

Office of Animal Care Compliance

DVM, Director

September 19, 2018

Attn:

Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare, National Institutes of Health
Bethesda, MD
Phone:
FAX:
E-mail:

RE: Assurance # D16-00228 (A3350-01) – Failure to place food and water in two animal cages resulting in death (e.g., unexpected animal deaths due to human error)

As per our telephonic report to a september 4, 2018, a new animal technician failed to place food and water in two mouse cages on Thursday August 30th. The omission was not identified until Saturday September 1st and this failure resulted in the death of 7 mice.

Consequently, additional staff training was conducted and a plan was implemented to require a secondary observer to check all cages after cage changes by new animal care staff for a minimum of four weeks. If no errors are identified during the four-week secondary observation period, we will consider new animal care staff to be competent and secondary observations will cease.

Secondary observations have been occurring for two weeks and currently no errors have been identified for the individual that was involved in the incident. The secondary observation period for this individual will cease after two additional weeks if no further errors are observed.

Sincerely,

Executive Vice Chancellor. Vice Chancellor for Research

CC:

D.V.M., DACLAM, Attending Veterinarian
Ph.D., IACUC Chair
MS, CPIA, Senior Operations Manager, OACC

Albuquerque, NM



DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY Office of Laboratory Animal Welfare

Bethesda, Marylan d

Home Page: http://grants.nih.gov/grants/olaw/olaw.htm

October 10, 2018

FOR EXPRESS MAIL:
Office of Laboratory Animal Welfare

Bethesda, Maryland
Telephone:
Facsimile:

Re: Animal Welfare Assurance A3350-01 [OLAW Case T]

Executive Vice Chancellor	
University of New Mexico	
Maria de la companya della companya de la companya de la companya della companya	
Albuquerque, NM	
Dear	

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your September 19, 2018 letter reporting a serious deviation from the provisions of the Guide for the Care and Use of Laboratory Animals at the University of New Mexico following up on an initial telephone report on September 5, 2018. According to the information provided, OLAW understands that a new animal technician failed to provide food and water to two cages which resulted in the deaths of seven mice.

The corrective actions consisted of retraining the animal care staff and having a second individual observe cages changed by new staff for the first four weeks of employment. No further issues have occurred with the new employee.

Based on its assessment of this explanation, OLAW understands that measures have been implemented to prevent recurrence of this problem. OLAW concurs with the actions taken by the institution to comply with the PHS Policy on Humane Care and Use of Laboratory Animals.





cc: IACUC Chair

From: OLA

OLAW Division of Compliance Oversight (NIH/OD)

To:

; OLAW Division of Compliance Oversight (NIH/OD)

Cc:

Subject:

RE: Assurance # D16-00228 (A3350-01) – Failure to place fcod and water in two animal cages resulting in death

(e.g., unexpected animal deaths due to human error)

Date:

Monday, October 1, 2018 8:01:02 AM

[[-- External - This message has been sent from outside the University --]]

Thank you for providing this final report. We will send an official response soon. Unless you desire to do so, there is no need to send the original.

Best regards,

DVM, DACLAM

Director

Division of Compliance Oversight Office of Laboratory Animal Welfare National Institutes of Health

Please note that this message and any of its attachments are intended for the named recipient(s) only and may contain confidential, protected or privileged information that should not be distributed to unauthorized individuals. If you have received this message in error, please contact the sender.

From: Sent: Friday, September 28, 2018 5:41 PM

To: OLAW Division of Compliance Oversight (NIH/OD)

Cc:

Subject: Assurance # D16-00228 (A3350-01) — Failure to place food and water in two animal cages resulting in death (e.g., unexpected animal deaths due to human error)

Good afternoon,

Please see the attached, signed final report as previously discussed. I am also mailing the original.

Thank you!

From: To: Cc: OLAW Case A3350-T

Subject: Date:

Thursday, October 11, 2018 5:57:25 AM

Attachments: 2284_001.pdf

[[-- External - this message has been sent from outside the University --]]

Dear

Attached please find final response to OLAW Case A3350-T.

If you have any questions, feel free to contact us by phone or by e-mail.

Regards,



Program Specialist
Office of Laboratory Animal Welfare
National Institutes of Health

Bethesda, MD



Office of Animal Care Compliance

December 13, 2018

,	sion of Compliance Oversight <u>oratory Animal Welfare (OLAW), National Inst</u> itutes of Health (NIH
Bethesda, I Phone: FAX: E-mail:	
Attn:	, DVM, Director

RE: Assurance # D16-00228 (A3350-01) – Failure to ensure air flow in a mouse smoke exposure chamber resulting in death (e.g., unexpected animal deaths due to human error)

As per our telephonic report to on December 4, 2018, a Research Technician in a Principle Investigator's (Pl's) lab failed to ensure adequate air flow to mice in a smoke exposure chamber resulting in death by asphyxiation of 13 out of 16 mice in the chamber.

