SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

TO: Senate

FROM Joy Johnson
Chair – Senate Committee on Agenda and Rules (SCAR)

DATE: October 27, 2023

SUBJECT: Amended R20.01 Policy

SCAR has reviewed S.23-121 and is forwarding it to Senate for approval.

Motion 1:

"That Senate approve the change to Policy R20.01 Procedures related to the definition of quorum - namely accepting the proposed change to SOP 302.004 section 5.4.1 (removal of definition), and recommend to the Board of Governors the approval of changes to Policy R20.01 Appendix A - namely the insertion of 2.5.7 - Definition of Quorum."

Motion 2:

"That Senate approve the Procedures for Policy R20.01 as revised, and recommend to the Board of Governors approval of Policy R20.01 and associated Appendix A as revised."

SUBJECT	Amended R20.01 Policy
DATE	Oct 18, 2023
FROM	Dugan O'Neil, VPRI
RESOURCE PEOPLE TO ATTEND MEETING	Trevor Davis

BACKGROUND

Policy R20.01 sets out the responsibilities for researchers and the University with respect to the review of human participants-related research. In early 2023, the Policy Authority (VPRI) proposed changes to the R20.01 procedures. The proposed change to procedures was significant: a wholesale adoption of a national standard set of operating procedures termed the 'N2/CAREB SOPs'. After considerable debate, Senate and the BOG chose to create a joint BoG/Senate committee (Special Joint Committee or SJC) to review specific elements of the change, as well as the associated policy and the roles and responsibilities of BOG, Senate and senior administration. The SJC focused on a specific subset of those SOPs – but also made changes to the policy itself.

SJC brought these changes back to Senate in May, and they were approved as an interim policy (until Jan 31, 2024). The policy and procedures were termed 'interim' because the process had not followed the prescribed (B10) process for policy review. Only some SOPs had been reviewed by stakeholders, the policy changes had received limited review, and no community consultation had taken place.

Community consultation took place between Sept 7, 2023 and Oct 6, 2023. Five submissions were received. SFUFA was consulted at the Sept 12, 2023 Joint Committee meeting through Faculty Relations, and a subsequent response was received. The REB Chair was consulted after edits were made to the policy and procedures and has endorsed all the changes included in this package.

CONSIDERATIONS

Two of the feedback items considered worthy of inclusion do modify the SJC interim policy/procedures and so the rationale for the changes is highlighted here.

(1) The membership of the REB was defined by the SJC in SOP 201 – consisting of at least seven members. In SOP 302, SJC defined a quorum of those seven+ members as *"50% plus 1 of the voting members of the REB…provided that the members in attendance at a meeting have the specific expertise, relevant competence, and knowledge necessary to provide an adequate research ethics review of the proposals under consideration."* This text is drawn from TCPS2 Article 6.9, but omits the following:
"Institutions shall establish quorum rules for REBs that meet the minimum requirements of membership representation outlined in Article 6.4", which are, at least five voting members – 2 experts, 1 ethicist, 1 community member, 1 legal (if required) - with the SOPs adding 1 in a non-scientific discipline in order to satisfy US clinical requirements. The 50%+1 count is only required for research falling under US regulations.

… /2

There is no issue in defining REB membership more broadly than TCPS2 and the CAREB/N2 SOPs (eg, including a student). However, creating an SFU-specific definition of *quorum* is problematic for several reasons:

a. It does not follow TCPS2. TCPS2 Article 6.4 includes the list later echoed in the SOP definitions, and Article 6.9 states that "Institutions shall establish quorum rules for REBs that meet the minimum requirements of membership representation outlined in Article 6.4.". TCPS2 requires that quorum must, at least, contain the minimum five *specific* members. Adherence to TCPS2 is a basic condition of our federal funding agreement.
b. It reduces interoperability. Disagreements regarding administrative procedures can negatively affect SFU's ability to work within the BC Harmonization Model and across the country. For example, all the UBC ethics boards operate under the standard SOPs using the original TCPS2-derived definition of quorum.
c. US regulatory incompatibility. When a researcher is receiving many types of US funding SFU must operate under the Federal Wide Assurance (FWA) and Office of Human Research Protections (OHRP) regulations. These require the strict use of the definitions found in the original SOPs – including the addition of a majority.

(2) SOP 402 covers the same information as the policy sections added by the SJC, except for the specifics of who to submit to and the time limit. SJC incorrectly noted in their submission that *"Section 5.5 and 5.6 were added to the policy directly from the procedures because this information is not covered in the CAREB SOPs"*. Procedural details should be located in the SOPs – the policy now only references the right to reconsiderations and the right to appeal. Note that the procedures for the actual appeal must be those of the university undertaking the work.

ATTACHMENTS

Draft Policy R20.01, procedures and schedules, with track changes from the interim approved documents.
Summary of all comments received and changes made.

Respondent	Section	Comment	Action	Note
1	Pol 7.1	For consistency in defined terms, it shouldn't be "Office of Research Ethics" but "Research Ethics"	Changed	
1	Pol 11.1, 12.1, 13.1 and 14.1	"Policy" should be capitalized	Changed	
1	Pol 5.5,5.6	Sections 5.5 and 5.6 are addressed in SOP 402. Since the Appeals Board is normally (and currently) the board of another university, these procedures cannot dictate the methods they use to carry out the appeal - that is covered by their own university policy/procedures.	Changes made . Note that this modifies SJC-produced changes. Section 5.5.3 is additional, more specific procedures (specifying the time limit for appeals) and was added to SOP 402. A reference to the right to reconsideration and appeal was added.	The SJC focused on just 3 of the SOPs. They noted that they added 5.5. and 5.6 because 'appeals' were not covered in the SOPs. However, most of the additions to the policy are already covered in SOP 402. Further, these are procedural specifics that are more appropriate outside the main Policy. * See attached Notes
1	App A	Research Involving Human Participants – "Human Participants" should not be capitalized in the definition as it is not a defined term	Changed	
1	SOP 201 – 5.2.3	re: "at least one member who is a graduate student of the University" – would a graduate student meet the requirements of section 5.2.5 (i.e. have the qualifications and experience?). TCPS2 also provides that a REB may consider adding a student REB member if the REB mainly reviews student research, which to my understanding, SFU REB does not.	Not changed.	While the addition of a graduate student is not typical, 5.2.5 does state that the members must **collectively** have the qualifications and experience to review the studies. The TCPS2 statement is not within the main body but part of the interpretations.
1	202 – 5.6.1	What about community members? (for compensation)	Not changed	"Other REB Members" is included in the compensation section.
1	202 – 5.8.3	It is common practice to make REB members list publicly available with at the very least, their name and role on the REB	Not changed	5.8.3 refers to a specific list with detailed information about each member. This does not preclude the members being listed on a website. They are currently listed on the Senate website, for example.
1	203 – 5.3.9 bullet point 10	proposing removal as the Policy says the Director will do the reporting	Removed, as this is covered in Policy 7.1	
1	402	as per above, duplicate of Policy sections 5.5 and 5.6	See above.	
1	402 – 5.2.3	should revert to "organization"	Changed	
1	601 – 5.2.2	should revert to "organization"	Changed	
2	SOP 105B, 201, 203, 801	his/her to their	Changed	To match CAREB/N2 SOPs V4
2	SOP 108.004	Responsibility for SOPs – N2 responsible for changes	Changed	

2	SOP 302	meeting minutes – removed 'voting' on –presented and asked if any changes	Already changed	
2	SOP 303	retention period for records changed (Health Canada changed the retention period from 25 to 15 years)	Already changed	
2	SOP 701	provision of signed AND dated ICF	Already changed	
2	General	Policy: Change Office of Research Ethics to Research Ethics. Eliminate acronym 'ORE'.	Changed.	
2	Pol Section 5.6	policy speaks to the 'Research Ethics Appeal Board – REABC', but no such Board is currently in existence. It is suggested that clarity (ie authority/responsibility to create, etc) is provided and is appropriately linked to SOP 104.001, section 5.2 Reconsideration and Appeal...	Policy now retains only a reference to the right to reconsideration and appeal. Details are in SOP 402. New item added to SOP 402 detailing how the REAB is determined.	
2	Section 6.0	Senate's primary purpose relates to 'academic governance' (including matters relating to research) and it's members (faculty with a vested interest in ensuring research is approved) results in a direct conflict with the mandate of the REB which is to protect the safety and welfare of participants; not to expedite nor ensure the approval of research	Not changed	Senate and the SJC have been clear that, at least a present, the Senate will retain authority over the REB procedures and will delegate authority to the REB.
2	SOP 302	The definition of quorum put forward at 5.4.1 in the draft SOP 302.004 is not in compliance with TCPS2, Article 6.9. The TCPS2 definition is a mandatory provision as signaled by the use of the term "shall".	Changed. Brought back the original SOP definition of Quorum and removed the new definition from 302. Retained the 50%+1 stipulation as this is required by US regulators. Note that this modifies SJC-produced changes.	This is a potential non-compliance issue with TCPS and other regulatory bodies. SJC used only a portion of the TCPS-required quorum definition. They omitted the requirement for the 5 key board members to be present. The definition of quorum from TCPS has therefore been added to Appendix A, and the SJC definition removed from SOP 302. However, the 50%+1 stipulation SJC has added has been retained. * See attached Notes
2	SOP 202 s5.1.1	5.1.1 Approval/information process through both Senate/BoG is potentially inefficient in terms of timeliness, particularly given the longstanding historical difficulties in maintaining membership/quorum requirements	Not changed	This should be monitored and modified in the future if it is problematic.

3	Pol s. 11.2	If the process of amending procedures to SFU policies is governed by s. 3.0 of Appendix A to B 10.00 Policy on University Policies and Procedures, revisions to s. 11.2 of R20.01 are in conflict with B 10.00. The revised s. 11.2 grants the Senate the authority to approve the procedures. However, such authority rests with the Board of Governors (s. 3.3 of Appendix A to B 10.00) and Responsible Authority (s. 5.5 of the B10.00).	Not changed	The Board of Governors should make the final determination of which BoG policy takes precedence.
3	App A 2.22	It is advisable to update the definition of human biological materials in accordance with the TCPS2 Glossary: Human biological materials – Tissues, organs, blood, plasma, skin, serum, DNA, RNA, proteins, cells, hair, nail clippings, urine, saliva, and other body fluids. The term also includes materials related to human reproduction, including embryos, fetuses, fetal tissues and human reproductive materials.	Changed.	
4	General	Statement that the SFU REB and Human Ethics generally does not meet this individual's needs for performing Indigenous-related research (the method of 'testimonio'), driving them to work outside the system	Not changed	While this reply represents a specific individual's issues, the general need for a more Indigenous-sensitive review process is being looked into as a priority area of the SRP.
5	General	Recommends that both sets of SOPs (Clinical and Behavioural) be adopted and used in the appropriate context	Not changed	Future plans (as part of the runup to a medical school) include exploring operating two separate boards - that would likely run under the two different sets of SOPs.
5	General	Suggests that the requirement for "at least two faculty members with expertise in relevant disciplines - be a much larger number.	Not changed	The SOPs allow for a larger board ("...at least") but this has proven problematic in the past due to difficulty reaching quorum. The provisions for alternate members and ad-hoc members are intended to alleviate this issue.
5	General	Need to consider having more than one REB	Not changed	As noted above, this is currently under serious consideration/investigation, and is allowed for in the current policy.

SFUFA	General	Concern with REB autonomy - independence of the REB from senior administration and legal; appropriate contraints on staff, including the Director Research Ethics in terms of appointments, and independence of internal procedures and decision-making.	Added 6.7 to the Policy: "To ensure independence in REB decision making, the Vice-President, Research and International and other University senior administrators shall not serve on the REB, nor shall such individuals be present during REB deliberations". This is a paraphrase of guidance in ch 6 of the TCPS2	While this statement was added to SOPs, it has also been added here to the Policy to underline the decision-making independence of the REB. The new SJC terms added to the SOPs do already make the recruitment and appointment of new members a joint responsibility of the Director and the Chair, with the Chair having veto power over proposed appointments.
SFUFA	General	The Senate must be be provided with complete authority over the REB - ie the policy and procedures - with no oversight from the Board of Governors. This cannot be a delegated authority, but must be absolute.	No Change	The SJC debated this matter and decided to approach this as a shared responsibility - hence their use of the term 'University' ("The REB derives its authority from the University"). The University Act (section 37-1) defines specifically and exhaustively the academic powers of the Senate. This does not include any research or research compliance elements. Therefore the BoG is delegating to the Senate in this matter. Any change would require the BoG to make the determination.
Comments from SFUFA Received by the SJC during their deliberations (for information - only one minor oversight corrected in this edit)				
	Pol 6.1	Change to "The Research Ethics Board (REB) derives its authority from **Senate**."	Rejected by SJC.	
	Defs	Delete "University" from the Definitions	Rejected by SJC.	
	SOP 201 5.1.4	Add "Members of the REB will be reminded that all applicable University Policies and collective agreement provisions relating to confidentiality and conflict of interest apply to and are of particular import in their work on the REB."	Rejected by SJC	
	SOP 201 5.2.3	Modify to read "At least two SFU Faculty members who have expertise in relevant research disciplines, field and methodologies covered by the REB (for biomedical clinical trials, this will include at least one member who practices medicine or dentistry and who is in good standing with their regulatory body). **This is mandatory for biomedical research and is advisable, but not mandatory, for other areas of research**.	Rejected by SJC	

	SOP 201 5.2.3	Add "Faculty members will constitute the majority of voting members of the REB."	Rejected by SJC	
	SOP 202 5.5.4	Remove reference to "or mismanaged conflict of interest…"	Accepted by SJC	
	SOP 201 5.1.3	Modify to " 5.1.3 The REB membership will not consist entirely of members of one profession and will include members with diverse methodological and disciplinary expertise**. To ensure the independence of REB decision making, institutional senior administrators shall not serve on the REB.**	Accepted by SJC	
	Policy - Exec Summary	Modify to "...This Policy describes the responsibilities of the University as a whole with respect to the REB, and specifically those responsibilities of Senate, the Vice-President, Research and International, and the Director, Office of Research Ethics. **The Board of Governors authority and responsibilities remain as defined in the University Act and SFU Board of Governors policies...**	Rejected by SJC	
	Pol s6.2	Modify to "The Vice-President, Research and International is responsible **only** for the administrative and operational aspects of the REB.	Rejected by SJC	
	Pol s7.1	Modify to " The Director of the Office of Research Ethics will submit an annual report of the REB's activities to the REB Chair for approval. Once approved, the Director of the Office of Research Ethics will submit the report to both Senate and the Board of Governors for information. The Director of the Office of Research Ethics will be available to present the report and answer questions from Senate and/or the Board of Governors upon request"	Rejected by SJC	
	App A	Def of REB Chair: "REB Chair means the chair of the REB, as elected by current members of the REB in accordance with the Procedures (SOP 201.003 5.4.1)."	Rejected by SJC	

	SOP 201 s 5.0	Modify to " Individual members of an REB must be qualified through training, experience, and expertise to ascertain the acceptability of proposed research in terms of ethical principles, and applicable regulations, guidelines, and standards pertaining to human participant protection. **Faculty members are deemed qualified. Questions about individual REB member qualifications will be brought to the REB Chair, whose determination regarding qualifications is final.**	Rejected by SJC	
	SOP 201 s5.4.1	Modify to "The REB Chair will be selected from experienced, **current faculty** REB members who have expressed interest in becoming the REB Chair and who are familiar with the applicable regulations and guidance documents"	Rejected by SJC	
	SOP 201 s 5.4.1	Add "5.4.2 The REB Vice-Chair will be elected by the regular voting REB members"	Rejected by SJC	
	SOP 201 s 5.4.2	Add "5.4.2 The REB Vice-Chair will be elected by the regular voting REB members."	Rejected by SJC	
	SOP 201 s5.5.6	Remove "5.5.6…the Vice-Chair will take their place and a new Vice-Chair will be elected"	Rejected by SJC	
	SOP 201 s 5.1.1	Remove "and ongoing" from "This process requires active and ongoing communication between the REB, the REB Chair, and the Director of Research Ethics"	Rejected by SJC	
	SOP 201 s 5.6.1	Modify to "5.6.1The REB **Chair** may allow observers to attend its meetings	Rejected by SJC	
	SOP 202 s3.0	Change to "All REB members **(including ex-officio, non-voting** Research Ethics staff members)"	Rejected by SJC	
	SOP 202 s5.1.2	Change to "Community Members (meeting membership requirements) **can be identified by any member of the REB, the REB Chair, or the Director of Research Ethics and** are solicited from the greater local community.	Rejected by SJC	
	SOP 202 s5.2.2	Change to " The REB Vice-Chair will be elected by the regular voting **board** REB members"	Rejected by SJC. Change made (apparent oversight)	

	SOP 202 s5.4.1	Change to "The Research Ethics staff and the REB Chair will recommend discretionary qualification and training procedures to members of the REB. The latest TCPS-2 Core training should be completed before REB members attend their first meeting and must be completed before REB members attend their second meeting."	Rejected by SJC	
	SOP 302 s 5.1.4	Change to "5.1.4 Research Ethics staff, in consultation with the REB Chair or their designee as **necessary, addresses meeting schedule matters** as required"	Rejected by SJC	
	SOP 302 s5.3.1	Add new section "All members of the REB, including non-voting members, are expected to attend all REB meetings. Members who cannot attend are expected to inform the Director of Research Ethics and the REB Chair at least 24 hours in advance."	Rejected by SJC	Already covered in SOP 201 s 5.1.2
	SOP 302 s 5.4.10	Change to "The Chair may invite or permit observers to attend REB meetings"	Rejected by SJC	

ETHICS REVIEW OF RESEARCH INVOLVING HUMAN PARTICIPANTS

Date	Number
Oct 1, 1992	R20.01
Date of Last Review/Revision	**Mandated Review**
TBD	TBD

Policy Authority: Vice-President, Research and International

Associated Procedure(s): The most current version of the N2/CAREB Standard Operating Procedures, as amended as necessary, and approved for adoption, by the University in accordance with this Policy.

Commented [TD1]: Redundant

Deleted: As of [TBD] date, version 3 of the N2/CAREB Standard Operating Procedures are so approved for adoption by the University.

EXECUTIVE SUMMARY

This Policy sets out the ethical principles that the University must apply when seeking to conduct Research Involving Human Participants and the framework that will govern the application of those principles through the process for Ethics Approval by the Research Ethics Board (REB). Where Ethics Approval is not granted by the REB, a researcher may request Reconsideration, or as applicable, an appeal of an REB decision; provided that the onus is on the researcher to justify the grounds on which a Reconsideration or appeal is justified. This Policy describes the responsibilities of the University as a whole with respect to the REB, and specifically those responsibilities of Senate, the Vice-President, Research and International, and the Director, Office of Research Ethics, as delegated authority by the Board of Governors.

1.0 PREAMBLE

1.1 The University is fundamentally committed to the advancement of knowledge through scholarly activities, including Research Involving Human Participants. The University is committed to ensuring the highest level of ethical conduct for Research Involving Human Participants, recognizing that such Research should balance the need for scientific inquiry with the need to respect cultural and community context, human dignity, and well-being.

2.0 PURPOSE

2.1 To cultivate an environment in which the conduct of Research Involving Human Participants, performed Under the Auspices of the University, follows the highest ethical standards;

2.2 To promote an awareness and understanding of how the Core Ethical Principles of Respect for Persons, Concern for Welfare, and Justice are applied within TCPS2, as well as all relevant institutional, national, and international standards and best practices; and

2.3 To establish an independent human research ethics review process.

3.0 SCOPE AND JURISDICTION

3.1 This Policy applies to all Research Involving Human Participants, their biological material, or data that is not specifically exempted by the TCPS that is:

3.1.1 conducted by University faculty, staff or students;

3.1.2 conducted Under the Auspices of or in affiliation with the University; or

3.1.3 conducted using University equipment, space, or resources]

4.0 DEFINITIONS

4.1 Please see Appendix A for the definitions of words used in this policy and its associated procedures.

5.0 POLICY

5.1 **Core Ethical Principles**

5.1.1 The University will regulate all Research Involving Human Participants in accordance with the Core Ethical Principles contained within the Tri-Council Policy Statement:

a Respect for Persons – a recognition of the intrinsic value of human beings and the respect and consideration they are due;

b Concern for Welfare – a requirement of researchers and research ethics boards to aim to protect the welfare of research participants; and

c Justice – an obligation to treat people fairly and equitably.

5.1.2 Building on Chapter 9 of the TCPS, the University recognizes that research involving Indigenous peoples requires additional ethical considerations, including but not limited to the need to co-create research projects in a community-led process. This recognition is consistent with the *United Nations Declaration on the Rights of Indigenous Peoples*, and informed by the *Truth and Reconciliation Commission of Canada: Calls to Action*. The University also takes direction from the *SFU Aboriginal Reconciliation Council (ARC) Final Report*, particularly in encouraging the "use (of) Indigenous methodologies and respect (for) Indigenous protocols and ethics in conducting research." Thus,

a The University shall ensure that research involving Indigenous peoples aligns with the standards and recommendations referred to herein.

b The University shall also ensure that research involving Indigenous peoples aligns with the stated goal on Culturally Respectful Indigenous Research, from the Accord on Indigenous Education, that speaks to “partnering with Indigenous communities at all levels in ethically based and respectful research processes.”

5.1.3 The University shall ensure that those who conduct Research Involving Human Participants understand their responsibilities for the ethical conduct of their research and receive appropriate training in the skills necessary for such conduct. This includes not only awareness of but also understanding of the relevant policies, procedures, professional standards, and practices that both support and promote the responsible conduct of research.

5.1.4 This Policy and its affiliated Procedures conform to the requirements stated within the *Tri-Agency Agreement on the Administration of Agency Grants and Awards by Research Institutions*.

5.2 **Ethics Approval**

5.2.1 A researcher must not initiate Research Involving Human Participants, including through contact with or recruitment of potential participants, until Ethics Approval has been granted. However, REB review is not required for the initial exploratory phase, which may involve contact with individuals or communities intended to establish research partnerships or to inform the design of a research proposal.

5.2.2 If the REB rescinds or terminates an Ethics Approval, the REB may give notice and direction to the University. Upon receipt of such notice and direction from the REB, the University must freeze or close the relevant research account as appropriate.

5.3 **Non-Compliance**

5.3.1 As required by the Tri-Agency Agreement on the Administration of Agency Grants and Awards by Research Institutions, the University shall maintain adequate controls to ensure that the REB has approved all Research Involving Human Participants before Research Involving Human Participants has commenced, and that approval remains in place as long as such activities are carried out.

5.3.2 Failure to comply with this Policy and pertinent federal, provincial, and international guidelines/legislation for the protection of Human Participants and/or failure to conduct research in the manner in which it has been approved by the REB may be considered Misconduct in Research and may, accordingly, be handled under the procedures of Policy R60.01 (Responsible Conduct of Research).

5.4 **Ethics Review Agreements**

5.4.1 In order to facilitate collaborative research projects involving researchers, data, or participants from more than one institution, and in order to avoid a duplication of efforts with respect to research ethics reviews, the SFU REB may cede review to another institutional REB or it may conduct the research ethics review on behalf of other institutional partners.

5.4.2 The SFU REB must satisfy itself that there is a formal agreement between SFU and the other institution involved and/or that the other institution is compliant with the requirements set out in the Tri-Council Policy Statement.

5.4.3 An Ethics Review Agreement may be limited to a specific Research project.

5.5 **Reconsideration and Appeal of REB Decisions**

5.5.1 Researchers have the right to request, and the REB has an obligation to provide, reconsideration of an REB decision.

5.5.2 A researcher who continues to dispute an REB decision after reconsideration by the REB may appeal that decision through the formal appeals process.

5.6

6.0 ROLES AND RESPONSIBILITIES

6.1 The Research Ethics Board derives its authority from the University.

6.2 The Vice-President, Research and International is responsible for administrative and operational aspects of the REB.

6.3 The Vice-President, Research and International is responsible for determining ongoing financial and administrative resources that are required for the REB to fulfill its duties. By approving this Policy, the Board of Governors has delegated authority to the Vice-President, Research and International to ensure that these resources are provided.

6.4 The University shall authorize such number of REBs organized around volume and type of submission, as recommended to be appropriate by the Vice-President, Research and International.

6.5 The REB is responsible for reviewing all research covered by this Policy. It has the mandate to review and maintain ongoing oversight of the ethical acceptability of research on behalf of the institution, including approving, rejecting, proposing Provisos to, or suspending or terminating any proposed or ongoing research involving Human Participants.

6.6 The REB shall operate in an impartial manner and be independent in its decision making. The decisions of the REB are not subject to review or interference by the Vice-President, Research and International, the Senate, the Board of Governors, or any other person or body except to the extent that such decisions may be reviewed through Reconsideration or the Research Ethics Appeal Process, pursuant to this Policy or its Procedures.

6.7 To ensure independence in REB decision making, the Vice-President, Research and International and other University senior administrators shall not serve on the REB, nor shall such individuals be present during REB deliberations.

6.8 The Vice-President, Research and International and/or other senior administrators responsible for research compliance shall meet at least once per semester with the REB to discuss policy issues, general issues arising from the REB's activities, or training and education needs, to the benefit of the overall operation and mandate of the REB.

6.9 The Vice-President, Research and International or their delegate is responsible for ensuring that members of the REB are informed and educated regarding all ethics requirements of the Tri-Council granting agencies and all other provincial, national, and international laws, as well as regulations, policies, standards, and guidelines that are relevant to research ethics review.

7.0 REPORTING

Commented [TD2]: Covered in SOP 402 s5.2 (Reconsideration) and 5.3 (Appeal) Note that 5.2 and 5.3 are based on TCPS2 s6.18 to 6.20.

Commented [TD3]: Covered in SOP 402 s5.3. Note - 5.5.3. moved to SOP 402 to provide the specificity requested by the SJC. Other details are already covered in that document

Deleted: **Reconsideration of REB Decisions** ¶
Researchers have the right to request, and the REB has an obligation to provide, prompt Reconsideration of an REB decision. ¶
Initial Reconsideration may simply consist of informal discussions between the researcher and the REB Chair. If the matter is resolved through this process, the resolution will be documented in the online application system of the Office of Research Ethics and will also be reflected in the application materials as appropriate. ¶
If informal discussions do not lead to a resolution, the researcher may request a formal Reconsideration. The researcher must provide a written request for Reconsideration to the REB Chair, outlining the concerns they have with the initial REB review. The researcher has the right to be heard in a meeting with the REB to discuss the issues identified. ¶
When requesting a Reconsideration, the onus is on the researcher to justify the grounds on which the Reconsideration is requested and to indicate any alleged breaches to the established research ethics review process, or any elements of the REB decision not supported by the Tri-Council Policy Statement. ¶
Appeal of REB Decisions ¶
If, after having fully exhausted the Reconsideration process, the researcher continues to be dissatisfied with the REB decision, the researcher may utilize the Research Ethics Appeal Process and appeal the decision of the REB to the Research Ethics Appeal Board (REAB). ¶
The appeal may be launched for either procedural or substantive reasons. The onus is on the researcher to justify the grounds on which the appeal is requested and to indicate any breaches to the review process or any elements of the REB decision that are not supported by the Tri-Council Policy Statement. ¶
Researchers may submit a request for appeal of a decisions of the REB to the Director of the Office of Research Ethics within 30 working days of the reconsideration and the Director of the Office of Research Ethics will notify the REAB of the request for appeal. ¶
Both the researcher and a representative from the REB whose decision is being appealed shall be granted the opportunity to address the REAB, but neither shall be present when the REAB makes its final decision. ¶
The decisions of the REAB are final and binding in all respects for any appeal lodged against a decision of the REB and may include approving, rejecting, or requesting modifications to the Research project. ¶

Commented [TD4]: Transcribing error. SJC used the term "University" in the interim policy approved by Senate.

