DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE
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FOR US POSTAL SERVICE DELIVERY:
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Bethesda, Maryland 20817
Telephone: (301) 496-7163
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DATE: October 17, 2018

TO: Michael M. Gottesman, M.D.
Deputy Director for Intramural Research, NIH

FROM: Director
Division of Compliance Oversight, OLAW

SUBJECT: Animal Welfare Investigation (#014-18) - Animal Welfare Assurance A4149-01 [Case 12N]

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your October 2, 2018 memo regarding an incident of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the Office of Research Services/Division of Veterinary Resources. According to the information provided, OLAW understands that between the evening of July 30, 2018 and the morning of July 31st two rhesus macaques escaped their caging due to unsecured cage floors and a third escaped due to an unsecured cage divider allowing the animal access to an unlocked cage. The three animals fought and sustained injuries to the hands, arms, faces, and tongues. They were captured on the morning of July 31st and treated. Two additional caged animals were also treated for injuries apparently obtained from interactions with the escaped animals. The three animals escaped due to insufficient communication between the regular caretaker and temporary replacement staff while the regular caretaker was on vacation.

Corrective and preventive actions included recommendations from the ACUC subcommittee that cage locks be double checked and that all animal caretakers meet with new staff or caretakers covering their areas to go over any pertinent information or issues prior to going on leave. It is further understood that the unsecured cage floors have been welded in place and that the cage divider was removed for the third animal and both cages have been locked. Supervisors will sweep the facilities to look for similar cages with removable bottom floors to be repaired. There was an all-staff meeting to review practices for assessing cages and locks and staff have been asked to record any cage design flaws and to notify management. An ante-room cage has been installed to the back doors of the building to decrease the possibility of an escaped animal getting out of the building.

The actions taken to resolve the issues and prevent recurrence were appropriate and accepted by OLAW. We appreciate being informed of this matter and find no cause for further action by this office.

Sincerely,

(b) (6)

Brent C. Morse, DVM
Director
Division of Compliance Oversight
Office of Laboratory Animal Welfare

cc: Dr. Stephen Denny
Dr. Richard Wyatt
Mr. Scott Green, Chair, ORS ACUC

A4149-12N

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

www.nih.gov

October 2, 2018

TO: Brent C. Morse, D.V.M.
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare

FROM: Deputy Director for Intramural Research, NIH

SUBJECT: Animal Welfare Investigations - Assurance A4149-01 (#014-18)

This correspondence conveys the results of an investigation by the Office of Research Services/Division of Veterinary Resources ACUC, in accordance with Assurance A4149-01 and PHS Policy IV.F.3. The adverse event involved a caging design flaw that failed to prevent the escape of animals and the subsequent injury of other colony animals.

The event was first reported to the NIH Office of Animal Care and Use by the DVR Attending Veterinarian on August 1, 2018. The details of the ACUC investigation and the corrective actions taken by the animal care program are outlined in the attached memorandum.

Please contact me or Dr. Stephen Denny, Acting Director, Office of Animal Care and Use, if additional information or clarifications are required.

(b) (6)

Michael M. Gottesman, M.D.

Attachment

cc: Dr. Wyatt
Mr. Green
Dr. Denny

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

Date: August 23, 2018

To: Michael M. Gottesman, MD
Deputy Director for Intramural Research, NIH

From: Scott Green,
Chair, ORS Animal Care and Use Committee

Subject: NIH Animal Center (Poolesville) Building 104 Incident Summary
NIH Animal Welfare Assurance # A4149-01

This memorandum summarizes findings regarding a report of three NHPs which escaped from their cages, leading to injuries to five animals: Two from NIA, two from USAMRIID, and one from NIAID-IRF. These animals were on holding protocols. On Thursday, August 2, 2018, the ORS ACUC Chair was notified of the incident by the DVR FMB Chief. An ACUC Subcommittee was formed on August 7, 2018 to investigate the event, which was also briefly discussed during the August 21, 2018 ACUC meeting.

This report is necessitated due to non-compliance with the Guide, which requires that "The primary enclosure should provide a secure environment that does not permit animal escape...".

The DVR ACUC Subcommittee met with the following individuals as part of their investigation: NIH Animal Center (NIHAC) DVR Government Facility Manager, NIHAC DVR Facility Veterinarian, NIHAC Contract Project Manager, NIHAC Task Manager, two DVR Veterinary Behavior Technicians, the government caretaker for Building 104, and two contract caretakers responsible for jumping the animals in the absence of the government caretaker. The Subcommittee also teleconferenced with the previous NIHAC Facility Veterinarian who provided veterinary care to three of the animals following the incident.

