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| **Committee:** | Southern Health and Disability Ethics Committee |
| **Meeting date:** | 14 August 2018 |
| **Meeting venue:** | Sudima Hotel, Christchurch Airport, 550 Memorial Drive, Christchurch |

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| **Time** | **Item of business** |
| 11:30am | Welcome |
| 11:35am | Confirmation of minutes of meeting of 10 July 2018 |
| 11:45am | New applications (see over for details) |
|  | i 18/STH/146  ii 18/STH/155  iii 18/STH/156  iv 18/STH/161  v 18/STH/162  vi 18/STH/163  vii 18/STH/164  viii 18/STH/165  ix 18/STH/167 |
| 3:30pm | General business:  Noting section of agenda |
| 3:45pm | Meeting ends |

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| **Member Name** | **Member Category** | **Appointed** | **Term Expires** | **Apologies?** |
| Ms Raewyn Idoine | Lay (consumer/community perspectives) | 27/10/2015 | 27/10/2018 | Present |
| Dr Sarah Gunningham | Non-lay (intervention studies) | 27/10/2015 | 27/10/2018 | Present |
| Dr Nicola Swain | Non-lay (observational studies) | 27/10/2015 | 27/10/2018 | Present |
| Dr Devonie Waaka | Non-lay (intervention studies) | 13/05/2016 | 13/05/2019 | Present |
| Assc Prof Mira Harrison-Woolrych | Non-lay (intervention studies) | 27/10/2015 | 27/10/2018 | Present |
| Dr Cordelia Thomas | Lay (Law) | 20/05/2017 | 20/05/2020 | Present |

## Welcome

The Chair opened the meeting at 11:30am and welcomed Committee members.

The Chair noted that it would be necessary to co-opt members of other HDECs in accordance with the Standard Operating Procedures. Dr Cordelia Thomas confirmed her eligibility, and was co-opted by the Chair as member of the Committee for the duration of the meeting.

The Chair noted that the meeting was quorate.

The Committee noted and agreed the agenda for the meeting.

## Confirmation of previous minutes

The minutes of the meeting of 10 July 2018 were confirmed.

## New applications

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| **1** | **Ethics ref:** | **18/STH/146** |
|  | Title: | HCV sero-prevalence NZ |
|  | Principal Investigator: | Dr Arlo Upton |
|  | Clock Start Date: | 01 August 2018 |

Dr Arlo Upton and Prof Ed Gane were present by teleconference for discussion of this application.

Potential conflicts of interest

The Chair asked members to declare any potential conflicts of interest related to this application.

No potential conflicts of interest related to this application were declared by any member.

Summary of study

The main ethical issues considered by the Committee were as follows.

Summary of study

1. The Committee noted that the intended study is interesting but ethically challenging.
2. The Committee asked the researchers to provide justification for why this study is needed. The researcher stated that there is no accurate prevalence data in New Zealand. Original anonymous sero-prevalence studies were done on blood donors in the early 1990s but due to the donating population, the prevalence of 0.4% was likely underestimated. More recently Prof Gane has been involved in some modelling work based on the number of patients presenting to the liver unit with undiagnosed HCV. Australian data has also been used to provide estimates of sero-prevalence in NZ. The estimate of 1-1.5% is based on these pieces of work. The researcher then referred to a study conducted approximately 5 years ago in Dunedin among patients aged 40-59 years presenting for community and hospital blood tests that demonstrated prevalence rates closer to 4%. Work done by Robert Kent in high risk populations (prison populations) also showed higher rates. The Ministry of Health and ESR have done some work that showed 25,000 people may be infected with Hepatitis C. The research team noted that this data was not current and may be a gross underestimate.

Summary of ethical issues (outstanding)

The main ethical issues considered by the Committee and which need addressing by the Researcher are as follows.

1. The two key ethical issues raised by this application are:
   1. the use of human tissue (blood) without informed consent;
   2. the non-disclosure of results of a serious, yet treatable condition, to participants.
2. The Committee accepted the argument that there are challenges to obtaining consent and that it may be difficult, expensive and costly to do so, and also accepts that seeking consent would introduce bias. The Committee argued that the disorder being tested has significant medical consequences, and that there are effective treatments currently available for HCV. The researchers acknowledged that they have grappled with these issues, but noted that this is the only way to do true sero-prevalence studies. The Researchers noted that they had had discussions with medical ethicist Tim Dare which included reference to the need to satisfy the following ethical principles: the importance of the study, and the risk to those participating in the study. The researchers argued that the study was important in terms of public health, and that individuals would be no worse off than if they hadn’t had their blood tested.
3. The Committee sought clarification about whether the samples intended for use in this study will be from all individuals who have had their bloods taken for a renal profile test. The researchers confirmed this. The Committee noted that patients have to consent to having their blood taken (for the renal profile test) because of Right 7 of the HDC patient Code of Rights and queried why they couldn’t be informed of this research and consent to that at the same time. The Committee noted that the option to opt out is not consent in terms of the Code of Rights. The Committee noted that if a study is not lawful then the Committee cannot approve it.
4. The Committee noted the researchers’ argument that scientific validity would be compromised; that obtaining consent would be impractical; and that there will be no harm to participants.
5. The Committee asked whether there is a mechanism by which patients could be informed of a positive HCV test. The Researchers stated that all samples will have been de-identified prior to HCV testing, precluding notification of individual results.
6. The Committee acknowledged the large resource required for:
   1. seeking consent from all individuals
   2. contacting all individuals with positive tests
   3. the potential for false positive tests due to testing a wide range of the population and the mechanisms for recall of those patients for further testing.
7. The Committee also noted that false positive tests could result in unwarranted anxiety/ fear in low-risk individuals.
8. However, the Committee noted at the same time that people have the right to make decisions about what is done to them. It was noted that recently The Health and Disability Commissioner has indicated that it is unwise not to tell people what they are being tested for in clinical practice as they are then, not in a position to request their results.
9. The Committee queried whether it might be possible to do a smaller study that the Researchers could resource and could do in line with our ethical standards. i.e with consent for testing and with the ability to inform people of positive results.
10. The Researchers argued that that while we have treatments that can cure HCV and that these treatments are about to be funded in New Zealand, there is little knowledge currently of the prevalence rate of HCV in the New Zealand population. NZ has signed up to the WHO initiative with the aim of rolling out an elimination strategy. For this to be successful the Researchers need to know what the target population is. This study would further this aim while individuals would not be placed in a worse situation. The idea of this study is to determine which populations are most at risk in order to target these groups in planned public health campaigns. Only a sero-prevalence study of this size will be able to give the Researchers the data to know which groups to target. A small study like that proposed by the Committee is unlikely to provide this data.
11. The Committee noted again that it can see the need for the study to be done and that one way to do it could be to work in with one of the laboratories and work on having a simple and short consent form that is given to people when they are having a blood test. On a population basis the Committee noted that it can see the need and the logic for this study but on an individual basis there is a need to meet ethical and legal requirements.
12. The Committee noted that if it is impractical or impossible to get consent then the Researchers could rely on a clause 3 of the Code exemption but the Committee was not convinced of the impossibility of gaining consent in this instance.
13. The Researchers offered to look at doing a community pilot study in Dunedin that would include a short information sheet and consent form, and a managed process for communication of positive results to GPs and participants. The number of people who did not consent to study participation would be collected, to inform the research team about the feasibility of this approach on a larger scale. A study done in this way would not give the Researchers reliable information on Maori and Pacific populations, but would be a starting point. The Researchers also indicated that they may prepare a supplementary questionnaire for participants to complete, about attitudes to the use of leftover blood samples for research.
14. The Committee agreed with the pilot study approach. The Committee strongly suggested that any application for the pilot study be resubmitted to this Committee as it is familiar with the issues.