Commented [TD5]: Drawn from TCPS2 article 7.3 guidance

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7.1 The Director, Research Ethics will submit an annual report of the REB's activities, which report has been approved by the REB Chair, to both the Board of Governors and the Senate.

Deleted: of the Office of

8.0 RELATED LEGAL, POLICY AUTHORITIES AND AGREEMENTS

8.1 The legal and other University Policy authorities and agreements that may bear on the administration of this policy and may be consulted as needed include but are not limited to:

8.1.1 *University Act*, R.S.B.C. 1996, c. 468

8.1.2 *Freedom of Information and Protection of Privacy Act*, R.S.B.C. 1996, c. 165

8.1.3 *Association of Canadian Deans of Education: Accord on Indigenous Education* (2010)

8.1.4 *SFU Aboriginal Reconciliation Council Final Report: Walk This Path With Us* (2017)

8.1.5 *Tri-Council Policy Statement 2: Ethical Conduct for Research Involving Humans* (2014)

8.1.6 *Truth and Reconciliation Commission of Canada: Calls to Action* (2015)

8.1.7 *United Nations Declaration on the Rights of Indigenous Peoples* (2013)

9.0 ACCESS TO INFORMATION AND PROTECTION OF PRIVACY

9.1 The information and records made and received to administer this policy are subject to the access to information and protection of privacy provisions of British Columbia's *Freedom of Information and Protection of Privacy Act* and the University's Information Policy series.

10.0 RETENTION AND DISPOSAL OF RECORDS

10.1 Information and records made and received to administer this policy are evidence of the University's actions to comply with the highest ethical practices and relevant institutional, national, and international standards and best practices in respect of Research Involving Human Participants. Information and records must be retained and disposed of in accordance with a records retention schedule approved by the University Archivist.

11.0 POLICY REVIEW

11.1 This Policy must be reviewed every five years and may always be reviewed as needed.

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11.2 Notwithstanding the latitude granted by Board Policy B10.00 section 5.5, any amendments subsequent to the adoption date of the Policy regarding the N2/CAREB Standard Operating Procedures adopted by SFU must be reviewed and approved by the Senate and sent to the Board of Governors for information.

12.0 POLICY AUTHORITY

12.1 This Policy is administered under the authority of the Vice-President, Research and International.

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13.0 INTERPRETATION

13.1 Questions of interpretation or application of this Policy or its procedures shall be referred to the Director, Research Ethics, whose decision shall be final.

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14.0 PROCEDURES AND OTHER ASSOCIATED DOCUMENTS

14.1 Appendix A contains the definitions applicable to this Policy and its associated procedures.

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14.2 The procedures for this policy are: the most current version of the N2/CAREB Standard Operating Procedures, as amended as necessary, and approved for adoption, by the University in accordance with this Policy.

APPENDIX A – DEFINITIONS – ETHICS REVIEW OF RESEARCH INVOLVING HUMAN PARTICIPANTS

Date	Number
October 1, 1992	R20.01
Date of Last Review/Revision	**Mandated Review**
[TBD]	[TBD]

Policy Authority: Vice-President, Research and International

Parent Policy: Ethics Review of Research Involving Human Participants (R20.01)

1.0 PURPOSE

1.1 The definitions in this Appendix define the words used in the Ethics Review of Research Involving Human Participants policy (R20.01)

2.0 DEFINITIONS

2.1 **Ad hoc advisor**: a person with relevant and competent knowledge and expertise consulted by a Research Ethics Board (REB) for a specific research ethics review, and for the duration of that review, in the event that the REB members lack specific expertise or knowledge to review with competence the ethical acceptability of a research proposal. The ad hoc advisor is not a member of the REB and is not counted in the quorum or allowed to vote on REB decisions.

2.2 **Adverse event (AE)**: any untoward medical occurrence in a research participant, administered investigational product, including an occurrence which does not have a causal relationship with this product. An AE can therefore be any unfavourable and unintended sign (including an abnormal laboratory finding, for example), symptom, or disease temporally associated with the use of an investigational product, whether or not related to the investigational product.

Local adverse event: those adverse events experienced by research participants enrolled by the Researcher at the centre(s) under the jurisdiction of the Research Ethics Board (REB).

Non-local (external) adverse event (EAE): those adverse events experienced by research participants enrolled by Researchers at other centres/organizations outside the REB's jurisdiction.

Serious Adverse Event (SAE) or Serious Adverse Drug Reaction (ADR): any untoward medical occurrence that at any dose: results in death, is life threatening, requires inpatient hospitalization or prolongation of existing hospitalization, results in persistent or significant disability/incapacity or is a congenital anomaly/birth defect.

2.3 **Alternate member**: a formally appointed voting member of the Research Ethics Board (REB) who may substitute for a regular member of the REB but who is not expected to attend every REB meeting. An alternate REB member's presence at the REB meeting in the place of an absent regular REB member is used to establish quorum.

2.4 **Amendment**: a written description of a modification or change(s) to the previously approved research study. Amendments include any changes to the protocol or related research documents, such as changes to the consent form, revisions to the Investigator Brochure, updated participant material, etc.

2.5 **Assent**: affirmative agreement to participate in research by an individual unable to provide consent.

2.6 **Authorized signatory**: individual(s) authorized to sign documents on behalf of an organization.

2.7 **Authorized third party**: Any person with the necessary authority to make decisions on behalf of the prospective participant who lacks the capacity to consent to participate, or to continue to participate, in a particular research project. (Also known as a "legally acceptable representative" or "substitute decision-maker").

2.8 **Concern for Welfare**: requires that the welfare of Participants in research be protected and promoted, and the recognition that the welfare of a person is the quality of that person's total experience of life, which consists of the impact caused, among other things, by factors such as one's physical, mental, and spiritual health, as well as one's physical, economic, social and cultural circumstances and concern for the community to which participants belong. Concern for Welfare acknowledges the important role of communities in promoting collective rights, interests and responsibilities that also serve the welfare of individuals. Research involving distinct communities should enhance their capacity to maintain their cultures, languages and identities and to support their full participation in, and contributions to, Canadian society.

2.9 **Confidentiality**: refers to the agreement between the Researcher and the participant as to how personal data will be managed and used, and an ethical and/or legal responsibility to safeguard information from unauthorized use, disclosure, modification, loss or theft. The term also refers to the REB's ethical and/or legal responsibility to safeguard information in its custody from unauthorized use, disclosure, modification, loss or theft.

2.10 **Conflict of Interest (COI):** circumstance of a person (e.g., Researcher or Research Ethics Board (REB) member) or organization in a real, perceived or potential conflict between their duties or responsibilities related to research and their personal, institutional or other (secondary) interests.

Example: COI may occur when an individual's judgments and actions or an organization's actions in relation to research are, or could be, affected by personal, organizational or other interests, including, but not limited to, business, commercial or financial interests, whether of individuals, their family members, their friends, or their former, current or prospective professional associations or of the organization itself.

Examples of secondary interests for a Researcher include the following:

- Is receiving or expecting to receive compensation from the sponsor in which the value of the compensation could be affected by the outcome of the study;
- Acts as an officer, director, or agent of the sponsor;

- His/her job status or compensation is impacted by the research (e.g., payment for speaking or leading study groups on behalf of the sponsor);
- Is receiving a finder's fee for the recruitment of research participants;
- Has a proprietary interest (e.g., patent, trademark, copyright interest, licensing agreement) in the tested product;
- Has (or family, spouse, close relationships) any equity interest in the sponsor;
- Receives payments of other sorts, which are made by the sponsor exclusive of the costs of conducting the clinical research (e.g., a grant to fund ongoing research, compensation in the form of equipment or retainers for ongoing consultation or honoraria);
- Is intending to recruit his/her own patients as research participants;
- Has identified him or herself for any other reason as having a conflicting interest (i.e., organizational conflict that may impact the research).

Examples of secondary interests for an REB member include the following:

- Is a Researcher or sub-Researcher on the protocol;
- Is directly involved in the conduct of the research;
- His/her job status or compensation is impacted by the research (e.g., research coordinator, payment for speaking/leading study groups on behalf of the sponsor);
- Is receiving or expecting to receive compensation from the sponsor in which the value of the compensation could be affected by the outcome of the study;
- Acts as an officer, director, or agent of the sponsor;
- Has a proprietary interest (e.g., patent, trademark, copyright interest, licensing agreement) in the tested product;
- Has any equity interest in the sponsor that when aggregated for the member and the member's spouse and dependent children;
- Any equity interest in the sponsor (i.e., any ownership interest, stock options, or other financial interest whose value cannot be readily determined through reference to public prices);
- Significant payments of other sorts, which are payments made by the sponsor exclusive of the costs of conducting the clinical research (e.g., a grant to fund ongoing research, compensation in the form of equipment or retainers for ongoing consultation or honoraria);
- Is in direct competition with the Researcher of the research project for limited resources, funding, sponsorship, or research participants; acts as a consultant for the sponsor; is considered a personal or professional adversary of the Researcher;
- Has identified him or herself for any other reason as having a conflicting interest.

2.11 **Continuing research ethics review (also referred to as "continuing review")**: any review of ongoing research conducted by a Research Ethics Board (REB) occurring after the date of initial REB approval and continuing throughout the life of the project to ensure that all stages of a research project are ethically acceptable in accordance with the principles in the Policy.

2.12 **Controlled forms**: documents that require formal change control, and that form part of the permanent record of Research Ethics Board (REB) operations and processes.

2.13 **Core Ethical Principles**: refers to the three Core Principles of the Tri-Council Policy Statement that together express the overarching value of respect for human dignity. These are: Respect for Persons, Concern for Welfare and Justice.

2.14 **Data and Safety Monitoring Board (DSMB):** a multi-disciplinary, expert advisory group established by a research sponsor, that is responsible for safeguarding the interests of participants by reviewing emerging data, assessing the safety and efficacy of research procedures, and monitoring the overall conduct of the research.

2.15 **Debriefing**: The full disclosure of the research purpose and other pertinent information to participants who have been involved in research employing partial disclosure or deception. Debriefing is typically done after participation has ended, but may be done at any time during the study.

2.16 **Delegated review (also referred to as expedited review):** the level of Research Ethics Board (REB) review assigned to minimal risk research studies, to minor changes in approved research and to continuing review applications that meet the delegated review criteria. Delegated reviewers are selected from among the REB membership to conduct the review.

2.17 **Designee**: may refer to a member of the Research Ethics Board (REB) or to the REB Office Personnel depending on the context of the statement and the accompanying requirements of the organization.

2.18 **Ethics Approval:** refers to the research ethics approval granted in accordance with the Policy and its Procedures by the Research Ethics Board (REB) for proposed research involving human participants.

2.19 **Ethics Review Agreement:** refers to an agreement between the University and another research institution or organization that authorizes an alternative model or models for the ethics review of Research Involving Human Participants. Such agreements may or may not be reciprocal in nature.

2.20 **Expiry date:** the first day that the Research Ethics Board (REB) approval of the research is no longer valid without further review and approval by the REB. When the REB determines that review more than annually is required, the expiration date will be determined by the REB (e.g., six months from the date of the approval).

2.21 **Full Research Ethics Board (REB) review:** the level of Research Ethics Board (REB) review assigned to above minimal risk research studies. Conducted by the full membership of the REB, it is the default requirement for the ethics review of research involving human participants.

2.22 **Human biological materials:** means tissues, organs, blood, plasma, skin, serum, DNA, RNA, proteins, cells, hair, nail clippings, urine, saliva, and other body fluids. The term also includes materials related to human reproduction, including embryos, fetuses, fetal tissues and human reproductive materials.

Deleted: tissues, organs, blood, plasma, serum, DNA, RNA, proteins, cells, skin, hair, nail clippings, urine, saliva and other body fluids, embryos, fetuses, fetal tissues, reproductive materials, and stem cells

2.23 **Human genetic research:** the study of genetic factors responsible for human traits and the interaction of those factors with each other, and with the environment.

2.24 **Impartial:** without prejudice or bias, fair; a principle of justice holding that decisions should be based on objective criteria, rather than on the basis of bias, prejudice, or preferring the benefit to one person over another.

2.25 **Impracticable:** incapable of being put into practice due to a degree of hardship or onerousness that jeopardizes the conduct of the research; it does not mean mere inconvenience.

2.26 **Incentive:** anything offered to research participants, monetary or otherwise, to encourage participation in research.

2.27 **Incidental findings:** unanticipated discoveries made in the course of research that are outside the scope of the research. Material incidental findings are findings that have been interpreted as having significant welfare implications for the participant, whether health- related, psychological or social. If, in the course of research, material incidental findings are discovered, Researchers have an obligation to inform the participant.

2.28 **Indigenous peoples:** In Canada, the term "Indigenous peoples" refers to persons of Indian (First Nations), Inuit, or Metis descent, regardless of where they reside and whether their names appear on an official register. In Canada, a comparable term, "Aboriginal peoples," is also used in certain contexts.

2.29 **Inspection:** a systematic examination and evaluation of study-related activities and documents in comparison to specified requirements and standards.

2.30 **Institutional conflicts of interest:** an incompatibility between two or more substantial institutional obligations that cannot be adequately fulfilled without compromising one or another of the obligations

2.31 **Investigational product:** refers to new or new uses of drugs, biologics, medical devices or natural health products.

2.32 **Justice:** refers to the obligation to treat people fairly and equitably. Fairness entails treating all people with equal respect and concern. It should ensure that any knowledge collected/generated is not misappropriated, and that community norms are respected, not violated. Equity requires distributing the benefits and burdens of research participation in such a way that no segment of the population is unduly burdened by the harms of research or denied the benefits of the knowledge generated from it. It should ensure that knowledge is shared with participants and that they are not stigmatized or misrepresented through its dissemination.

2.33 **Mature minor:** is an individual who demonstrates adequate understanding and decision- making capacity.

2.34 **Medical device trials:** clinical trials that test the safety and/or efficacy of one or more instruments used in the prevention, diagnosis, mitigation, or treatment of a disease or abnormal physical condition or restoration, correction or modification of body function or structure.

2.35 **Minimal risk:** research in which the probability and magnitude of possible harms implied by participation in the research is no greater than those encountered by participants in those aspects of their everyday life that relate to the research.

2.36 **Minor change:** any change that would not materially affect an assessment of the risks and benefits of the research or the integrity of the data, and does not substantially change the specific aims or design of the study.

2.37 **Misconduct in Research:** refers to conduct that breaches the scholarly standards and practices generally accepted within the relevant research/scholarly field and may include, but is not limited to, fabrication or falsification of research results, plagiarism, failure to comply with the requirements of funding applications and agreements, and failure to obtain the necessary approvals before commencing work with human participants.

2.38 **Multi-centred:** multi-centre means that the research is reasonably expected to be conducted at more than one centre.

2.39 **Natural health product (NHP) trial:** a clinical trial testing the safety and/or efficacy of one or more natural health products (NHP). The term NHP is used to describe substances such as vitamins and minerals, herbal medicines, homeopathic preparations, energy drinks, probiotics, and many alternative and traditional medicines.

2.40 **Non-compliance:** failure to follow applicable guidelines and regulations governing human participant research; failure to follow the protocol approved by the Research Ethics Board (REB), or failure to follow stipulations imposed by the REB as a condition of approval.

2.41 **Non-controlled forms:** documents that are not part of the permanent record of Research Ethics Board (REB) operations and processes. Non-controlled forms also will contain version dates.

2.42 **Ongoing research:** research that has received Research Ethics Board (REB) approval and has not yet been completed.

2.43 **Organizational Official:** a senior official who signs an organization's human participants' assurance, making a commitment on behalf of the organization to comply with 45 CFR Part 46, the US Code of Federal Regulations covering protection of human participants, and with Health Canada regulations.

2.44 **Participant**: an individual whose data or responses to interventions, stimuli, or questions by a Researcher are relevant to answering a research question; also referred to as "human participant" and in other policies/guidance as "subject" or "research subject."

2.45 **Periodic safety update or summary report:** a summary report, created by the sponsor, listing all of the reported unexpected serious adverse events that have occurred in a given reporting period, and which includes any significant areas of concern and the evolving safety profile of the investigational product.

2.46 **Personal health information:** Personal health information (PHI), is a subset of Personal information which is identifiable information about an individual. (See "Identifiable information" which also is "personal information"). Personal health information is identifying information about an individual in either an oral or in a recorded form, if the information:

- Relates to the individual's physical or mental health, including family health history;
- Relates to the provision of health care, including the identification of persons providing care;
- Is a plan of service for an individual requiring long-term care;
- Relates to payment or eligibility for health care;
- Relates to the donation of body parts or bodily substances or is derived from the testing, or examination of such parts or substances;

- Is the individual's health number; or
- Identifies an individual's substitute decision-maker.

Any other information about an individual that is included in a record containing personal health information is also included in this definition. This definition does not include information about an individual if the information could not reasonably be used to identify the individual.

2.47 **Personal information (also referred to as "identifiable information"):** information that identifies an individual and/or for which it is foreseeable that may reasonably be expected to identify an individual, alone or in combination with other available information.

Directly identifying information: the information identifies a specific individual through direct Identifiers (e.g., name, social insurance number, personal health number).

Indirectly identifying information: the information can reasonably be expected to identify an individual through a combination of indirect identifiers (e.g., date of birth, place of residence, or unique personal characteristic).

Coded information: direct identifiers are removed from the information and replaced with a code. Depending on access to the code, it may be possible to re-identify specific participants (e.g., the Researcher retains a list that links the participant's code name with their actual name so data can be re-linked if necessary).

Anonymized information: the information is irrevocably stripped of direct identifiers, a code is not kept to allow future re-linkage, and risk of re-identification of individuals from remaining indirect identifiers is low or very low.

Anonymous information: the information never had identifiers associated with it (e.g., anonymous surveys) and risk of identification of individuals is low or very low.

2.48 **Policy**: refers to the University Policy on the Ethics Review of Research Involving Human Participants (R20.01).

2.49 **Privacy**: an individual's right to be free from intrusion or interference by others. Privacy refers to persons and their interest in controlling the access of others to themselves (their personal information).

2.50 **Privacy breach**: the unauthorized collection, use, or disclosure of personal information or personal health information (PHI) in the custody and control of an individual or a Health Information Custodian (HIC) or in the custody and control of the organization or its affiliated partners.

2.51 **Procedures**: refers to the most current version of the N2/CAREB Standard Operating Procedures as amended as necessary by the University and approved for adoption by the University in accordance with the Policy.

2.52 **Proportionate approach to research ethics review**: the assessment of foreseeable risk to determine the level of scrutiny the research will receive (i.e., delegated review for minimal risk research or full Research Ethics Board (REB) review for research above minimal risk), as well as the consideration of foreseeable risks, potential benefits, and ethical implications of the research in the context of initial and continuing review.

2.53 **Protocol deviation:** the term protocol deviation is not well defined by regulations or guidelines, but deviations are identified as any unplanned or unforeseen change to a Research Ethics Board (REB) approved protocol or protocol procedures. Deviations are different from amendments in that they generally apply to a single occurrence or participant and are not intended at the time to modify the entire protocol.

2.56 **Provisos**: refer to a written explanation of the conditions and/or modifications that must be made to a submitted application for ethics review for it to receive approval.

2.57 **Quorum:** Quorum shall include at least five (5) voting members, including (at minimum):

- two (2) members with expertise in the relevant disciplines, fields and methodologies covered by the REB (for biomedical clinical trials, this will include at least one member who practices medicine or dentistry and who is in good standing with their regulatory body);
- one (1) member who is primarily experienced in non-scientific disciplines;
- one (1) member knowledgeable in ethics;
- one (1) member from the community who has no affiliation with the University and who is not part of the immediate family of a person who is affiliated with the University;

In addition, quorum shall also include one (1) member knowledgeable in the relevant law (for biomedical research) as required by applicable legislation or guidelines.

Quorum shall also include a majority (50%+1) of voting members.

When there is less than full attendance, decisions requiring full review should be adopted only when the members in attendance at that meeting have the specific expertise, relevant competence, and knowledge necessary to provide an adequate research ethics review of the proposals under consideration.

2.58 **Reconsideration**: refers to the process by which a researcher and the REB attempt to resolve any disagreements, through deliberation and consultation, about the decision rendered by the REB.

2.59 **Reportable event:** includes anything that could significantly impact the conduct of the research or alter the Research Ethics Board's (REB) approval or favourable opinion to continue the research.

2.60 **Research**: an undertaking intended to extend knowledge through a disciplined inquiry or systematic investigation.

2.61 **Researcher**: the leader of a research team who is responsible for the conduct of the research, and for the actions of any member of the research team. (Also known as "Qualified Investigator").

2.62 **Research Ethics:** refers to the Office of Research Ethics at the University.

2.63 **Research Ethics Appeals Board (REAB):** refers to an established REB at another TCPS compliant institution in BC.

2.64 **Research Ethics Appeals Process:** refers to the process that allows a researcher to request a review of an REB decision when, after reconsideration, the REB has refused ethics approval of the research.

2.65 **Research Ethics Board (REB):** a body of Researchers, community members, and others with specific expertise (e.g., in ethics, in relevant research disciplines) established by an organization to review the ethical acceptability of all research involving humans conducted within the organization's jurisdiction or under its auspices.

2.66 **Research Ethics Board (REB) Chair:** means the chair of the REB, as elected by the REB in accordance with the Procedures.

2.67 **Research Ethics Board (REB) of record:** the Research Ethics Board (REB) that has been granted ultimate authority for the ethics review and oversight of a research study.

2.68 **Research Involving Human Participants:** means research involving living human participants; or Human Biological Materials, as well as human embryos, fetuses, fetal tissue, reproductive materials, and stem cells, whether derived from living or deceased individuals.

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2.69 **Respect for Persons:** requires the recognition of the intrinsic value of human beings and the respect and consideration that they are due, whether they are involved in research directly as subjects, or whether they are involved solely by virtue of their data or Human Biological Materials being used in research. This principle also incorporates the requirement that all Human Participants give their free, informed, and ongoing consent as a prerequisite for participation in research. In research involving First Nations, Inuit and Métis peoples, Respect for Persons extends beyond individual ethical protections to include collective protection, which recognizes interconnections between humans and the natural world, and Indigenous obligations to maintain, and pass on to future generations, knowledge received from Ancestors as well as innovations devised in the present generation.

2.70 **Risk**: the possibility of the occurrence of harm. The level of foreseeable risk posed to participants by their involvement in research is assessed by considering the magnitude or seriousness of the harm and the probability that it will occur, whether to participants or to third parties.

2.71 **Secondary Use:** the use in research of information or human biological materials originally collected for a purpose other than the current research purpose.

2.72 **Suspension**: a temporary or permanent halt to all research activities pending future action by the Research Ethics Board (REB), by the sponsor and/or by the Researcher.

2.73 **Termination**: a permanent halt by the Research Ethics Board (REB), by the sponsor and/or by the Researcher to all or some research activities.

2.74 **Tri-Council Policy Statement (TCPS):** means the most current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2).

2.75 **Unanticipated issues:** issues that occur during the conduct of research; may increase the level of risk to participants or have other ethical implications that may affect participants' welfare; and were not anticipated by the Researcher in the research proposal submitted for research ethics review.

2.76 **Unanticipated problem:** any incident, experience, or outcome (including an adverse event) 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 Research Ethics Board (REB) approved research protocol and informed consent document, or the Investigator Brochure; and (b) the characteristics of the research participant population being studied; and
- +Related or possibly related to participation in the research, (possibly related means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the [investigational product(s)] or procedures involved in the research); and
- Suggests that the research places research participants or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

***Unexpected:** an event is "unexpected" when its specificity and severity are not accurately reflected in the protocol-related documents such as the Research Ethics Board (REB) approved research protocol, the Investigator Brochure, or the current REB approved informed consent document, or other relevant sources of information such as product labelling and package inserts; or when the event is not associated with the expected natural progression of any underlying disease, disorder, predisposing risk factor, or condition of the participant(s) experiencing the adverse event.

+Related to the research procedures: an event is "related to the research procedures" if in the opinion of the Researcher or sponsor, the event was more likely than not to be caused by the research procedures.

2.77 **Under the auspices**: means with the protection or support of someone or something, especially an organization such as the University.

2.78 **University**: means Simon Fraser University.

2.79 **Vulnerability**: a diminished ability to fully safeguard one's own interests in the context of a specific research project. This may be caused by limited decision-making capacity or limited access to social goods, such as rights, opportunities and power. Individuals or groups may experience vulnerability to different degrees and at different times, depending on their circumstances.

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Title	Authority and Purpose
SOP Code	101.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

The purpose of this standard operating procedure (SOP) is to:

1. State the organizational authority under which the Research Ethics Board (REB) is established and empowered;
2. Define the purpose of the REB;
3. State the principles governing the REB to assure that the rights and welfare of participants are protected;
4. State the authority of the REB.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

The responsible official(s), all REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

The REB will maintain and follow all written policies and procedures consistent with federal and provincial regulations, good clinical practice, and ethics guidelines when reviewing proposed research.

5.1 Statement of Organizational Authority

5.1.1 The University has authorized the REB to review research involving human participants conducted under the auspices of the University;

5.1.2 The REB is established and empowered under the authority of the University. The University requires that all research involving human participants be reviewed and approved by an REB prior to initiation of any research related activities.

5.2 Purpose of the REB

5.2.1 The REB's purpose is to protect the rights and welfare of human participants participating in research;

5.2.2 The REB reviews and oversees the research to ensure that it meets ethical principles and that it complies with all applicable regulations and guidelines pertaining to human participant protection;

5.2.3 These include, but are not limited to, the *Food and Drugs Act* and applicable *Regulations*, the International Council on Harmonization Good Clinical Practice Guidelines, the Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects, the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, and where applicable, US Federal Regulations.

5.3 Governing Principles

5.3.1 The REB is guided by the ethical principles regarding all research involving human participants including:

- Respect for Persons:
  - Recognize the intrinsic value of human beings and the respect and consideration they are due,
  - Incorporate moral obligations to respect autonomy and to protect those with developing, impaired or diminished autonomy.
- Concern for Welfare:
  - Aim to protect the welfare of participants, and, in some circumstances, to

promote that welfare in view of any foreseeable risks,
  - Provide participants with enough information to be able to adequately assess risks and potential benefits associated with their participation,
  - Ensure that participants are not exposed to unnecessary risks.
- Justice:
  - Obligation to treat people fairly with equal respect and concern,
  - Vulnerable or marginalized people may need to be afforded special attention.

5.4 REB Authority

5.4.1 The REB is established to review all research involving human participants within its established jurisdiction;

5.4.2 The REB has the authority to ensure that all research conducted under its oversight is designed and conducted in such a manner that it protects the rights, welfare, and privacy of participants.