Incident Summary:

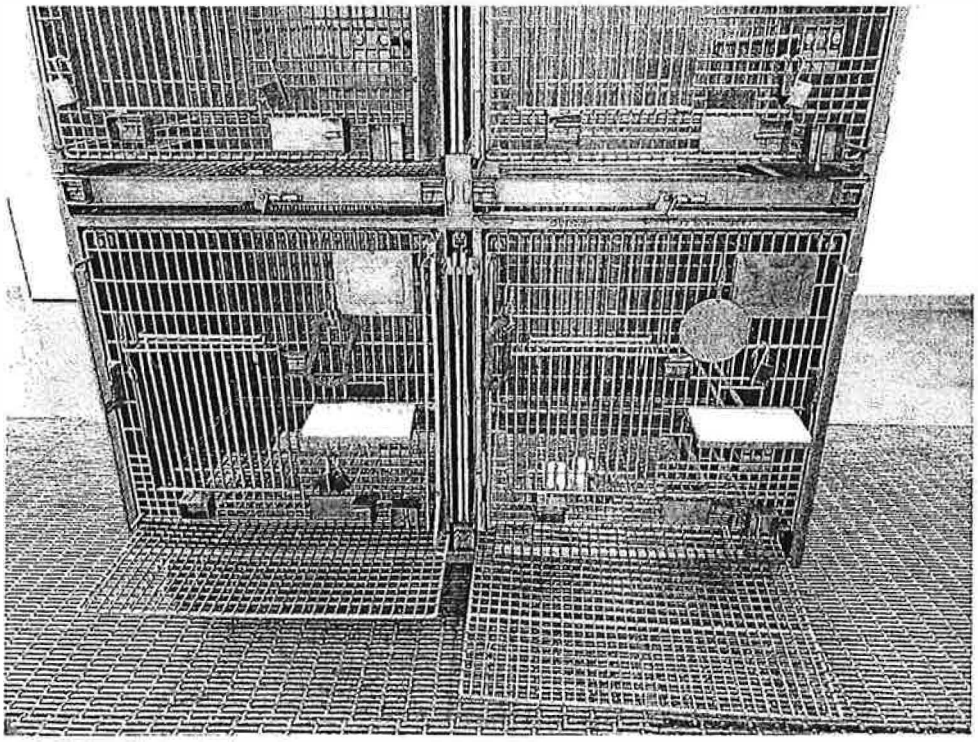
On Monday July 30, 2018, room (b) (4) in building 104 at the NIHAC was jumped by two contract caretakers while the regular government caretaker for this room was on vacation. The caretakers completed the task and the animals (Rhesus NHPs) were last observed at the afternoon feeding around 3:30pm. During the morning check around 7:15am on July 31, the government caretaker found three animals had escaped from their cages; the pair 04D240 and 09U008, as well as a singly housed animal RA0984. The animals appeared to have fought with each other sometime following their escape after the Monday afternoon feeding. The escaped animals were immediately caught, evaluated by veterinary staff, and sedated for treatment. Additionally, after assessing the room, two additional caged animals, ZC44 and ZC09, were

noted with injuries presumptively from interactions with the escaped animals and were sedated for treatment.

The initial pair, 04D240 and 09U008, was being housed in a C-quad designed to have removable flooring to allow the entire quad to be opened for paired NHPs or extra space for enrichment purposes. However, we were informed that the quad had a design flaw given the manufacturer simply duplicated the design of the top two caging with removable flooring when designing the bottom two cages. The bottom two cages of the quad should not have been designed with removable flooring, thus requiring the flooring to be secured with a chain to avoid the NHPs from escaping.

The new caretakers stated they were unaware of the requirement to chain the floors of the bottom two cages (see picture below). The Subcommittee was informed by the government animal caretaker that only two individuals, including himself, knew the floors at the bottom of the C-quad came out if unsecured by a chain and neither of them were at work on July 30. In retrospect, the government caretaker could have chained the floors for the bottom cages following cage wash. Per conversation at the ACUC meeting, the Subcommittee recommended all animal caretakers meet with new staff or caretakers covering their areas to go over any pertinent information or issues prior to going on leave.