Decision

This application was *declined* by consensus, as the Committee did not consider that the study would meet the following ethical standards.

The overall principle of the Human Tissue Act 2008 is that informed consent should come, in the first instance, from the individual whose tissue would be collected and/or used. While section

20 (e) of the Human Tissue Act states that secondary use for research without prior consent can be done with ethics approval, the Committee was not convinced of the impossibility of gaining consent in this case and noted the ethical issue of the non-disclosure of results of a serious, yet treatable condition, to participants. The Committee agreed to decline this study with reliance on Right 6 of the HDC Code of Rights and Paragraphs 3.2 and 6.43 of the Ethical Guidelines for Observational Research.

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| **2** | **Ethics ref:** | **18/STH/155** |
|  | Title: | Phase I, Double-blind, Randomized, Parallel Group Study to Demonstrate the Equivalent Pharmacokinetic Properties of a Single Intravenous Dose of HD204 and Avastin in Healthy Male Subjects |
|  | Principal Investigator: | Doctor Christian Schwabe |
|  | Sponsor: | Prestige Biopharma |
|  | Clock Start Date: | 02 August 2018 |

Dr Christian Schwabe, and Ms Roselyn Shah were present by teleconference for discussion of this application.

Potential conflicts of interest

The Chair asked members to declare any potential conflicts of interest related to this application.

Dr Waaka declared a potential conflict of interests but the Committee decided that she could remain in the room and take part in the discussion and decision-making for this application.

Summary of study

1. The researchers presented an overview of the study. The bioequivalence study is very similar to others conducted at ACS. Branded Avastin is a costly cancer drug. This study will compare the pharmacokinetics of US and European sourced Avastin with a generic. The study will look at data from 120 evaluable participants to determine whether there is bio similarity based on PK parameters. Participants will be in the study unit for three nights and then have 11 follow up visits over three months. As this is a first in human study, dosing will start with three sentinel groups of 3, 6, 9 subjects, who will be dosed in a staggered way. A safety review will be completed for each group prior to dosing of the remaining participants.

Summary of ethical issues (resolved)

The main ethical issues considered by the Committee and addressed by the Researcher are as follows.

1. The Committee queried why women are excluded from this study. The Researchers explained that historically studies do tend to focus on male populations, as this reduces inter-subject variability and reduces the potential for reproductive harm. Ultimately the drug will be used in both female and male patients. If this study is successful only then will the next study be done and that study will likely involve females. The Committee noted that excluding females from this study is acceptable on this basis of reproductive risks.
2. The Committee noted in ACS applications there appears to be a templated answer provided about new information arising during the study (question p.2.7). ACS states each time that it will amend the informed consent, have it approved by HDEC and then provide this to participants. The Committee has in the past requested that this be amended to say that, in the event of important new safety information, participants will be informed in person / by telephone / by email prior to development and approval of a new information sheet. The Committee asked that this be addressed in future applications.

The Committee requested the following changes be made to the participant information sheet and consent forms:

1. Page 5 under the heading ‘Are there any other study restrictions?’ states: “during your in-house stay you will not be allowed to leave the study site”. The Committee reminded the Researchers that they cannot stop people from leaving the study site and asked that they instead state something along the lines of if the participant wishes to remain in the study they will not be allowed to leave. The Committee noted that this point should applies to all bullet points in the section and that the additional statement could be added to the start of the section.
2. Page 7, Schedule of Assessments has crosses missing for some clinic visits.
3. The reproductive risks section could be stated more clearly, as stating that people should abstain while in the study is not an effective method of contraception. The Committee advised the Researchers of a recently developed template that covers risks for both men and women and suggested that the Researchers use this template. The template also includes the statement that it the responsibility of the man to advise his female partner that he is in the study and taking a medicine that is potentially teratogenic. <https://ethics.health.govt.nz/guides-templates-forms-0/participant-information-sheet-templates>
4. Page 13 ‘What happens if I have any ill effects from the study?’: the Committee noted that compensation could be available and the use of “would” guarantees insurance will be given when this is not always the case. The Committee noted that a new template is available as follows and once it is reviewed and approved by the study sponsor’s legal team it should be inserted into the participant information sheet.

*As this research study is for the principal benefit of its commercial sponsor [insert name], if you are injured as a result of taking part in this study you* ***won’t*** *be eligible for compensation from ACC.*

*However, [insert name] has satisfied the [ insert name] Health and Disability Ethics Committee that approved this study that it has up-to-date insurance for providing participants with compensation if they are injured as a result of taking part in this study.*

*New Zealand ethical guidelines for intervention studies require compensation for injury to be at least ACC equivalent. Compensation should be appropriate to the nature, severity and persistence of your injury and should be no less than would be awarded for similar injuries by New Zealand’s ACC scheme.*

*Some sponsors voluntarily commit to providing compensation in accordance with guidelines that they have agreed between themselves, called the Medicines New Zealand Guidelines (Industry Guidelines).These are often referred to for information on compensation for commercial clinical trials. There are some important points to know about the Industry Guidelines:*

*On their own they are not legally enforceable, and may not provide ACC equivalent compensation.*

*There are limitations on when compensation is available, for example compensation may be available for more serious, enduring injuries, and not for temporary pain or discomfort or less serious or curable complaints.*

*Unlike ACC, the guidelines do not provide compensation on a no-fault basis:*

*The Sponsor may not accept the compensation claim if:*

*Your injury was caused by the investigators, or;*

*There was a deviation from the proposed research plan, or;*

*Your injury was caused solely by you.*

*The injury was caused by <<NAME OF COMPARATOR DRUG>> (include only if holds true for specific study)*

*An initial decision whether to compensate you would be made the by the sponsor and/or its insurers.*

*If they decide not to compensate you, you may be able to take action through the Courts for compensation, but it could be expensive and lengthy, and you might require legal representation. You would need to be able to show that your injury was caused by participation in the trial.*

*You are strongly advised to read the Industry Guidelines and ask questions if you are unsure about what they mean for you.*

*If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won’t affect your cover.*

1. Page 9, risks section: The Committee suggested that the Researchers include estimates of incidence rates, i.e. how often adverse events are expected to occur. The Researchers noted the difficulty in this is that the numbers come from patients who have an underlying disease and also receive a higher dose and more than one dose and therefore they are not sure how informative such numbers would be as they may give a skewed picture of the incidence. The Committee suggested that the researchers could qualify by stating, “rare”, “common”, “rare but serious”.
2. Pregnancy consent form, page 2 states: “You may be contacted by the study doctor or study personnel regarding the status of your pregnancy and for a while after your pregnancy is completed”. Please amend to a specific number or weeks rather than use the phrase “for a while”. The Committee also asked that the pregnant partner is given a copy of the PIS and is not required to have to ask for it.
3. In the consent form that is signed after baby is born the Committee noted the statement: “I agree to allow data concerning the outcome of this pregnancy to be held by the sponsor and be forwarded to regulatory agencies as necessary.” The Committee noted that consent is rather for a follow up of the health of the child for 8 weeks and asked that it be made more specific here about what the participant is consenting to.