Specifically the REB has the authority to:

- establish the ethics review processes, and provide research ethics oversight to ensure the ethical conduct of the research,
- approve, require modifications to, or disapprove, any research activity that falls within its jurisdiction,
- ensure that the researcher has policies and procedures to protect the rights, safety and welfare of participants,
- request, receive and share any information involving the research that the REB considers necessary to fulfil its mandate, while maintaining confidentiality and respecting privacy,
- conduct continuing ethical review to protect the rights and welfare and privacy of participants,
- suspend or terminate the ethics approval for the research,
- place restrictions on the research,
- take any actions considered reasonably necessary, and consistent with policies and procedures, to ensure the protection of the rights, safety, and well-being of participants in research conducted under the REB's jurisdiction.

5.5 Research Subject to US Regulations

The REB shall apply the requirements of the applicable US regulations to the extent that they vary from the protections set out in the applicable Canadian regulations and guidelines.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP101.001	15-Sept-2014	Original version
SOP101.002	08-Mar-2016	No revisions needed
SOP101.003	08-Oct-2019	5.2.3: ICH 'Conference' changed to 'Council'; Removed "Research ethics oversight of biomedical clinical trials (CAN/CGSB-191.1-2013)
SOP101.004	15-May-2023	No revisions needed

SOP 102.004

Title	**Research Requiring REB Review**
SOP Code	102.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

The purpose of this standard operating procedure (SOP) is to describe research activities that require Research Ethics Board (REB) review and research activities that do not.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

All research involving human participants must be reviewed and approved by an REB. No intervention or interaction with human participants in research, including recruitment, may begin until an REB has reviewed and approved the research protocol, consent documents and recruitment materials.

5.1 Research that Requires REB Review

5.1.1 The following requires ethics review and approval by an REB before the research commences:

(a) Research involving living human participants,

(b) Research involving human biological materials, as well as human embryos, fetuses, fetal tissue, reproductive materials and stem cells. This applies to materials derived from living and deceased individuals.

5.2 Research Exempt from REB Review

5.2.1 Research that relies exclusively on publicly available information does not require REB review when:

(a) The information is legally accessible to the public and appropriately protected by law,

(b) The information is publicly accessible and there is no reasonable expectation of privacy;

5.2.2 REB review is not required for research involving the observation of people in public places where:

(a) It does not involve any intervention staged by the Researcher, or direct interaction with the individuals or groups,

(b) Individuals or groups targeted for observation have no reasonable expectation of privacy, and

(c) Any dissemination of research results does not allow identification of specific individuals;

5.2.3 REB review is not required for research that relies exclusively on secondary use of anonymous information, or anonymous human biological materials, so long as

the process of data linkage or recording or dissemination of results does not generate identifiable information;

5.2.4 The opinion of the REB should be sought whenever there is any doubt about the applicability of the guidelines and regulations.

5.3 Activities Not Requiring REB Review

5.3.1 Activities outside the scope of research subject to REB review may still raise ethical issues that would benefit from careful consideration by an individual or a body capable of providing some independent guidance, other than an REB;

5.3.2 Quality assurance and quality improvement studies, program evaluation activities, performance reviews, or testing within normal educational requirements when used exclusively for assessment, management or improvement purposes, do not constitute research for the purposes of this SOP, and do not fall within the scope of REB review;

5.3.3 Creative practice activities, in and of themselves, do not require REB review. However, research that employs creative practice to obtain responses from participants that will be analyzed to answer a research question is subject to REB review.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP102.001	15-Sept-2014	Original version
SOP102.002	08-Mar-2016	No revisions needed
SOP102.003	08-Oct-2019	No revisions needed
SOP102.004	15-May-2023	No revisions needed

SOP 103.004

Title	**Training and Education**
SOP Code	103.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the training and education requirements for Research Ethics Board (REB) members and Research Ethics staff.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REB members, Research Ethics staff and others charged with the responsibility for reviewing, approving, and overseeing human participant research should be well-versed in the regulations, guidelines, policies, and ethical principles applicable to human participant research. Adequate training and education in these areas is critical for the REB to fulfill its mandate to protect the rights and welfare of participants in a consistent manner.

5.1 Training and Education – REB Members

5.1.1 The REB Chair or designee and Research Ethics staff will provide new REB members with a general overview of the policies and procedures pertinent to REB meeting functions and REB member expectations, as well as an orientation to the principles and guidelines for research ethics;

5.1.2 New REB members will receive an orientation before beginning their formal duties. REB members are required to complete the TCPS online tutorial and are expected to participate in the orientation process which may include, but is not limited to:

- Background on the REB (e.g., Terms of Reference, governance structure, annual reports, process flowchart),
- Policies and Procedures (e.g., relevant SOPs and associated forms, consent form template, consent form checklist),
- Member information (e.g., meeting schedule, membership list, information and guidelines for members, reviewer guide),
- Regulatory and guidance documents,
- Other member-specific information (e.g., copy of signed confidentiality and conflict of interest agreement, membership appointment letter),
- Resource information (e.g., list of training and education references, relevant articles, etc.);

5.1.3 As part of their orientation, new REB members will be offered the opportunity to observe at least one REB meeting prior to commencing their REB member duties;

5.1.4 REB members are encouraged to attend conferences and other educational sessions pertaining to human participant research protection, such as the Canadian Association of Research Ethics Board (CAREB) annual general meeting and CAREB regional meetings. Research Ethics will support such activities to the extent possible and as appropriate to the responsibilities of REB members. Conference attendance is based on availability of funding and other

practical considerations (e.g., timing, conference location);

5.1.5 Ongoing ethics education in areas germane to the REB members' responsibilities may be provided at REB meetings;

5.1.6 New or revised policies and SOPs will be disseminated to the new REB members;

5.1.7 REB members are encouraged to engage in self-directed learning in research ethics and in the conduct of research to enhance their ability to fulfill their responsibilities.

5.2 Training and Education – Research Ethics Staff

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5.2.1 The Director, Research Ethics establishes the educational and training requirements for Research Ethics staff and others who perform related administrative duties. Initial and ongoing training for Research Ethics staff may be provided by the Director, Research Ethics or their designee, and/or the REB Chair or designee and is documented by the Research Ethics staff ;

5.2.2 New Research Ethics staff will receive an orientation package. Before commencing their official duties in Research Ethics, Research Ethics staff are expected to read and become familiar with the information;

5.2.3 New Research Ethics staff will receive training on the REB SOPs and will be expected to be knowledgeable and compliant with the SOPs;

5.2.4 New Research Ethics staff are required to complete the TCPS online tutorial, and are encouraged to complete additional and ongoing relevant education and training in research ethics and in the conduct of research;

5.2.5 Research Ethics staff are encouraged to attend conferences and educational sessions pertaining to human participant research protection, such as the CAREB annual general meeting and CAREB regional meetings. Research Ethics will support such activities to the extent possible and as appropriate to the responsibilities of Research Ethics staff . Conference attendance is based on availability of funding and other practical considerations (e.g., workload, staffing, conference location);

5.2.6 New or revised policies and SOPs will be disseminated to the Research Ethics staff ;

5.2.7 Research Ethics staff are encouraged to engage in self-directed learning to enhance their ability to fulfill their responsibilities.

5.3 Documentation of Training and Education

5.3.1 Research Ethics will retain copies of the CVs of all REB members and Research Ethics staff ;

5.3.2 REB members and Research Ethics staff will record their relevant training and education and provide copies of their certificates of completion. Training records will be kept on file in Research Ethics;

5.3.3 REB members and Research Ethics staff are encouraged to retain copies of agendas of relevant workshops, seminars and conferences attended;

5.3.4 REB agendas and minutes will record the distribution of any educational materials presented at the REB meetings.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP103.001	15-Sept-2014	Original version
SOP103.002	08-Mar-2016	No revisions needed
SOP103.003	08-Oct-2019	5.1.4: deletion of reference to Research Ethics staff 5.2.5: deletion of reference to REB members
SOP103.004	15-May-2023	No revisions needed

SOP 104.004

Title	**Management of Research Ethics Staff**
SOP Code	104.004
Effective Date	15-May-2023

Deleted: s

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the overall management of the Research Ethics Board (REB) Office Personnel.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

The Organizational Officials, REB Chair or designee and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met. The University is responsible for providing sufficient resources to adequately support the functions of the REB.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

The Research Ethics staff provide consistency, expertise and administrative support to the REB, and serve as a daily link between the REB and the research community. The Research Ethics staff are vital to ensuring the efficient and effective administration and enforcement of REB decisions, thus the highest level of professionalism and integrity is expected.

5.1 Job Descriptions

5.1.1 Job descriptions will be developed to establish the role requirements for the Research Ethics staff , in accordance with University policies and procedures;

5.1.2 Each Research Ethics staff will be provided with a copy of his or her job description, job expectations and access to all applicable University policies and procedures.

5.2 Responsibilities

5.2.1 Research Ethics staff responsibilities may include:

- the pre-review of submissions and requests to the REB,
- quality management activities,
- the management of administrative issues involving REB research ethics oversight as described by applicable REB policies,
- the implementation of REB directives, and
- the provision of advice and information to the REB.

5.3 Hiring and Terminating Research Ethics Staff

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5.3.1 The University will determine responsibility for the recruitment, hiring, and termination of Research Ethics staff , in accordance with University policies and procedures.

5.4 Delegation of Authority or Responsibility

5.4.1 Appropriate tasks or responsibilities may be delegated to the Research Ethics staff in accordance with University/REB policy, if the individual has the expertise to carry out the task(s), the task is compliant with University and REB policies and procedures, and the task delegation has been agreed to by the Research Ethics staff, the Director, Research Ethics and the University.

5.5 Performance Evaluations and Documentation

5.5.1 Performance feedback will be provided on an ongoing basis;

5.5.2 The Director, Research Ethics is responsible for conducting formal performance evaluations in accordance with University policies and procedures;

5.5.3 The Director, Research Ethics is responsible for identifying, documenting and retaining formal Research Ethics staff interactions.

5.6 Periodic Evaluation of Research Ethics Human Resource Needs

5.6.1 A periodic evaluation of the adequacy of the REB resources will be conducted;

5.6.2 The evaluation will assess whether the Research Ethics staff, equipment, finances and space are adequate to carry out its function in support of the REB;

5.6.3 The assessment takes into consideration the volume, complexity and types of research projects administered by the Research Ethics staff and whether activities in support of the REB can be completed in a timely manner;

5.6.4 The need for additional resources will be discussed by the Director, Research Ethics with the appropriate Organizational Official as appropriate.

6.0 REFERENCES

Note: references will reflect the University policies and practices

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP104.001	15-Sept-2014	Original version
SOP104.002	08-Mar-2016	5.4.1: revised wording for delegation of responsibilities to Research Ethics staff
SOP104.003	08-Oct-2019	No revisions needed
SOP104.004	15-May-2023	No revisions needed

SOP 105A.004

Title	**Conflicts of Interest – REB Members and Research Ethics Staff**
SOP Code	105A.004
Effective Date	15-May-2023

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Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes potential Conflicts of Interest (COI) for Research Ethics Board (REB) members (including the REB Chair and any ad hoc advisors) and Research Ethics staff, and describes the requirements and procedures for disclosure and management of COI.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for disclosing any real, potential or perceived COI and for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

COI (real, potential or perceived) arise when an individual in a position of trust has competing professional or personal interests. Such competing interests may influence their professional judgment, objectivity and independence and can potentially influence the outcome of a decision, for personal benefit. A COI may exist even if no unethical or improper act results from the conflict.

REBs should identify and manage COI to maintain the public confidence and trust and to maintain the independence and integrity of the ethics review. If a COI cannot be avoided, procedures should be in place to mitigate the conflict.

The REB must be perceived to be fair and impartial, immune from pressure either by the sponsor, affiliated organizations or the Researchers whose research is being reviewed, or by other professional and/or non-professional sources.

The standard that guides decisions about determining COI is whether an independent observer could reasonably question whether the individual's actions or decisions are based on factors other than the rights, welfare and safety of the participants.

5.1 REB Reviewer Assignment

5.1.1 The REB Chair or designee reviews the agenda prior to the REB meeting to identify potential COI;

5.1.2 When the agenda is distributed, REB members are expected to disclose as soon as possible, any conflicting interest(s) for any of the projects on the agenda;

5.1.3 If a member is unclear as to whether a COI exists, he or she must contact the REB Chair or designee to seek clarification. The REB Chair or designee will determine whether the circumstances should be defined as a COI and the member shall follow the REB's decision regarding any actions required to mitigate their real or perceived COI;

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5.1.4 If a COI is identified in the reviewer assignments, the project is assigned to another REB member.

5.2 Full Board Meeting

5.2.1 At the outset of the meeting, REB members are reminded of their obligation to orally disclose/declare any real, potential or perceived COI. All declared COI will be recorded in the REB meeting minutes;

5.2.2 If a COI is declared and determined as such, the REB member may be asked to provide information about the research, but must be recused for the deliberation and decision;

5.2.3 The REB member's recusal will be recorded in the minutes and the REB member will not be counted towards Quorum.

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5.2.4 If recused, the REB member should abstain from voting on/approving the minutes of that meeting.

5.3 Delegated Review

5.3.1 The REB Chair or designee will assess projects undergoing the delegated review process to determine potential COI;

5.3.2 REB members involved in the delegated review process are expected to disclose any conflicting interests;

5.3.3 If a COI is identified, the project is assigned to another REB member.

5.4 REB Chair

5.4.1 In the event that the REB Chair declares a COI, the Vice-Chair or alternate REB member will assume the REB Chair's responsibilities for the specific project(s).

5.5 Research Ethics Staff

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5.5.1 All Research Ethics staff are expected to disclose any conflicts that arise and any Research Ethics staff whose job status or compensation is impacted by research that is reviewed by the REB must recuse themselves when such research is reviewed;

5.5.2 Any disclosure of a COI by Research Ethics staff should be referred to the REB Chair or designee for the development of a management plan;

5.5.3 If Research Ethics staff are unclear as to whether a COI exists, they must contact the REB Chair or designee to seek clarification. The REB Chair or designee will determine whether the circumstances should be defined as a COI.

5.6 External Ad Hoc Advisors

5.6.1 At their discretion, the REB Chair or designee may 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 REB;

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5.6.2 All ad hoc advisors must sign a *Confidentiality of Information and Conflict of Interest Agreement* prior to commencement of their consultation, and disclose any COI to the REB Chair.

5.6.3 Any disclosure of a COI by an ad hoc advisor should be referred to the REB Chair or designee for the development of a management plan, as applicable.

5.6.4 If ad hoc advisors are unclear as to whether a COI exists, they must contact the REB Chair or designee to seek clarification. The REB Chair or designee will determine whether the circumstances should be defined as a COI.

5.7 Documentation

5.7.1 All REB members, guests and ad hoc advisors sign a *Confidentiality of Information and Conflict of Interest Agreement* and agree to abide by the REB COI and confidentiality policies;

5.7.2 REB members sign a *Confidentiality of Information and Conflict of Interest Agreement* annually, or as determined by the University;

5.7.3 The signed *Confidentiality of Information and Conflict of Interest Agreement* is filed in Research Ethics;

5.7.4 The REB minutes will record any COI that are declared on any of the projects under review at the REB meeting, and the decision on the management of the conflict;

5.7.5 The REB minutes will also record the recusal of an REB member;

5.7.6 At the time of hire, all Research Ethics staff sign a *Confidentiality of Information and Conflict of Interest Agreement* as a condition of their employment with the agreeing to abide by the COI and confidentiality policies of the University. Research Ethics staff must also comply with REB COI SOPs;

5.7.7 The signed *Confidentiality of Information and Conflict of Interest Agreement* will be retained;

5.7.8 The REB management plan for Research COI declarations will be documented in the appropriate research files. Any discussion at the REB meeting regarding the COI and the management plan will be documented in the REB meeting minutes.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP105A.001	15-Sept-2014	Original version
SOP105A.002	08-Mar-2016	No revisions needed
SOP105A.003	08-Oct-2019	No revisions needed
SOP105A.004	15-May-2023	No revisions needed

SOP 105B.004

Title	**Conflicts of Interest – Researcher**
SOP Code	105B.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes potential Conflicts of Interest (COI) for Researchers and research staff engaged in human participant research, and the requirements and procedures for disclosure and managing COI.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REBs) that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members, Research Ethics staff and Researchers are responsible for ensuring that the requirements of this SOP are met.

Researchers are responsible for disclosing any real, potential or perceived COI to the REB.

The REB is responsible for determining whether the disclosed COI is likely to affect or appear to affect the design, conduct, or reporting of the research.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

COI (real, potential or perceived) arise when an individual in a position of trust has competing professional or personal interests. Such competing interests may influence their professional judgment, objectivity and independence and can potentially influence the outcome of a decision, for personal benefit. A COI may exist even if no unethical or improper act results from the conflict.

Researchers and research staff should identify and manage COI to maintain the public confidence and trust and to maintain the independence and integrity of the research process. If a COI cannot be avoided, procedures should be in place to manage and/or to mitigate the conflict.

This SOP is not intended to prohibit Researcher relationships with companies; however, the REB should ensure that participant protection, the integrity of the ethics review, and the conduct of the research are not jeopardized by an unidentified and unmanaged COI.

REBs should identify and manage COI to maintain the public confidence and trust and to maintain the independence and integrity of the ethics review. If a COI cannot be avoided, procedures should be in place to mitigate the conflict.

The REB must be perceived to be fair and impartial, immune from pressure either by the sponsor, affiliated organizations or the Researchers whose research is being reviewed, or by other professional and/or nonprofessional sources.

The standard that guides decisions about determining COI is whether an independent observer could reasonably question whether the individual's actions or decisions are based on factors other than the rights, welfare and safety of the participants.

5.1 Researcher Disclosure of Conflicts of Interest

5.1.1 Researchers submitting research applications to the REB are required to declare any COI including those of their sub/co-Researcher(s), research staff, and their immediate families (which includes spouse, domestic partners and dependent child), and close relationships;

5.1.2 The Researcher is additionally required to provide information on the clinical trial budget, as applicable, when submitting a research application;

5.1.3 Such disclosures shall be in writing utilizing the process and forms detailed in Policy GP 37, and sufficiently detailed to allow accurate and objective evaluation of conflict;

5.1.4 The Researcher shall disclose any conflicts to the REB at the following times:

- With the initial REB application,
- At each continuing review of the project,
- Whenever a COI arises, such as changes in responsibilities or financial circumstances;

5.1.5 The Researcher shall cooperate with the REB and with other officials involved in the review of the pertinent facts and circumstances regarding any COI disclosed, and shall comply with all the requirements of the REB and with University COI policies to eliminate and/or to manage the conflict;

5.1.6 The Researcher shall ensure that all requirements from any COI reviews are appropriately incorporated into the corresponding informed consent documents and research, as applicable.

5.2 REB Review of Researcher Conflict of Interest

5.2.1 The REB will review each application for disclosure of COI;

5.2.2 If the Researcher indicates on the REB application that a conflict exists, the REB will determine whether the disclosed COI is likely to affect or appear to affect the design, conduct, or reporting of the research;

5.2.3 The REB review shall focus on those aspects of the COI that may reasonably affect human participant protection and the steps taken should be context-based and commensurate with the risks;

5.2.4 In determining the appropriate action, the REB may take into consideration information presented by the Researcher such as:

- The nature of the research,
- The magnitude of the interest or the degree to which the conflict is related to the research,
- The extent to which the interest could affect the research,
- Whether a specific individual is unique in their clinical or scientific qualifications to conduct the research,
- The degree of risk to the human participants involved in the research that is inherent in the research, and/or
- The management plan for the COI already developed by the Researcher;

5.2.5 The REB may approve the research and may require a management plan, which may include changes at the Researcher's or sponsor's expense, to eliminate or to mitigate the conflict. The researcher may be required to provide a management plan for review by the REB. Required actions may include, but are not limited to:

- Divestiture or termination of relevant economic interests,
- Mandating Researcher recusal from research,
- Modifying or limiting the participation of the Researcher in all or in a portion of the research,
- In cases involving equity, by imposing a bar on insider trading or requiring the transfer of securities to an independent financial manager or blind trust, or limited the timing of sales or distributions,
- Monitoring research (i.e., independent review of data and other retrospective review for bias, objectivity, comprehensiveness of reporting (versus withholding data)),
- Independent clinical review of appropriateness of clinical care given to participants, if applicable,
- Monitoring the consent process, and/or
- Disclosure of the conflict to University committees, participants, journals, and the data safety monitoring boards;

5.2.6 The REB has the final authority to determine whether a COI has been eliminated or managed appropriately;

5.2.7 Any COI management plan will be documented in the final project files. Any discussions at the REB meeting regarding the COI and the management plan will be documented in the REB meeting minutes;

5.2.8 After review by the REB and input by the appropriate Organizational Official, if applicable, the REB may reject research that involves a COI that cannot be appropriately managed.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP105B.001	15-Sept-2014	Original version
SOP105B.002	08-Mar-2016	No revisions needed
SOP105B.003	08-Oct-2019	5.2.5: inclusion of: 'The researcher may be required to provide a management plan for review by the REB'
SOP105B.004	15-May-2023	Changed his/her to their

Title	**Conflicts of Interest - University**
SOP Code	105C.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes potential Conflicts of Interest (COI) in the relationship between the University establishing the Research Ethics Board (REB) and the REB itself, and the requirements and procedures for disclosure and for managing potential COI within this relationship.

2.0 SCOPE

The SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

University policies should address the roles, responsibilities and process for identifying, eliminating, minimizing or otherwise managing COI relevant to research, including disclosure to REBs. Management of COI includes, but is not limited to, prevention, evaluation, disclosure and the application of appropriate remedies as defined by the University.

The REB must be fair and impartial, immune from pressure by the sponsor, the parent organization and the Researchers whose research is submitted for review. In the interest of public trust and the integrity of the ethics review, the REB must act independently from its parent organization, and avoid or manage real or apparent COI. The organization must respect the autonomy of the REB and ensure that the REB has the appropriate financial and administrative independence to fulfill its primary duties.

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

5.1 Disclosure of Conflict of Interest

5.1.1 All University employees must be familiar Policy GP 37 (Conflict of Interest and Conflict of Commitment) and must complete a disclosure form at the time of hire and annually thereafter, or as per University Policy GP 37;

5.1.2 Prior to engaging in any of the professional activities listed in the Conflict of Interest Policy, employees must seek the approval of the appropriate Organizational Official to ensure that no conflict exists in doing so;

5.1.3 REB members shall be apprised of the University structure with emphasis placed on the independent nature of the relationship between the REB and the University. The actions of the REB members relating to their responsibilities to protect human participants shall not be measured or evaluated in terms of University or financial goals;

5.1.4 REB meetings are closed to employees of the University unless they are REB members, Research Ethics staff, permitted as observers, or invited by the REB to provide information, and only after signed confidentiality agreements are in place;

5.1.5 University senior administrators shall not serve as REB members nor observe REB meetings when their presence may influence REB deliberations.

5.2 Management of Conflicts of Interest

5.2.1 The REB Chair or designee must be notified if an University COI relating to the REB is declared or discovered;

5.2.2 The REB Chair or designee must be notified immediately if any University employee attempts to, or appears to attempt to, influence the research ethics review process or to obtain preferential treatment;

5.2.3 The REB Chair or designee will review the available information to determine if a conflict exists, and to determine those aspects of the COI that might reasonably affect human participant protection;

5.2.4 The REB Chair or designee may require a management plan, which may include actions to eliminate or to mitigate the conflict. Required actions may include, but are not limited to:

- Divestiture or termination of relevant economic interest,
- Recusal of Research Ethics staff whose job status or compensation is impacted by research that is reviewed by the REB,
- If University staff members are involved, inform the appropriate responsible University management personnel to develop and implement a management plan for remediation;

5.2.5 If the REB Chair or designee is unable to satisfactorily manage the COI, or if there are unresolved concerns about any undue influence on the REB, the REB Chair or designee will bring this to the appropriate Organizational Officials for determination of the appropriate course of action;

5.2.6 In the event that the REB Chair or designee cannot bring the matter to the appropriate Organizational Officials because of an emergent situation or competing COI with the University, the REB Chair or designee may escalate the issue to the board authority.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP105C.001	15-Sept-2014	Original version
SOP105C.002	08-Mar-2016	No revisions needed
SOP105C.003	08-Oct-2019	No revisions needed
SOP105C.004	15-May-2023	No revisions needed

SOP 106.004

Title	**Signatory Authority**
SOP Code	106.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) specifies who has the authority to sign documents on behalf of the Research Ethics Board (REB) and describes the responsibilities of such individuals, and the circumstances under which signing authority may be delegated.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or designee is responsible for signing documents related to REB review and approval of research. If the task of signing is delegated to a qualified individual or individuals, the responsibility for oversight remains with the REB Chair.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REBs are accountable for their activities and decisions, and appropriate controls must be applied to ensure that documentation related to REB review and approval of research are signed by a person or persons having the appropriate authority to do so.

5.1 Delegation of Signing Authority

5.1.1 The REB Chair or designee may delegate signing authority for documents related to REB review and approval;

5.1.2 The REB Chair or designee may only delegate signing authority to REB members or Research Ethics staff with the skill and knowledge necessary for the effective exercise of the authority;

5.1.3 The REB Chair or designee may not delegate their signing authority to ad hoc advisors or to independent contractors;

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5.1.4 The REB Chair or designee should clearly define the parameters of the delegated authority;

5.1.5 The REB Chair or designee may delegate signing authority indefinitely or for defined periods of time (e.g., for absences);

5.1.6 Delegation of signing authority must be documented and kept on file.

5.2 REB Reviews, Decisions and Other Correspondence with the Researcher

5.2.1 For each submission reviewed at a Full Board meeting, the responsible Research Ethics staff records the decision made by the Full Board;

5.2.2 Communication of the REB decision made at a Full Board meeting must be reviewed and authorized by the REB Chair or designee or as otherwise delegated by the REB Chair or designee;

5.2.3 For each submission that undergoes delegated review, the reviewer's decision is documented;

5.2.4 Once a final decision is documented by the REB Chair or designee, the responsible Research Ethics staff may issue the decision or letter;

5.2.5 All activities are documented in the research file;

5.2.6 Any letters, memos, or emails between the REB and Researchers that provide information concerning the review of research (e.g., requests for consent form changes, requests for additional information) and that do not imply or appear to imply approval of the research, may be issued as per delegated signing authority;

5.2.7 All reviews, actions, decisions and signatures are filed within the research file;

5.2.8 All correspondence is retained in the research file.

5.3 Correspondence with External Agencies

5.3.1 The responsible Organizational Official or the REB Chair or designee signs all correspondence with agencies of the federal government (Health Canada, OHRP, FDA) and with all funding agencies and/or sponsors.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP106.001	15-Sept-2014	Original version
SOP106.002	08-Mar-2016	No revisions needed
SOP106.003	08-Oct-2019	No revisions needed
SOP106.004	15-May-2023	No revisions needed

SOP 107.004

Title	**Use and Disclosure of Personal Information**
SOP Code	107.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the duties of the Research Ethics Board (REB) and Research Ethics in the protection of the Personal Information (PI) of participants.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members, Research Ethics staff and Researchers are responsible for ensuring that the requirements of this SOP are met.

