## DEPARTMENT OF HEALTH & HUMAN SERVICES

EOR 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

June 10, 2019

PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH

> FOR EXPRESS MAIL: Office of Laboratory Animal Welfare 6700B Rockledge Drive, Suite 2500 Bethesda, Maryland 20817 <u>Telephone</u>: (301) 496-7163

Re: Animal Welfare Assurance A3922-01 [OLAW Case 2J]

Ms. Peggy McGill Sr. Vice President of Research Administration Rhode Island Hospital 1 Hoppin St., <sup>(b) (4)</sup> Providence, RI 02903

Dear Ms. McGill,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your letter dated May 28, 2019 regarding a reportable non-compliance at your institution.

According to the information provided, our office understands that on May 8, 2019 a single weanling mouse was found dead in a dry mop bucket underneath a countertop euthanasia station. The mouse was traced by inspection of bagged carcasses in the disposal freezer and it was determined that it belonged with a litter of mice euthanized the previous day. It is surmised that the mouse escaped by clinging to the cage top when it was removed, and the mouse was likely alive upon entering the bucket, since it was found with fecal pellets and there was no physical evidence that the secondary euthanasia method had been performed. The Animal Care and Use Committee discussed the incident at its meeting on 5/22/19 and as a corrective measure implemented a procedure checklist at each euthanasia station that includes checking for mice on the underside of cage tops and wire bars, and confirming numbers when cleaning cages or performing procedures.

Based on its assessment of this explanation, OLAW understands that measures have been taken to prevent recurrence of this problem. OLAW concurs with the actions taken by your institution to comply with the PHS Policy on Humane Care and Use of Laboratory Animals. Although this activity was not PHS funded, the establishment and application of policies and practices that are consistent with the provisions of the PHS Policy on Humane Care and Use of Laboratory Animals are commendable and avoid the perception of a double standard. We appreciate having been informed of this matter and find no cause for further action by this office

Sincerely,

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Nicolette Petervary, VMD, DACAW Veterinary Medical Officer Office of Laboratory Animal Welfare

## Lifespan

Office of Research Administration Administrative Office for the Animal Welfare Committee 1 Hoppin St, Suite 1.300 Providence, RI 02903 Phone: 401-444-2093 Fax: 401-444-7960

Rhode Island Hospital The Miriam Hospital

A3922-2J

May 28, 2019

Brent Morse, DVM, DACLAM Director, Division of Compliance Oversight Office of Laboratory Animal Welfare (OLAW) Rockledge 1, Suite 360, MSC 7982 Bethesda, Maryland 20892-7982

RE: Animal Welfare Incident at Rhode Island Hospital (Institutional Assurance No: A3922-01)

Dear Dr. Morse,

I am writing to inform you of the unanticipated death of one mouse pup at our institution. The incident was associated with work supported with internal funding.

On May 8, 2019 a single weanling mouse was found dead in a dry mop bucket beneath a countertop euthanasia station. "Ownership" of the mouse was determined by reviewing use of the euthanasia equipment and inspecting bagged carcasses in the disposal freezer: a litter of mice had been euthanized on May 7, but only seven (7) of the eight (8) anticipated mouse carcasses were in the freezer. Most likely the mouse escaped by clinging to the cage top when it was removed: the lab's procedure for euthanasia involved removing the cage top and wire bar, replacing the top and wire bar with the CO<sub>2</sub>-plumbed lid, and then applying the CO<sub>2</sub>. The euthanasia was carried out by an experienced lab staff member, and the PI in the laboratory cooperated with the investigation and took full responsibility.

The incident was discussed at the regularly scheduled meeting of the full IACUC on 5/22/19. The IACUC could not conclude definitively whether the mouse was alive or dead before entering the bucket. However, the circumstantial evidence suggests it was most likely alive – there were also two fecal pellets in the bucket, and the found mouse had not been subjected to secondary cervical dislocation, as the others had been – hence, this report.

To minimize the risk of this recurring, the procedure sheet posted at each euthanasia station will be updated to include: 1) checking for mice on the underside of cage tops or wire bars when cages are opened, and 2) confirming mouse/pup numbers when cleaning cages or performing procedures.

Sincerely,

(b) (6)

Peggy McGill, MA, CRA Vice President, Research Administration Lifespan Institutional IO

cc: (b) (6)

## Ward, Joan (NIH/OD) [E]

From:
Sent:
To:
Cc:
Subject:

OLAW Division of Compliance Oversight (NIH/OD) Thursday, May 30, 2019 9:03 AM (b) (6) OLAW Division of Compliance Oversight (NIH/OD) RE: Animal Welfare Incident- Assurance A3922-01

Thank you for this report (b) (6) Dr. Morse will respond soon.

## Regards, Joan Joan Ward Program Specialist Office of Laboratory Animal Welfare National Institutes of Health 6705 Rockledge Dr., Suite 360 Bethesda, MD 20892 301-496-7163 wardjoa@od.nih.gov

From: (b) (6)

Sent: Thursday, May 30, 2019 8:41 AM To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov> Subject: Animal Welfare Incident- Assurance A3922-01

Good Morning, enclosed please find a letter from our IO regarding an unanticipated problem involving one mouse pup. Please contact me if you have any questions about this matter.

For more information, please visit our website at www.Lifespan.org/research

This transmission is intended only for the addressee(s) listed above and may contain information that is confidential. If you are not the addressee, any use, disclosure, copying or communication of the contents of this message is prohibited. Please contact me if this message was transmitted in error.