Decision

This application was *approved* by consensus with non-standard conditions.

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| **3** | **Ethics ref:** | **18/STH/156** |
|  | Title: | Prophylaxis in gout |
|  | Principal Investigator: | Professor Lisa Stamp |
|  | Clock Start Date: | 02 August 2018 |

Prof Lisa Stamp was present by teleconference for discussion of this application.

Potential conflicts of interest

The Chair asked members to declare any potential conflicts of interest related to this application.

No potential conflicts of interest related to this application were declared by any member.

Summary of study

1. The Committee commended the Researchers on a well completed application.
2. The Researcher presented an overview of the study. The randomised controlled trial looks to see whether people with gout need extra medication to prevent flares when they start long term urate-lowering therapy using a “start-low, go slow” approach. It is well documented that when starting long term therapy patients are likely to having gout attacks.
3. The Committee asked the Researcher why the term ‘Prophylaxis’ has been used and queried whether the lay person would know what this term means. The researcher stated that prophylaxis is the term used for medications trying to prevent gout flares. Colchicine is one of three treatments used in this setting. The Committee noted that the term ‘prophylaxis’ is not one that participants would necessarily understand and suggested the Researchers change the study title to a lay one.

Summary of ethical issues (resolved)

The main ethical issues considered by the Committee and addressed by the Researcher are as follows.

1. The Committee noted that the scientific peer reviews had questioned the choice of colchicine dose for the study. The Researcher noted that 0.6 milligrams daily is the standard recommended dose for the drug in this setting and is used in new urate-lowering therapy trials. The three drugs used in this setting are colchicine non-steroidal anti-inflammatories and prednisone, and none need to be used at high doses in this setting, which is why they have chosen the lowest possible dose.
2. Researchers chose not to allow for a colchicine dose increase in the event of a flare. This decision was made because there are a number of significant interactions with colchicine and some patients should not receive doses greater than 0.6 milligrams daily. If needed, participants would be offered another treatment for acute gout. The Researcher added that doses of more than 0.6 mg daily are not needed for prophylaxis.
3. The Committee noted the peer review comment around non-inferiority vs superiority in relation to the trial design. The Researcher advised that this was addressed and the protocol updated.

The Committee requested the following changes be made to the participant information sheet and consent forms:

1. The information sheet states that patients are usually given colchicine when starting urate lowering therapy. It is not made clear that urate therapy is now commenced using a “start low, go slow” approach, which may mean that colchicine is not required. The Committee noted that it would be helpful to include this information so that patients can see that they might not need colchicine, and to give them context as to why colchicine is being withheld from some.
2. The Committee sought clarification in relation to information about future research. The researchers explained that data collected for this study will be kept and may be used for future research. Separate consent will be required for samples to go into the Pathmed tissue bank. No other future research is planned for blood samples. The Committee recommended that the Researchers remove references to blood samples being used for future studies from the PIS, as participants will sign an optional separate consent form in relation to this.
3. There is not much information about participant rights should they want to withdraw from the study. The Committee asked that the Researchers state that participants are free to withdraw by contacting researcher, but that samples and data analysed up to the point of withdrawal will continue to be used.
4. The Committee noted that the box ‘Do you have interpreters available’ can be removed if interpreters are not available.
5. The Committee asked whether the study will include anyone of reproductive age and whether the reproductive risks of the medicines have been considered. The Researcher explained that participants will typically be older patients and that the chances of enrolling someone in the female reproductive age group is low. It was noted that the drugs are used as per standard clinical practice and are not new medicines. The Committee noted that there is documentation available on the HDEC website that talks about reproductive risks <https://ethics.health.govt.nz/guides-templates-forms-0/participant-information-sheet-templates> and noted that should someone in this population group enter the study then there is information about reproductive risks that the Researchers can use. In the event that the Researchers did have someone of reproductive age enter the study would they be inviting them to use contraception while on these medicines. The Researcher advised that part of standard practice is that people on allopurinol take precautions. The Researcher advised that decisions about allopurinol will be made before the trial and the clinician would have the discussion with each patient in the clinic about taking allopurinol prior to enrolment in the study.
6. The Committee queried whether, in addition to participants receiving a study information sheet, they would also be receiving a drug information sheet about the side effects of Colchicine. The researcher stated that they would. The Committee recommended they include a statement that informs participants that they have been given a sheet about the risks of colchicine and to have a look at it and ask any questions as needed.

Decision

This application was *approved* by consensus with non-standard conditions

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| **4** | **Ethics ref:** | **18/STH/161** |
|  | Title: | 298 YHC ACE Survey |
|  | Principal Investigator: | Dr Ronan Whyte |
|  | Sponsor: | Korowai Youth Wellbeing Trust |
|  | Clock Start Date: |  |

Dr Ronan White was present in person for discussion of this application.

Potential conflicts of interest

The Chair asked members to declare any potential conflicts of interest related to this application.

No potential conflicts of interest related to this application were declared by any member.

Summary of study

1. The Committee asked the Researcher to give an overview of the study and to explain why it is being done.
2. This is a study looking at adverse childhood experiences (ACES) and seeing how they impact on recovery from mental illness. It is a longitudinal study where the researchers aim to recruit participants from 298 Youth Health Centre who are seeing a youth worker. As part of the youth worker assessment they undergo a background assessment called a ‘heds’ assessment. During these visits the Researchers would also like to give them a survey ACE-Q on adverse childhood experiences. Then they plan to follow up with the participants in a year and correlate their adverse childhood experiences with their mental health outcomes. The Researcher noted that there has been a lot of research done using adverse childhood experiences to predict the onset of mental health issues, particularly depression and substance use, but not much research done on adverse childhood experiences as a prognostic factor for recovery from these issues. The Researchers want to see whether they can use the ACE-Q questionnaire as a predictive tool that could be used as part of clinical care. However, prior to this, they need to determine whether there is any correlation.

Summary of ethical issues (outstanding)

The main ethical issues considered by the Committee and which need addressing by the Researcher are as follows.