The Researcher is responsible for submitting information to the REB and to the participant regarding the nature of the PI (including personal health information (PHI)) that will be collected for the research, including the manner in which it is identified, collected, accessed, used, disclosed, retained, disposed of and protected.

The REB Chair, REB members and the Research Ethics staff are responsible for maintaining the confidentiality of any PI received by Research Ethics during the course of the research.

Each organization's privacy office is responsible for providing Researchers and research staff with guidance on privacy policies and regulations.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Privacy is a fundamental value that is essential for the protection and promotion of human dignity. Breaches in privacy and confidentiality may cause harm to individuals or groups of individuals. Hence, PI must be collected, used and disclosed in a manner that respects a participant's right to privacy, and in accordance with applicable federal and provincial privacy regulations.

Privacy regulations permit the use and the limited disclosure of PI for research purposes as long as certain requirements are met. One of the key ethical challenges for the health research community is in protecting appropriately the privacy and confidentiality of PI used for research purposes. The REB plays an important role in balancing the need for research against the risk of the infringement of privacy and in minimizing invasions of privacy for participants. Individuals should be protected from any harm that may be caused by the unauthorized use of their PI and they should expect that their rights to privacy and confidentiality are respected.

5.1 REB Review of Privacy Concerns

5.1.1 The REB shall review the research submitted to determine if the Researcher has access to and/or is using PI and whether appropriate privacy legislation is adhered to;

5.1.2 In reviewing the research, the REB will include such privacy considerations as:

- The type of PI to be collected,
- The research objectives and justification for the requested personal data needed to fulfill these objectives,
- The purpose for which the personal data will be used,
- How the personal data will be controlled, accessed, disclosed, and de-identified,
- Limits on the use, disclosure and retention of the personal data,
- Any anticipated secondary uses of identifiable data from the research,
- Any anticipated linkage of personal data gathered in the research with other data about participants, whether those data are contained in public or in personal records,

- Whether consent for access to, or the collection of personal data from participants is required,
- How consent is managed and documented,
- If and how prospective participants will be informed of the research,
- How prospective participants will be recruited,
- The administrative, technical and physical safeguards and practices in place to protect the personal data including de-identification strategies and managed linkages to identifiable data,
- How accountability and transparency in the management of personal data will be ensured;

5.1.3 The REB must find that there are adequate provisions to protect the privacy interests of participants before approving the research.

5.2 Receipt, Use and Disclosure of PI

5.2.1 The REB Chair, REB members and the Research Ethics staff are bound by confidentiality agreements signed prior to commencement of their duties;

5.2.2 The REB does not intentionally collect PI;

5.2.3 Subject to consent, as applicable, the REB is permitted to access PI for the purposes of the review, the approval, the ongoing monitoring, and/or the auditing of the conduct of the research;

5.2.4 Research Ethics must adopt reasonable safeguards and ensure that there is training for REB Office Personnel to protect PI from unauthorized access;

5.2.5 REB members or Research Ethics staff may consult with the REB Chair or designee if they are uncertain about the appropriate use or disclosure of PI;

5.2.6 If any PI is received inadvertently in Research Ethics (e.g. disclosed by a Researcher), appropriate notification must take place and any corrective action that is required including, if applicable, notification to the appropriate Organizational Official. The facts surrounding the breach, the appropriate steps taken to manage the breach, remedial activities to address the breach and the outcome will be documented. The PI will be destroyed in a secure manner as per the University policies and procedures;

5.2.7 If there is an internal breach involving the use or dissemination of PI, the REB Chair or designee will be notified, and if applicable, notification of the appropriate Organizational Official, and a determination will be made in a timely manner regarding a corrective action plan. This process may include notification, containment, investigation and remediation, and strategies for prevention. The facts surrounding the breach, the appropriate steps taken to manage the breach

and the outcome will be documented. The PI will be destroyed in a secure manner as per the University policies and procedures;

5.2.8 At the discretion of the REB Chair or designee, in consultation with the University, the provincial privacy office (or equivalent) may be notified.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP107.001	15-Sept-2014	Original version
SOP107.002	08-Mar-2016	No revisions needed
SOP107.003	08-Oct-2019	No revisions needed
SOP107.004	15-May-2023	No revisions needed

SOP 108.004

Title	**Standard Operating Procedures Maintenance by Network of Networks and CAREB**
SOP Code	108.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the processes for establishing and maintaining written SOPs. The purpose of having written SOPs is to promote quality and consistency in the ethics review process; ensure compliance with the principles, guidelines and regulations applicable to the ethics review and oversight of research involving humans; and facilitate training of new personnel. The REB SOPs are prepared and distributed by N2.

2.0 SCOPE

The REB SOPs are made available to Research Ethics Boards (REB) that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

The N2/CAREB REB SOP Committee is responsible for developing and maintaining this set of SOPs to ensure that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Written SOPs provide the framework to promote ethical standards in the review, oversight and conduct of research involving human participants. SOPs describe the processes that must be followed and documented to ensure that the rights and welfare of human participants of such research are overseen and protected in a uniform manner.

5.1 Development, Review, Revision and Approval of Policies & Procedures

5.1.1 The REB SOP Committee will review the SOPs at least every 3 years. If re-versioning is not required a Memo will be posted with the documents to indicate that the review was conducted. Applicable SOPs will be reviewed sooner if changes to regulations, guidelines, or standard practice warrant revisions or the creation of new SOPs;

5.1.2 SOPs may be revised for reasons including, but not limited to: changes to regulations or guidelines, new policies, or changes to REB or administrative practices;

5.1.3 The REB SOP Committee will make the necessary modifications to existing SOPs, or draft a new SOP(s). SOPs are controlled documents and new drafts will be indicated by the addition of “DRAFT version date” and removal of the previous “Final Version Date”;

5.1.4 The revised SOP(s) will be circulated to the REB SOP Committee for review. Comments will be incorporated into a new version with an updated version date;

5.1.5 Once the SOP content is approved, the draft version date will be removed and the date of the approved version will be entered as the “Final Version Date”. The history of revisions will be recorded in the ‘SOP History’ section of each SOP;

5.1.6 Signatures on the SOP as determined by University policy will denote SOP approval. A new final version of the SOP supersedes any previous versions.

5.2 Distribution and Communication

5.2.1 New or revised SOPs will be communicated and disseminated through posting on the N2 and the CAREB websites.;

5.2.2 The SOPs will be available to REBs, Researchers and researcher sites, Sponsors and Regulatory Authorities as required;

5.2.3 Qualified Research Ethics staff will train members of the REB and Research Ethics staff on any new or revised policy and or relevant procedure, as applicable;

5.2.4 Each new REB member must review the applicable policies and procedures prior to undertaking their responsibilities as an REB member;

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5.2.5 Each new Research Ethics staff must review the applicable policies and procedures prior to undertaking their responsibilities with Research Ethics;

5.2.6 Evidence of training must be documented;

5.2.7 Research Ethics shall maintain all documentation of SOP training.

5.3 Forms, Memos and Guidance Documents

5.3.1 Forms such as checklists and worksheets may be developed to facilitate compliance with the SOPs and to ensure that policies are integrated into daily operations. Forms may be either controlled or non-controlled;

5.3.2 Memos and guidance documents may be developed to provide guidance for the interpretation and implementation of the SOP;

5.3.3 Memos and guidance documents will be made available to the Researchers and researcher sites as applicable;

5.3.4 The REB SOP Committee will evaluate the need for new or revised forms, memos or guidance documents.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP108.001	15-Sept-2014	Original version
SOP108.002	08-Mar-2016	No revisions needed
SOP108.003	08-Oct-2019	5.1.1: revision (sp) of word biennial
SOP 108.004	15-May-2023	Responsibility for the SOP revised to indicate the responsibility for the management of the SOPs is with the N2/CAREB REB SOP Committee

Title	Composition of the REB
SOP Code	201.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the membership composition requirements of the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or designee is responsible for ensuring that the composition of the REB meets the applicable regulatory requirements.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Individual members of an REB must be qualified through training, experience and expertise to ascertain the acceptability of proposed research in terms of ethical principles, and applicable regulations, guidelines and standards pertaining to human participant protection.

To promote complete and adequate review of the type of research commonly reviewed by the REB, the REB must include appropriate diversity; therefore, selection of members must include a consideration of professional expertise (including both scientific and non-scientific) to assess the research submitted for review. Important consideration are also race, gender, cultural backgrounds, clinical and research experience, organizational affiliation, and sensitivity to such issues as broad representation from organizations served by the REB.

5.1 Selection of REB Members

5.1.1 In selection of REB members, equal consideration shall be given to qualified persons of both sexes. No appointment shall be made solely on the basis of sex;

5.1.2 The REB will make every effort to include cultural and ethnic minorities to represent the population from which participants are recruited, within the scope of available expertise needed to conduct its functions;

5.1.3 The REB membership will not consist entirely of members of one profession and will include members with diverse methodological and disciplinary expertise. To ensure the independence of REB decision making, institutional senior administrators shall not serve on the REB;

5.1.4 REB members (including alternate members) shall sign a *Confidentiality of Information and Conflict of Interest Agreement*.

5.1.5 REB members will be selected based on the needs of the REB as outlined below and per applicable regulations, guidelines and standards.

5.2 Composition of the REB

5.2.1 The membership of the REB will be in compliance with the *Food and Drugs Act* and applicable *Regulations*, the Tri-Council Policy Statement; Ethical Conduct for Research Involving Humans, the International Council on Harmonisation Good Clinical Practice Guidelines, and the US Code of Federal Regulations;

5.2.2 The REB Chair or designee monitors the REB membership composition for appropriate membership in relation to the nature and volume of research submissions;

5.2.3 The REB will include at least seven voting members represented by the following categories:

- At least two SFU faculty members who have expertise in relevant research disciplines, field and methodologies covered by the REB (for biomedical clinical trials, this will include at least one member who practises medicine or dentistry and who is in good standing with their regulatory body),
- At least one member who is primarily experienced in non-scientific disciplines
- At least one member who is knowledgeable in ethics,
- At least one member who is knowledgeable in the relevant law and is not the institution's legal counsel or risk manager. This is mandatory for biomedical research and is advisable, but not mandatory, for other areas of research,
- At least one community member who has no affiliation with the University or the sponsor, and who is not part of the immediate family of a person who is affiliated with the University, and
- At least one member who is a graduate student of the University;

5.2.4 A member may not fulfill more than two of the representative capacities or disciplines cited in paragraph 5.2.3;

5.2.5 Members will be gender diverse, a majority of whom are Canadian citizens or permanent residents, and who collectively have the qualifications and experience to review and evaluate the science, medical aspects and ethics of the proposed research;

5.2.6 Membership, when required, should include at least one member who has expertise in complementary or alternative care or pediatric health research;

5.2.7 Membership should include a member with relevant and competent knowledge and expertise in Indigenous cultures.

5.2.8 Additional membership as required by applicable legislation or guidelines.

5.3 Alternate Members

5.3.1 The REB Chair or their designee may ask an alternate REB member to attend an REB meeting to draw on their expertise in an area that may be relevant to that meeting's deliberations, or to establish a Quorum for that meeting in the absence of the regular REB member. Alternate members contribute to the decision making and are eligible to vote on matters before the REB

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5.3.2 Only alternate REB members of comparable qualifications may substitute for an REB member (a non-scientific member may not substitute for a scientific member);

5.3.3 The minutes shall document when an alternate REB member replaces a primary

REB member.

5.4 REB Chair

5.4.1 The REB Chair will be selected from experienced REB members who have expressed interest in becoming the REB Chair and who are familiar with the applicable regulations and guidance documents;

5.4.2 The Research Ethics staff updates the REB membership roster and OHRP registration, if applicable, to reflect this change.

5.5 Ad Hoc Advisors

5.5.1 The REB Chair or their designee may invite individuals with expertise and competence in special areas to assist in the review of issues that require expertise beyond or in addition to that available on the REB;

5.5.2 The ad hoc advisor may be asked to participate in the REB meeting to lend their expertise to the discussions;

5.5.3 All ad hoc advisors shall sign a *Confidentiality of Information and Conflict of Interest Agreement;*

5.5.4 The ad hoc advisor may not contribute directly to the REB's decision and their presence or absence shall not be used in establishing a Quorum;

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5.5.5 Documentation of key information provided by the ad hoc advisor shall be summarized in the REB minutes and if available, the written report shall be placed in the REB files.

5.6 Observers at REB Meetings

5.6.1 The REB may allow observers to attend its meetings;

5.6.2 Observers will sign a *Confidentiality of Information and Conflict of Interest Agreement* agreeing to abide by the REB conflict of interest and confidentiality policies;

5.6.3 Where the REB finds that an observer qualifies as an expert in relation to the research under consideration, the observer may be allowed to contribute input if it is relevant and significant to the discussion;

5.6.4 Observers shall not participate when the REB discusses its decision, reaches consensus or votes on the application;

5.6.5 The minutes will reflect the presence of any observers as well as their expertise and contributions, when applicable.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP201.001	15-Sept-2014	Original version
SOP201.002	08-Mar-2016	No revisions needed
SOP201.003	08-Oct-2019	5.2.1: ICH 'Conference' changed to 'Council'; Removed "Research ethics oversight of biomedical clinical trials (CAN/CGSB-191.1-2013) 5.2.7: change in language and requirements for addressing research involving the Indigenous community. Removal of: 'At least one member, when possible, who is from an identifiable Aboriginal community or Native centre, when the REB reviews research that recruits participants from that community'; New Language: 'Membership, when regularly required, for the review of research on topics related to Indigenous peoples or affecting Indigenous communities, should include a member with relevant and competent knowledge and expertise in Indigenous cultures, or the inclusion of an ad hoc advisor for occasional review.'
SOP201.004	15-May-2023	Changed his/her to their

SOP 202.004

Title	**Management of REB Membership**
SOP Code	202.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the management of the membership of the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or their designee is responsible for monitoring and managing the REB membership.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REB membership (e.g., appointment, terms) must be adequately managed to continue to meet applicable regulatory composition requirements and to maintain the appropriate diversity, experience and expertise for the type and volume of research reviewed.

5.1 Appointments – Regular Members and Alternates

5.1.1 The Director of Research Ethics or their designee will identify prospective REB members and bring nominations forward to the REB Chair for conditional approval and appointment. This process requires active and ongoing communication between the Director of Research Ethics or their designee and the REB Chair. Once such nominations and conditional approvals and appointments have been made, the Director of Research Ethics or their designee will bring the slate of conditionally approved and appointed REB members to Senate for approval and the Board of Governors for information;;

5.1.2 Community members (meeting membership requirements) are solicited from the greater local community;

5.1.3 Candidates selected to serve on the REB will be asked to sign a letter of appointment and a *Confidentiality of Information and Conflict of Interest Agreement*.

5.2 Appointments – REB Chair and Vice-Chair

5.2.1 The REB Chair is normally a faculty member of the University with previous REB experience gained at the University or elsewhere. The REB Chair will be elected by the current regular voting REB members.;

5.2.2 The REB Vice-Chair will be elected by the regular voting REB members.

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5.2.3 The REB Chair and Vice-Chair will be asked to sign a *Confidentiality of Information and Conflict of Interest Agreement.*

5.3 Terms of Appointment

5.3.1 Each REB member will serve a 3-year term;

5.3.2 Re-appointment of an REB member for (an) additional term(s) is allowed, by mutual agreement of the REB member and the REB Chair or designee. Normally REB members will serve only 2 consecutive full terms;

5.3.3 The REB Chair and Vice-Chair will serve for a 1-year term. Normally, the REB Chair will serve no more than 3 consecutive

terms;;

5.3.4 REB member terms will be partially overlapping to preserve the experience level, expertise, and continuity of the REB.

5.4 Qualifications and Training of REB Members

5.4.1 Each member of the REB will follow qualification and training procedures as recommended by the Research Ethics staff and the REB Chair. The latest TCPS2 Core training should be completed before REB members attend their first meeting.

5.5 Resignations and Removals

5.5.1 An REB member may resign before the conclusion of their term upon provision of notice to the REB Chair or designee;

5.5.2 The REB Chair or their designee may ask an REB member (including the Vice-Chair) to step down if they consistently miss a specified percentage of the scheduled Full Board meetings in their term;

5.5.3 The REB Chair or designee may otherwise remove an REB member at any time, if they are not fulfilling their designated REB duties in a timely, competent and ethical manner;

5.5.4 An REB member must resign immediately upon substantiated and final determination of a breach of SFU Policy R60.01 as per the process set out by SFU Policy R60.01, including (without limitation) by way of research misconduct;

5.5.5 Every effort will be made to recruit a similarly qualified replacement prior to the departure of an REB member to preserve the level of experience and expertise and to ensure the continuity of the functions of the REB.

5.5.6 The REB Chair may be removed by a two-thirds vote of REB regular voting members at any time, if the REB Chair is not fulfilling their designated REB duties in a timely, competent and ethical manner. If the REB Chair is removed, the Vice-Chair will take their place and a new Vice-Chair will be elected.

5.6 Compensation

5.6.1 Participation by University faculty members as an REB member is considered a service component of their employment duties. The REB Chair, Vice-Chair, and other REB members may receive compensation as permitted, and in the form determined by the Vice-President, Research and International in consultation with the Director, Research Ethics .

5.7 Liability and Coverage

5.7.1 All REB members are insured for their research ethics review-related work by the organization's insurance policy, subject to the terms and conditions of that policy.

5.8 Documentation

5.8.1 Research Ethics staff will maintain an updated electronic REB membership list;

5.8.2 The REB membership list will be reviewed and updated by Research Ethics staff as required, or with the initiation of new or conclusion/termination of existing terms;

5.8.3 The current REB membership list and archived lists are maintained and available through the Research Ethics staff; The membership list will set out: name, contact information, degree(s), area(s) of expertise and organizational affiliation(s), role on the REB (e.g. scientific, nonscientific), gender, Canadian citizenship status, indications of experience such as board certification, licenses, etc., sufficient to describe each member's chief anticipated contribution to REB deliberations (as applicable), and any additional information on areas of expertise for the purposes of communication and reviewer assignment. These lists will be kept confidential for access only by REB members and the Research Ethics staff to the extent permitted by applicable privacy legislation;

5.8.4 CVs, other supporting documents related to education and expertise, signed members' letters of appointment and confidentiality agreements for all current and past REB members will be maintained by Research Ethics staff;

5.8.5 Research Ethics staff will update the REB registration with the US Office for Human Research Protection (OHRP) when applicable.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP202.001	15-Sept-2014	Original version
SOP202.002	08-Mar-2016	No revisions needed
SOP202.009	08-Oct-2019	No revisions needed
SOP202.004	15-May-2023	No revisions needed

SOP 203.004

Title	**Duties of REB Members**
SOP Code	203.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the duties of the members of the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or designee is responsible for clearly articulating all required duties associated with membership to the REB to potential and current REB members.

REB members and alternates are responsible for fulfilling their duties as specified in this SOP.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Each REB member's primary duty is the protection of the rights and welfare of the individual human beings who are serving as the participants of research. In order to fulfill their duties, REB members must be versed in regulations governing human participants' protection and biomedical research ethics, and policies germane to human participant protection.

5.1 Attendance

5.1.1 Regular REB members are expected to attend the regularly scheduled REB meetings. REB Members may be asked to step down if they consistently miss a specified percentage of the scheduled REB meetings;

5.1.2 REB members must notify Research Ethics if they will be absent for an REB meeting to ensure that Quorum can still be met and/or so that an appropriate alternate may attend in their place;

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5.1.3 Alternate REB members are expected to attend the identified REB meetings for which they have confirmed their availability to replace a regular REB member, and/or a minimum of two REB meetings per year;

5.1.4 REB members are expected to be available for the entire REB meeting, not just the sections for which they have been assigned as reviewers.

5.2 Terms of Duty

5.2.1 All members of the REB, including the REB Chair and Vice-Chair, will be appointed for a term as specified by the Policy and Procedures.

5.3 Duties

5.3.1 All REB members attending an REB meeting are expected to review the relevant materials submitted for each item under review or consideration by the REB, to submit comments in writing in advance of the REB meeting, and to be prepared to discuss each agenda item and provide input at the Full Board meeting;

5.3.2 Each REB member is expected to fulfill specific duties based on the role as outlined below. More than one REB member may fulfill each role;

5.3.3 **Scientific members:** are expected to contribute to the evaluation of the research on its ethical, scientific and statistical merits and standards of practice. These members should also advise the REB if additional expertise in a scientific or non-scientific area is required to assess whether the research adequately protects the rights and welfare of human participants;

5.3.4 **Non-scientific members:** are expected to provide input on areas germane to their knowledge, expertise and experience, professional and otherwise. Non-scientific members should advise the REB if additional experience in a non-scientific area is required to assess whether the research adequately protects the rights and welfare of participants and to comment on the comprehension of the consent document;

5.3.5 **Community member(s):** are expected to provide input regarding their knowledge about the local community and be able to discuss issues and research from that perspective;

5.3.6 **Member(s) knowledgeable in relevant law:** are expected to alert the REB to legal issues and their implications, but not to provide formal legal opinions nor to serve as legal counsel to the REB;

5.3.7 **Member(s) knowledgeable in ethics:** are expected to guide the REB in identifying and addressing ethics issues related to the research under review;

5.3.8 **Ad hoc advisors:** individuals with competence in special areas may be required to provide input on issues that require expertise beyond or in addition to that available on the REB. The ad hoc advisor may be required to submit a written report and to participate via teleconference or to attend the REB meeting to lend their expertise to the discussions;

5.3.9 **REB Chair:** The REB Chair or designee provides overall leadership to the REB:

- The REB Chair can delegate any of their responsibilities, as appropriate to a Vice-Chair or other qualified individual(s),
- Any responsibilities that are delegated by the REB Chair must be documented,
- The REB Chair or designee facilitates the review process based on Policies and Procedures, and applicable regulations and guidelines. The REB Chair or designee determines the level of risk of each research project. The REB Chair or designee monitors the REB's decisions for consistency and ensures that decisions are recorded accurately and communicated to Researchers in writing in a timely fashion,

- The REB Chair or designee ensures that all REB members are free to participate in discussions during the REB meetings. The REB Chair or designee can ask a substitute REB member to attend an REB meeting in order to draw their expertise in an area that may be relevant to the REB's review and deliberations of the research,
- The REB Chair or designee determines the appropriateness of a Full Board or delegated review of the research,
- The REB Chair or designee performs or delegates authority to (an) REB member(s) to perform a delegated review,
- The REB Chair or designee signs off on all REB decisions in writing,
- For REB approval of clinical trials approved by Health Canada, the REB approval letter which includes the REB attestation, is signed by the REB Chair or designee,
- The REB Chair or designee can suspend the conduct of any research project deemed to place participants at unacceptable risk pending discussion by the Full Board. The REB Chair or designee can suspend the conduct of the research if he/she determines that a Researcher is not adhering to the REB approved protocol or to the REB's policies and procedures,
- The REB Chair or designee, in conjunction with the Research Ethics staff and other organizational representatives as applicable, ensures the REB members are informed of all new legislation, regulations, policies and guidelines pertaining to human participant research and shall advise the University on policies and procedures related to research conduct,
- The REB chair, in conjunction with the Research Ethics staff, shall assess the educational and training needs of the REB members, and will address any gaps identified.
- The REB Chair or designee reviews and approves REB policies and procedures at set intervals, to ensure the REB SOPs meet all current standards.

5.3.10 **REB Vice-Chair:** The REB Vice-Chair or equivalent is responsible for performing the responsibilities of the REB Chair when the REB Chair is unable to do so:

- The REB Vice-Chair performs all responsibilities assigned by the REB Chair,
- The REB Vice-Chair assists with the overall operation of the REB.

Deleted: <#>The REB Chair or designee will report on the activities of the REB to the University on an annual basis,¶

5.4 Primary and Secondary Reviewers

5.4.1 REB members will act as primary and/or secondary reviewers for assigned research projects at Full Board meetings. The primary and secondary reviewers present their findings resulting from review of the REB submission materials and provide an assessment of the soundness and safety of the research and recommends specific action to the REB. They lead the discussion of the research project during the REB meeting. The primary and secondary reviewers review additional material(s) as requested by the REB for the purpose of approval of the research.

5.5 Training and Education

5.5.1 REB members are expected to follow training and education procedures.

5.6 Conflict of Interest

5.6.1 REB members are expected to follow conflict of interest procedures.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP203.001	15-Sept-2014	Original version
SOP203.002	08-Mar-2016	No revisions needed
SOP203.003	08-Oct-2019	No revisions needed
SOP203.004	15-May-2023	Changed his/her to their

SOP 204.004

Title	**Research Ethics Staff Serving as REB Members**
SOP Code	204.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the duties of Research Ethics staff serving as members of the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

The REB Chair, Director, Research Ethics, and Organizational Official(s) are responsible for ensuring that the requirements of this SOP are met.

The Director, Research Ethics is responsible for ensuring that the Research Ethics staff serving as members have the requirements for fulfilling this role and the REB Chair or designee is responsible for clearly articulating all required duties associated with their duties as members of the REB.

Research Ethics staff are responsible for understanding and fulfilling their roles as REB members and as Research Ethics staff and managing real, potential or perceived COI appropriately.

The Organizational Official(s) is responsible for ensuring that the Research Ethics staff serving as members of the REB understand and execute their functions appropriately.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Each REB member's primary duty is the protection of the rights and welfare of the individual human beings who are serving as the participants of research. In order to fulfill his or her duties, REB members must be versed in regulations governing human participants' protection and biomedical research ethics, and policies germane to human participant protection.

5.1 Duties

5.1.1 Research Ethics staff who are designated as Board members may attend convened meetings and participate in discussions, but they shall not be counted in determining a Quorum and they shall not participate in any votes;

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5.1.2 Research Ethics staff that have been appointed to serve as REB members may perform delegated review in accordance with the delegated review procedure;

5.1.2 The assignment of these tasks to Research Ethics staff will be documented.

5.2 Appointment Criteria

5.2.1 Research Ethics staff serving as REB members shall have knowledge, experience, and training comparable to what is expected of REB members. The REB shall ensure that Office Personnel can fulfill their responsibilities as REB members independently.

5.4 Training and Education

5.4.1 Research Ethics staff serving as REB members are expected to additionally follow training and education procedures for REB members.

5.5 Conflict of Interest

5.5.1 Research Ethics staff serving as REB members are additionally expected to follow conflict of interest procedures for REB members.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP204.001	15-Sept-2014	Original version
SOP204.002	08-Mar-2016	No revisions needed
SOP204.003	08-Oct-2019	No revisions needed
SOP204.004	15-May-2023	No revisions needed

SOP 301.004

Title	**REB Submission Requirements and Administrative Review**
SOP Code	301.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the Research Ethics Board (REB) submission requirements and the administrative review procedures. This SOP applies to all submissions including, but not limited to: applications for initial review, amendments or changes to approved research and any new information.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REB members must rely on the documentation provided by the Researcher for initial and continuing review. Therefore, the materials submitted must provide sufficient information to conduct the review and to make the required determinations.

