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 14, 2022

Re: Animal Welfare Assurance
#A3187-01 [OLAW Case 9S]

Dr. Bill Yates
Acting Vice Chancellor for Research Protections
University of Pittsburgh
3500 Fifth Avenue, (b) (4) Hieber Building
Pittsburgh, PA 15213

Dear Dr. Yates,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your March 4, 2022 letter reporting three similar instances of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the University of Pittsburgh. According to the information provided, OLAW understands that:

For incident 1: On Saturday, December 18, 2021, one box of five mice was found on an auto-water rack without a lixit. Three of the mice were found deceased. The surviving two mice were given supportive care. It is estimated they went two days without water. The PI has several boxes at any given time in the room for which they disconnect the lixits and supply "special water" in bottles, but it was not determined why this specific box was without a lixit.

For incident 2: On Sunday, January 23, 2022, one box of two mice was found on an auto-water rack without a lixit. Both mice were found deceased. The investigator's technician may have accidentally placed the box in a slot used by a different investigator who uses "special water" bottles instead of the lixit, which is typically removed. It was not determined why this specific box was in a slot without a lixit. Animal facility technicians did not notice the missing lixit during two daily room checks.

For Incident 3: On Tuesday, January 11, 2022, five boxes of five total mice were found housed on an auto-water rack with the wrong type of grommet in the boxes and without access to water. Three of the mice, each in a different box, were found deceased. The PI staff did not notice the difference and housed mice in the wrong boxes. It was not caught during the daily room checks.

The IACUC approved the corrective action plan submitted by the animal facility director, which included the following items:

1. Animal facility technicians were retrained to ensure a lixit is in place in every slot and is properly installed during daily checks (incident 1, 2, and 3).

2. A designated row on one rack was labeled for use for water bottles only (incidents 1 and 2).

3. The cagewash and husbandry technicians were retrained to notice the differences in the two types of boxes and remove them if found in the wrong corridor (incident 3).

The IACUC levied the following sanction:

- A letter was sent to the animal facility director regarding these events.

Based on the information provided, OLAW is satisfied that appropriate actions have been taken to investigate these incidents and prevent recurrences. OLAW concurs that the incidents warranted reporting. We appreciate being informed of these matters and find no cause for further action by this office.

Sincerely,

Brent C. Morse -S

Digitally signed by Brent C. Morse -S
Date: 2022.03.15 07:45:59 -04'00'

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

cc: IACUC contact

University of Pittsburgh | Office of Research Protections

A3187-98

Bill J. Yates, PhD
Vice Chancellor for Research Protections
Professor of Otolaryngology & Neuroscience &
Clinical and Translational Science

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March 4, 2022

Brent Morse, DVM, DACLAM
NIH Office of Laboratory Animal Welfare
Rockledge One, Suite 360
6705 Rockledge Drive – MSC 7982
Bethesda, MD 20892-7982

Dear Dr. Morse:

As the Institutional Official responsible for the University of Pittsburgh's Animal Care and Use Program (Assurance number D16-00118), I am writing to advise your office of three similar reportable incidents[1].

Incident 1: On Saturday, December 18, 2021, one box of five mice was found on an autowater rack without a lixit. Three of the mice were found deceased. The surviving two mice were given supportive care. The room underwent a box change on December 13th. The PI has several boxes at any given time in the room for which they disconnect the lixits and supply "special water" in bottles. Animal facility personnel could not determine who moved the box or why the lixit was missing, however, and the technician who changed the room on the previous Monday was certain all lixits were in place. Given the condition of the mice when found, it is estimated they went two days without water.

Incident 2: On Sunday, January 23, 2022, one box of two mice was found on an autowater rack without a lixit. Both mice were found deceased. The room underwent a box change on January 18th and the lixit was present. The investigator's technician may have accidentally placed the box in a slot used by a different investigator who uses "special water" bottles instead of the lixit, which is typically removed. Animal facility personnel could not determine if or when this happened, however, or when the box was placed in the wrong space. Animal facility technicians missed the missing lixit during two daily room checks.

Incident 3: On Tuesday, January 11, 2022, five boxes of five total mice were found housed in an automatic water rack with the wrong type of box and without access to water. Three of the mice, each in a different box, were found deceased. The animal facility in question has two types of housing boxes that look very similar. One type is a flat grommet and the other is a deep grommet box. They are kept in separate corridors. Five of the deep grommet boxes were mistakenly sent to a flat grommet corridor. The PI staff did not notice the difference and housed mice in the wrong boxes. It was not caught during the daily room checks.

[1] PHS Policy IV.C.1.d

The IACUC approved the corrective action plan submitted by the animal facility director, which included the following items:

1. Animal facility technicians were retrained to ensure a lixit is in place in every slot and is properly installed during daily checks (incident 1, 2, and 3).
2. A designated row on one rack was labeled for use for water bottles only (incidents 1 and 2).
3. The cagewash and husbandry technicians were retrained to notice the differences in the two types of boxes and remove them if found in the wrong corridor (incident 3).

The IACUC levied the following sanction:

- A letter was sent to the animal facility director regarding these events.

Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

Bill J. Yates, PhD

Wolff, Axel (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Monday, March 7, 2022 7:15 AM
To: (b) (6)
Cc: OLAW Division of Compliance Oversight (NIH/OD)
Subject: RE: Reportable Event Notices

Thank you for these reports. We will send responses soon.

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

From: (b) (6)
Sent: Sunday, March 6, 2022 8:41 PM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Subject: [EXTERNAL] Reportable Event Notices

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and are confident the content is safe.

Please review the attached correspondence forwarded on behalf of Bill J. Yates, PhD, Vice Chancellor for Research Protections. Thank you.

(b) (6)