1. The Committee sought clarification of the age range of participants for this study and the Researcher confirmed that the age range is intended to be 10-24 year olds and mostly the researchers will expect them to be in the 15-24 range. The Committee asked the Researcher if it were to stipulate that participants only be in the 15 to 24 year old age range would that raise an issue for the intended study. The Researcher noted that it would be easier to recruit participants in the 14-24 age range and noted that it is unlikely they would see participants who are under the age of 14. The Committee noted that the participant information sheet as it is currently written is not appropriate for 10 year olds.
2. The Committee asked what the demographic of patients are who go to 298 YHC and why they go there. The Researcher explained that 298 YHC is a youth health centre that provides GP and counselling and youth worker services and also some psychologist time. Given that 298 YHC is a free centre it tends to receive people from low socioeconomic backgrounds who can’t afford GP services in Christchurch and the age range ranges from 10-24 years of age. The Committee queried whether patients are referred from other services or whether they self-refer to this service. The Researcher advised that this varies and at the moment they are referred from another service but for the duration of this study as their books are about to “be opened” they may receive participants who self-refer as well.
3. The Committee noted that the Researchers are only going to see those who already have mental health issues and the Researcher noted that they want to look at recovery from a mental health issue and see whether there is any correlation with adverse childhood experiences. Primarily, the participants have to have a mental health issue to be considered for the study so they can correlate that recovery in a year’s time with their experiences.
4. The Committee sought clarification on whether they will ask participants to complete the questionnaire before they have been diagnosed with a mental health issue. The Researcher confirmed they would not.
5. The Committee asked who will decide that the participants have a mental health issue. The Researcher noted that they could have been given a diagnosis prior to presenting at 298 YHC. If they are seeing a social worker and have a mental health diagnosis they will be considered eligible for this study.
6. The Committee asked the Researcher how a mental health issue is defined for the purpose of this study and asked whether ICD codes will be relied upon. The Researcher confirmed that it will only be from patient notes where a qualified health practitioner has diagnosed. E.g. depression
7. The Committee queried whether there will be any parental involvement in this process. The Researcher noted that some people go to the centre with their parents. Ultimately the extent of parental involvement is up to the individual patient.
8. The Committee noted that the legal age for consent in New Zealand is16 years old or above and that for the purpose of research that people under the age of 16 can consent if they are assessed by as being competent by a clinician. The Researcher noted that the plan is that they will see the young person at their second visit to the youth worker and if the youth worker has any concerns about their competence then they won’t be eligible to enter the study. The Committee queried whether a youth worker’s scope of practice includes assessing competence. The Researcher indicated that the youth worker has access to patient notes and if there are any diagnoses that might flag them as not being competent such as psychosis then they would not be included in the study. The Committee noted that diagnoses such as psychosis or bipolar disorder do not necessarily mean that a person is not able to consent. The Committee noted concern that a youth worker would assess competence as it expected that this would not be in their scope of practice.
9. The Committee noted the younger end of the spectrum for participants, i.e. 10 years old and queried whether they would understand the questionnaire and information as it is currently presented and therefore be fully able to answer the questionnaire. The Committee noted that it had tested the information sheet on a 12 year old who had not understood the information. The Committee asked whether the Researchers had tested the form with young people. The Researcher confirmed that they hadn’t but that they had run it past a researcher from the Collaborative and had made some amendments. The Committee’s view was that this form needs to be tested on the age range that the Researchers want to use it with. The Committee noted the information form as it is currently presented is text heavy and not laid out in a way that is age appropriate. The Committee also noted that some of the information as it is presented is confronting and could trigger negative responses from participants as they read through. The Researcher confirmed that that is why the information and questionnaire is intended to be given to participants prior to meeting with the youth worker so there is a safety net and wrap around.
10. The Committee asked whether someone will sit with the participants and go through the questionnaire form with them and the Researcher confirmed that they will not go through the questionnaire with them but they will go through the consenting process with them. The Committee noted that this will mean that young people will complete the forms themselves and be required to answer questions such as “have you been incarcerated?” and wondered whether 10 to 12 year olds will know what this means. The Committee reiterated that it is of the view that the form is not fit for purpose for this age group.
11. The Committee noted that it would only approve any such study for participants who are 16 years old and above and for 14 to 16 year olds who are deemed to be competent and, that the information will need to be rewritten in lay language that is age appropriate.
12. The Committee noted that the general public don’t understand what ACE is. Another example the Committee noted was the opening statement in the information sheet that stated that “you are invited to take part in a study on negative childhood experiences” and suggested that it be rewritten along the lines of “you are invited to take part in a study on childhood experiences”. While the study wants to look at negative experiences the Committee noted the importance of not presupposing what the results might be and the way in which the information is presented to participants appears to be slanted with a negative bias. The Committee noted that the language could be adapted and softened to avoid this.
13. The Committee asked the Researchers to revisit the participant information form and to rewrite with the young person with mental health issues in mind and to address the information to them directly. For example they could state in the opening statements about the purpose of the study something along the lines of “We want to ask you some questions about how you were as a kid and how your experiences might have affected where you are now”.
14. The Committee noted that if participants divulge things that suggest criminality whether the Researchers have a process for dealing with this. The Researcher explained that they don’t expect that there will be a specific allegation against a person but if issues of abuse are raised then the form will be given to youth worker so that they can discuss this.
15. The Committee noted that some of its members have been involved in studies involving youth and it is not uncommon that allegations of criminality or abuse are made. If a child says that they have been abused there is a legal obligation to report that. The Committee recommended that the Researchers have a policy in place for managing any disclosures. The Researcher advised that 298 YHA has a policy around disclosure of abuse. The Committee noted that the information sheet needs to tell the child about what will happen in such circumstances.
16. The Researcher advised that the social worker at 298 is qualified in social work and has been at 298 for a few years now. The social worker works with clinical team but does not have clinical qualifications himself. The Committee noted the importance of someone who is clinically qualified to assess competence being the person who makes the determination about whether a young person can consent. The Researcher who is a house surgeon currently stated that he would make the assessment about competence and the Committee suggested that a specialist with expertise in adolescent health would be best placed to make the determination and argued that it would be difficult for someone who is a house surgeon to make a determination of competence independently of the specialist.
17. The application form stated that in the event that a member of the 298 clinical team believed a participant was not competent after they are in the study, the Researchers remove the participant’s data. The Committee noted that a decision about competence must be made before a person is enrolled in the study.
18. The Committee suggested another way of approaching a study like this could be that the Researcher could consider referring to people who have data with recovery statistics and could co-author a paper. The Committee suggested that if prognosis and recovery is what interests the Researcher that a different set of data could be chosen. The Dunedin multi-disciplinary study for example may have such data along with recovery statistics and the Researcher could co-author a paper with that data across a longitudinal population could be another way of approaching a study like this.
19. The Committee suggested that the yes/no boxes be removed from the consent form and that consent statements not relevant to the study, e.g. compensation provisions, are removed. The Committee asked that the Researcher review these statements and include only statements that are relevant to this study.
20. The Committee noted that it can see the benefit in the study but that it is not able to be approved in its current format. The Committee agreed to decline the application but encouraged the Researcher to resubmit covering the issues discussed above.

Decision

This application was *declined* by consensus, as the Committee did not consider that the study would meet the following ethical standards.