The REB is supported by administrative procedures that ensure that REB members not only have adequate time for the assessment of the proposed research, but that the materials they receive allow them to adequately assess whether the research submission meets the criteria for REB approval.

The requirements for REB submissions are made available to all Researchers. The Research Ethics staff are responsible for maintaining and disseminating this information to Researchers.

5.1 Submission Requirements

5.1.1 The required documents, checklists, number of copies, format and submission procedures are outlined on the REB's website and on the appropriate REB submission forms and checklists such as, but not limited to:

- REB application form,
- Submission checklist,
- Continuing Review form,
- Amendment and/or Administrative Change form,
- Change in Researcher/Coordinator form,
- Changes in Research Personnel form,
- Serious Adverse Event Reporting form,
- Research Completion form;

5.1.2 The REB may request any additional documentation it deems necessary to the ethics review, or for research ethics oversight;

5.1.3 **Research Requirements:** The research question and methodology is written in sufficient detail to permit evaluation of the merit of the project. The research should include all of the required elements applicable to the research such as, but not limited to:

- Research rationale and objectives,
- Design and detailed description of methodology,
- Eligibility criteria, description of the population to be studied,
- Recruitment and consent process,
- Research interventions,

- Treatment allocation (if applicable),
- Primary and secondary outcome measures,
- Assessment of safety,
- Sample size justification,
- Data analysis,
- Data monitoring.

5.2 Administrative Review Procedures

5.2.1 A unique number is assigned to each submission at the time of the receipt of the application. Research Ethics staff screens the submission for overall completeness;

5.2.2 If the submission is incomplete (e.g. documents are missing or incorrect documents were uploaded), the Research Ethics staff will follow up with the Researcher and/or research coordinator to request the required information for inclusion with the submission;

5.2.3 Upon receipt of a complete submission, the responsible Research Ethics staff identifies any outstanding items that will be required to issue approval, as applicable;

5.2.4 For submissions requiring Full Board review, the Research Ethics staff posts the submission to the agenda of the next Full Board meeting. Primary and secondary reviewers are assigned once the agenda is complete, if applicable;

5.2.5 For submissions reviewed via delegated review procedures, the REB Chair or designee assigns a reviewer(s) and sends the research.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP301.001	15-Sept-2014	Original version
SOP301.002	08-Mar-2016	No revisions needed
SOP301.003	08-Oct-2019	No revisions needed
SOP301.004	15-May-2023	No revisions needed

SOP 302.004

Title	**REB Meeting Administration**
SOP Code	302.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the required activities for the preparation, management and documentation of Full Board meetings of the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Except when a delegated review procedure is used, the REB must review proposed research at Full Board meetings at which a Quorum is present.

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The REB meeting agenda provides the meeting content and establishes a sequence of

review. It also provides an overview of all items that have been previously (i.e., during the preceding time between REB meetings) reviewed and approved by delegated review procedures, a list of items that are pending review by the Full Board and assigned reviewer(s) for each of those items. Information documented in the REB meeting agenda provides the foundation for the REB meeting minutes.

The REB meeting minutes document the actions that occur during an REB meeting. The minutes should enable a reader who was not present at the REB meeting to determine how and with what justification the REB arrived at its decisions. They should also provide the REB itself with sufficient detail to help it reconstruct its discussions at a later date, if necessary.

5.1 Agenda Preparation

5.1.1 Following an administrative review of the submission (e.g., new studies, amendments, continuing review applications, reportable events) by Research Ethics staff and the determination of the review type by the REB Chair or their designee, the responsible Research Ethics staff adds any submissions requiring Full Board review to the next appropriate Full Board meeting agenda;

5.1.2 For submissions that were reviewed and approved via delegated review procedures, the REB will be made aware of these approvals in a timely manner ;

5.1.3 The Research Ethics staff attaches to the agenda any previous REB meeting minutes for Full Board review and approval, and adds any other items for information or discussion at the REB meeting (e.g., SOPs, educational articles, presentations, reports, etc.);

5.1.4 The Research Ethics staff, in consultation with the REB Chair or designee as necessary, reviews the agenda, confirms REB meeting attendance and assigns the reviewers;

5.1.5 The REB Chair or designee invites the appropriate alternate REB member to the meeting when a regular REB member is not able to attend;

5.1.6 The reviewer assignment and the agenda are issued in a timely manner prior to the REB meeting date. The REB members attending the REB meeting will receive a copy of the REB meeting agenda;

5.1.7 Ad hoc advisors will receive copies of relevant submissions;

5.1.8 Any changes to the agenda are communicated to all REB members and Research Ethics staff. The Research Ethics staff or designee also may issue an updated agenda notice depending on the nature of the changes.

5.2 Primary and Secondary Reviewers

5.2.1 Prior to the meeting, the Research Ethics staff, in consultation with the REB Chair or designee as necessary, will assign a primary and may assign one or more secondary reviewers for each new research project and at least one reviewer for each amendment;

5.2.2 No REB member will be assigned as a reviewer on a submission in which they are a Researcher or co-Researcher or in which there is a declared conflict of interest;

5.2.3 The Research Ethics staff will issue the reviewer assignment. The assigned reviewers will receive notification with a copy of the meeting agenda;

5.2.4 If any of the assigned reviewers declare a conflict, the submission is reassigned to another reviewer.

5.3 Prior to the REB Meeting

5.3.1 The primary and secondary reviewers (if applicable) will conduct in-depth reviews of their assigned submissions and will submit reviewer comments prior to the REB meeting. The primary reviewer should be prepared to lead the discussion at the Full Board meeting;

5.3.2 All REB members are expected to conduct a review of each agenda item prior to the Full Board meeting, including previous REB meeting minutes on the agenda and any attachments to the agenda for review or discussion;

5.3.3 REB members who are not assigned as primary or secondary reviewers may submit their individual comments for each submission prior to the meeting;

5.3.4 All REB members should be prepared to present their comments and participate in the discussion at the Full Board meeting.

5.4 During the REB Meeting

5.4.1 ~~A quorum must be present to proceed with a Full Board meeting. A quorum shall consist of 50% plus 1 of the voting members of the REB (for clarity, quorum for an REB consisting of 7 voting members will be 5 voting members), provided that the members in attendance at a meeting have the specific expertise, relevant competence, and knowledge necessary to provide an adequate research ethics review of the proposals under consideration.;~~

Proposed rewording: A Quorum must be present to proceed with a Full Board meeting.

5.4.2 Should Quorum fail during a Full Board meeting (e.g., through recusal of REB

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Commented [TD1]: "Quorum" is defined in the Policy Glossary. See discussion.

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members with conflicts of interest or early departures), the REB may not make further decisions unless Quorum is restored;

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5.4.3 An alternate REB member may attend in the place of a regular REB member to meet Quorum requirements. When a REB member and their alternate both attend the REB meeting, only one is allowed to participate in the deliberations and final decisions regarding approval;

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5.4.4 If an REB member is unable to be physically present during a Full Board meeting, he/she may participate via videoconference or teleconference. REB members participating by videoconference or teleconference count towards Quorum;

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5.4.5 Ad hoc advisors do not count when determining Quorum and do not vote;

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5.4.6 REB members recusing themselves due to a conflict of interest are not counted toward Quorum;

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5.4.7 Research Ethics staff serving as REB members for purposes of delegated review are not counted toward Quorum and do not vote.

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5.4.8 The REB Chair or their designee may, at their discretion, conduct an REB meeting with all REB members attending via simultaneous videoconference or teleconference, provided everyone has access to the review materials and Quorum is met;

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5.4.9 Subject to section 5.4.3, only those REB members present (i.e., in person, or via videoconference or teleconference) at the Full Board meeting may participate in the deliberation and final decision regarding approval;

5.4.10 Observers may be invited or permitted to attend REB meetings, subject to the agreement of the REB and execution of a *Confidentiality Agreement*. Observers must disclose any vested interest in, or scientific or management responsibility for, any applications being considered at the REB meeting;

5.4.11 If requested, Researchers may (in person or via teleconference) attend the REB meeting to present their research and respond directly to any comments or questions raised by the REB, subject to the agreement of the REB;

5.4.12 Any individual not listed on the official REB membership roster may not participate in the decisions of the REB.

5.5 Meeting Minute Preparation

5.5.1 The Research Ethics staff will draft the REB meeting minutes including key discussions, decisions and votes;

5.5.2 The key REB discussions and decisions for submissions are recorded;

5.5.3 The REB's concerns, clarifications and recommendations to the Researcher as

discussed at the REB meeting are included in the REB review letter that is sent to the Researcher:

5.5.4 The meeting may be audio tape recorded (on an encrypted device) for reference purposes and to provide additional reference information for the generation of the final draft of the minutes;

5.5.5 The minutes are intended to reflect what the REB decided, how it resolved controverted issues, and any determinations required by the regulations;

5.5.6 The draft minutes should be completed prior to the next REB meeting.

5.6 Meeting Minute Approval

5.6.1 The minutes are made available at the next appropriate REB meeting and members are requested to review the minutes and to note any errors for correction;

5.7 Documentation

5.7.1 The REB meeting minutes include the following items:

- Date, place, and time the REB meeting commenced and adjourned,
- Names of REB members in attendance (present, teleconference, videoconference),
- Names of Research Ethics staff present at the meeting,
- Presence of observers,
- Use of ad hoc advisors and their specialty,
- List of declared conflicts of interest, a summary of any discussions, and the decision taken by the REB to address them (as applicable) or a note that none were declared,
- A summary of key discussions and controverted issues and their resolution for each submission, as applicable,
- The decisions taken by the REB regarding approval for each submission, as applicable,
- The basis for requiring changes or for disapproving submissions,
- Number of REB members in attendance for the review of each submission requiring a decision,
- REB member(s) recused related to conflicts of interest for each submission requiring a decision,
- Number(s) voting for, against and abstaining in the event of a vote for each submission requiring a decision,
- Reference to any attachments to the agenda;

5.7.2 All REB meeting agendas and minutes are retained in the REB records;

5.7.3 The agendas, REB meeting minutes and review documents are confidential and

will not be released or made available unless required for inspection or auditing purposes.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP302.001	15-Sept-2014	Original version
SOP302.002	08-Mar-2016	5.1.2: revision to the reporting criteria and notification of the REB for all delegated reviews.
SOP302.003	08-Oct-2019	5.5.3: deletion of last sentence, “The information documented in the letter is included in the REB meeting minutes”; 5.7.1: deletion of ‘Names of REB members absent’
SOP302.004	15-May-2023	5.6 : deletion of approval 5.6.1 : deletion of ‘are presented at the meeting for REB approval’; inclusion of ‘members are requested to review the minutes and to note any errors for correction’ 5.6.2 : deletion 5.6.3 : deletion 5.7.1 : deletion of ‘or’ replaced by ‘and’; ‘Number(s) voting for, against and abstaining. ..’

SOP 303.004

Title	Document Management
SOP Code	303.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the requirements for document management, including document retention and document archiving. This SOP applies to documents submitted to the Research Ethics Board (REB) for initial or for continuing review, as well as to all REB administrative documents.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Research Ethics must retain all relevant records (e.g., documents reviewed and approved or disapproved, REB meeting minutes, correspondence with Researchers, written SOPs, REB membership rosters) to provide a complete history of all actions

related to the REB review and approval of submitted research. Such records must be retained for the length of time required by applicable regulations and guidelines.

Relevant records must be made accessible to authorized regulatory authorities, representatives of the University, Researchers and funding agencies within a reasonable time upon request.

5.1 Research-Related Documents

5.1.1 Research Ethics retains the submission materials for all research that have been submitted for REB review and have been either approved, acknowledged or disapproved;

5.1.2 Research-related documents include, but are not limited to, the following (as applicable):

- REB initial application form and all associated attachments;
- Correspondence between the REB and the Researcher, including REB approval letters, requests for modifications, etc.;
- Records of ongoing review activities such as,
  - Reportable event submissions, including reports of significant new findings, Data and Safety Monitoring Board (DSMB) reports, interim analysis reports, local adverse events and non-local (external) adverse events, research deviations, privacy breaches, any investigations into allegations of serious or continuing non-compliance, and reports of inspections and audits by regulatory agencies or others,
  - Modifications to the application including amendments to the research and/or any changes to the consent(s), participant materials or Investigator Brochures;
- Continuing review applications;
- Copies of correspondence between the REB and regulatory agencies;
- Reports of any complaints received by the REB and their resolution.

5.2 REB Administrative Documents

5.2.1 Research Ethics retains all administrative records related to the REB review activities;

5.2.2 REB administrative documents include, but are not limited to, the following:

- Agendas and minutes of all REB meetings;
- Submitted REB member reviews;

- REB member records:
  - Current and obsolete REB membership rosters, including alternate REB members,
  - CVs and training/qualification documentation of current and past REB members;
- Signed conflict of interest and confidentiality agreements;
- Current and obsolete SOPs;
- Current and obsolete documentation of the REB Chair or designee's delegation of authority, responsibilities, or specific functions;
- Records of registration of the REB with the US Office of Human Research Protection, if applicable, and REB membership updates.

5.3 Document Access, Storage and Archiving

5.3.1 Access to individual research projects and related documents, is role-based to ensure that users only have access to documents and activities that are required by their role;

5.3.2 The REB records are housed securely with back-up, disaster and recovery systems in place.

5.4 Confidentiality and Document Destruction

5.4.1 All submissions received by the REB are considered confidential and are accessible only to REB members (including the REB Chair and Vice-Chair), and the Research Ethics staff;

5.4.2 Relevant research projects and associated documents may be made accessible to organizational officials, as well as to sponsor or CRO representatives, if the Researcher or their research team submits a request for access to the research;

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5.4.3 Relevant research projects and associated documents may be made accessible to members of regulatory agencies, or representatives of the sponsor or Researcher for review. Access is limited to the applicable research and research-related submissions;

5.4.4 The REB will retain required records (e.g., research-related or REB administrative documents, as applicable) for a minimum of 3 years after completion/termination of the trial, or for the maximum amount of time stipulated in any applicable governing regulation(s);

5.4.5 Any confidential materials in paper format in excess of the required documentation will be shredded.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP303.001	15-Sept-2014	Original version
SOP303.002	08-Mar-2016	5.3.2: revised to state securely housed with removal of the reference to an onsite location.
SOP303.003	08-Mar-2019	5.1.2: deletion of 'signed' from first bullet; 5.3.1: deletion of 'and to centre and Researcher profiles'; 5.4.1: deletion of 'as well as to organizational official(s)'; 5.4.2: deletion of 'other' and 'guest'
SOP303.004	15-May-2023	5.4.4: remove specific reference to HC retention requirement

SOP 401.004

Title	**Delegated Review**
SOP Code	401.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the processes for determining when research meets the criteria for delegated ethics review and the associated delegated review procedures.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or designee is responsible for determining if research is eligible for delegated review. In some circumstances, the REB Chair or designee may delegate this task to qualified Research Ethics staff; however, the responsibility for oversight remains with the REB Chair or designee.

The REB Chair or designee or qualified REB member(s) is responsible for conducting the delegated review.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REBs should adopt a proportionate approach to ethics assessment based on the general principle that the more invasive or harmful the proposed and ongoing research, the greater should be the care in assessing the research. Full Board review by an REB should be the default requirement for all research involving human participants unless the REB decides to authorize delegated review based primarily on the harms that are expected to arise from the research. While all research must be reviewed adequately, requirements for proportionate review allow the REB to provide a higher level of scrutiny, and correspondingly more protection, for the most ethically challenging research.

In practice, the proportionate review implies different levels of REB review for different research projects. The two levels typically used by REBs are Full Board review or delegated review by one or more experienced REB members, as determined by the REB Chair or designee.

5.1 Determination of Qualification for Delegated Review

5.1.1 Full Board review is the default for most new research projects submitted to the REB; however, some research may be eligible for delegated review;

5.1.2 Submissions that meet the following criteria may be eligible for delegated review:

- Research projects that involve no more than minimal risk,
- Minor or minimal risk changes to approved research,
- Continuing review of approved minimal risk research,
- Continuing review of research that is more than minimal risk for which enrolment is closed permanently and all research-related interventions for all participants are complete and the only remaining research activities are post-intervention activities or follow-up of participants; or, where the remaining research activities are limited to data analysis; or, where no participants have been enrolled and no additional risks have been identified,
- Continuing review of research that is more than minimal risk when there has been little or no modification of the research; and when there has been no increase in risk to or other ethical implications for participants since the initial review by the full REB; if permissible under all applicable governing Regulations,

- The submission by the Researcher in response to the REB review as a condition of approval, as authorized by the Board,
- Changes to consent documents that do not affect the rights and welfare of participants or involve increased risk, or affect data integrity, or require significant changes in research procedures,
- Reportable events, including adverse events and safety updates such as reports from Data and Safety Monitoring Boards (DSMB);

5.1.3 The REB Chair or designee may use delegated review procedures for the review of other types of minor changes including, but not limited to, the following:

- Participant materials such as: recruitment posters or scripts, diaries, validated questionnaires, clinical trial identification/wallet cards,
- Authorized translations of English versions of documents previously-approved by the REB;

5.1.4 The REB Chair or designee may be authorized by the full Board to use delegated review procedures for the review of miscellaneous items such as changes to meeting minutes that previously received approval with conditions at a Full Board meeting;

5.1.5 When determining if initial review of research or modifications to previously approved research are eligible for delegated review, the REB Chair or designee will take into consideration the methods used to conduct the research, recruitment practices, participant population, confidentiality of data, and all regulatory and ethics guidance requirements as applicable.

5.2 Delegated Review Process

5.2.1 Qualified Research Ethics staff will perform an initial screening of the submission. Those submissions that meet a pre-defined set of criteria for delegated review as determined by the REB may be forwarded for delegated review. For all other submissions, the REB Chair or designee will make the determination of whether the submission meets the criteria for delegated review;

5.2.2 For research that meets the criteria, delegated review may be conducted by the REB Chair, or by one or more qualified REB members as designated by the REB Chair or designee;

5.2.3 The REB Chair or designee reviewing research under delegated review must not have a conflict of interest in the research;

5.2.4 In reviewing the research under delegated procedures, the REB Chair or designee may exercise all of the authorities of the REB, except that he/she may not disapprove the research; the research may be disapproved only after it has been reviewed by the REB at a Full Board meeting;

5.2.5 REB member(s) conducting a delegated review will contact the REB Chair or designee to request the expertise of an ad hoc advisor, if applicable. Ad hoc advisors may not participate in the final decision regarding approval of the research;

5.2.6 If the REB Chair or designee subsequently determines that the level of risk for the submission is greater than minimal, the submission will be referred to a Full Board meeting for review;

5.2.7 The REB Chair or designee will record the decision regarding the designation of the research (i.e., either requiring FB or delegated review) and the outcome of the review. The responsible Research Ethics staff may issue the review or decision letter.

5.3 Notification of the REB

5.3.1 At its next Full Board meeting the REB will be informed of research that was reviewed and approved using delegated review procedures.

5.4 Documentation

5.4.1 The type of REB review conducted (i.e., Full Board or delegated) is documented in the REB records and noted in the decision letter issued to the Researcher, where appropriate;

5.4.2 The REB will be provided with a list of submissions that were reviewed and approved using delegated review procedures from the time that the agenda for the previous REB meeting was issued.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP401.001	15-Sept-2014	Original version
SOP401.002	08-Mar-2016	No revisions needed
SOP401.003	08-Oct-2019	5.4.2: deletion of 'meeting agendas and minutes will include', replaced with 'will be provided with'
SOP401.004	15-May-2023	No revisions needed

SOP 402.004

Title	**REB Review Decisions**
SOP Code	402.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the decisions that the Research Ethics Board (REB) may make resulting from its review of proposed research for ethical acceptability.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or designee is responsible for ensuring that a decision is made for every submission that is reviewed by the REB, that the decision is clearly understood, and that the delegation of responsibility for considering any further information prior to issuing approval is clearly agreed.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

As a result of its review, an REB has the authority to approve, disapprove, or to require modifications to submitted research. If there are questions that must be addressed prior to a determination, the REB may defer its decision. When the Full Board review procedure is used, decisions will be made by consensus or a majority vote of the REB members who are present at a Full Board meeting at which there is a Quorum.

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REB members with a conflict of interest in the research under review must not participate in the deliberations or in the vote of the REB (if applicable), in accordance with the REB and organization's conflict of interest policies.

When the delegated review procedure is used, the REB Chair and/or REB member(s) who are assigned to the review can decide to approve the research or to request revisions to the research; the decision to disapprove the research must be made by the Full Board.

Researchers have the right to request reconsideration of the REB's decisions and to appeal the decision of the REB.

5.1 REB Decisions

5.1.1 REB decisions are made either by consensus or a majority vote of the REB members present at a Full Board meeting, with the exception of those who have recused themselves in accordance with the conflict of interest policies.

5.1.2 The REB should reach one of the following decisions as a result of its review of research submitted for initial or for continuing review:

- **Approval** (approve the application as submitted, including the consent form):
  - When an acceptable risk/benefit ratio exists and the regulatory criteria required for approval are satisfied, the research may be approved as submitted,
  - The approval date is defined according to local REB procedure,
  - The expiry date of the REB approval is calculated from this date.

- **Approval with Modifications/Clarifications**:
  - When an acceptable risk/benefit ratio exists, and the regulatory criteria required for approval are satisfied, but the REB members require modification to any aspect of the application or clarification or further information to secure approval, the REB may recommend "Approval with Modifications/Clarifications",
  - When the REB recommends "Approval with Modifications/Clarifications", the REB Chair or designee should ensure that the additional information,

modifications, or clarifications required are identified at the REB meeting and that the procedures for reviewing the additional information and issuing the approval are clear. The responsibilities for additional review and the decision regarding approval conditions should be delegated to one of the following:
  - The REB Chair alone,
  - The REB Chair and one or more named REB members that were present at the REB meeting or who submitted written comments on the application,
  - A sub-group of the REB members designated by the REB Chair or designee or by the REB,
  - A designated REB member or members with sufficient knowledge and experience regarding the research and the regulations.
- In deciding the procedures to be followed, the REB should consider the significance of the requested additional information or modifications and the expertise necessary to assess it. Where the information or modifications are straightforward, it is acceptable to delegate the consideration of that material to the REB Chair or designee alone,
- Where the additional information/modification is technical (e.g., statistical clarifications), the REB Chair or designee should review the information with consideration given to involving other REB members, such as the lead reviewer(s) or relevant expert member(s),
- If the Researcher's response is deemed complete and satisfactory, approval can be issued,
- If the Researcher's response is incomplete and does not fully address the matters raised, requests for further information, modifications or clarification should be sent to the Researcher,
- The reviewers may decide upon reviewing the Researcher's response that the decision should be deferred and that the application and the Researcher's response materials should be reviewed at a subsequent Full Board meeting (see 'Deferral' process below),
- The approval date is defined according to local REB procedures. The expiry date of the REB approval is calculated from this date; however, the approval letter is not issued until all of the conditions for approval have been met.

- **Deferral** (defer decision-making on the application and continue the deliberation of the application at a future Full Board meeting):
  - The REB will defer its decision to a subsequent Full Board meeting when significant questions are raised during its review of the research and/or when the criteria required for approval have not been met,
  - The REB Chair or designee should ensure that all additional information, modifications or clarifications that are required are specifically identified at

the Full Board meeting,
- The research and the Researcher's response materials shall be reviewed at a Full Board meeting,
- Upon consideration of the research along with the response from the Researcher, at the Full Board meeting, the REB should issue its final decision (approved, approved with modifications, deferral or disapproved),
- Researcher responses must be received and reviewed at a Full Board meeting. The approval date is defined according to local REB procedures. The expiry date of the REB approval is calculated from this date; however, the approval letter is not issued until all the conditions for approval have been met.

- **Disapproval**:
  - The REB may disapprove the research when it fails to meet the ethical standards for approval and where revision is unlikely to enable the REB to reach a positive determination,
  - Disapproval cannot be decided through the delegated review mechanism. If the recommendation under delegated review is to disapprove the research, a final decision must be made by the REB at a Full Board meeting,
  - The REB Chair or designee should ensure that the reasons for the disapproval are identified at the Full Board meeting for communication to the Researcher,
  - If the research is disapproved, the reasons for disapproval will be communicated to the Researcher and the Researcher will be given an opportunity to respond in person or in writing.

5.1.3 **Delegated Reviews**:

- When the research qualifies for delegated review, the reviewer(s) has the authority to approve the application, to require modifications to any aspect of the application, or to request clarification or further information before considering it eligible for ethics approval. The reviewer(s) may also refer the applications as submitted for a review at a Full Board meeting,
- When delegated review procedures are followed, approval is considered as the day the research is approved by the REB Chair or designee as well as all other designated reviewer(s), if applicable. The expiry date of the REB approval is calculated from this date; however, the approval letter is not issued until all of the conditions for approval have been met,
- If the research cannot be approved through the delegated review mechanism, it must be reviewed at a Full Board meeting.

5.2 Reconsideration and Appeal of REB Decisions

5.2.1 The Director, Research Ethics, shall negotiate and maintain an agreement with an external Research Ethics Appeal Board (REAB).

5.2.2 A Researcher may appeal the decision of the REB if the disagreement between the Researcher/applicant and the REB cannot be resolved through a reconsideration process at a Full Board meeting at which the Researcher/ applicant shall have the right to be heard;

5.2.3 Researchers may submit a request for appeal of a decisions of the REB to the Director, Research Ethics within 30 working days of the reconsideration and the Director will notify the REAB of the request for appeal.

5.2.4 The Researcher must justify the grounds on which a reconsideration of the decision is requested. An appeal may be launched only for procedural or substantive reasons, and a final decision after reconsideration must be issued by the REB prior to the initiation of an appeal process;

5.2.5 Appeals are conducted in accordance with the established policy of the REAB.;

5.2.6 The REAB shall have the authority to review negative decisions made by the REB and in so doing it may approve, disapprove or request modifications to the research proposal. Its decision shall be final and shall be communicated to the Researcher and the REB in writing.

Commented [TD2]: Deleted text contradicts the definition of the REAB and 5.2.1. This text is useful only if there is more than one REAB

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Deleted: The University at which the appeal will take place will be determined on a case-by-case basis by the REB in consultation with the Researcher (and his/her affiliated organization)

Deleted: appeal committee

5.3 Documenting REB Decisions

5.3.1 The REB meetings minutes will satisfy the applicable requirements;

5.3.2 The REB shall notify the Researcher in writing of its decision to approve or disapprove the proposed research, or of modifications/clarifications required to secure approval of the research;

5.3.3 If the REB defers its decision, the letter to the Researcher should include the issues of concern and what further information is required;

5.3.4 The final approval letter should include standard conditions of approval to which the Researcher must adhere;

5.3.5 When the decision to approve a submission is recorded on behalf of the Full Board, or when a delegated reviewer electronically signs off on a decision (under delegated review procedures), the notification or correspondence to the Researcher may be issued by the Research Ethics staff.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP402.001	15-Sept-2014	Original version
SOP402.002	08-Mar-2016	No revisions needed
SOP402.003	08-Oct-2019	5.1.1: deletion of, 'The Chair abstains from voting except to break a tie vote.'
SOP402.004	15-May-2023	No revisions needed

Title	Initial Review – Criteria for REB Approval
SOP Code	403.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the minimum requirements that research proposals involving human participants must meet in order to be approved by the Research Ethics Board (REB), independent of the review pathway (i.e., Full Board or delegated review).