The third animal which escaped was housed in a cage of a 6.0 quad which was adjacent to an empty cage. He escaped by opening the divider, which had been left unlocked and exiting through the empty cage. The caretakers failed to secure the lock as stated on the daily log sheets. The Subcommittee recommends a secondary lock check in addition to the caretaker signing off on the log sheet.



The five adult animals involved in this case belonged to three different institutes (NIA, NIAID-IRF, and USAMRIID) and sustained wounds consistent with conspecific aggression. Sustained injuries were localized to the hands, arms, face and tongue and ranged in severity from mild superficial abrasions, to lacerations requiring suture repair, and a fractured finger requiring amputation. All animals were promptly treated by veterinary staff and received antibiotics, analgesia, and close monitoring as directed by a veterinarian until fully healed. There was some initial concern about a loss of appetite for three of the five monkeys involved in the incident, however, after receiving dietary supplements and enrichment, the five animals were okay after a few days. Following the event, all animals in the room were also monitored by DVR Behavior Staff who reported that they noted the room was rattled and unsettled on Tuesday 7/31, but okay by Friday 8/3. Specifically, one animal in the room not directly involved in the event but on treatment for abnormal behavior was observed to be agitated on Tuesday 7/31, then gradually became relaxed after a few days. The Subcommittee observed that all animals involved were healed, active, and in good health on 8/22/18.

The previous Facility Vet remains concerned that the animals could have gotten out of the building. She indicated the back door in the room has no anteroom cage as with the front door, so the escaped animals could have exited the entire building given the emergency exit doors out the back cannot be locked. Additionally, while room (b) (4) is a level three room restricted to "clean" or uninfected animals, the situation could have been much worse if this were a different room where uninfected animals fought with SIV animals. The veterinary and behavioral staff indicated the need for animal caretakers to "slow down" when checking cages, and "double and triple check locks, etc".

Corrective actions taken:

- The two C-quads with removable floors have been taken out of circulation. After the investigations were completed, the floors of these quads were welded in place.
- Supervisors will sweep the facilities to look for similar cages with removable bottom floors for repair.
- The singly housed animal was given access to both sides of the quad, and both cages have been locked.
- On Wednesday 8/1, there was an all staff meeting to review practices for assessing cages and locks before and after jumping. Staff have been asked to record any cage design flaws they see and will henceforth notify management to replace/modify any caging that currently requires chains to be secured. In fact, the Subcommittee was informed that following the all-hands staff meeting, management was informed of a flawed cage which was immediately fixed.
- The facility recently installed an ante-room cage to the back doors of Building 104 to provide additional security and prevent the possibility of an escaped animal getting out of the building.

The Subcommittee recommends the creation of a plan that incorporates an in-depth inspection of any new caging required for identifying design flaws or areas of concern prior to placing the new caging into circulation. A document capturing all known design flaws on the different cage types would also be beneficial as a quick reference.

The ORS ACUC reviewed the findings of the subcommittee at its September 18, 2018 meeting and believes the corrective actions taken will significantly minimize the possibility of a similar incident occurring in the future.

The Committee voted unanimously that this incident is a reportable/non-reportable incident.

Morse, Brent (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Tuesday, October 09, 2018 1:52 PM
To: Denny, Stephen (NIH/OD) [E]; OLAW Division of Compliance Oversight (NIH/OD)
Subject: RE: 4149-01 NIH Animal Incident Report (DVR #014-18)

Thank you for this final report Dr. Denny We will send an official response soon. Please consider submitting prompt preliminary reports as was OACU's previous practice. If you have any questions, please feel free to contact me.

Best regards, Brent Morse

Brent C. Morse, DVM, DACLAM
Director
Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health

From: Denny, Stephen (NIH/OD) [E]
Sent: Tuesday, October 09, 2018 11:39 AM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Subject: 4149-01 NIH Animal Incident Report (DVR #014-18)

Dear OLAW/DCO,

Final reports from the NIH Institutional Official and the Office of Research Services – Division of Veterinary Resources ACUC addressing an animal incident reported to this office on 1 August are attached. The incident involved escape of primates from two cages due to caretakers' failure to lock two different caging components after changing the cages in a room for sanitation purposes. Several primates were injured following the escape.

If you have any questions please contact me via email or the phone number listed below. Thanks, Steve

STEPHEN L DENNY, DVM, MS, DACLAM | Acting Director, Office of Animal Care and Use | National Institutes of Health | Bldg 31-Rm B1C37, 9000 Rockville Pike, Bethesda, MD 20982 | Phone: (301) 496-5424 | http://oacu.od.nih.gov