University of Washington
February 18, 2021 IACUC Meeting Minutes

Members Present:

| AB | JA | KM |
| :--- | :--- | :--- |
| AW | JM | KS |
| CM | JPVH | MB |
| DM | JS | MK |
| FRR | KG | MRK |
| GS | KAG | SL |
|  |  | SRH |

Members Absent:

## Opening Business

- The IACUC Chair called the meeting to order at $2: 31 \mathrm{pm}$.


## Confirmation of a Quorum and Announcement

- Quorum was confirmed by JS.
- New Non-Scientist member MRK was welcomed


## IACUC Training - MB

- Overview of submission review process


## Approval of the IACUC Meeting Minutes

- The IACUC Chair called for the approval of the January 21, 2021 meeting minutes.

Motion was made and seconded: to approve the minutes as written.
Further Discussion: None.
Vote: Approved with 17 members voting in favor, 0 against and 1 abstention.

## Attending Veterinarian's/OAW Director's Report - KS

- IACUC metrics- see meeting documents
- Facility issues: None
- Protocol Monitoring:
- Eighteen total protocols. Of the protocols, eight involve surgery, one restraint (and sx), 2 tumor modeling, 7 miscellaneous (tape skirt, infection, water quality, prolonged anesthesia). Ten are inactive right now.
- Adverse Events:
- 4452-01 \#1: 4 of 5 mice were found dead in a cage with no food. The remaining mouse was euthanized due to poor condition. The mice were no longer on a study that required water restriction for behavioral testing; however, this cage was on a dedicated rack in the room for food and water restriction studies which is maintained by the lab group. DCM husbandry
staff do daily animal health checks on this rack but are not responsible for adding food to cages. The group last handled the cage two days prior. Corrective Action: Vet Services emphasized with the group to remove cages from the dedicated rack to another rack in the room to ensure food is provided by husbandry and not by the lab.


## Reported to OLAW.

- 4452-01 \#2: One cage of mice was found to be disengaged from the rack by husbandry staff. The lixit was not engaged, however food was present in the hopper. The cage consisted of one dam and 8 pups that were about 18 days old. The adult female and 7 pups were found dead when the cage was discovered. The remaining pup was treated and survived. The day before the discovery, a lab member had handled the cage and mistakenly did not fully engage the cage in the rack. Corrective Action: The investigator stated that they will double check that cages are always engaged in the rack moving forward. Also, they were advised to take Engaging Rodent Cages into Racks on-line lesson as refresher training.


## Reported to OLAW

This lab has had recent previous incidents. These 2 adverse events involved different lab members in different facilities. The IACUC Chair and AV are scheduling a meeting with the PI and lab members involved to emphasize the level of significance and concern. It is a very large lab, so they will need to work with the PI on the logistics of communication and monitoring to prevent future occurrences. It was suggested that this lab be more closely monitored including regular check-ins with the lab by their OAW liaison. It was also suggested having the lab members attend the IACUC meetings. It was recommended that the letter be strongly worded about the possibility of losing their animal privileges if issues continue to be seen.

IACUC Member Entered at 2:55 PM
Motion was made and seconded: to send a Letter of Reprimand. Further Discussion: None.
Vote: Approved with 19 members voting in favor, 0 against, 0 abstentions.

- 3380-02: One approximately 10-day old pup with an ear tag was found alone in a cage on the rack. The pup was moribund when it was found and euthanized by Vet Services. The investigator had been ear-tagging pups earlier that morning. As the investigator was ear tagging, they transferred pups into a new clean cage and missed one pup as pups were returned to the home cage. Corrective Actions: After Vet Services discussed this event with the investigator, they will no longer transfer pups to a new cage while ear tagging if they are too young to be weaned. This change should ensure that the pups will always be with the dam during this process and no risk of leaving a pup behind again.


## Reported to OLAW

The AV is not recommending a letter, as this was a one-time incident and the PI and lab do not have a history of incidences. There is a historical precedent to not send a letter when the lab is understanding of their responsibility, have not had previous issues, and have developed a plan to ensure it will not happen again.

- Non-compliance:
- Husbandry: Eleven New Zealand White Rabbits arrived from an approved vendor on a Wednesday and were housed in ARCF. Prior to their arrival there had been no animals in
that housing room. The rabbits' arrival was communicated in writing to the husbandry staff member responsible for these rooms over the weekend. On both Saturday and Sunday, the room was not checked for the regularly scheduled A.M. and P.M. checks and the rabbits were not fed their regular pellet diet. On Monday morning, another animal technician discovered the incomplete room log, and reported it to Veterinary Services and the facility manager. At that time, all rabbits were bright, alert, and well-hydrated. The husbandry staff member responsible for the room checks over the weekend stated that they thought the room was empty and therefore did not check the room. Corrective action: HR is investigating to determine any personnel actions to be taken.


## Reported to OLAW and USDA.

The technician was sent an email stating that there were rabbits in the room, and there was a log sheet on the outside of the room indicating animals were present in that room. An IACUC member was concerned that this level of communication may not be sufficient to prevent this type of issue. The AV mentioned that there is currently a discussion to incorporate electronic room logs that could be checked by supervisory staff even remotely rather than using paper room logs. This would be part of a long-term plan to prevent situations like this from occurring. Additional room door signage could help but it could also blend in with other signage. The IACUC will table further discussion of this incident until the HR process is completed.

- From Arizona
- Facilities items: No items to report.
- Adverse events: No adverse events to report.


## Standard Operation Procedures / Policies / Guidelines

- Anesthesia Certification Requirements in USDA-Covered Animals - KS
- A recertification is now required if a person has not practiced general anesthesia within 18 months. Additional certification is now required if special equipment or special techniques are being used.
- Blood Collection in Laboratory Animals - KS
- Additional wording was added to consider impacts of anesthesia and sedation on blood parameters. There was an addition of positive reinforcement training for conscious blood collection. Additional wording was added about alternating retroorbital blood collections between the right and left eyes to allow for a minimum of 7 days between collections from the same eye.

Motion was made and seconded: to approve the two policies as written.
Further Discussion: None.
Vote: Approved with 19 members voting in favor, 0 against, 0 abstentions.

## Closing Business:

The Meeting was brought to a close at $3: 33 \mathrm{pm}$. The floor was opened to public comment.