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The REB members are responsible for determining whether the research meets the criteria for approval.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

All research involving human participants must meet certain criteria before REB approval may be granted. Initial REB approval of the research is based on assessment of a complete submission to the REB. The REB and/or Research Ethics staff may consult the Researcher for additional information as necessary.

Following initial review of the research, the REB should be prepared to make a determination as to the approvability of the research.

In addition to REB approval, the requirements of the organization where the research will be conducted must also be met before the research can begin (e.g., department approvals, adequate resources, etc.).

5.1 Minimal Criteria for Approval of Research

In order for the research to receive REB approval, the REB will take the following into consideration:

5.1.1 That the Researcher has the qualifications to conduct the research;

5.1.2 Any potential conflicts of interest are declared and are managed appropriately to prevent any compromises to the safety or well-being of the participants or to the integrity of the data;

5.1.3 There is a state of clinical equipoise when there is a comparison of two or more treatment arms;

5.1.4 The research will generate knowledge that could be generalized and lead to improvements in health or well-being;

5.1.5 The methodology is scientifically sound and capable of answering the research question;

5.1.6 The risks to participants are minimized by:

- Using procedures that are consistent with sound research design and that do not unnecessarily expose participants to risk, and
- By using procedures already being performed on the participants for diagnostic or treatment purposes whenever appropriate;

5.1.7 The risks to participants are reasonable in relation to the anticipated benefits, if any, and the importance of the knowledge that will be generated;

5.1.8 The selection of participants is equitable. In making this assessment, the REB

will take into account the purpose of the research and the research setting. The REB will consider the scientific and ethical reasons for including vulnerable populations, if applicable;

5.1.9 There are sound scientific and ethical reasons for excluding classes of persons who might benefit from the research;

5.1.10 When some or all of the participants, such as children, prisoners, the elderly, pregnant women, those with mental health issues, and those with diminished capacity for self-determination who may be vulnerable to coercion or undue influence, in the context of research, additional safeguards have been included in the research, and in the REB review process to protect the rights and welfare of these participants;

5.1.11 The amount and method of payment to participants is appropriate to ensure that there is no coercion or undue influence and that information regarding payment to participants including method, amounts and schedule is provided to participants when applicable;

5.1.12 Informed consent will be sought from each prospective participant or from the participant's legally authorized representative, in accordance with and to the extent required, by applicable regulations and guidelines;

5.1.13 The informed consent form will accurately explain the research and contain the required elements of consent;

5.1.14 The informed consent process will be appropriately documented in accordance with the relevant regulations;

5.1.15 There will be provisions for on-going data and safety monitoring procedures that are appropriate to the size, complexity, phase, and level of risk of the research. The REB may recommend the use of a Data and Safety Monitoring Board (DSMB) to enhance participant protection;

5.1.16 There will be adequate provisions to protect the privacy of participants and to maintain the confidentiality of data;

5.1.17 There will be adequate provisions for continued access to the agent or device or adequate replacement of the test agent after the research is complete, when appropriate;

5.1.18 There will be adequate provisions for the timely publication and dissemination of the research results;

5.1.19 If applicable, evidence that the research has been or will be registered via an

internationally recognized clinical trial registry.

5.2 Additional Criteria

5.2.1 Studies proposing access to or collection of personal information require consideration of additional items to ensure the protection of the privacy of the personal information and to determine whether appropriate privacy legislation is adhered to;

5.2.2 Additional criteria for research involving Indigenous peoples in Canada, or research on materials related to human reproduction, or genetic research, or children, or prisoners, or pregnant women shall be applied when applicable in accordance with governing principles and/or Regulations.

5.3 Length of Approval Period

5.3.1 The REB shall review research at periods appropriate to the degree of risk and at least annually;

5.3.2 The REB may require review more often than annually when there is a high degree of risk to participants relative to the population;

5.3.3 The REB may consider reviewing the research more often than annually as required by the continuing review procedure.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP403.001	15-Sept-2014	Original version
SOP403.002	08-Mar-2016	No revisions needed
SOP403.003	08-Oct-2019	5.1.1: deletion of ' The application has been signed by the Researcher and, if applicable, by a designated Organizational Official, indicating'; 5.1.10: addition of ….who may be vulnerable 'in the context of research'; 5.1.19: First sentence changed to 'If applicable, **evidence that** the research has been or will be registered via an internationally recognized clinical trial registry; deletion of 'and a registration number has been/will be submitted to the REB. If the research is not yet registered, the researcher shall provide the REB with the registration number upon registration.'; 5.2.2: replaced the word Aboriginal with Indigenous
SOP403.004	15-May-2023	No revisions needed

Title	Ongoing REB Review Activities
SOP Code	404.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the procedures for the ongoing review activities that occur after the initial Research Ethics Board (REB) approval of a research project and prior to the formally scheduled continuing review of the research project.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members, Research Ethics staff and Researchers are responsible for ensuring that the requirements of this SOP are met.

The Researcher is responsible for reporting to the REB any new information generated throughout the course of the research that might affect the rights, safety and well-being of participants, including reportable events that meet the reporting criteria as per this SOP.

The Researcher is responsible for reporting to the REB any information about the conduct of the research that could affect the rights, safety and well-being of participants, including information about any serious or continuing non-compliance.

When action is taken to ensure the protection of the rights, safety, and well-being of participants (e.g., for an unanticipated problem involving risks to participants or others) the REB is responsible for reporting to the Researcher and the Organizational Official(s) and has the authority to notify the sponsor and/or the appropriate regulatory authorities of any events that meet the reporting criteria. The REB may delegate regulatory authority reporting (as applicable) to the University.

The REB Chair or designee is responsible for reviewing all reportable events submitted to the REB as well as any proposed amendments to the research, and for determining the type of review (i.e., delegated or Full Board) or action required.

The REB members are responsible for reviewing any new information, reportable events or proposed amendments that are assigned to them or that are assigned to a Full Board meeting, and for recommending the appropriate course of action.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

It may be that the real risk/benefit ratio can be evaluated only after the research has begun; therefore, in addition to the formally scheduled continuing review, the REB must receive and review any new information generated throughout the course of the research that might affect the rights, safety and well-being of participants.
Such information may include:

- Modifications or changes to the previously approved research,
- Reports of unanticipated problems involving risks to participants or others,
- Reports of any serious or continuing non-compliance,
- Reports of any changes significantly affecting the conduct of the research or increasing the risk to participants,
- Results of any interim analysis or Data and Safety Monitoring Board (DSMB) assessments,
- Deviations to the previously approved research,
- Adverse events that meet the reporting criteria,
- Reports of any privacy breaches,
- Summary reports of any audits and inspections,
- Any other new information that my affect adversely the safety of the participants or the conduct of the research,

Modifications to the approved research may not be initiated without prior REB review

and approval except where necessary to eliminate apparent immediate hazards to human participants. If changes are made to eliminate immediate hazards, the Researcher must notify the REB immediately.

5.1 Amendments to the Approved Research

5.1.1 The Researcher is responsible for submitting to the REB any changes to the approved research in the form of an amendment. Changes to the approved research include modifications including (for example) modifications to the research, to the consent form, to the Investigator Brochure (IB) or product monograph (PM), changes in participant materials (e.g., wallet cards, diary cards, recruitment materials), a change in the Researcher etc.;

5.1.2 When the amendment includes a change to the consent form, the Researcher must indicate their recommendation for the provision of the new information to current and/or past participants;

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5.1.3 The Researcher must indicate the type of review being requested (i.e., Full Board, delegated review or acknowledgement for a minor correction). Supporting correspondence documentation and/or background information may be appended to the amendment submission;

5.1.4 The REB Chair or designee reviews the amendment to determine the appropriate level of REB review required (i.e., Full Board or delegated review);

5.1.5 The REB Chair or designee also may use delegated review procedures for review of amendments when the conditions are met:

5.1.6 If the proposed change represents more than minimal risk, it must be reviewed by the REB at a Full Board meeting. Amendments that may be classified as more than minimal risk may include:

- Addition of genetic testing, new genetic tests, or tissue banking where genetic testing may or will be performed,
- Addition of an open label extension phase following a randomized trial,
- Emergency amendments that arise because of participant safety and may include, but are not limited to:
  1. A change in drug dosing/duration of exposure,
  2. A change in recruitment that may affect confidentiality or the perception of coercion,
  3. A change in experimental procedure or research population;

5.1.7 For amendments requiring Full Board review, the responsible Research Ethics staff assigns the amendment to the next available Full Board meeting. For amendments that meet the criteria for delegated review, the responsible Research Ethics staff will forward the amendment to the designated reviewer;

5.1.8 When an amendment involves a revised consent, the REB will consider the recommendations of the Researcher in determining if, how and when the new information should be provided to the participants and whether re- consent is required;

5.1.9 The REB must find that the criteria for approval are still met in order to approve the amendment;

5.1.10 The amended research may not be implemented prior to the REB review and approval, except when necessary to eliminate immediate hazards to participants.

5.2 Reportable Events

5.2.1 The Researcher is responsible for submitting reportable events that meet the REB's reporting criteria according to the local procedures;

5.2.2 Local AEs: The Researcher must report the following to the REB in a timely manner:

- Any local adverse event that in the opinion of the Researcher meets the definition of an unanticipated problem,
- All reports submitted to the REB must have all participant identifiers removed (i.e., participant research number only),
- Once a local AE is acknowledged by the REB, subsequent important follow-up reports related to the AE should be submitted when relevant information is available as a AE update(s). All initial and subsequent follow-up reports will be retained with the reportable event;

5.2.3 Non-Local (External) Adverse Events: Upon receipt of an external adverse event (EAE) or a periodic safety update or safety summary report, the Researcher must determine if it meets the REB reporting criteria:

- Non-local adverse event reports are reportable to the REB, if in the opinion of the Researcher, it meets the definition of an unanticipated problem AND requires a change to the research and/or informed consent form and/or requires immediate notification to participants for safety reasons,
- The report submitted to the REB must include **all** of the following information:
  - The description of the serious and unexpected event(s),
  - All previous safety reports concerning similar adverse events,

- An analysis of the significance of the current adverse event(s) in light of the previous reports, **and**
- The proposed research changes, informed consent form changes or other corrective actions to be taken by the sponsor in response to the event(s),

- The individual AE reports or periodic safety updates or safety summary reports that meet the reporting criteria must be submitted to the REB in a timely manner;

5.2.4 Other Reportable Events: The Researcher is responsible for reporting to the REB other events or findings, such as:

- Any new information (e.g., sponsor's safety notice or action letter) that would cause the sponsor to modify the Investigator's Brochure, the research or the consent form, or would prompt other action by the REB to ensure protection of participants,
- Any changes to the risks or potential benefits of the research, such as:
  - An interim analysis indicates that participants have a lower rate of response to treatment than initially expected,
  - Safety monitoring indicates that a particular side effect is more severe, or more frequent than initially expected,
  - Information is published from another research project that shows that an arm of the research is of no therapeutic value,
- A change in Health Canada or FDA safety labeling or withdrawal from marketing of a drug, device, health product, genetic therapy or biologic used in research,
- The Researcher is also responsible for submitting to the REB other types of reportable events, such as:
  - DSMB reports,
  - Interim analysis results,
  - Any unanticipated problems or other events that could significantly impact the overall conduct of the research or alter the REB's approval or favorable opinion to continue the research,
- A change to the research that was initiated without prior REB review to eliminate an apparent immediate hazard to a participant,
- Any unanticipated problems or other events that could significantly impact the conduct of the research at the site (e.g., concerns of non-compliance),
- Other reportable events must be submitted to the REB within a timely manner;

5.2.5 Deviations to Previously Approved Research: The Researcher must report to the REB any deviations that meet the following reporting criteria:

- Deviations that in the opinion of the Researcher jeopardize the safety of participants, or that jeopardize the research efficacy or data integrity,
- Any sponsor-approved waivers to the participant eligibility criteria,
- Any change in the approved process for obtaining consent (e.g., improper translation, current ICF not implemented),
- Any deviations that lead to an SAE,
- Deviations must be reported within a time frame specified by the REB; deviations that lead to an SAE should be reported with a timely manner;

5.2.6 Privacy Breaches: The Researcher must report to the REB any unauthorized collection, use, or disclosure of personal information (PI) including, but not limited to:

- The collection, use and disclosure of PI that is not in compliance with the jurisdictional legislation or its regulation,
- Circumstances where PI is stolen, lost or subject to unauthorized use or disclosure or where records of PI are subjected to unauthorized copying, modifications or disposal,
- In the Researcher context, any unauthorized collection, use or disclosure of PI that was not authorized under the research and approved in the plan that was submitted to the REB,

The breach must be reported to the REB and to the appropriate Organizational Official as soon as the Researcher becomes aware of the breach;

5.2.7 Audit or Inspection Findings: The Researcher must report to the REB a summary of any relevant audit or inspection findings following a Health Canada inspection, an FDA or other regulatory audit, an internal QA audit or other audits at the site;

5.2.8 Participant Complaint: The Researcher must report to the REB, and to the University if required by local procedures, a complaint from a participant when the participant reports concerns about their rights as a participant or about ethical issues related to the research.

5.3 Review of Reportable Events by the REB

5.3.1. The responsible Research Ethics staff will screen the reportable event submission for completeness;

5.3.2. Privacy breaches are reviewed by the REB Chair or designee, and any recommendations including remedial action are determined in consultation with the organization's privacy office. The privacy breach report is forwarded to the

REB Chair or designee for review and final acknowledgement;

5.3.3. The Research Ethics staff may route the submission back to the Researcher to request clarifications, missing documents or additional information;

5.3.4. The Research Ethics staff will forward the submission to the designated REB reviewer(s);

5.3.5. The assigned REB reviewer(s) will conduct a review of the report and determine if any action or follow-up is required;

5.3.6. The assigned reviewer(s) may request further information from the Researcher;

5.3.7. When reviewing a reportable event, the REB should:

- Assess the appropriateness of any proposed corrective or preventative measures by the sponsor and/or Researcher,
- Consider any additional appropriate measures that may or may not have been identified or proposed by the sponsor and/or Researcher,
- Consider whether the affected research still satisfies the requirements for REB approval; in particular whether risks to participants are still minimized and reasonable in relation to the anticipated benefits, if any, to the participants and the importance of the knowledge that may reasonably be expected to result,
- Consider whether some or all of the participants should be notified of the events (i.e., if it may affect the participant's willingness to continue participation in the research), and
- Consider whether suspension or termination of the ethics approval of the research is warranted;

5.3.8. If the event does not raise concerns and does not appear to involve risks to participants or others, the REB Chair or designee acknowledges the report, and no further action is required;

5.3.9. If the REB Chair or designee determines that the event meets the criteria for an unanticipated problem, and if immediate action is required to protect the safety of participants, he/she may suspend ethics approval of the research pending review by the Full Board, providing the justification for such action is documented;

5.3.10. If the event raises concerns or involves risk to participants such that REB action may be required, the item is added to the agenda of the next Full Board meeting;

5.3.11. For reportable events reviewed at a Full Board meeting, the REB determines whether further action is required. Possible actions that could be taken by the REB include, but are not limited to:

- Placing a hold on the research pending receipt of further information from the Researcher,
- Requesting modifications to the research,
- Requesting modifications to the consent form,
- Providing additional information to past participants,
- Notifying current participants when such information might affect the participants willingness to continue to take part in the research, and requiring that current participants re-consent for ongoing participation,
- Altering the frequency of continuing review,
- Observing the research or the consent process,
- Requiring additional training of the Researcher and research staff,
- Termination or suspension of the research,
- If the REB determines that the event does not raise concerns about risks to participants, the REB may decide that no further action needs to be taken;

5.3.12. When action is taken to ensure the protection of the rights, safety, and well-being of participants (e.g., for an unanticipated problem involving risks to participants or others) the REB chair or designee is responsible for reporting to the Researcher and the Organizational Official(s) and has the authority to notify the sponsor and the appropriate regulatory authorities (as applicable). The REB may delegate regulatory authority reporting (as applicable) to the University.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP404.001	15-Sept-2014	Original version
SOP404.002	08-Mar-2016	No revisions needed
SOP404.003	08- Oct-2019	5.2.2: Local AEs heading: 'within a time frame specified by the REB', changed to 'in a timely manner';

SOP Code	Effective Date	Summary of Changes
		Second bullet deleted: 'The completed sponsor's serious adverse event (SAE) form (if applicable), must be appended to the reportable event form'; Fourth bullet deleted: 'The completed sponsor's serious adverse event (SAE) form (if applicable), must be signed by the Researcher or medical designee'; Final bullet first sentence changes bolded: 'Once a local SAE is acknowledged by the REB, subsequent important follow-up reports related to the SAE should be submitted when '**relevant information is available'** as a SAE update(s); delete; 'The sponsor's follow up reporting form(s) signed by the Researcher or designee must be appended to the updated reportable event.'; 5.2.3 : last bullet: 'within a time frame specified by the REB', changed to 'in a timely manner'; 5.2.4 : last bullet: 'within a time frame specified by the REB', changed to 'in a timely manner'; 5.2.5 : last bullet: 'within a time frame specified by the REB', changed to 'in a timely manner'; 5.2.6 : deletion of 'if applicable' in the final sentence
SOP404.004	15-May-2023	No revisions needed

Title	Continuing Review
SOP Code	405.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the procedures for the continuing review of research that is overseen by the Research Ethics Board (REB), and the criteria for continued REB approval.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or designee and the assigned REB reviewer are responsible for conducting an in-depth review of all submitted materials for their assigned research projects.

All other REB members are responsible for reviewing the submitted materials for each research application in enough depth to be prepared to discuss the research meaningfully at a Full Board meeting.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REBs must establish procedures for conducting the continuing review of approved research involving human participants at intervals appropriate to the degree of risk, but not less than once a year. Periodic review of research activities is necessary to determine whether approval should be continued or withdrawn.

5.1 Continuing Review by the Full Board

5.1.1 The Researcher is required to submit an application for continuing review of research at a frequency to be determined by the REB and which will be defined at the time of the initial approval of the research, or as otherwise revised;

5.1.2 At a minimum, the REB requires that an application for continuing review be submitted once per year until all of the data has been collected, all contact with participants has concluded and the closure of the research has been acknowledged by the REB;

5.1.3 The REB may determine that the research requires continuing review more frequently than once per year by considering the following:

- The nature of any risks posed by the research,
- The degree of uncertainty regarding the risks involved,
- The vulnerability of the participant population,
- The projected rate of enrolment and estimated research closure date,
- Whether the research involves novel interventions,
- The REB believes that more frequent review is required;

5.1.4 Continuing review applications are due by the deadline for the applicable REB meeting (i.e., the expiry date must be on or after the REB meeting date and prior to the date of the subsequent REB meeting), regardless of the type of review they may undergo;

5.1.5 To assist the Researchers in submitting on time, a courtesy reminder(s) prior to the expiry date may be generated;

5.1.6 The responsible Research Ethics staff reviews the application for completeness, and requests any clarifications, missing documents or other information from the Researcher, as applicable;

5.1.7 The REB may request verification from sources other than the investigator that no material changes have occurred since previous REB review. For example:

- Based on the results of a previous audit or inspection (internal or external),
- Suspected non-compliance,
- Studies involving vulnerable populations,
- Studies involving a potentially high risk to participants,
- Suspected or reported protocol deviations,
- Participant or Research Staff complaints,
- Any other situation that the REB deems appropriate;

5.1.8 The responsible Research Ethics staff will assign the application to the agenda of the next REB meeting if the research meets the criteria for Full Board review;

5.1.9 A summary report of the continuing review applications assigned to the REB meeting may be attached to the REB meeting agenda;

5.1.10 For research that meets the criteria for Full Board review, the REB will discuss the research at a Full Board meeting and will make a decision regarding the continued approval of the research, as well as any other additional determinations regarding the conduct of the research, as applicable.

5.2 Continuing Review by Delegated Review Procedures

5.2.1 When the research received initial approval via delegated review it may undergo delegated review at the time of continuing review;

5.2.2 Research that was previously reviewed by the Full Board may also be reviewed at the time of continuing review using delegated review procedures if the conditions are met;

5.2.3 The responsible Research Ethics staff reviews the continuing review application for completeness, including verification of the currently approved informed consent form(s), and requests any clarifications, missing documents or other information as applicable;

5.2.4 The responsible Research Ethics staff will forward the application to the appropriate REB reviewer;

5.2.5 The reviewer may request additional information or clarification, as necessary, and will make a decision regarding the continued approval of the research and the continued conduct of the research;

5.2.6 Upon reviewing an application that was sent for delegated review, if the reviewer determines that the risks are now greater than minimal, the reviewer will refer the application for review by the Full Board.

5.3 REB Determinations

5.3.1 To grant a continuation of the approval of the research the REB must determine that:

- There have been no material changes to the research or to the informed consent form that have not been previously submitted and approved,
- There is no new conflict of interest or new information that has emerged that might adversely affect the safety or the well-being of participants,
- Risks to participants are minimized and reasonable in relation to the anticipated benefits,
- Selection of participants is equitable,
- Informed consent processes continue to be appropriate and documented,
- Adequate provisions are in place for monitoring and data protection to ensure the safety and privacy of participants and confidentiality and integrity of the data,
- Any complaints from participants have been followed-up appropriately;

5.3.2 The REB may also make additional determinations, including:

- Request changes to the informed consent form(s),
- Request changes for the continuing review interval (based on risks),
- Impose special precautions (e.g., frequency of monitoring, the requirement for interim reports or duration of approval period),
- Require modifications to the research,
- Suspend or terminate REB approval.

5.4 Continuing Review Applications not Received by the Expiry Date

5.4.1 If an application for continuing review is not submitted by the expiry date, a warning or suspension notice will be issued to the Researcher. When suspended, the Researcher must suspend all research activities as specified by the REB. The responsible Research Ethics staff will follow-up with the Researcher to ensure that the application for continuing review is submitted as soon as possible;

5.4.2 In the event of a lapse in approval, the Researcher is responsible for notifying the REB if there is a need to continue research-related medical treatment of current

participants for their safety and well-being. The Researcher should provide as much detail as possible about the proposed continued activities. The REB Chair or designee will review the request as quickly as possible and discuss the proposed continued activities with the Researcher;

5.4.3 The Researcher must document the reasons for the lapse and identify the steps taken to prevent future lapses;

5.4.4 If the REB approval lapses and the Researcher wants to continue with the research, the REB will complete the review of the research as soon as possible and the Researcher may resume the suspended activities once approval of the research has been issued. The lapse in approval will be documented.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP405.001	15-Sept-2014	Original version
SOP405.002	08-Mar-2016	No revisions needed
SOP405.003	08-Oct-2019	No revisions needed
SOP405.004	15-May-2023	No revisions needed

SOP 406.004

Title	**Research Completion**
SOP Code	406.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the procedures for the closure of research with the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or designee is responsible for determining if any of the submitted materials should be reviewed by the Full Board.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

The Completion of research is a change in activity that must be reported to the REB.

Although participants will no longer be at risk under the research, a final report allows the REB to close its files in addition to providing the REB with information that may be used in the evaluation and approval of related studies.

5.1 Determining when Research can be Closed

5.1.1 The Researcher may submit a research closure report to the REB when there is no further participant involvement at the site, all new data collection is complete, and the sponsor closeout activities, if applicable, have been completed;

5.1.2 The responsible Research Ethics staff will review the research closure application and request any outstanding information, clarification or documentation from the Researcher, if needed;

5.1.3 The REB Chair or designee will review the submission and issue a letter of Acknowledgement to the Researcher. The research state will change to "*Closed*";

5.1.4 Once a research project is "*Closed*" with the REB, no further submissions for that research will be permitted; however, if required, the Researcher still may submit relevant documents for acknowledgement and, if applicable, further investigation and/or action may be undertaken by the REB;

5.1.5 If the sponsor requests additional data following the closure of the research, a request for approval shall be made to the REB and the conditions of this request will be determined at the time of the review.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP406.001	15-Sept-2014	Original version
SOP406.002	08-Mar-2016	No revisions needed
SOP406.003	08-Oct-2019	No revisions needed
SOP406.004	15-May-2023	No revisions needed

Title	Suspension or Termination of REB Approval
SOP Code	407.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the procedures associated with the suspension or termination of the Research Ethics Board's (REB) approval of research (including the suspension or termination of approval).

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The REB is responsible for determining whether any information received throughout the course of the research requires the suspension or termination of REB approval for the research being considered.

The Researcher is responsible for notifying the REB and the University of any suspensions or terminations of the research by the Sponsor and for providing a detailed explanation for the action.

The REB Chair or designee is not authorized to terminate REB approval; however, the REB Chair or designee is authorized to suspend REB approval, which must be reported

to the REB at its next Full Board meeting. The REB is authorized to terminate REB approval following its review at a Full Board meeting.

The REB Chair or designee shall notify the Researcher, and the Organizational Official(s), of any suspension or termination of REB approval of the research and has the authority to notify the regulatory authorities (as applicable) and the Sponsor. The REB may delegate regulatory authority reporting to the University.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

As a result of ongoing review activities, the REB may require that research be modified, or may suspend or terminate REB approval if the risks to the participants are determined to be unreasonably high; for example, cases in which there are high numbers of unexpected serious adverse events, or when there is evidence that the Researcher is not conducting the research in compliance with applicable regulations and guidelines. The REB also has the authority to suspend new enrollment while additional information is requested.

A decision to suspend or to terminate the REB's approval of the research must include consideration of the safety, rights and well-being of the participants already enrolled in the research; specifically, how to continue the care of enrolled participants, and how and when the notification to participants of the suspension or termination of the research will take place.

The REB has the authority to suspend or to terminate the REB's approval of the research. The REB Chair or designee has the authority to suspend ethics approval. Any requests to lift a suspension or to re-approve the research must be reviewed by the Full Board.

A Researcher may decide to voluntarily suspend or terminate some or all research activities; however, this is not considered a suspension or termination of REB approval.

5.1 Suspension or Terminations of Research by the Sponsor

5.1.1 The sponsor of the research may suspend or terminate the research (e.g., following results of interim analyses, due to inadequate drug availability, in response to a Data and Safety Monitoring Board (DSMB) recommendation, due to pre-planned stopping criteria, etc.);

5.1.2 The Researcher must immediately notify the REB of any suspensions or terminations of the research and the reasons for the action;

5.1.3 Reports of suspensions or terminations of the research by the sponsor will be forwarded to the REB Chair or designee for review;

5.1.4 If the REB Chair or designee decides to suspend REB approval of the research, he/she must notify the REB at its next Full Board meeting;

5.1.5 If REB approval is suspended, a subsequent review must be conducted and the REB suspension must be lifted prior to resumption of the research following the sponsor's lifting of a suspension.

