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

October 15, 2020

Re: Animal Welfare Assurance
A3031-01 [OLAW Case 1F]

Dr. Andrew Weyrich
Vice President for Research
University of Utah
201 S. Presidents Circle
Salt Lake City, UT 84112

Dear Dr. Weyrich

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your October 6, 2020 letter reporting an adverse event within the animal care and use program at the University of Utah. According to the information supplied, OLAW understands that on August 13, 2020 the IACUC became aware of a potential serious adverse event involving two marmosets. On August 12, 2020, the two animals entered a nest box in their home cage and the door to the nest box closed on them so they could not get out. How the door closed is not clear. It is believed that the animals were in the box for a period of 18-24 hours. The cause of death was suspected to be an increase in heat (body heat plus warm room temperature) and distress in a small enclosed space. This type of nest box has been in the marmoset cages for over 3 years without incident. The study was funded by the PHS. The Principal Investigator was requested to report this to the agency that is funding the associated research.

Corrective and preventive actions included removing doors from all other nest boxes in the room. In addition, animal husbandry personnel will perform an additional viability/head count during the afternoon feeding to ensure each animal is visualized.

The prompt consideration of this matter by the University of Utah was consistent with the philosophy of institutional self-regulation. Similarly, the actions taken to resolve the issues and prevent recurrence were appropriate. We agree that notifying the funding component and the USDA is appropriate. We find no cause for further action by this office at this time.

Sincerely,

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

cc: IACUC contact
Dr. Robert M. Gibbens, USDA, APHIS, AC

October 6, 2020

Brent C. Morse, DVM
Department of Health and Human Services
Rockledge, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

Dear Dr. Morse,

Under provision of IV.F.3 of the Animal Welfare Assurance Policy and as the Institutional Officer at the University of Utah (U of U), I am providing OLAW with a full explanation of circumstances in regard to an adverse event.

Name of Institution: University of Utah
Assurance Number: A3031-01

The Clinical Veterinarian notified the IACUC of a potential serious adverse event via an Event Notification form concerning the below mentioned protocol on August 13, 2020. The IACUC Director notified the IACUC Chair and the Institutional Veterinarian of the potential adverse event on August 13, 2020. It was discussed that additional information needed to be obtained and that this event would be reviewed at the convened IACUC meeting on September 30, 2020.

The following is a summary of the adverse event:

1. Protocol number: 18-12008
2. Protocol title: Anatomy, Physiology and Imaging of the Visual Cortex in the Non-human Primate
3. Funding agency: NIH
4. Animal species: Marmoset
5. Age of animal(s): Female (4 years, 6 months old)
   Male (3 years, 9 months old)
6. Number of animals involved in the event: 2
7. Date(s) that the event occurred: August 12, 2020
8. Overview of the adverse event (as provided by the Clinical Veterinarian):
   The two marmosets entered a nest box in their home cage and the door to the nest box closed on them so they could not get out.
9. Was there inadvertent pain involved in the adverse event (more than momentary)?:
   Yes
10. Describe the corrective actions to avoid future problems:
    All doors have been removed from all other nest boxes in the room.
11. Provide a conclusion:
    The marmosets were trapped in the nest box because the door closed with them inside and they were unable to extricate themselves. We have no idea how the door got closed. We think this happened over a period of 18 – 24 hours. The tech that fed in the morning 8-10am on 11AUG20 remembers interacting with Solomon at that time. The pair were found dead the next morning. We suspect the cause of death was an increase in heat (body heat plus warm room temperature) and distress in a small enclosed space. This type of nest box has been in the marmoset cages for over 3 years without incident.

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The committee further requested a brief summary of the event and proposed corrective actions from the Clinical Veterinarian during the convened meeting. The Clinical Veterinarian summarized that these next boxes have been used for the past three years without incident and that in addition to removing all the doors from the nest boxes, that animal husbandry personnel will perform an additional viability/head count during the afternoon feeding to ensure each animal is visualized.

The committee determined that this was a serious adverse event due to an unfortunate animal husbandry accident and that it should be reported to the Office of Laboratory Animal Welfare (OLAW) and to USDA. The committee agreed with the corrective actions as described by the Clinical Veterinarian. No additional action was requested by the committee. The committee voted unanimously to report the adverse event and agreed with the corrective actions, and that no further action was required.

In conclusion, the committee determined that this is a serious adverse event and will be reported to the regulatory agency of the Office of Laboratory Animal Welfare (OLAW) and USDA since it is federally funded. The Principal Investigator was requested to report this to the agency that is funding this research.

The IACUC Director and the IACUC Chair met with the Institutional Official on October 6, 2020 and determined that the corrective actions presented by the Clinical Veterinarian and the Institutional Veterinarian were adequate and no additional action is required.

Sincerely,

(b) (6)

Andrew Weyrich, Ph.D.
Vice President for Research
Institutional Official

cc. Derek Dosdall, Ph.D.
IACUC Chair

Robert Gibbens, DVM
Director, Animal Welfare Operations
USDA-APHIS-AC

Jack Taylor, DVM, Ph.D.
Institutional Veterinarian

U of U IACUC Office Files

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