve a human being as a participant in research or in a clinical investigation unless the investigator has obtained IRB approval and, when required by the IRB, that person's legally effective informed consent. The IRBs may alter or waive the requirement of consent under the Department of Health and Human Services (DHHS) regulations governing human subject research [46.116(c)], but may not waive consent for studies regulated by the Food and Drug Administration (FDA) unless the subject is in a life-threatening condition and criteria under 21 CFR 50.23 or 50.24 are met. If the participant is an adult who is unable to consent for him/herself, the investigator must describe the process of evaluating the individual's capacity to provide consent, and if that capacity is lacking in a subject, must obtain informed consent from a legally authorized representative in accordance with federal and state law. If the participant is a minor, the investigator must describe the consent/assent process in accordance with federal and state law

The IRB determines that any significant new findings that arise from the review process and that might affect participants' willingness to continue participation are provided to participants.

**E. Authority to suspend or terminate approval of research:**

The IRB has authority to suspend or terminate approval of research that is not being conducted in accordance with IRB's decisions, conditions, or requirements or that has been associated with unexpected serious harm to subjects. When approval has been suspended or terminated, research shall stop until such time that IRB has determined that its requirements have been met. Suspension or termination of IRB approval shall be accompanied by a statement of the reasons for IRB's actions and shall be reported promptly to the CEO or designee and, where required, to the DHHS/OHRP and the FDA.

**F. IRB Findings and Special reporting requirements and procedures:**

The Office of Research Subject Protections reports IRB activities and decisions regarding Initial review, continuing review and amendments on a monthly basis to the Medical Staff Office. IRB vote, determinations and deliberations are not included in this report. The IO has access to all IRB minutes.

RPCI has the responsibility to report unanticipated problems involving risk to subjects or others, serious or continuing non-compliance, and suspension or termination of approved research under, to the appropriate agencies. The Institutional Official (IO) is authorized as the individual who will submit reports when an Institutional Review Board (IRB) has made a determination under the three cited policies. In cases where the IRB and/or IO determine that additional information is required before submitting a final report, a preliminary report may be made to the appropriate officials, supporting federal agency (as applicable), OHRP, and FDA (as applicable), within one month of the IRB's determination.

A draft preliminary or final report will be prepared for review by the IO. The draft report will contain the following information:

- The nature of the event
- The findings of the organization
- The actions taken by the organization and IRB, including plans to protect the rights and welfare of the participants
- The reasons for the organization's and IRB's actions
- The plans for continued oversight or investigation or action.

Once the IO has reviewed the final report, and made a determination if the event is to be reported to an outside agency governing the research, the IO will send written report back to the IRB responsible for oversight of that study, indicating the result of IO review.

Reports will be submitted to the OHRP in all cases; to FDA, if the research is regulated by FDA; and to other agencies that are signatories to the Common Rule [1], if the research is conducted, funded or overseen by that agency. A copy of the report will be sent to the reviewing IRB, Grants Management Office if the project is funded by an outside sponsor, Risk Management (if applicable), and the Principal Investigator (PI). The IO may determine the report should be provided to the Director of the Department in which the PI is appointed as faculty. If the event involves unauthorized use, loss, or disclosure of PHI, a copy will be sent to the HIPAA Privacy Officer. If the IO's response is not immediately received, ORSP staff will follow up with the IO every 5 working days until received.

No report will be submitted to regulatory agencies when the research is sponsored. It is the PI's responsibility to report to the Sponsor and submit back to the IRB their determinations..

#### **G. Records:**

IRB shall prepare and maintain adequate documentation of IRB activities. A detailed description of these records can be found in HRP-071, 072, 073

#### **H. Institutional policies and procedures:**

IRB is responsible for reviewing, developing, and/or proposing changes in institutional policies and operational procedures to assure the IRB is meeting the requirements of the Federal Wide Assurance for the Protection of Human Subjects.

## I. Protocol Designation And Review Procedures:

There are three designations for review of research protocols involving human subjects: 1) exempt; 2) expedited review; and 3) full review by IRB.