1. The Information Sheets as written are not fit for purpose. *(Ethical Guidelines for Observational studies, paras 6.10 and 6.11)*
2. The Committee agreed it would consider a future application with a lower age range limit of 14 years. The Committee would like to see a parental information sheet and an assent sheet for 14-16 year olds who are assessed as not competent. *(Ethical Guidelines for Observational studies, paras 6.10, 6.11, 6.20 and 6.21)*
3. The Committee would like to see more information about who will do the competence assessment and that this be included in the protocol along with more detail about recall bias (with distance in age from those events), and how the Researchers will manage this. The Committee would also like to see power calculations and statistical considerations stated in more detail in the protocol. *(Ethical Guidelines for Observational Studies, paras 5.11 and 5.12)*
4. The Peer review has been provided by someone within the study centre. Given the context of the study peer review must be independent from the site and from an expert in adolescent mental health.*(Ethical Guidelines for Observational Studies, Appendix: Joint Health Research Council and NEAC guidance on features of robust peer review for assessing the scientific validity of research)*

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| **5** | **Ethics ref:** | **18/STH/162** |
|  | Title: | RELIEF: RE-LInk Feasibility |
|  | Principal Investigator: | Dr Andrew McDaid |
|  | Sponsor: | University of Auckland |
|  | Clock Start Date: | 02 August 2018 |

Dr Andrew McDaid was present by teleconference for discussion of this application.

Potential conflicts of interest

The Chair asked members to declare any potential conflicts of interest related to this application.

No potential conflicts of interest related to this application were declared by any member.

Summary of ethical issues (resolved)

The main ethical issues considered by the Committee and addressed by the Researcher are as follows.

1. The Committee queried whether development of this device will be done for the benefit of the manufacturer or designer. The Researchers noted that this is not the case. The Committee then queried why the Researchers have chosen this particular device. The Researcher explained that the project started about 6 years ago at the university to test the hypothesis that acute stage stroke rehab would be more effective than current rehabilitation methods. The Researcher was the PI for the original grant working with Kathy and Jim (physios) at the medical school and they have continued to get grants to continue to develop this device. The Committee asked whether this device will be made available to wider field or is it only going to be used by Kathy and Jim with their patients. The Researcher noted that it would be ideal if the device showed efficacy in the current study and the Researchers might then look at commercialising it but this is not intended at this stage. If there is a decision later to commercialise then a different company would become involved.
2. The Committee asked the Researcher why they are doing this particular trial. The Researcher noted that the project has been running for six years and this study is about testing hypothesis about gait rehabilitation early after stroke with idea that this device could constrain patients’ motions or gait patterns to a more normal gait in the early stage and could prevent patients from ever developing an impaired gait pattern. The Researchers have gone through the development of the device and tested in healthy and chronic stroke patients and now for we think that it is ready to be implemented for use in acute stroke unit. Doing this study as a feasibility to be able to do a full RCT if this study is successful.
3. The device has been trialled in mostly healthy people and in 10 chronic stroke patients. The stroke patients adapted to using it more effectively than healthy participants, probably because healthy participants have an already optimised gait pattern. A step further is to trial its use for acute patients where the stroke has just happened. The Researchers are hoping that the device will provide more benefits in the acute stroke population.
4. The Committee asked the Researchers to explain how they will recruit the 25 participants. As part of the grant a study co-ordinator, who is a physiotherapist will work on this study on a half time basis. She will screen potential participants and identify them. She is part of the clinical team at the hospital but won’t be the participants’ therapist. She will report back on reasons people were ineligible for the study, and why people chose not to participate over the 12 month period.
5. The Committee noted that there is some discrepancy in answers provided in the application about potential participants’ ability to make decisions about their participation in the study. The Researchers confirmed that participants may be vulnerable post-stroke in medical or social terms, but would all be assessed for competency prior to entry into the trial. Only those competent to provide informed consent would be enrolled.
6. The Committee noted that it would have been useful in question p.4.1 for the researchers to include data about incidence of stroke and stroke outcomes in Maori, as this could help demonstrate how the study would benefit Maori. As far as cultural issues are concerned there could be elements of shame/whakama about not being able to walk properly or not being able to speak and this needs to be addressed. The Researchers noted that this information was included in HRC application.
7. In the FSAC review summary there were a few questions asked about study design, for example whether near falls could be considered an outcome, and how drop-out rates were to be addressed. The Committee asked whether these points were addressed. The Researcher confirmed that they were.
8. The Committee noted that the researchers have stated in the application form that they have an internal data safety monitoring committee. The information provided is not consistent with an internal data safety monitoring committee, and the Committee noted it was more appropriate to state that ‘other data safety monitoring’ was intended. The Committee noted that the procedures outlined were appropriate for the study.

Summary of ethical issues (outstanding)

The main ethical issues considered by the Committee and which require addressing by the Researcher are as follows.

1. The Committee noted the protocol used an unusual definition of adverse events and adverse reactions. The definition used may result in unintended triggering of the study termination criteria. The Committee noted it might be worth using standard terminology to define and categorise “adverse events”, The study termination criteria could then be restricted to adverse events that have been determined as related or probably related to the study device, rather than to any adverse reaction.
2. Please make clear in the inclusion criteria in the protocol that participants must be competent to give consent.

The Committee requested the following changes be made to the participant information sheet and consent forms:

1. The Committee asked that the Researchers provide a lay title for patient facing information that is not an acronym. The Committee noted its preference for lay titles over acronyms and names that imply success in patient facing material.
2. Please label in the heading which information sheet is for the physiotherapist and which is for the stroke patient/participant.
3. There appears to be a mix up about in the information about compensation for participation as currently participants are not being compensated for their time with petrol or grocery vouchers but the physiotherapists are. Please review this in the sheets and remove from the information sheets for the physiotherapists.
4. The Committee noted that it is stated that participation in this study this won’t adversely impact on the provision of health and disability services. The Committee queried whether the physiotherapists will be completing this in their own time or whether it will be done in other patients’ time. The Researcher explained that they will leave it up to the primary therapist of the participant to use the device as they see fit. If they believe that it is a better therapy tool then they can use it. Long term feasibility of using this as a therapeutic tool is that it has to fit into regular clinical practice. The Researchers wanted to make it a pragmatic trial approach. The Committee noted that a trainer is only available when the participant is in hospital and then after they will have to go to Newmarket campus and will the walking be without the trainer. The Researcher confirmed that is the case and that follow up assessments are without the trainer. The Committee asked that the Researchers make clear in the information sheets that these sessions will be conducted without the use of the trainer.
5. Pages 4-5: intermittently refer to “the study” and “the project”. The Committee asked that the Researchers chose one expression and use it consistently throughout the document.
6. The Committee noted the statement that participants will be asked to sign a consent form and noted that if they are unable to sign that there will be a section for another adult to sign but could not see that on the form. Please include provision for this on the form.
7. Physiotherapist form: notes they are only eligible if 18 years old and the Committee queried whether there are any eligible physiotherapists who are 18 years old. Please amend this to reflect an appropriate age or delete.
8. The Committee considered that the statement “You and your patient will set up the relink trainer” is ambiguous, and suggested that more information about what the physio is expected to do would be useful.
9. The information states that participation takes 30 mins of the physiotherapist’s time, but also says the questionnaire itself takes 30 minutes. Please clarify total time requirements in the information sheet.
10. The Committee asked what happens if the patient wants to participate but their physiotherapist doesn’t or vice versa. The researcher stated that both parties need to consent in order to participate, as ‘pairs’ were needed. The Committee asked that this be stated in the Information Sheets.
11. The ‘summary of rights’ states that: “You may have your data withdrawn from the study within three months of your participation”. The Committee asked that this be amended to “you may request that your data be withdrawn from the study within 3 months of your participation”.
12. The Committee asked when data would be de-identified. The researcher stated it would be de-identified by the study coordinator who would retain a key to link subject codes and identifiers. The Committee asked that is be made clear in the Information Sheets.

