DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:
Office of Laboratory Animal Welfare
6700B Rockledge Drive, Suite 2500, MSC 6910
Bethesda, Maryland 20892-6910
Home Page: http://grants.nih.gov/grants/olaw/olaw.htm

FOR EXPRESS MAIL:
Office of Laboratory Animal Welfare
6700B Rockledge Drive, Suite 2500
Bethesda, Maryland 20817
Telephone: (301) 496-7163
Facsimile: (301) 480-3387

March 17, 2020

Re: Animal Welfare Assurance
#A3290-01 (OLAW Case 1Z)

Dr. Todd Evans
Associate Dean for Research
Weill Cornell Medical College
1300 York Avenue, LC710
New York, NY 10065

Dear Dr. Evans,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your March 12, 2020 letter reporting several instances of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at Weill Cornell Medical College. According to the information provided, OLAW understands the following about the incidents and the corresponding corrective actions:

1) Two separate investigators performed toe clipping on mice that were older than 17 days, which is noncompliant with the protocol and institutional policy.

Corrective action: The Principal Investigators and staff were counseled to follow the protocol approved procedures.

2) Two mouse cages contained dead or moribund mouse weanlings which had been unable to access water because the water bottle had been incorrectly placed. The animal care staff failed to identify the problem because the bottles contained water.

Corrective action: The research and animal care staff members were counseled on ensuring that all animals have access to food/water. The animal program is phasing in a new style of water bottle that should prevent similar incidents.

3) Several cages of mice had been kept in a laboratory past the 12 hour limit approved in the protocol. This constituted a repeat violation for this research team.

Corrective action: The Institutional Animal Care and Use Committee (IACUC) rescinded the privilege of the laboratory to remove mice from the vivarium for six months. The surgical equipment used in this study was placed in a procedure room in the vivarium to allow the work to continue.

Based on its assessment of this explanation, OLAW understands that measures have been implemented in each situation to correct and prevent recurrence of the problem. OLAW concurs with the actions taken by the IACUC to comply with the PHS Policy. Note that if the same problem occurs in different laboratories, it may be necessary to take a program-wide approach such as reminding all animal users about institutional expectations. Thank you for informing OLAW about this matter.

Sincerely,

(b) (6)

Axel Wolff, M.S., D.V.M.
Deputy Director
Office of Laboratory Animal Welfare

cc: IACUC Chair

A3290-17

Weill Cornell Medicine

Institutional Animal Care and Use Committee
1300 York Avenue, Box 5
New York, NY 10065

445 East 69th Street, Olin Hall Rm-423
New York, NY 10065

Telephone: 646-962-2981/2
Email: iacucadmin@med.cornell.edu

March 12, 2020

Brent Morse, DVM
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
Rockledge 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

Re: Assurance # D16-00186

Dear Dr. Morse:

We are writing to report incidents of non-compliance that occurred within the animal care and use program at Weill Cornell Medicine. The incident was presented to and discussed by the IACUC during the month of March. The incident and resolution is as follows:

In separate incidents involving two investigators, mice were toe clipped at ages that exceeded the age specified in the protocol. Toe clipping is approved on the protocols for mice up to 17 days of age and thus, the procedure was not performed in accordance with the protocol or our institutional policy. Both PIs were contacted by the IACUC and instructed to inform their lab members of the requirement to adhere to the protocol performing only approved procedures as described. (National Institute of Arthritis and Musculoskeletal and Skin 1R01AR065530- 01A1)

In addition, in incidents involving two investigators, the veterinary staff found two cages with dead or moribund mouse weanlings. In both cases, although the drilled water bottle was placed correctly, they were not flush against the cage bars so the young mice could not access the water. The animal care staff assumes the primary responsibility for making sure that all cages have food and water. Investigators should be observing their animals on a regular basis and share the responsibility of assuring that cages have food and water and

that mice have access to both. The specific animal care technicians involved were counseled about being vigilant in checking for improperly placed water bottles, however identifying this rare occurrence is extremely challenging as there is sufficient water noted when the cage is evaluated daily and there is variability in water consumption between mice of different strains and/or number of cage occupants. Both PIs were also asked to address this issue with their laboratory members and to reiterate their responsibility with regard to assuring access to food and water. We have begun a multi-year process to replace all stoppered drilled bottles with bottles with stainless steel cap and integrated sipper to prevent these incidents. In addition, all animal care staff have been informed of the possibility of improperly placed water bottles and the expectation that they identify them and resolve the issue.

During an inspection of laboratory space, several cages of mice were found that had exceeded the 12 hour time period allowed outside of the vivarium that was approved in the IACUC protocol. This was a repeat of a previous incident. The IACUC voted to rescind the labs privileges to remove mice from the vivarium for a period of 6 months. Equipment that had been used for surgical procedures in the lab was relocated to a procedure room within the vivarium. (National Institute of Diabetes & Digestive & Kidney Diseases 1 DP3 DK111907-01 Ye & 1 R01 DK119667-01A1; National Cancer Institute 1 U01 CA224326-01)

We believe that these issues have been adequately addressed and that the procedures implemented should prevent recurrence. Should you have any questions or concerns, please contact me at (b) (6) (b) (6) or the IACUC Chairman, Dr. Andrew Nicholson, at (b) (6)

Sincerely,

(b) (6)

Todd R. Evans, Ph.D.
Institutional Official
Associate Dean for Research
Weill Cornell Medicine

Wolff, Axel (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Friday, March 13, 2020 9:51 AM
To: (b) (6)
Cc: OLAW Division of Compliance Oversight (NIH/OD)
Subject: RE: WCM IACUC Incident Report (#D16-00186)

Thank you for this report, (b) (6) We will send a response soon.

Axel Wolff, M.S., D.V.M.
Deputy Director, OLAW

From: (b) (6)
Sent: Thursday, March 12, 2020 4:36 PM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Cc: Andrew C. Nicholson <nicholso@med.cornell.edu>; Todd R. Evans <tre2003@med.cornell.edu>
Subject: WCM IACUC Incident Report (#D16-00186)
Importance: High

Dear OLAW:

Please find a WCM IACUC incident report attached and let me know if any further clarifications are required.

Best regards,
(b) (6)

(b) (6)

Weill Cornell Medicine