5.2 Suspension or Termination of REB Approval

5.2.1 If any concerns are raised during the REB's oversight of the research that are related to new information or to the conduct of the research, the REB may suspend or terminate its approval of the research as appropriate. These concerns may include:

- The research not being conducted in accordance with the REB-approved protocol or REB requirements,
- The research is associated with unexpected serious harm to participants (i.e., as may be determined following REB review of reportable events or DSMB reports),
- Falsification of research records or data,
- Failure to comply with prior conditions imposed by the REB (i.e., under a suspension or approval with modifications),
- Repeated or deliberate failure to properly obtain or document consent from participants,
- Repeated or deliberate failure to limit administration of the investigational drug or device to those participants under the Researcher's supervision,
- Repeated or deliberate failure to comply with conditions placed on the research by the REB, by the sponsor, or by regulatory agencies,
- Repeated or deliberate failure to obtain prior REB review and approval of amendments or modifications to the research, or
- Repeated or deliberate failure to maintain accurate research records or submit required reportable event reports to the REB;

5.2.2 The REB Chair or designee is authorized to suspend REB approval of research. If the Chair or designee suspends approval of the research, he/she must notify the REB as per applicable requirements;

5.2.3 The REB is authorized to terminate its approval of the research following a review at a Full Board meeting;

5.2.4 Prior to suspending or terminating REB approval, the REB must consider:

- Risks to current participants,
- Actions to protect the safety, rights and well-being of currently enrolled participants,
- The appropriate care and monitoring of participants,
- Whether withdrawal of enrolled participants is warranted and the specific procedures for their safe withdrawal,
- Whether participants should be informed of the termination or suspension,
- Whether adverse events or outcomes should be reported to the REB,
- Identification of a time frame in which the corrective measures are to be implemented;

5.2.5 The REB Chair or designee will notify the Researcher of any suspensions or terminations of REB approval, and the reasons for the decision;

5.2.6 Unless otherwise stated by the REB, when the REB Chair or designee suspends or terminates ethics approval of the research, no further activities can take place other than the submission of an amendment or reportable events;

5.2.7 If the research is suspended or terminated, the REB Chair or designee will issue a formal letter to the Researcher with the reason(s) for the REB action and the corrective measures proposed by the REB;

5.2.8 If REB approval of a research or if the conduct of the research has been suspended, the suspension may be lifted after corrective actions are completed to the REB's satisfaction.

5.3 Reporting Suspensions or Terminations

The REB Chair or designee will report any suspension or termination of REB approval to the appropriate Organizational Official(s) and has the authority to notify the regulatory authorities (as applicable), and the sponsor. The REB may delegate regulatory authority reporting to the University.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP407.001	15-Sept-2014	Original version
SOP407.002	08-Mar-2016	5.1.5: revised to remove requirement for Full Board review; 5.2.2: revised to remove the requirement to report suspension of approval by the REB Chair/designee at the next Full Board Meeting.
SOP407.003	08-Oct-2019	No revisions required
SOP407.004	15-May-2023	No revisions required

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CAREB ACCER

SOP 408.001

Title	Course-based Review
SOP Code	408.001
Effective Date	

Site Approvals

Name and Title	Signature	Date dd/mm/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the review procedure for research that will be conducted for pedagogical purposes as part of a student's course.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) and non-REB reviewers that review human participant research in compliance with applicable policies and guidelines.

3.0 RESPONSIBILITIES

All REB members, Research Ethics staff and non-REB reviewers are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or designee or REB member(s) or non-REB reviewer(s) is responsible for conducting the course-based delegated review.

The REB Chair or designee is responsible for oversight of the research undergoing course-based delegated review.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REBs should adopt a proportionate approach to ethics review based on the general principle that the more invasive or risky the proposed and ongoing research, the greater the care in its assessment. Full Board review by the REB shall be the default requirement for all research involving human participants unless the REB decides to authorize delegated review based primarily on foreseeable risks of harm anticipated to arise from the research. While all research must be reviewed adequately, provisions for proportionate review allow the REB to reserve a higher level of scrutiny, and correspondingly more protection, for more ethically challenging research.

When research will be conducted by a student as part of a course, for pedagogical purposes only (e.g., to learn how to conduct research), the institution may decide that ethics review can be conducted through the delegated review procedure by an REB member or by a non-REB reviewer at the institution's department or equivalent level.

In delegating ethics review of course-based research, the REB should carefully select REB member(s) or non-REB reviewer(s) and ensure that they have the appropriate experience, expertise, training and resources required to review the ethical acceptability of all aspects of the proposal in accordance with this Policy.

Research undergoing the course-based review procedure must meet the criteria for delegated review. Greater than minimal risk course-based research cannot use the course-based review procedure and must be reviewed by the Full Board.

5.1 Course-Based Review Process

5.2.1 Research Ethics staff will perform an initial screening of the submission. If the submission covers research activity within a recognized course (with valid course code) for a pedagogical purpose, the submission is then screened against a pre-defined set of criteria for delegated review as determined by the REB. If the submission meets the delegated review criteria, it may be forwarded for course-based review.

5.2.2 For research that meets the criteria, course-based review may be conducted by an REB member or a non-REB reviewer who has the appropriate experience, expertise, training and resources as an REB member;

5.2.3 The non-REB reviewer reviewing research under course-based review must not have a conflict of interest in the research;

5.2.4 In reviewing the research under course-based procedures, the non-REB reviewer may exercise all of the authorities of the REB, except that he/she may not disapprove the research; the research may be disapproved only by the REB at a Full Board meeting;

5.2.5 If the non-REB reviewer subsequently determines that the level of risk for the submission is greater than minimal, the submission will be referred to a Full Board meeting for review;

5.2.6 The decision regarding the designation of the research (i.e., course-based or FB review) and the outcome of the review will be recorded. The responsible Research Ethics staff may issue the review letter or decision.

5.3 Reporting to the REB

5.3.1 At minimum once per year, the REB will be informed of research that was reviewed and approved using course-based review procedures.

5.4 Documentation

5.4.1 The type of REB review conducted (i.e., course-based or FB review) is documented in the REB records and noted in the decision issued to the Researcher, where appropriate;

5.4.2 The REB annual report will include a list of submissions that were reviewed and approved using delegated review procedures.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP408.001		Original version

Title	REB Review During Publicly Declared Emergencies
SOP Code	501.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the research ethics review procedures during a publicly declared emergency.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

A publicly declared emergency is an emergency situation that, due to the extraordinary risks it presents, has been proclaimed as such by an authorized public official in accordance with legislation and/or public policy. Publicly declared emergencies arise

suddenly or unexpectedly and require urgent or quick responses. Examples include natural disasters, large communicable disease outbreaks, environmental disasters and humanitarian emergencies. Such emergencies may represent significant risks for participants in ongoing research or in new research initiated as a result of the emergency. Potential participants who may not normally be considered vulnerable may become so by the very nature of the public emergencies, while those already vulnerable may become acutely so.

During publicly declared emergencies, the REB must have established procedures to continue to provide the necessary research ethics oversight. Research ethics review during publicly declared emergencies may necessitate the use of innovative practices. Depending upon the nature of the emergency, for example, REBs might not be able to meet in person, and delegated review procedures may have to be designed to respond to either urgent opportunities for new research or to current ongoing research. The existence of an emergency does not override established procedures to protect the welfare of participants. Any relaxation of the usual procedural requirements for review should be proportionate to the complexity and urgency of the emergency, as well as to the risks posed by the research under review. Any modifications that are made in the application of research ethics policies and procedures during a publicly declared emergency must be documented and appropriately justified.

5.1 Determining the Level of Impact

5.1.1 Subsequent to an officially publicly declared emergency, the REB Chair or designee will assess the level of impact on the research ethics review processes;

5.1.2 There are three levels of impact that may influence how ethics review will be conducted during the publicly declared emergency:

- **Mild** – little or no impact,
- **Moderate** – some impact; decisions to proceed at the discretion of the Chair or designee, in consultation with the Researcher, as necessary,
- **Severe** – extremely debilitating to normal research ethics review procedures;

5.1.3 The REB Chair or designee will use the level of impact to guide the review of research submissions during the publicly declared emergency;

5.1.4 Pending the determination of the level of impact on the review of ongoing or new research, the currently established ethics review procedures should be followed.

5.2 Emergency Preparedness Procedures

5.2.1 Subsequent to an officially publicly declared emergency, temporary ethics review processes may be instituted;

5.2.2 When the impact on the ethics review processes is deemed to be severe, teleconferences or videoconferences may be used to conduct REB meetings;

5.2.3 When the impact on the ethics review processes is deemed to be severe, the Research Ethics staff may conduct their activities remotely (via remote email and voice mail access), with minimal disruption of services;

5.2.4 The REB Chair or designee may suspend the currently established REB meeting Quorum, in which case an REB subcommittee would be established for the duration of the publicly declared emergency;

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5.2.5 The REB subcommittee composition should be in accordance with the standard REB membership requirements and should include at least five members drawn from the existing REB membership;

5.2.6 The current REB Chair or designee should serve as the Chair of the REB subcommittee;

5.2.7 At their discretion, the REB subcommittee Chair or designee may invite individuals with expertise in special areas to assist in the review of issues that require expertise beyond that available to the REB subcommittee; however, ad hoc advisors may not contribute directly to the subcommittee's decision and their presence shall not be used in establishing a Quorum;

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Deleted: quorum

5.2.8 When the impact is deemed to be severe, the REB Chair or designee may refer the ethics review and research oversight of new and ongoing research to another REB, subject to the applicable regulations and agreements;

5.2.9 Where research submissions are deemed to be more than minimal risk and subject to applicable regulations, the REB Chair or subcommittee Chair or designee will use their judgment in determining the type of review required (delegated or Full Board), taking into account the severity of the impact of the emergency and the complexity and urgency of the submission;

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5.2.10 Any modifications that are made in the application of research ethics policies and procedures during a publicly declared emergency must be documented and appropriately justified;

5.2.11 The REB Chair or designee should periodically assess the impact of the emergency on the ethics review processes and adjust any temporary ethics review processes accordingly;

5.2.12 Any modifications that are made in the application of research ethics policies and procedures during a publicly declared emergency will cease as soon as is

feasible after the emergency has officially ended (i.e., as declared by an authorized public official). The REB Chair or designee will determine when to resume routine ethics review processes;

5.2.13 All delegated approvals of research following a publicly declared emergency must be assessed to determine if subsequent Full Board review is required at the first opportunity subsequent to the cessation of the publicly declared emergency;

5.2.14 At the conclusion of the publically declared emergency, the REB Chair or designee and the Research Ethics staff should work with the REB subcommittee members to evaluate the effectiveness of its declared emergency procedures and to make recommendations for improvements.

5.3 Review of Ongoing Research NOT Related to or Arising from the Publicly Declared Emergency

5.3.1 When the impact of the publicly declared emergency on ethics review is determined to be mild to moderate, the following will apply to the review of ongoing research:

- The REB Chair or designee will determine if the research needs to continue, or if it can be postponed until after the emergency is over,
- The research may continue at the discretion of the REB Chair or designee in consultation with the Researcher, as necessary,
- Researcher's response to REB reviews, major amendments, and adverse events will be prioritized for review,
- Continuing reviews will receive the next priority for review, followed by research completion reports,
- Other submissions will be reviewed as time allows;

5.3.2 When the impact of the publicly declared emergency on ethics review is determined to be severe, the following will apply to the review of ongoing research:

- Research activities not involving, or no longer involving, recruitment or direct contact with participants may continue,
- Research activities involving recruitment or direct contact with participants may only continue if ceasing such activity might pose significant risks to participant safety,
- Major amendments and adverse events related to these studies will be reviewed by the REB subcommittee or the REB subcommittee Chair or designee, as appropriate;

5.3.3 At the REB Chair or designee's discretion, and subject to applicable regulations, review procedures may be delayed or temporarily suspended depending upon volume. In such cases, research shall be deemed to have continuing approval until such time that the REB is able to conduct its review.

5.4 Review of New Research NOT Related to or Arising from the Publicly Declared Emergency

5.4.1 When the impact of the publicly declared emergency on ethics review is determined to be mild to moderate, the REB Chair or designee will determine whether review of any new research not related to the publicly declared emergency may proceed or will be postponed until after the emergency is over;

5.4.2 When the impact of the publicly declared emergency on ethics review processes is determined to be severe, any new research not related to the publicly declared emergency will not be reviewed until the emergency is declared to be over.

5.5 Review of Research RELATED to or Arising from the Publicly Declared Emergency

5.5.1 If a request to review research related to a publicly declared emergency is received, it will be directed to the REB Chair or REB subcommittee Chair or designee, as applicable;

5.5.2 The REB Chair or designee will assess the risks associated with the proposed research, as well as aspects of the research that might require enhanced scrutiny or diligence, taking into account the severity of the impact of the emergency on ethics review processes;

5.5.3 When the impact of the publicly declared emergency on ethics reviews is determined to be mild to moderate, research related to the publicly declared emergency has priority for review;

5.5.4 When the impact of the publicly declared emergency on ethics review is determined to be severe, time-sensitive review processes may be followed, such as delegated review as appropriate, review by an REB subcommittee, and/or meetings conducted via teleconference or videoconference.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP501.001	15-Sept-2014	Original version
SOP501.002	08-Mar-2016	No revisions needed
SOP501.003	08-Oct-2019	No revisions needed
SOP501.004	15-May-2023	No revisions needed

SOP 601.004

Title	Communication – Researcher
SOP Code	601.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the Research Ethics Board's (REB) communication with the Researcher and with their research team.

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2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

In the interest of enhancing human participant protection, it is important for the REB to foster collaboration and open communication between and among the REB, Researcher, research staff, and University representatives. This applies not only to

communication related to a specific research project, but also to communication related to ethical issues and REB processes, policies and procedures.

All Researchers participating in REB approved research shall be informed, in writing, of all determinations made by the REB regarding specific research.

Feedback from Researchers should be encouraged and should be considered as an opportunity to review and to improve the function of the REB and of Research Ethics procedures.

In order to facilitate clear and accurate communication with Researchers and research staff, the REB will follow standardized notification and documentation procedures.

5.1 Notification of REB Decisions

5.1.1 The REB will notify the Researcher and/or their research staff of the REB's decision in a timely manner, following the review (i.e., from the REB meeting or delegated review date) of new research, modifications, or amendments to currently approved research, applications for continuing review or reportable events;

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5.1.2 The determinations of the REB will be summarized noting any concerns or requests for clarification including recommended changes to the consent form, and clarifying the reasons for the disapproval of the submission (when appropriate);

5.1.3 If the research does not receive initial approval or is denied re-approval (for continuing review), the REB Chair or designee will notify the Researcher of the REB's decision as soon as possible following the REB meeting. Formal written notification will follow;

5.1.4 The REB Chair or designee will review the draft REB review letter, make revisions as necessary, and will indicate their approval;

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5.1.5 The REB review letter will be issued to the Researcher(s);

5.1.6 The Researcher will be asked to include the REB number or equivalent designation assigned to the research in all subsequent correspondence with the REB;

5.1.7 Upon receipt of the Researcher response to the REB review letter, the REB will follow-up with the Researcher and/or their staff to request any additional clarifications as needed, or as requested by the REB Chair or designee, or the reviewers;

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5.1.8 Once all of the REB conditions are satisfied, the REB will issue an approval letter.

5.2 Researcher Appeal of REB Decision

5.2.1 A Researcher may request a reconsideration or appeal the decision of the REB and/or any of the revisions to the research requested by the REB;

5.2.2 Appeals are conducted in accordance with established organizational policy at the applicable organization;

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5.2.3 Only the REB may lift a restriction or re-review previously disapproved research. Delegated review procedures may not be used.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP601.001	15-Sept-2014	Original version
SOP601.002	08-Mar-2016	No revisions needed
SOP601.003	08-Oct-2019	5.1.1: 'within a time frame specified by the REB' changed to 'in a timely manner.'
SOP601.004	15-May-2023	No revisions needed

SOP 602.004

Title	Communication –Participants
SOP Code	602.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the Research Ethics Board's (REB) communication with participants.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Participants should be able to voice their concerns, questions and request information regarding their participation or potential participation in research, in confidence, to an informed individual on the REB or in Research Ethics.

5.1 Communication with Participants

5.1.1 Participants are encouraged to contact (by telephone or in writing) Research Ethics with questions and concerns, using the contact information provided in the informed consent document(s). The identity of the participant will be shared with the REB chair and with the organization's appropriate representative, if applicable, and if the participant provides their consent;

5.1.2 The Research Ethics staff must document all communication with the participant;

5.1.3 The Research Ethics staff will communicate participant concerns to the REB Chair or designee;

5.1.4 The REB Chair or designee works to resolve participant issues which may include a follow-up with the Researcher or the Researcher's supervisor or other University representative, and with appropriate federal agencies, as applicable;

5.1.5 The REB Chair or designee documents all communication with the participant and a de-identified record of this communication is maintained securely and in the relevant research file.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP602.001	15-Sept-2014	Original version
SOP602.002	08-Mar-2016	No revisions needed
SOP602.003	08-Oct-2019	5.1.1: revision of last sentence including deletion of, 'if requested' and 'will not be recorded,' new language bolded: '~~If requested~~ The identity of the participant will ~~not be recorded~~ **be** shared **with the REB chair and with the organization's appropriate representative if applicable, and if the participant provides their consent**'.

SOP 602.004

SOP Code	Effective Date	Summary of Changes
SOP602.004	15-May-2023	No revisions required

Title	**Informed Consent Form Requirements and Documentation**
SOP Code	701.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the requirements for the informed consent form and the process for waiving or obtaining and documenting initial and ongoing informed consent.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

The Researcher is responsible for providing the REB with a detailed description of the rationale for a consent waiver or the consent documents and a description of the consent process. The Researcher also is responsible for providing a description of the recruitment methods and recruitment materials (if applicable).

When a written informed consent form is used, the Researcher, the research sponsor and the REB are jointly responsible for ensuring that the consent form contains all of the basic elements of consent and the applicable additional elements of consent. The REB is responsible for verifying that the consent form (if applicable) contains the required elements.

The REB is responsible for determining whether informed consent exemptions or waivers are applicable and appropriate.

The REB Chair or designee is responsible for reviewing consent forms or changes to consent forms if the changes meet the criteria for delegated review.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

5.1 REB Review of Required Elements of Informed Consent

5.1.1 The REB members will review the proposed consent process for appropriateness, and the proposed consent form(s) for general readability, for appropriateness of the language and content and for the inclusion of the applicable elements per the organization's guidelines and all applicable regulations;

5.1.2 The REB will review the proposed consent form to ensure that it contains adequate information to safeguard the privacy and confidentiality of participants;

5.1.3 The REB may require a separate consent form for optional procedures or sub-studies (e.g., tissue, blood, genetic testing or specimen banking);

5.1.4 Following the review, the REB may approve the consent form(s) as submitted or require changes;

5.1.5 When changes are required by the REB and are made by the Researcher, the REB or designee will review the consent form(s) to confirm that the required changes have been made and that the version date has been updated;

5.1.6 When the changes meet the criteria for delegated review, the revised consent will be provided to the REB Chair or designee for review and approval;

5.1.7 When changes do not meet the criteria for delegated review, the revised consent form will be reviewed at the next Full Board meeting.

5.2 Translation of Informed Consent Documents

5.2.1 The informed consent document should be in language understandable to the participant (or acceptable representative);

5.2.2 When a participant is non-English or French speaking, documentation of informed consent can be by one of two methods:

- **Written consent**: The REB approved English/French version of the informed consent document is translated into the participant's native language. The REB may require that translated informed consents be accompanied by an attestation from a translator certifying that the translated informed consent accurately reflects the REB approved English informed consent. This method is preferred if it is anticipated that a significant percentage of a prospective research population is non-English speaking. A translated informed consent document does not replace the need for an interpreter to be present during the consent process and throughout the research. The participant will sign the translated version of the informed consent form document,
- **Oral consent**: If applicable/acceptable, a qualified interpreter fluent in both English/French and the participant's native language orally interprets the REB approved English /French consent form to the participant. The interpreter should be an impartial person. When the person obtaining consent is assisted by an interpreter, the interpreter must sign and date the consent form;

5.2.3 If a participant is unable to read, an impartial witness must be present during the entire informed consent discussion. Verbal consent is obtained from the participant after the informed consent document and any other written information is read and explained to the participant. Signatures will be obtained from the participant (if capable) and the impartial witness on the informed consent document, where applicable. The signature of the impartial witness attests that the information was accurately explained to, and apparently understood by, the participant, and that informed consent was freely given by the participant;

5.2.4 The REB requires that the translated informed consent materials be submitted for review and approval prior to use in enrolling non-English/French-speaking participants. The REB may require that the Researcher include a certificate or statement signed by the translator indicating that the translated materials are a true and accurate translation of the REB approved English materials;

5.2.5 The REB may follow delegated review procedures to review and approve translated informed consent materials if the English language materials have already been approved (particularly if a signed translation certificate or statement is on file);

5.2.6 An interpreter should be available to the participant throughout the research;

5.2.7 The interpreter must sign and date the consent form attesting that the research was accurately explained to, and appeared to be understood by, the participant.

5.3 Consent Update for Ongoing and Completed Participants

5.3.1 The Researcher must inform participants of any new information that might affect their willingness to continue their participation in the research or that may affect their long term health even if they have completed their participation in the research, including those who have withdrawn or been removed from the study;

5.3.2 The Researcher must obtain the currently enrolled participant's consent to continue to participate if there is a significant change to the research or risk;

5.3.3 If required, written documentation of ongoing consent for currently enrolled participants may be obtained by having the participant sign an REB approved consent document containing the updated information;

5.3.4 If applicable, ongoing consent may be obtained orally by contacting the participant by phone, providing the updated information, and documenting their agreement to continue;

5.3.5 The nature of the provision of the new information to currently enrolled participants and the documentation required will be determined by the REB;

5.3.6 The Researcher must inform former participants of any new information that may be relevant to their long-term health by contacting them via phone or mail or in person, as applicable.

5.4 Recruitment Methods

5.4.1 **Researcher's Patients: If** the patient is under the care of the Researcher, the Researcher may approach the patient directly, but in such a manner that the patient does not feel pressured or obligated in any way. In this instance, the patient's consent should be obtained by an individual other than the Researcher. Any exceptions to this procedure must be appropriately justified and submitted to the REB for review;

5.4.2 **In circumstances where the Researchers will obtain consent:** The Researcher must ensure that the consent has been obtained without undue coercion or influence and that there is no likelihood of therapeutic misconception, if applicable;

5.4.3 **Referrals: The** Researcher may send a letter to colleagues asking for referrals of potential patients. The Researcher may provide colleagues with an REB approved consent form or research information sheet to give to their patients. The patient will then be asked to contact the Researcher directly, or, with documented permission from the patient, the Researcher may initiate the call;

5.4.4 **Health Records Department: The** Researcher may ask the Health Records Department to identify patients who appear to meet the research's eligibility criteria. The Researcher should supply Health Records with a standard letter describing the research to give the patient's physician, and asking whether the physician would be willing to approach their patients about participation. It is NOT acceptable for the Researcher or their staff to contact patients identified through hospital records, clinic charts or other databases independently by phone, unless the patient has previously agreed, or is already under the medical care of the Researcher;

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5.4.5 **Registries: If** the REB has previously approved a patient research registry and the patient has provided permission to be contacted for potential research, the Researcher or their research team may contact these patients directly. The person contacting the patient should identify him/herself as associated with the patient's clinical caregiver, and remind the patient that they have agreed to be contacted. The patient must be offered the option of having their name removed the database;

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5.4.6 **Advertising: The** REB must first review and approve the text and the use of any advertisements, notices or media messages.

5.5 Recruitment Materials

5.5.1 The REB reviews the recruitment materials (e.g., advertisements, letters, notices) for evidence of coercion or undue influence and consistency with the REB approved research and informed consent document;

5.5.2 Advertisements should be reviewed by the REB, as applicable, and according to REB requirements;

5.5.3 All recruitment materials must be approved by the REB and by each organization where the recruitment material will be displayed, as per local practice prior to their use.

5.6 Documentation of Informed Consent

5.6.1 The REB typically requires documentation of informed consent by the use of a written informed consent form approved by the REB and signed and dated by the participant or the participant's legally acceptable representative, and by the person obtaining consent;

5.6.2 As required by the Research Sponsor or if required by University policies, the Researcher must also sign and date the informed consent form for clinical trials;

5.6.3 A copy of the signed and dated consent form shall be provided to the participant;

5.6.4 The Researcher or designee should document details of the consent process in the participant's medical record, according to the organization's guidelines;

5.6.5 The Researcher should inform the participant's primary physician about the research participant's involvement in the research if the participant agrees to the primary physician being informed;

5.6.6 The REB may approve a short form written consent document in cases where the participant may lack the capacity to consent. The short form consent form contains all required elements of informed consent. A written summary of the information in presented orally to the participant or their substitute decision maker. The short form consent document is signed by the participant or the substitute decision maker. An impartial witness must be present during the oral presentation. The witness must sign both the short form consent document and a copy of the written summary. The person obtaining consent must sign a copy of the written summary of the information that is

presented orally;

5.6.7 The REB may approve a process that allows the informed consent document to be delivered by regular mail, email or facsimile to the potential participant, and to conduct a consent interview by telephone or videoconference when the participant can read the consent document as it is discussed. All other applicable conditions for documentation of informed consent must also be met when using this procedure;

5.6.8 In some types of research, and for some groups or individuals where written signed consent may be felt by the participants as mistrust on the part of the Researcher, the REB may approve the process of oral consent, a verbal agreement or a handshake;

5.6.9 Where consent is not documented in a signed consent form, Researchers may use a range of consent procedures (e.g., oral consent, field notes, implied consent through the return of a completed questionnaire). The procedures used to seek consent must be documented by the Researcher and approved by the REB;

5.6.10 Whenever possible, the participant should have written documentation of participation in a research project unless it may compromise their safety or confidentiality.

5.7 Consent Monitoring

5.7.1 In considering the adequacy of informed consent procedures, the REB may require monitoring of the consent process by an impartial observer;

5.7.2 Such monitoring may be particularly warranted when the research presents significant risks to participants, or if participants are likely to have difficulty understanding the information to be provided;

5.7.3 Monitoring may also be appropriate as a corrective action when the REB has identified problems associated with a particular Researcher or a research project.

5.8 Waiver or Alteration of Informed Consent

5.8.1 The REB may approve a consent procedure that does not include, or which alters, some or all of the elements of informed consent, or waive the requirements to obtain informed consent, provided that the REB finds and documents that:

- The regulatory and ethics guidance framework supports the waiver,
- The research involves no more than minimal risk to the participants,
- The waiver or alteration is unlikely to adversely affect the rights and welfare of the participants,
- The research could not practicably be carried out without the waiver or alteration,
- The precise nature and extent of any proposed alteration is defined,
- The information is used in a matter that will ensure its confidentiality,
- Whenever appropriate, the participants will be provided with additional pertinent information after participation;

5.8.2 Debriefing should be a part of all research involving an alteration to consent requirements whenever it is possible, practicable and appropriate;

5.8.3 Participants should have the opportunity to refuse consent and request the withdrawal of their data and/or specimens whenever possible, practicable and appropriate;

5.8.4 These findings and their justifications shall be clearly documented in the REB minutes when the REB exercises this waiver provision;

5.8.5 Researchers are not required to seek participant consent for secondary use of non-identifiable information or non-identifiable biological specimens.