Decision

This application was *provisionally approved* by consensus, subject to the following information being received.

* Please provide criteria for study termination. (*Ethical Guidelines for Intervention Studies* *para 6.64*).
* Please amend the information sheet and consent form, taking into account the suggestions made by the Committee (*Ethical Guidelines for Intervention Studies* *para 6.22*).

This information will be reviewed, and a final decision made on the application, by Dr Nicola Swain and Dr Cordelia Thomas.

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| In **6** | **Ethics ref:** | **18/STH/163** |
|  | Title: | RELEVENT Study -Resolution of left ventricular thrombus with different anticoagulation strategies |
|  | Principal Investigator: | Professor Ralph Stewart |
|  | Sponsor: |  |
|  | Clock Start Date: | 02 August 2018 |

Dr Jocelyn Benatar was present by teleconference for discussion of this application.

Potential conflicts of interest

The Chair asked members to declare any potential conflicts of interest related to this application.

No potential conflicts of interest related to this application were declared by any member.

Summary of study

1. The Researcher gave an overview of the study. Patients who have large heart attacks have parts of the heart that don’t move very well, resulting ln left ventricular clot formation in approximately 5%. The clots can break off and cause stroke. Current standard of care is warfarin in conjunction with antiplatelet drugs such as aspirin. Warfarin has a lot of interactions and has side effects and must be maintained within a narrow therapeutic window, which makes it an unpredictable drug. New anticoagulants have been effectively used for similar indications and do not require monitoring. There are no robust studies comparing warfarin and these newer anticoagulants in the treatment of LV thrombus.
2. Part 1 of this multi-centre clinical trial compares the safety and efficacy of warfarin and dabigatran in LV thrombus post myocardial infarction. Part 2 of the study evaluates the need to continue anticoagulation after 3 months of therapy, in terms of LV thrombus recurrence rate.

Summary of ethical issues (resolved)

The main ethical issues considered by the Committee and addressed by the Researcher are as follows.

1. The Committee asked who would make the initial approach to patients regarding study participation. The Researcher noted that in larger hospitals it is easy for research staff to make the first approach but in smaller hospitals the coronary care doctor would approach the patient for the study. The Committee noted that it would prefer someone involved with clinical care to make the first approach to the patient, with the research team notified if the person shows interest.
2. The Committee noted that the Researchers state that an echo cardiogram will be done as part of clinical care, and also state that this will be anonymised. The Researcher clarified that the imaging will be identifiable and remain in the patient’s medical file to enable clinical decision making. A copy of each echocardiogram will be de-identified and retained for analysis by the research team.
3. The Committee noted that the Researchers have stated in the cultural section that an aim of the study is to improve outcomes for Maori and that this would be achieved by engaging with health providers and whanau at the DHBs. When questioned, the Researcher stated that they were likely to enrol approximately 10 – 20 Maori at best in the study. The Committee noted therefore that it is probably not an aim of the study to improve outcomes for Maori. The Committee suggested that for future applications it would be good to bear in mind specific outcomes and benefits for Maori that may arise.
4. The Committee noted that the protocol flow diagram includes a final ‘study blood test’ which is not referred to elsewhere in the protocol. The researcher confirmed that this was an error and would be removed.
5. The Committee noted that the Researchers will randomise 50 participants in New Zealand prior to other countries commencing enrolment and asked and why it was starting in New Zealand. The Researcher explained that the study was led by New Zealand Investigators. The research team wanted to ensure the study was running smoothly locally prior to rolling it out in other countries.
6. The Committee asked how the study was funded. The Researcher explained that the study had received a $50 000 grant from the Green Lane Education Research Fund , with applications made to the Health Research Council and the National Heart Foundation for further funding. No pharmaceutical company funding has been sought.

Summary of ethical issues (outstanding)

The main ethical issues considered by the Committee and which require addressing by the Researcher are as follows.

1. The Committee suggested the protocol eligibility criteria should include a statement that the participant is competent to give fully informed consent, given the intended target population. The Researcher confirmed that all patients will be competent.
2. The Committee noted the protocol does not specify the choice of anti-platelet therapy in part 2, and asked whether this will be clinician determined. The Researcher confirmed this and explained that choice of antiplatelet therapy will be driven by each patient’s clinical circumstances. The Committee asked that this be stated in the information sheet – i.e. that the participant’s doctor will decide what they will receive.
3. The Committee queried the independence of the peer review of this study. While the guidelines state that a letter is acceptable the Committee cannot see the comments from the reviewers outlining what has been assessed as part of the peer review. The Committee suggested that the Researcher obtain peer review using the HDEC template on its website, or the researcher could provide known reviewer comments if available.

The Committee requested the following changes be made to the participant information sheet and consent forms:

1. The Committee commended the Researcher on the information sheet submitted, but suggested that the Researchers view the HDEC information sheet pro forma as it has helpful guidance for Researchers on what additional information should be included.
2. The Committee prefers that acronyms or titles that imply success are not included in patient-facing material as they predetermine the role of research. The Committee requested that the Researchers use a simply lay title for the Participant Information Sheet (PIS) rather than the current acronym.
3. The Committee noted that the protocol flow diagram provided a useful overview of the study and that a lay version would be a helpful addition to the PIS.
4. The Committee asked whether participants will be given information sheets about warfarin and dabigatran, as the information provided in the PIS was minimal. The Researcher confirmed that all participants would be discharged with information sheets about the medications they are taking. The Committee asked that the Researchers include a statement in the PIS that informs participants that they would be provided with appropriate drug information sheets.
5. The Committee asked the Researchers to have a closer look at the information provided about data safety, withdrawal of consent and cultural statements. The HDEC pro forma could be used for guidance.
6. The Committee asked that the Researchers include a statement about who was funding the study.
7. The Committee questioned the wording of the following statement on Page 2 of the PIS, under the heading ‘Side Effects of Warfarin and Dabigatran’: “You should try not to take medications which increase your risk of stomach bleeding…” The Researcher explained that participants in this study group will likely have other disorders and they discourage them from using the listed drugs. The Committee suggested that a dosing diary for participants could be helpful. The Committee suggested that the researchers could instead say something along the lines of “No other medications should be taken during the study, without prior approval”. –

Decision

This application was *provisionally approved* by consensus, subject to the following information being received.