### 1. Receipt of proposals:

All research protocols shall be received by the ORSP and reviewed by the IRB specialists to assign an initial review category. The IRB specialist, using federal and state review criteria, determines whether the research protocol meets the criteria for an exemption or expedited review or a full committee review. Exempt protocols are then pre-reviewed by the IRB specialist and prepared for review by the VP of Corporate Ethics/RSP or designee.

### 2. Determination of review procedures:

If the VP of Corporate Ethics/RSP or designee concurs that the research project falls within the exempt category (~~Policy 202-6~~), it need not be submitted for further IRB review. If the exempt study is approved, it is processed by the IRB specialist. The approved exempt study is reported at the next IRB meeting.

If a determination is unable to be made by the VP of Corporate Ethics/designee, then the research project will be forwarded to the IRB Chair to review to determine if it qualifies for an exemption under the regulations. If the Chair cannot render a determination, then the proposal will be scheduled for review by the full committee.

Protocols that do not meet the exemption criteria are pre-reviewed by the IRB specialist to determine whether the research meets the criteria for an expedited review or a full committee review. If the research meets the criteria for expedited review (see (3) below), it is forwarded to an approved reviewer for determination of approval. All other protocols are prepared for full board review (see (4) below).

The full IRB board shall be informed of research protocols which have been approved under the exempt review procedure at the next board meeting. At the convened IRB meeting, any member may request that a protocol found to be exempt be reviewed by the full IRB. If such a review is requested, decisions

reached at the full IRB meeting shall supersede any decision made through the exempt review.

3. Expedited review:

Expedited review shall be conducted by IRB chair, co-chair or designee(s). Eligibility of some research for review through the expedited procedure is not intended to negate or modify the policies of RPCI or the requirements of 45 CFR 46 or 21 CFR 50.

The IRB may use the expedited review procedure to: 1) review minor changes in previously approved research during the period for which approval is authorized. 2.) review research that involves no more than minimal risk to the subjects and in which the only involvement of human subjects is in one or more of the categories specified in 45 CFR 46 and 45 CRF 46.110

An expedited reviewer may approve that research or refer the research protocol to the full committee for review. The full IRB board shall be informed of research protocols which have been approved under the expedited review procedure at the next board meeting. At the convened IRB meeting, any member may request that a protocol approved under the expedited review procedure be reviewed by the full IRB. If such a review is requested, decisions reached at the full IRB meeting shall supersede any decision made through the expedited review.

4. Full review:

Research protocols scheduled for review shall be distributed to members of IRB prior to the meeting. Requests for information from investigators will be made prior to the meeting, whenever possible, in order to facilitate action on a proposal. When it is determined that consultants or experts will be required to advise IRB in its review of a protocol, the research protocol shall also be distributed to them prior to the meeting, if at all possible.

The IRB shall conduct initial and continuing reviews of research at timely intervals. Continuing reviews may not be less than annual and may be more frequent if the IRB has determined them to be higher risk. The IRB shall determine which projects require review more often than annually.

A simple majority of membership on the IRB constitutes a quorum and is required in order to convene a meeting for the review of research protocols. One member of that quorum must represent non-scientific research concerns. For a research

protocol to be approved, it must receive the approval of a majority of those members present at the convened meeting. Protocols are approved, approved with specific conditions, deferred or disapproved at convened meetings of IRB.

Regulations in 21 CFR 312 and 812 for research on investigational new drugs or significant risk devices will be followed where applicable.

5. Notification of IRB decisions:

The IRB shall notify PI's in writing of IRB decisions, conditions and requirements in a timely fashion. The PI shall be provided with reasons for a decision to defer or disapprove a research protocol and provide an opportunity for the PI to respond.

6. Appeals Process:

Notification of intent to appeal will be made to IRB chair who will then make arrangements for the PI submit supplemental information and/or to argue the case before the full board. Such an appeal will contain reasons by the investigator for appealing the decision(s) of IRB. If the board rejects the appeal, this decision shall be final.

