DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:
Office of Laboratory Animal Welfare
Rockledge One, Suite 360
6705 Rockledge Drive - MSC 7982
Bethesda, Maryland 20892-7982
Home Page: http://grants.nih.gov/grants/olaw/olaw.htm

FOR EXPRESS MAIL:
Office of Laboratory Animal Welfare
Rockledge One, Suite 360
6705 Rockledge Drive
Bethesda, Maryland 20817
Telephone: (301) 496-7163
Facsimile: (301) 402-7065

December 15, 2017

Re: Animal Welfare Assurance
#A3436-01 (OLAW Case E)

Dr. Judy Hayman
Acting Medical center Director
Syracuse VA Medical Center
800 Irving Avenue
Syracuse, NY 13210

Dear Dr. Hayman,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your December 7, 2017 letter reporting an adverse event at the Syracuse VA Medical Center. According to the information provided, OLAW understands that on November 22, 2017, the anesthetic nose cone attached to the rodent surgical board ignited while performing a surgical procedure on a PHS supported study. The 4x4 inch fire was quickly extinguished, surgical gases turned off and damp towels placed around the area to prevent reignition. The deeply anesthetized rat that was undergoing the surgical procedure was promptly euthanized. A similar incident occurred on June 22, 2017 which resulted in the loss of one rat on a protocol that was not supported by PHS funds. Although the cause of the fire could not be definitively identified, risk assessment suggested that turning off the oxygen flow while using the cautery device should eliminate any fire hazards.

The corrective actions included implementing a Standard Operating Procedure which includes monthly preventative maintenance of the surgical board and a supply list for extinguishing a fire during surgery, replacing the plastic surgical board with a stainless steel model, using an electronic power adjustable, instead of battery operated, cautery device and shutting off oxygen flow for a limited time with lower flow rates when using the cautery device during surgery.

Based on the information provided, OLAW is satisfied that appropriate actions have been taken to investigate, correct and prevent recurrence of the noncompliance. We appreciate having been informed about this matter and find no cause for further action by this Office.

Sincerely,

(b)(6)

Neera V. Gopee, DVM, PhD, DACLAM, DABT
Animal Welfare Program Specialist
Division of Compliance Oversight
Office of Laboratory Animal Welfare

cc: IACUC Contact
(b)(6) D.V.M., Ph.D., VA Chief Veterinarian
(b)(6) DVM, MPH, DACLAM, Office of Research Oversight (ORO)
(b)(6) Ph.D., Director, RSAW, ORO, VHA, VA

A3436-E

VA | U.S. Department of Veterans Affairs

New York/New Jersey VA Health Care
Syracuse VA Medical Center
800 Irving Avenue | Syracuse, NY 13210
315-425-4400

www.syracuse.va.gov

Animal Welfare Assurance #D16-00275

December 7, 2017

Brent Morse, D.V.M.
Acting 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

Dear Dr. Morse,

This report is to inform you of an incident that occurred at the Syracuse VA Medical Center on November 22, 2017. The animal involved in this incident was supported by NIH funding, Grant HL133577.

On the morning of November 22, 2017, a surgical procedure was being performed by laboratory personnel and the anesthesia nose cone attached to a rodent surgical board caught fire. The 4x4 inch flare-up was quickly contained and extinguished, surgical gasses were turned off, and damp towels were placed around the area to prevent another flare up. The rat having the surgical procedure at the time was completely anesthetized and humanely euthanized before it could regain consciousness. There were no other animals in the vicinity and the staff member performing the surgical procedure was unharmed.

The incident was immediately reported to the IACUC Chair, the Veterinary Medical Consultant, the Subcommittee on Research Safety (SRS) Chair, and facility safety personnel. Laboratory personnel were also verbally notified that no additional surgical procedures should occur until further notice. SRS action to cease all surgical procedures using cautery until specific requirements were met was executed on November 28, 2017.

An ad hoc meeting of the IACUC was held on December 4, 2017 to discuss this incident and an almost identical incident that occurred on June 22, 2017 involving the loss of one rat undergoing surgery. This rat was not supported by NIH funding. The June 22nd incident was reviewed by the IACUC at that time and it was determined the event did not constitute an animal welfare issue and was not reportable. A determination to include both incidents as a reportable event was made at the December 4th IACUC meeting. The actual cause of both fires is unknown, although risk assessment suggests ignition should not occur without the oxygen flow. The following remedial action was required:

An interruption of oxygen flow during utilization of the cautery instrument.

The IACUC also provided a recommendation to utilize a new, tighter fitting anesthesia mask. This information was made available at a convened SRS meeting on December 5, 2017 and approval for all surgical procedures to recommence was granted.

The following is a summary of all corrective actions in response to both incidents:

1. A standard operating policy has been developed that includes monthly preventative maintenance of the surgical board and lists the supplies to extinguish a fire during surgery;
2. The plastic surgical board has been replaced with a stainless steel model;
3. A tighter fitting, new anesthesia mask will be used;
4. A regulated, electronic cautery pen (power adjustable) will be used instead of a battery operated pen;
5. Oxygen will be shut off for the limited time when cautery is in use and lower flow rates during the surgery will be utilized.

Please contact (b)(6) Associate Chief of Staff for R&D at (b)(6) or myself at (b)(6) if you have any questions concerning this incident or any aspect of our animal care and use program.

Sincerely,

(b)(6)

Judy Hayman, Ph.D.
Acting Medical Center Director

Hayman, Acting Medical Center Director
Reportable Event

Ward, Joan (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Friday, December 08, 2017 11:24 AM
To: (b)(6) OLAW Division of Compliance Oversight (NIH/OD)
Cc: (b)(6) VHACO ORO RSAW; accredit@aaalac.org; Hayman, Judy A; (b)(6)
Subject: RE: Report of Incident - Syracuse VAMC

Thank you for this final report Ms. Knickerbocker. We will send an official response soon.

Best Regards,
Neera

Neera V. Gopee, DVM, PhD, DACLAM, DABT
Veterinary Medical Officer
Office of Laboratory Animal Welfare
National Institutes of Health

From: (b)(6) @va.gov]
Sent: Friday, December 08, 2017 10:48 AM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Cc: (b)(6) @va.gov>; VHACO ORO RSAW (b)(6) @va.gov>; accredit@aaalac.org; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @va.gov>; (b)(6) @gmail.com>
Subject: Report of Incident - Syracuse VAMC

Attached please find notification of an incident resulting in unanticipated loss of animal life at the Syracuse VA Medical Center.

OLAW AWA# D16-00275
AAALAC International# VA-071

Thank you,

(b)(6)
Research & Development (151)
Syracuse VAMC
(b)(6)