* Please provide evidence of favourable independent peer review of the study protocol (*Ethical Guidelines for Intervention Studies* Appendix 1).
* Please amend the information sheet and consent form, taking into account the suggestions made by the Committee (*Ethical Guidelines for Intervention Studies* *para 6.22*).

This information will be reviewed, and a final decision made on the application, by Dr Devonie Waaka and A/Prof Mira Harrison-Woolrych.

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| **7** | **Ethics ref:** | **18/STH/164** |
|  | Title: | RESOLVE |
|  | Principal Investigator: | Dr Mark Marshall |
|  | Clock Start Date: | 02 August 2018 |

Dr Marshall was present in person and Mrs Howie and Ms Railton were present by teleconference for discussion of this application.

Potential conflicts of interest

The Chair asked members to declare any potential conflicts of interest related to this application.

No potential conflicts of interest related to this application were declared by any member.

Summary of study

1. The Researchers gave an overview of study. Dialysis is used for renal failure and prolongs life from a matter of weeks to months to a matter of months to years. There are numerous technical variations in dialysis and these can be manipulated to meet the wishes and medical needs of patients. The concentration of sodium in dialysate is one such variable. A range of sodium concentrations are used worldwide. In New Zealand dialysis units use concentrations ranging from 136 -141 mmol/L. The concentration used in each unit is determined largely by customary practice, habit, history and occasionally biomedical need.
2. This study aims to see whether sodium dialysate concentration affects cardiovascular outcomes in dialysis patients. The study will cluster randomise 400 dialysis units around the world, including 15 units in New Zealand, to one of two sodium dialysate concentrations. Both concentrations are widely used in New Zealand and overseas, and fall within the range currently used by New Zealand sites.
3. The Researcher noted that dialysis accounts for 2 – 3% of New Zealand’s health-care spend. An improvement in patient outcomes would therefore be of significant benefit.

Summary of ethical issues (resolved)

The main ethical issues considered by the Committee and addressed by the Researcher are as follows.

1. The Researchers explained their rationale for choosing an opt-out consent option for this study. The researchers believe the level of harm is low and that the intervention is comparing two standard-of-care practices. The only difference to standard of care is the use of routinely-collected health information for research purposes.
2. The Researcher explained that the Australian research team had also requested opt-out consent. The reviewing Ethics Committee instead approved the study with a waiver of consent. This decision was made on the basis that vulnerable populations might opt out at a higher rate than other patients, and thus would not be adequately represented in any analysis of study data. As the study results will be applied to all patients, all patients’ data should be included in the analysis to avoid disadvantage to certain groups.
3. The Researcher confirmed that dialysis participants, by the nature of their underlying disorders, tend to be frail. He agreed that an opt-out consent could impact significantly on the scientific validity of the study. He stated that Chinese Ethics Committees had approved the study in a 50/50 mix of opt-out and waiver of consent decisions. Australia, Canada and India had approved with waiver of consent. The UK sites has not yet approved ethical approval.
4. The Committee noted that a simplified consent process is in place here for registries and queried whether a simplified consent could be used in the same way for this study. The Researcher confirmed that this is the approach they have taken in the application before the Committee today with a generic opt-out adaptation. The Researchers intend to provide all dialysis patients with a simple PIS/CF. Those who do not wish to participate may opt out. All dialysis patients will receive the sodium dialysate level assigned to their dialysis unit, regardless of study participation. Their routinely collected health information will be used for the study unless they opt out. The Committee noted that this approach does not comply with Right 7(4) of the Code of Rights.
5. The Committee noted that the Code states that people must make an informed choice and give informed consent. The Committee discussed whether this applies here as everyone will get the opportunity to see the information sheet and will have the opportunity to opt out.
6. The Researcher confirmed that the information sheet will go to everybody. Previous experience with opt-in research suggests that an opt-in approach may result in between 10-25% of patients participating. This would not make it feasible to proceed with the study in New Zealand.
7. The Committee noted that participants have a right to know that their health information is being used in research. Right 6(1)(d) of the HDC Code of Rights states:
   1. *Every consumer has the right to information that a reasonable consumer, in that consumer’s circumstances, would expect to receive, including … notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval.*
8. The Committee noted that they can approve access to identifiable health information without consent for research in certain circumstances. The Ethical Guidelines for Observational Studies states at Paragraph 6.43:
   1. *Access to identified or potentially identifiable data for research without the consent of the people the data identifies or makes potentially identifiable may be justifiable when:*
      1. *the procedures required to obtain consent are likely to cause unnecessary anxiety for those whose consent would be sought; or the requirement for consent would prejudice the scientific value of the study; or it is impossible in practice to obtain consent due to the quantity or age of the records; and*
      2. *there would be no disadvantage to the participants or their relatives or to any collectives involved; and*
      3. *the public interest in the study outweighs the public interest in privacy.*
9. To approve a study involving access to health information without consent the Committee must be satisfied that these requirements are met by the study concerned.The Committee agreed that arguably (a), (b) and (c) are satisfied.
10. The Committee noted that there is always the risk to participants of breach of confidentiality but appears to be low risk in the current study. It agreed that an opt-out option is not an acceptable approach in this study, however there is a strong case for waiver of consent. The non-inclusion of participants will impact on the scientific validity of the study, and there is a case that they will benefit significantly potentially if an optimal sodium dialysate level can be determined.
11. The Committee noted that, according to clause 3 of the Code of Rights, it is not a breach of the Code if reasonable actions have been taken to comply with the rights in the Code. Because of all the circumstances discussed it can be argued that the Researchers have reasonably attempted to comply with the rights in the Code. This does not include opt-out consent however.
12. The Researcher confirmed that the HRC peer reviews submitted with this application relate to this intended study.
13. The Committee commended the Researchers on the answer stated at question p.4.1 of the application form in relation to potential benefit for Maori.

Decision

This application was *approved* by consensus.

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| **8** | **Ethics ref:** | **18/STH/165** |
|  | Title: | Gaps in the provision of radiotherapy for early breast cancer. |
|  | Principal Investigator: | Dr Karen Bartholomew |
|  | Sponsor: | Waitemata District Health Board |
|  | Clock Start Date: | 02 August 2018 |

Dr Karen Bartholomew and Dr Charis Brown were present by teleconference for discussion of this application.

Potential conflicts of interest

The Chair asked members to declare any potential conflicts of interest related to this application.

No potential conflicts of interest related to this application were declared by any member.

Summary of study

1. The Researchers presented an overview of the study. This quantitative study will utilise the new consolidated breast cancer registries and collaboration across five District Health Boards (DHBs) to specifically address inequities around radiotherapy for early breast cancer, looking from the perspective of women’s experience in particular. The Researchers hope that this study gives some richness to the quantitative data and will lead to direct service improvements. They have good buy in from each of the services at the sites and they are really interested in this question and what changes they can make.
2. The researchers noted that they are very pleased to have this study funded, having worked on the proposal for over three years. They see the study as a great opportunity to do a collaborative piece of work between academics and DHBs, with the purpose of trying to reduce inequities, and to improve care for Maori women in particular.
3. The Committee congratulated the Researchers on a well-completed application, noting the merit of the study and that it is well planned.

