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

January 4, 2022

Re: Animal Welfare Assurance
A3368-01 [OLAW Case 11R]

Dr. Nadine Connor
Associate Vice Chancellor
for Research Policy and Compliance
University of Wisconsin-Madison
(b) (4)Bascom Hall – 500 Lincoln Drive
Madison, WI 53706

Dear Dr. Connor,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your November 30, 2021 letter reporting an instance of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the University of Wisconsin - Madison. Your letter supplemented the information in the preliminary telephone report on the same day. According to the information provided, OLAW understands that four rats died approximately 10 minutes following administration of a combination of ketamine and xylazine being used to anesthetize animals for a protocol-approved procedure. The dose, and route of administration were the same as had previously been given successfully and followed the protocol description. After remixing the drug, four additional rats underwent anesthesia with no complications. Following consultation with a veterinary anesthesiologist it was determined that the likely cause was a mixing error. The veterinary technician involved underwent retraining regarding proper mixing at this time and in order to prevent a similar incident in the future a lower concentration of xylazine was ordered. Approximately three weeks later, two rats died in a similar incident. In this case, it was found that the ketamine/xylazine combination was freshly mixed and the calculations were correct, but the veterinary technician wrote down the final amount to be mixed incorrectly so the incorrect amount of anesthetic was administered. At the time, the lower concentration of xylazine had not yet been received.

Corrective and preventive measure include: the lower concentration of xylazine is now available and the mixing procedure has been modified so that if only a higher concentration of xylazine is available it will be diluted prior to mixing with the ketamine. The veterinary technician involved has undergone further retraining regarding proper anesthetic mixing, dosing, administration, and attention to detail. The animals involved were supported by PHS funds.

The consideration of this matter by the University of Wisconsin - Madison was consistent with the philosophy of institutional self-regulation. Similarly, the actions taken to address the issue and prevent recurrence were appropriate. We appreciate being informed of this matter and find no cause for further action by this office.

Sincerely,

Brent C. Morse -S

Digitally signed by Brent C. Morse -S
Date: 2022.01.04 10:53:03 -05'00'

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

cc: IACUC contact

A3368-11R

THE UNIVERSITY of WISCONSIN MADISON

November 30, 2021

Dr. Brent Morse, DVM, DACLAM
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
RKL1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7892

Dear Dr. Morse:

The University of Wisconsin-Madison, in accordance with Assurance A3368-01 and PHS Policy IV.F.3, provides this report of an incident first reported to you via telephone by Dr. Janet Welter on November 29, 2021.

In this incident, 4 rats died approximately 10 minutes following administration of a combination of ketamine and xylazine being used to anesthetize animals for a protocol approved procedure. The dose, and route of administration were the same as had previously been given successfully and followed the protocol description. After remixing the drug, 4 additional rats underwent anesthesia with no complications. Following consultation with a veterinary anesthesiologist it was determined that the likely cause was a mixing error. The veterinary technician involved underwent retraining regarding proper mixing at this time and in order to prevent a similar incident in the future a lower concentration of xylazine was ordered. Approximately three weeks later 2 rats died in a similar incident. In this case, it was found that the ketamine xylazine combination was freshly mixed and the calculations were correct but the veterinary technician wrote down the final amount to be mixed incorrectly so the incorrect amount of anesthetic was administered. At the time, the lower concentration of xylazine had not yet been received. In order to prevent such incidents in the future, the lower concentration of xylazine is now available and the mixing procedure has been modified so that if only a higher concentration of xylazine is available it will be diluted prior to mixing with the ketamine. The veterinary technician involved has undergone further retraining regarding proper anesthetic mixing, dosing, administration and attention to detail. The animals involved were supported by PHS funds.

The LSVC ACUC discussed this incident in full committee and determined that the corrective steps taken were appropriate. If you have further questions, please feel free to contact either of us or Dr. Janet Welter.

Sincerely,

(b) (6)

Ricki Colman, Ph.D.
Chair, LSVC ACUC

Research Animal Resources Center
396 Enzyme Institute University of Wisconsin-Madison 1710 University Avenue Madison, Wisconsin 53726-4087
608/262-1238 Fax: 608/265-2698 Email: help@rarc.wisc.edu http://www.rarc.wisc.edu

(b) (6)

Nadine P. Connor, Ph.D.
Professor and Oros Family Chair in Communication Sciences & Disorders
Associate Vice Chancellor for Research Policy & Compliance
Institutional Official

xc: (b) (6)
Janet Welter
AAALAC-I

Wolff, Axel (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Friday, December 10, 2021 7:58 AM
To: (b) (6)
Cc: OLAW Division of Compliance Oversight (NIH/OD)
Subject: RE: Incident Report from Nadine Connor @ UW-Madison

Thank you for these 6 reports, (b) (6) We will send responses soon.

Axel Wolff

From: (b) (6)
Sent: Wednesday, December 8, 2021 2:24 PM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Cc: AAALAC International <accredit@AAALAC.org>; Nadine Connor <nadine.connor@wisc.edu>; RICKI COLMAN <rcolman@primate.wisc.edu>; (b) (6) Janet Welter <welter@rarc.wisc.edu>
Subject: [EXTERNAL] Incident Report from Nadine Connor @ UW-Madison

Dr. Morse:

Please see the attached incident final report from Nadine Connor @ UW-Madison. Thanks!

(b) (6)

11R

Office of Laboratory Animal Welfare

OLAW

Initial Report of Noncompliance

By: [redacted] (b) (6)

Date: 11/30/2021 Time: 3:50

Name of Person reporting: Janet Welter, DVM, AV
Telephone #: [redacted] (b) (6)
Fax #:
Email:

Name of Institution: University of Wisconsin - Madison
Assurance number: A3368

Did incident involve PHS funded activity? ?
Funding component:
Was funding component contacted (if necessary):

What happened? 6 rats died (did not recover) after sx. due to use of ↑ concentration of xylazine.

Species involved: Rat
Personnel involved:
Dates and times:
Animal deaths: Yes

Projected plan and schedule for correction/prevention (if known):

Projected submission to OLAW of final report from Institutional Official:

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Case #