**J. Notification of Suspension or Termination of Previously Approved Research:**

Federal regulations grant the IRB authority to suspend or terminate approval of research that is not being conducted in accordance with IRB requirements or federal regulations governing research or that has been associated with unexpected serious harm to subjects. Suspensions and terminations represent an action by the IRB to temporarily or permanently withdraw approval for some or all research procedures. Such actions will be reported to the appropriate organizational officials and the appropriate regulatory agencies.

**K. Notification of Expiration of IRB Approval:**

If the investigator has not submitted a completed continuing review application or a study closure/termination form to the IRB by the expiration date of the study approval, the IRB will notify the investigator that IRB approval has expired. This expiration is automatic; the IRB notification is a courtesy to the PI. The notification shall include a reminder that no human subject research activities may be conducted until IRB approval is obtained. For therapeutic studies where subject safety is a concern, federal regulations allow some flexibility towards the continued treatment for currently enrolled subjects and the IRB will review the research to determine if currently enrolled subjects will be allowed to continue on the therapy for best interest or safety reasons. However, no new

subjects may be contacted, recruited, or enrolled in the study until the investigator obtains current IRB approval.

In cases of externally funded research projects, the sponsor will be notified of the expiration of IRB approval, as appropriate. Once a study has been closed due to expiration of approval, it must be resubmitted for review and approved before any further research may continue. The IRB, at its discretion, may re-approve a study without a new full board review, if it is in the participants' best interest.

**L. Notification of Determination that the Project is Not Human Subjects Research:**

If the ORSP determines that a project does not qualify as human subject research the investigator will be notified of the basis for the determination; the regulations that permit this determination; and, any other information as appropriate. The IRB administrative staff will issue a determination of non-human subject research to the PI.

**VIII. Investigator Responsibilities**

- A. Primary/Principal investigators shall be responsible for complying with all federal and state regulations for conducting research in addition to all IRB policies, decisions, conditions, and requirements.
- B. Each PI is responsible for obtaining legally effective consent in accordance with 45 CFR 46.116 and 21 CFR 50 and as directed by the IRB and for assuring that no human subject will be involved in the research prior to obtaining consent.
- C. PI's shall be responsible for assuring that informed consent is documented by the use of a written consent form approved by IRB and signed by the subject or by the subject's legally authorized representative, unless this requirement is specifically waived by IRB. PI's shall assure that each research participant is given a copy of the consent form.
- D. Shall keep all research records and IRB approved documents for a minimum of three (3) years after the termination of the study, or longer if required.
- E. PI's are responsible for reporting promptly to the IRB any injuries to human subjects and any unanticipated problems that involve risks to human research subjects or to others.
- F. PI's are responsible for reporting promptly to IRB proposed changes in research activity. Changes in research during the period for which IRB approval has already been given shall not be initiated by research investigators without IRB review and approval, except to eliminate apparent immediate hazards to participants. Changes in approved research initiated without IRB approval to eliminate apparent immediate hazards to the

participants should be reported (within 30 days) to the IRB, which will review said change(s) to determine whether the change was consistent with assuring the participants' continued welfare. This will be reviewed by the IRB chair to determine whether each change was consistent with ensuring the participants' continued welfare. The Chair will refer all unanticipated problems to the conveyed IRB for review

- G. PI's hold major responsibility for reporting promptly to IRB any serious or continuing noncompliance with the requirements of the federal wide assurance or the determinations of IRB. Reports of noncompliance may come from a variety of sources, such as human subjects, research investigators, or other institutional staff or community members.
- H. To facilitate the review of research and the protection of the rights and welfare of human subjects, investigators may be required to attend IRB meetings. When a research protocol is scheduled for a particular IRB meeting, the investigator is notified, so they can be available if needed to attend the IRB meeting either in person or telephonically.

**SUMMARY:**

In keeping with Roswell Park Cancer Institute's mission and values, an Office of Research Subject Protections and an IRB has been established in accordance with 45 CFR 46 and 21 CFR 50. The function and responsibilities of the IRB are supported by the Board of Directors and Administration of RPCI.

This plan has been approved and is supported by:



---

Candace Johnson, Ph.D. President and CEO  
Roswell Park Cancer Institute