The Committee requested the following changes be made to the participant information sheet and consent forms:

1. The consent form states: ‘you agree that information may be collected about and may be used up to the point I withdraw’ and noted the yes/no option and asked whether this means, if the participant says ‘no’, that researchers are able to remove data collected prior to the point of withdrawal. The Researchers noted that this is possible for the interview group. It is not possible for the focus groups, as there are multiple voices that are represented. The Committee asked that the option be removed from the focus group consent form.
2. Follow up focus group information sheet, page 2: says “we will invite you to participate in a follow up focus group to get feedback.” The Committee queried whether the Researchers will have enough space to see everybody again. The Researchers confirmed that this is their intention.
3. The Committee asked who will pay for the study, noting no reference to parking and transport expenses. The Researchers advised that DHBs will fund this part of the study. A small Koha will be made. Parking and transport costs will also be covered. The Committee asked that this information be included in the information sheet.
4. The focus group information sheet, page 2 states: “Please be assured that the information you give us will be kept confidential”. The Committee questioned whether this can be stated for focus groups. The Committee suggested that the risks section should include the potential risk of privacy breach. This could be framed positively, for example “We would expect all participants in the focus group to respect the privacy of others and to keep the information confidential.”
5. The Committee sought clarification on the approach to participants, noting the Researchers have stated that the clinical team will make the initial approach either in person or by mail. The Researchers explained that the intention is for everybody approached to have been identified as eligible by the clinical team at each of the specific DHBs. The clinical specialist will aim to speak with each patient in person at their next appointment. In situations where this was not possible the patient would be sent a letter from the clinical specialist, inviting the patient to participate. This ensure eligible women will not miss out on the opportunity to participate. The Committee noted that it is ideal to have the study introduced by their clinician but rather than have them miss the opportunity altogether a carefully crafted cover letter is acceptable.
6. Consent form, Interpreter statement: please localise this to the site and say if you have interpreter or not.

Decision

This application was *approved* by consensus with non-standard conditions.

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| **9** | **Ethics ref:** | **18/STH/167** |
|  | Title: | BGB-A333 alone and in combination with Tislelizumab Dose Escalation and Dose Expansion Study in Solid Tumors |
|  | Principal Investigator: | Dr Peter Fong |
|  | Sponsor: | IQVIA RDS Pty. Limited |
|  | Clock Start Date: | 02 August 2018 |

Dr Peter Fong, Mrs Anna Bedrilovskaia and Mrs Joanne Lim were present by teleconference for discussion of this application.

Potential conflicts of interest

The Chair asked members to declare any potential conflicts of interest related to this application.

No potential conflicts of interest related to this application were declared by any member.

Summary of study

1. The Researchers presented a summary of the study. This is an international trial in 200 participants worldwide, with five participants in New Zealand.
2. The Committee asked whether SCOTT review had been completed. The Researchers advised that it has been submitted in parallel by the sponsors and that they are awaiting the outcome.

The Committee requested the following changes be made to the participant information sheet and consent forms:

1. The Committee noted that the title as it stands is long and requested that the Researchers amend and provide a lay title. The Committee also asked that the Researchers state who the information sheets are for/identify which group they are for.
2. Please remove the complex footers from the information sheets.
3. The Committee noted the statement in the information sheet that gene expression profiling would be performed on blood and tumour samples, and queried what gene expression profiling they are planning on the blood samples. The Researcher explained that they will not do genotyping or genetic studies on the blood samples. The only point at which the gene studies might emerge is to define which group the patient might go to. This is on the tumour tissue samples only and not the blood samples.
4. Level of de-identification of samples: The Committee noted it is stated in the application form that data will be available for future research in a de-identified form. The information sheet says when compatible with the requirements of the study and future research. The Committee would prefer that data used for future research is de-identified. The Committee noted that it was not sure why they would have a caveat “when it’s compatible” with future research. The Researchers confirmed that they will only collect data compatible with study IT numbers and all personal data will be removed. The Committee asked that they remove the phrase “when compatible”, as they plan to de-identify data in all cases.
5. The Committee noted that there is a standard new compensation statement that is available on the HDEC website. Once the sponsor legal team has approved the statement that should replace the current statement.

*As this research study is for the principal benefit of its commercial sponsor [insert name], if you are injured as a result of taking part in this study you* ***won’t*** *be eligible for compensation from ACC.*

*However, [insert name] has satisfied the [ insert name] Health and Disability Ethics Committee that approved this study that it has up-to-date insurance for providing participants with compensation if they are injured as a result of taking part in this study.*

*New Zealand ethical guidelines for intervention studies require compensation for injury to be at least ACC equivalent. Compensation should be appropriate to the nature, severity and persistence of your injury and should be no less than would be awarded for similar injuries by New Zealand’s ACC scheme.*

*Some sponsors voluntarily commit to providing compensation in accordance with guidelines that they have agreed between themselves, called the Medicines New Zealand Guidelines (Industry Guidelines).These are often referred to for information on compensation for commercial clinical trials. There are some important points to know about the Industry Guidelines:*

*On their own they are not legally enforceable, and may not provide ACC equivalent compensation.*

*There are limitations on when compensation is available, for example compensation may be available for more serious, enduring injuries, and not for temporary pain or discomfort or less serious or curable complaints.*

*Unlike ACC, the guidelines do not provide compensation on a no-fault basis:*

*The Sponsor may not accept the compensation claim if:*

*Your injury was caused by the investigators, or;*

*There was a deviation from the proposed research plan, or;*

*Your injury was caused solely by you.*

*The injury was caused by <<NAME OF COMPARATOR DRUG>> (include only if holds true for specific study)*

*An initial decision whether to compensate you would be made the by the sponsor and/or its insurers.*

*If they decide not to compensate you, you may be able to take action through the Courts for compensation, but it could be expensive and lengthy, and you might require legal representation. You would need to be able to show that your injury was caused by participation in the trial.*

*You are strongly advised to read the Industry Guidelines and ask questions if you are unsure about what they mean for you.*

*If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won’t affect your cover.*

1. In the interests of making the information accessible to a New Zealand audience, the Committee asked that the term “pulmonary function testing” be replaced with “lung function testing”.
2. The Committee noted the statement about BGB A333 being a first in human study on page 10 of the information sheet and asked that this be made more prominent. Please state this clearly and in bold upfront on the first page of the information sheet.
3. The Committee noted that for consistency there needs to be an addendum to the Pregnant Partner consent form, for the mother to sign after the baby has been born. This allows collection of neonatal / infant data.

Decision

This application was *approved* by consensus with non-standard conditions.

## General business

1. The Committee noted the content of the “noting section” of the agenda.
2. The Chair reminded the Committee of the date and time of its next scheduled meeting, namely:

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| **Meeting date:** | 11 September 2018, 08:00 AM |
| **Meeting venue:** | Sudima Hotel, Christchurch Airport, 550 Memorial Drive, Christchurch |

The following members tendered apologies for this meeting.

No apologies were tendered.

The meeting closed at 3:30pm.