5.9 Consent for Research Involving Individuals Who Lack Capacity

5.9.1 For research involving individuals who lack capacity, either permanently or temporarily, to decide for themselves whether to participate, the REB must ensure that at a minimum the following conditions are met:

- The Researcher involves participants who lack the capacity to consent on their own behalf to the greatest extent possible in the decision-making process,
- The Researcher seeks and maintains consent from authorized third parties,
- The authorized third party is not the Researcher or any other member of the research team,
- The Researcher demonstrates that the research is being carried out for the participant's direct benefit or for the benefit of other persons in the same category. If the research does not have the potential for direct benefit to the participant, the Researcher shall demonstrate how the research will expose the participant to only a minimal risk and how the participant's welfare will be

protected during participation in the research;

5.9.2 If an authorized third party has consented on behalf of a person who lacks legal capacity but that person has some ability to understand the significance of the research, the Researcher ascertains the wishes of that individual with respect to participation;

5.9.3 Assent from a participant is not sufficient to permit them to participate in a research project in the absence of consent by an authorized third party; however, their expression of dissent is respected;

5.9.4 Prospective participants who may be capable of verbally or physically assenting to, or dissenting from, participation in research include:

- Those whose capacity is in the process of development, such as children whose capacity for judgment and self-direction is maturing,
- Those who were once capable for making an autonomous decision regarding consent but whose capacity is diminishing or fluctuating, and
- Those whose capacity remains only partially developed, such as those living with permanent cognitive impairment;

5.9.5 If assent for research is required, the Researcher must submit to the REB the proposed procedures for obtaining consent from the capable substitute decision maker and assent from the participant. The Researcher must submit an assent form or summary of the assent process to the REB for approval as per the organization's guidelines;

5.9.6 When authorization for participation was granted by an authorized third party, and the participant acquires or regains capacity during the research, the Researcher will seek the participant's consent as a condition of continuing participation;

5.9.7 If an individual signed a research directive indicating their preference for ongoing and/or future participation in research, in the event that the individual loses capacity or upon their death, an authorized third party may be guided by these directives during the consent process.

5.10 Other Individuals and Groups who may be Vulnerable in the Context of Research

5.10.1 The REB will determine appropriate protections for individuals and groups who might be inappropriately excluded from research on the basis of attributes such as culture, language, sex, race, ethnicity, age and disability, and who require

additional protections. For these individuals and groups, the REB will take into account the risks and benefits of the research, and will consider protections afforded by University policies, and provincial and federal law.

Other individuals or groups whose circumstances may make them vulnerable in the context of research should not be inappropriately included or automatically excluded from participation in research on the basis of their circumstances;

5.10.2 In addition, when the REB regularly reviews research involving individuals, groups or populations who may be vulnerable in the context of research, consideration shall be given to the inclusion of one or more individuals who are knowledgeable and experienced in working with these participants.

Participants may include, but are not limited to:

- Children,
- The Elderly,
- Individuals with mental illness,
- Pregnant women,
- Individuals with limited language skills,
- Indigenous individuals and communities,
- Prisoners;

5.10.3 If research involves prisoners, children, pregnant women, fetuses and/or neonates, and is funded or supported by the US Federal Government, the REB shall apply the requirements of 45 CFR 46, including as appropriate, Sub-Parts, B, C and D.

5.11 Consent for Research in Health Emergencies

5.11.1 The REB establishes the criteria for the conduct of research involving medical emergencies prior to approval of the research. The Researcher must justify to the REB the reasons why an exception to obtaining informed consent from participants is required;

5.11.2 The REB allows research that involves health emergencies to be carried out without the free and informed consent of the participant or of their authorized third party if ALL of the following apply:

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- A serious threat to the prospective participant requires immediate intervention,
- Either no standard efficacious care exists or the research offers a real possibility of direct benefit to the participant in comparison with standard care,
- Either the risk of harm is not greater than that involved in standard therapeutic

care, or it is clearly justified by the potential for direct benefit to the participant,
- The prospective participant is unconscious or lacks capacity to understand risks, methods and purposes of the research project,
- Third-party authorization cannot be secured in sufficient time, despite diligent, and documented efforts to do so, and
- No relevant prior directive by the participant is known to exist;

5.11.3 When a previously incapacitated participant regains capacity, or when an authorized third party is found, free and informed consent is sought for continuation in the project and for subsequent research-related procedures.

5.12 Consent and Secondary Use of Identifiable Information and/or Human Biological Materials for Research Purposes

5.12.1 The REB allows the secondary use of identifiable information and/or human biological materials for research purposes without obtaining consent from participants if the Researcher is able to satisfy the following conditions:

- Identifiable information/materials is essential to the research,
- The use of identifiable information/materials without the participant's consent is unlikely to adversely affect the welfare of individuals to whom the information relates,
- The Researchers will take appropriate measure to protect the privacy of individuals, and to safeguard the identifiable information/materials,
- The Researchers will comply with any known preferences previously expressed by individuals about any use of their information/materials,
- It is impossible or impracticable to seek consent from individuals to whom the information relates/materials were collected, and
- The Researchers have obtained any other necessary permission for secondary use of information/materials for research purposes;

5.12.2 In cases where the secondary use of identifiable information/materials without the requirement to seek consent has been approved by the REB, if the Researcher proposes to contact individuals for additional information and/or materials, REB approval must be obtained prior to contact.

5.13 Incidental Findings

5.13.1 Within the limits of consent provided by the participant, researchers shall disclose any material incidental findings discovered in the course of research. The Researcher's plan to identify and to disclose incidental findings must be submitted to the REB and approved prior to implementation.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP701.001	15-Sept-2014	Original version
SOP701.002	08-Mar-2016	No revisions needed
SOP 701.002_1	08-Mar-2017	5.8.1 : removal of the criteria for a waiver that excludes a study with a therapeutic intervention; addition of 'The precise nature and extent of any proposed alteration is defined,' 5.8.2 : addition of 'Debriefing should be a part of all research involving an alteration to consent requirements whenever it is possible, practicable and appropriate'; 5.8.3 : addition of 'Participants should have the opportunity to refuse consent and request the withdrawal of their data and/or specimens whenever possible, practicable and appropriate'; 5.8.5: addition of 'Researchers are not required to seek participant consent for secondary use of non-identifiable information or non-identifiable biological specimens.'
SOP 701.003	08-Oct-2019	5.3.1: addition of, 'including those who have withdrawn or been removed from the study'; 5.10: revised Title to state '**Individuals and Groups who may be Vulnerable in the Context of Research;** 5.10 : 5.10.1; 5.10.2 revised language for consistency with TCPS2 updated definition of vulnerable participants - i.e., vulnerable in the context of the research; 5.10.1 : addition of, 'Other individuals or groups whose circumstances may make them vulnerable in the context of research should not be inappropriately included or automatically excluded from participation in research on the basis of their circumstances'; 5.10.2: revision of ' involving a vulnerable population'

SOP Code	Effective Date	Summary of Changes
		to 'involving individuals, groups or populations who may be vulnerable in the context of research'; deletion of ' Potentially vulnerable groups' in heading and change to 'Participants'; bullet #6: change to Indigenous from Aboriginal; 5.13.1: revision from, 'Researchers have an obligation to disclose to the participant any material incidental findings discovered in the course of research.' to, 'Within the limits of consent provided by the participant researchers shall disclose any material incidental findings discovered in the course of research.'
SOP 701.004	15-May-2023	5.2.2: addition of French 5.6.3 addition of "and dated" as per GCP 4.8.11? "*Prior to participation in the trial, the subject or the subject's legally acceptable representative should receive a copy of the signed and dated written informed consent form and any other written information provided to the subjects*"

SOP 801.004

Title	Researcher Qualifications and Responsibilities
SOP Code	801.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the qualifications and responsibilities of the Researcher who engages in research involving human participants.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All Researchers, REB members and Research Ethics staff are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Research involving human participants must be conducted by individuals appropriately qualified by education, training, and experience to assume responsibility for the proper conduct of the research and for the protection of human participants. The

REB must have assurance that the qualifications of new Researchers, for the conduct of research, are appropriate.

Researchers are required to conduct the research in compliance with applicable regulations and guidelines, and to comply with all REB policies.

5.1 Researcher Qualifications

5.1.1 The Researcher must make available to the REB their current CV and medical license number (if applicable) and their relevant training and experience, in sufficient detail for the REB to make an objective judgment regarding the Researcher's qualifications, if necessary;

5.1.2 If applicable, the Researcher must be a physician with a specialty qualification in their field and with current professional qualifications entitling them to provide health care under the applicable laws;

5.1.3 The Researcher must have completed appropriate training regarding the requirements of conducting and overseeing research;

5.1.4 If applicable, all specified Organizational Officials must approve the application to the REB;

5.1.5 The University approver's signature attests that:

- He/she is aware of the proposal and supports its submission for REB review,
- The application is considered to be feasible and appropriate,
- Any internal requirements have been met,
- The Researcher is qualified and has the experience and expertise to conduct this research,
- The Researcher has sufficient space and resources to conduct this research;

5.1.6 Any concerns raised in the REB review of the Researcher's qualifications will be communicated to the Researcher and must be satisfied prior to REB approval of the application.

5.2 Researcher Responsibilities

5.2.1 The Researcher is responsible for complying with the decisions and responsibilities set out by the REB. In addition, it is the Researcher's responsibility to comply with all applicable regulations and ensure that (if applicable):

- He/she and their staff members are appropriately qualified by education, training and experience to assume responsibility for the proper conduct of the research and for protection of human participants,
- He/she has adequate resources to properly conduct the research and conducts the research following written SOPs,
- All real, potential, or perceived conflicts of interest are declared to the REB at the time of the initial application, and as they arise,
- The REB review and approval is obtained before engaging in research involving human participants,
- All necessary documentation is signed by the responsible Researcher, as applicable,
- Informed consent, when required, is obtained from participants in accordance with applicable regulations prior to their enrollment into the research, and using the most current informed consent document(s) approved by the REB (as applicable),
- He/she personally conducts or supervises the described investigation(s),
- The research is conducted in compliance with the approved research and applicable reporting criteria are reported to the REB, including deviations, serious, unexpected adverse events and privacy breaches,
- Any changes in the approved research are not initiated without REB review and approval, except where necessary to eliminate an immediate hazard(s) to the participant(s),
- Premature termination or suspension of the research is reported to the REB;
- Accurate and complete records are maintained according to applicable regulatory requirements,
- Written summaries of the research status are submitted to the REB at least annually, or more frequently if required by the REB, and an application for continuing review is submitted to the REB prior to the expiration of REB approval,
- Any other unexpected finding or new research knowledge that could affect the risk/benefit ratio of the research is reported to the REB,
- The REB is notified if there is a change in Researcher,
- The REB is notified immediately if their medical or dental license or hospital privileges are suspended, restricted or revoked (if applicable) or should their qualifications otherwise no longer be appropriate,
- The REB is notified when the research is complete;

Note: (if applicable) the obligations of a Researcher holding a Clinical Trial Application (CTA) with Health Canada (i.e., sponsor-Researcher) include both those of a sponsor and those of a Researcher.

5.2.2 The University is responsible for maintaining current CVs and medical licenses (if appropriate) for each of its Researchers. The University is responsible for immediately advising the REB should it become aware of any information that would indicate that the qualifications of the Researcher may no longer be appropriate.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP801.001	15-Sept-2014	Original version
SOP801.002	08-Mar-2016	No revisions needed
SOP801.003	08-Oct-2019	No revisions needed
SOP801.004	15-May-2023	Replaced his/her with their

SOP 901.004

Title	**Quality Assurance Inspections**
SOP Code	901.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the processes for monitoring, evaluating and improving the effectiveness of the human research protection enterprise.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members, Research Ethics staff and the Director, Research Ethics, are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Quality Management programs, Quality Assurance (QA), and Quality Control (QC) activities, such as inspections of the REB and of Researchers, allow for a continuous evaluation and subsequent assurance of the human research protection enterprise.

Findings are measured against established policies and procedures and all of the applicable ethical, legal, and regulatory requirements. When areas for improvement are identified, corrective action is taken including training, education, and the revision of SOPs.

5.1 REB Quality Assurance Inspections (Internal)

5.1.1 The QA Officer will develop a schedule for routine QA inspections or initiate ad hoc inspections in response to complaints or other concerns;

5.1.2 QA inspections may include the REB and Research Ethics;

5.1.3 When the QA Officer conducts a QA inspection of the REB and Research Ethics the inspection may including the following:

- An assessment of the SOPs and compliance with applicable regulations and guidance,
- A review of research files, REB membership rosters, REB attendance records, and REB agendas and minutes,
- A review of workload, performance metrics and annual reports,
- A review of stakeholder satisfaction surveys,
- An assessment of quality control procedures for compliance with the SOPs,
- A review of checklists, forms, and templates,
- Interviews with REB members, Research Ethics staff, Researchers, sponsors, and regulators,
- A review of training/education records,
- A review of all continuous improvement activities,
- An assessment of whether any new requirements (ethical, legal, or regulatory) were incorporated into the policies and procedures,
- A review of the status of any corrective action items from previous reviews,
- A review of any deviations from ethical, legal, or regulatory requirements, or deviations from the organization's policies, and whether the deviations require remediation,
- An assessment of compliance with all applicable requirements;

5.1.4 The QA Officer compares the findings against established policies, SOPs and applicable ethical, legal, and regulatory requirements;

5.1.5 The QA Officer prepares a written summary of the inspection, including areas requiring improvement;

5.1.6 The QA Officer reports the findings to the REB Chair or designee, and to the REB and/or to the appropriate Organizational Official as required;

5.1.7 The QA Officer works with the REB Chair or designee to implement improvements (e.g., new or revised SOPs or forms, training, education, additional resources or modifications to existing resources).

5.2 Researcher Quality Assurance Inspections

5.2.1 The QA Officer will develop a schedule for routine QA inspections and implement inspections in response to Researcher requests;

5.2.2 The QA Officer will work with the REB and the University at which the research is being conducted to determine if and when a for-cause inspection of a Researcher is warranted;

5.2.3 The REB Chair or designee and/or the Director, Research Ethics and/or the Research Integrity Officer may conduct for-cause inspections;

5.2.4 The QA Officer or designee may request copies of the sponsor's monitoring reports for a designated research project or that a questionnaire from the REB is completed;

5.2.5 The criteria for selecting Researchers or research projects for inspection may include:

- The results of a previous external audit or inspection,
- The results of a sponsor audit,
- Researcher-initiated studies (i.e., where the Researcher is also the sponsor),
- Studies that involve a potentially high risk to participants,
- Studies that involve vulnerable populations, (in the context of research)
- Studies in which Researchers are enrolling large numbers of participants,
- Suspected noncompliance,
- Unanticipated problems involving risks to participants or others,
- Suspected or reported protocol deviations,
- Participant complaints,
- Research Staff complaints,
- Any other situation that the REB Chair or designee and/or the Director, Research Ethics and/or the Research Integrity Officer deems appropriate;

5.2.6 The QA Officer or designee will notify the Researcher of the inspection and a mutually acceptable time will be scheduled. It may be necessary to schedule an inspection without first obtaining the formal consent of a Researcher (e.g., participant safety or suspected non-compliance);

5.2.7 The QA Officer or designee will conduct the inspection using designated/ appropriate evaluation tools;

5.2.8 When the QA Officer conducts an inspection of the Researcher, the inspection may include some or all of the following (as applicable):

- An assessment of the SOPs and compliance with applicable regulations and guidance,
- A review of all regulatory binders including the REB approval documentation, REB approved consent documents, signed consent documents, correspondence between the Researcher and sponsor, etc.,
- Interviews with the research staff and/or the Researcher,
- A review of test article accountability,
- A review of specimens and associated collection processes,
- A review of computer hardware and/or software associated with the research,
- A review of the consent form(s) and associated processes including eligibility requirements,
- A review of the completed case report forms (CRFs) or other data collection mechanisms,
- A review of appropriate source material (participant medical records),and
- A review of other documentation, as relevant and available;

5.2.9 The REB or the QA Officer may choose to have a qualified impartial observer to monitor the consent process or to interview participants;

5.2.10 At the conclusion of the evaluation, the QA Officer or designee will discuss the findings with the Researcher;

5.2.11 The QA Officer or designee will draft a report or provide a summary of the inspection including: positive findings, areas for improvement and recommendations for corrective action, and submit the report to the REB Chair or designee for review;

5.2.12 The Researcher will be given an opportunity to respond to the report with responses and/or corrective action plans within a time specified by the REB;

5.2.13 The QA Officer or designee will send a copy of the final report to the Researcher and the REB. When applicable, the REB Chair or designee will provide the findings to the local Organizational Official.

5.3 Corrective Action

5.3.1 The QA Officer may recommend corrective action based on the findings;

5.3.2 Corrective action may include a recommendation for the provision of additional resources, training, or education, the development of, or revisions to the SOPs, and changes to forms, checklists or templates;

5.3.3 The QA Officer will evaluate the effectiveness of the implemented improvements and adjust processes accordingly;

5.3.4 The QA Officer will follow-up with the Researcher in a timely manner to determine if the corrective actions have been implemented by the Researcher following a Researcher audit or inspection.

5.4 Documentation

5.4.1 The QA Officer or designee files all reports and correspondence concerning QA inspections in the appropriate QA Files.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP901.001	15-Sept-2014	Original version
SOP901.002	08-Mar-2016	No revisions needed
SOP901.003	08-Oct-2019	5.2.5: addition of the following in the fifth bullet – vulnerable '(in the context of research)'
SOP901.004	15-May-2023	No revisions needed

SOP 902.004

Title	**External Inspections or Audits**
SOP Code	902.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the procedures to be followed before, during and following an external inspection or audit.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members, Research Ethics staff and Researchers are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Health Canada has the authority to inspect Researcher sites conducting clinical trials that fall under the *Regulations* to assess compliance with relevant regulations and guidelines.

The US Food and Drug Administration (FDA) has the authority to audit Researcher sites involved in studies conducted under a US Investigated New Drug Application (IND) or Investigational Device Exemption (IDE) to assess compliance with relevant regulations and guidelines. The US Office for Human Research Protection (OHRP) has the authority to audit Canadian REBs that oversee studies that are supported by the US federal government.

Sponsors, funding entities, or others authorized by regulations or agreements with the organizations may have the authority to audit or inspect research-related documents and procedures.

These audits or inspections may involve the REB; therefore, the REB must have policies in place for dealing with external audits or inspections. The Researcher is responsible for promptly notifying Research Ethics of any planned audits or inspections of research projects overseen by the REB.

5.1 Preparing for an Inspection or Audit

5.1.1 The Director, Research Ethics or designee will confirm with the Sponsor and/or the Researcher (or inspector/auditor, as applicable) regarding the agreed dates and times of the inspection/audit, and verify the purpose of the inspection/audit, the applicable project(s) undergoing inspection/audit and the inspection/audit plan and procedures;

5.1.2 The Director, Research Ethics or designee will notify the REB members, the Research Ethics staff and Legal Counsel of the inspection/audit;

5.1.3 The Director, Research Ethics or designee will review the inspection/audit procedures with the REB members and conduct a thorough review of the required documentation;

5.1.4 The Director, Research Ethics or designee will arrange for access to the appropriate documents for the inspector/auditor in accordance with the University's policies, applicable law and any applicable agreements.

5.1.5 The Director, Research Ethics or designee will confirm that the REB members and Research Ethics staff are available for interviews or to assist the inspector/auditor;

5.1.6 The Director, Research Ethics or designee will arrange for a suitable work area (e.g. private and with sufficient space, with access to a computer and in close proximity to a photocopier and telephone) for the inspector/auditor.

5.2 Participating in an Inspection or Audit

5.2.1 The Director, Research Ethics or designee will meet with the inspector/auditor as scheduled. Prior to being granted access to the research-specific REB documentation, the inspector/auditor must exhibit proof of authority or authorization to conduct the inspection/audit and may be required to execute a confidentiality agreement;

5.2.2 The Director, Research Ethics or designee will record the name, contact information and title of the inspector/auditor and retain any written notices of inspection/audit for the REB files;

5.2.3 The Director, Research Ethics or designee will provide a brief orientation to the inspector/auditor of REB procedures;

5.2.4 The Director, Research Ethics or designee will provide access to the research-specific documents requested by the inspector/auditor and maintain a list of the documents reviewed;

5.2.5 The Director, Research Ethics or designee will accompany the inspector/auditor at all times while in confidential areas of the Research Ethics office and/or the University;

5.2.6 The Director, Research Ethics or designee will ensure that the inspector/auditor's questions are answered by the most appropriate personnel. The Director, Research Ethics or designee, Research Ethics staff and REB members must make every reasonable effort to be available and to accommodate the requests of the inspector/auditor;

5.2.7 The Director, Research Ethics or designee will request meetings with the inspector/auditor at the end of each day, as needed, to discuss any observations. If questions are asked or observations are made during the daily meetings, the Director, Research Ethics or designee will research the issues and provide the inspector/auditor with clarification as soon as possible once the information is available;

5.2.8 The Director, Research Ethics or designee will ensure that the required personnel are present at the exit interview and that observations are understood before the inspector/auditors leave the facility;

5.2.9 The Director, Research Ethics or designee will record any observations of the inspector/auditor and any discussion and ascertain when/if a written response is required.

5.3 Follow-up after an Inspection or Audit

5.3.1 The Director, Research Ethics or designee will request a copy of the report from the Researcher;

5.3.2 The Director, Research Ethics or designee and any other designated individuals will review any findings relevant to the REB and prepare a written response to each item or observation, including any clarification or corrective action that will be taken. The response to the inspector/auditor should be coordinated through the appropriate channels (e.g., the sponsor via the Researcher);

5.3.3 The Director, Research Ethics or designee and any other designated individuals will institute any correction actions as applicable and revise the REB SOPs as needed;

5.3.4 The Director, Research Ethics or designee will file the original inspection/audit and response documents in the appropriate files (e.g., quality assurance).

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP902.001	15-Sept-2014	Original version
SOP902.002	08-Mar-2016	No revisions needed
SOP902.003	08-Oct-2019	No revisions needed
SOP902.004	15-May-2023	No revisions needed

Title	Non-Compliance
SOP Code	903.004
Effective Date	15-May-2023

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the Research Ethics Board's (REB) process for responding to reports of non-compliance.

2.0 SCOPE

This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines.

3.0 RESPONSIBILITIES

All REB members, Research Ethics staff and Researchers are responsible for ensuring that the requirements of this SOP are met.

Researchers are required to comply with all of the applicable guidelines and regulations governing the conduct of human research, as well as with the required conditions of approval of the REB.

The Research Ethics staff and the REB members are responsible for acting on information or reports of non-compliance received from any source by promptly notifying the Research Integrity Officer (RIO).

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

The R60.01 Responsible Conduct of Research: Procedures to Address Allegations shall apply.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP903.001	15-Sept-2014	Original version
SOP903.002	08-Mar-2016	No revisions needed
SOP903.003	08-Oct-2019	No revisions needed
SOP903.004	15-May-2023	No revisions needed

References

1. Food and Drugs Act
2. Food and Drug Regulations: Part C, Division 5, Drugs for Clinical Trials Involving Human Subjects
3. Natural Health Products Regulations: Part 4, Clinical Trials Involving Human Subjects
4. Medical Devices Regulations: Part 3, Medical Devices for Investigational Testing Involving Human Subjects
5. Personal Information Protection and Electronic Documents Act
6. United States Code of Federal Regulations: 21 CFR 50, 56, 312, 812 and 45 CFR 46
7. ICH GCP International Council on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use – ICH Harmonised Tripartite Guideline – Guidelines for Good Clinical Practice E6(R2)
8. Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, TCPS2 2022
9. World Medical Association (WMA). Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects
10. Guidance Document: Part C, Division 5 of the Food and Drug Regulations "Drugs for Clinical Trials Involving Human Subjects" (Gui-0100) –(August 20, 2019)
11. Canadian Association of Research Ethics Boards. Guidance on Reporting of Unanticipated Problems Including Adverse Events to Research Ethics Boards in Canada (July 2010)
12. U.S. Department of Health and Human Services, Office for Human Research Protections, and FDA Institutional Review Board Written Procedures Guidance for Institutions and IRBs (May 2018)
13. U.S. Department of Health and Human Services, Office for Human Research Protections. Guidance on Reporting Incidents to OHRP (May 2011).
14. U.S. Department of Health and Human Services, Office for Human Research Protections. Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events (January 2007)
15. U.S. Department of Health and Human Services, Office for Human Research Protections. Guidance on IRB Continuing Review of Research (November 2010)
16. U.S. Department of Health and Human Services, Office for Human Research Protections. Guidance on the Use of Expedited Review Procedures (August 2003)
17. U.S. Department of Health and Human Services, Office for Protection from Research Risks. Memorandum re: IRB Meetings Convened via Telephone Conference Call (March 2000)
18. U.S. Department of Health and Human Services, Office for Protection from Research Risks and Food and Drug Administration. Protection of Human Subjects: Categories of Research That May Be Reviewed by the Institutional Review Board (IRB) Through an Expedited Review Procedure. Federal Registrar: November 9, 1998 (Volume 63, Number 216)

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19. U.S. Department of Health and Human Services, Food and Drug Administration. A Guide to Informed Consent – Information Sheet; Guidance for Institutional Review Boards and Clinical Investigators
20. U.S. Department of Health and Human Services, Food and Drug Administration. Comparison of FDA and HHS Human Subject Protection Regulations
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22. U.S. Department of Health and Human Services, Food and Drug Administration. Information Sheet Guidance for IRBs, Clinical Investigators, and Sponsors; FDA Institutional Review Board Inspections (April 2019)
23. U.S. Department of Health and Human Services, Food and Drug Administration. Guidance for Institutional Review Boards, Clinical Investigators, and Sponsors; Exception from Informed Consent Requirements for Emergency Research (April 2013)
24. U.S. Department of Health and Human Services, Food and Drug Administration. Guidance for Industry; Investigator Responsibilities – Protecting the Rights, Safety, and Welfare of Study Subjects (October 2009)
25. U.S. Department of Health and Human Services, Food and Drug Administration. Guidance for Clinical Investigators, Sponsors, and IRBs; Adverse Event Reporting to IRBs – Improving Human Subject Protection (January 2009)
26. U.S. Department of Health and Human Services, Food and Drug Administration. Guidance for IBRs, Clinical Investigators, and Sponsors; IRB Responsibilities for Reviewing the Qualifications of Investigators, Adequacy of Research Sites, and the Determination of Whether an IND/IDE is Needed (August 2013)
27. U.S. Department of Health and Human Services, Food and Drug Administration. Guidance for IRBs, Clinical Investigators, and Sponsors; IRB Continuing Review after Clinical Investigation Approval (February 2012)
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29. U.S. Department of Health and Human Services. Financial Relationships and Interests in Research Involving Human Subjects: Guidance for Human Subjects Protection (May 2004)
30. U.S. Department of Health and Human Services, National Institutes of Health. NIH Policy and Guidelines on The Inclusion of Women and Minorities as Subjects in Clinical Research (November 2017)
31. U.S. Department of Health and Human Services, National Institutes of Health. Guidance on NIH Office of Extramural Research (OER) on-line tutorial Protecting Human Research Participants (PHRP) (February 2008)

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33. Canadian Institutes for Health Research. Best Practices for Protecting Privacy in Health Research (September 2005)