This incident was discussed in the December 6th, 2018 convened Health Sciences Center (HSC) Institutional Animal Care and Use Committee (IACUC) meeting and Post-Approval Monitoring (PAM) was performed on December 12th in order to observe the new exposure procedures and to review changes to the existing Standard Operating Procedures (SOPs). The following is a description of the incident and changes to be implemented to ensure this does not happen again as submitted in a report by the PI:

Description of incident

Depending on the assigned aim under this approved research protocol, mice are exposed to either mainstream or secondhand cigarette smoke, using a SciReq InExpose system. The air pumps of the exposure system are controlled by computer software. Pump #1 draws air through the filter of a lit cigarette (mainstream smoke), while pump #2 draws air from the chamber containing the lit cigarette (secondhand smoke). We have two software protocols, one protocol for mainstream smoke exposure (pump #1 only) inherently draws mainstream smoke through the exposure chamber and then exhausts in the hood, and the protocol for secondhand smoke exposure activates (pump #1 puffing the cigarette and exhausting to the fume hood and pump #2 continually drawing from the second hand smoke chamber into the exposure chamber and exhausting into the hood).



When preparing for a second hand smoke exposure study, the tubing connections were formatted correctly but the technician inadvertently selected the mainstream smoke exposure protocol from the program menu rather than the secondhand smoke exposure protocol. By selecting the mainstream smoke exposure protocol and with the instrument connections formatted for second hand smoke exposure, pump # 1 was exhausting mainstream smoke directly into the hood, and since pump #2 was not activated, no air or second hand smoke was being drawn into the exposure chamber. Thus, the sixteen mice in the exposure chamber failed to receive any airflow until the technician noticed they were not moving after ~30 min in the chamber. This resulted in 13 of the 16 mice dying.

The laboratory had a detailed written SOP for conducting secondhand smoke exposure and the technician had conducted this exposure protocol successfully two weeks prior and one day prior to the exposure day of the accident. Thus, we I do not believe that lack of training contributed to the accident; however, we believe that the improvements in the smoke exposure process are required to avoid future failures of this nature.

Changes to be implemented to ensure this does not happen again

- 1. The mainstream cigarette smoke exposure protocol was deleted from the software menu, so that it cannot be inadvertently selected when conducting secondhand smoke exposure.
- 2. Procedures describing additional safeguards were added to both of the mainstream and secondhand smoke written SOPs that require confirming the function of the pumps and air/smoke supply to the exposure chamber before placing the mice and initiating the exposure. This process, as changed, will assure that the instrument is formatted to match the exposure protocol. The new procedures will necessitate:
 - a. lighting and partially burning one cigarette prior to placing mice in the chamber, and confirming that air is being pulled from the correct origin (mainstream connection or second hand smoke chamber) and drawn into the exposure chamber and exhausted into the hood.
 - b. Once the format is confirm, mice are placed in the exposure chamber, the research personnel are required to monitor the mice between cigarettes or approximately every 10 minutes to confirm viability based upon their behavior and movement within the chamber. Since it takes approximately 10 min for each cigarette to be burned, the protocol states to check the viability of the mice after each cigarette is burned.
- 3. All individuals conducting these exposures of mice underwent hand's-on training on Dec 12, 2018 to assure competency under the newly amended SOPs before any further exposures were conducted.



Post-Approval Monitoring

The Attending Veterinarian (AV) and the Office of Animal Care Compliance (OACC) staff conducted a PAM on December 12, 2018 to observe and verify the new animal smoke exposure procedures and to review changes to the existing SOPs for those procedures. All changes are being carried out as described by the PI and were found to be acceptable.

Sincerely,

Executive Vice Chancellor Vice Chancellor for Research

Cc:

Attending Veterinarian

IACUC Chair

MS, CPIA, Senior Operations Manager, OACC

From: OLAW Division of Compliance Oversight (NIH/OD)

To:

Cc: OLAW Division of Complian @ Oversight (NIH/OD)

Subject: RE: Assurance # D16-00228 (A3350-01) – Failure to ensure air flow in a mouse smoke exposure chamber

resulting in death (e.g., unexpected animal deaths due to human error)

Date: Thursday, December 20, 2018 4:53:12 AM

[[-- External - this message has been sent from outside the University --]]

Thank you for this report. We will send a response soon.

From:

Sent: Wednesday, December 19, 2018 5:41 PM

To: OLAW Division of Compliance Oversight (NIH/OD)

ec.

Subject: Assurance # D16-00228 (A3350-01) – Failure to ensure air flow in a mouse smoke exposure chamber resulting in death (e.g., unexpected animal deaths due to human error)

As previously discussed, please see the attached, signed letter about this reportable incident.

Thank you and Happy Holidays!

, MS, CPIA

Senior Operations Manager

Office of Animal Care Compliance

Albuquerque, NM

, fax

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DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:
Office of Laboratory Animal Welfare

Betliesda, Maryland

Home Page: http://grantsnih.gov/grants/olaw/olaw.htm

FOR EXPRESS MAIL:
Office of Laboratory Animal Welfare

Bethesda, Maryland
Islephons:
Eassimile:

December 26, 2018

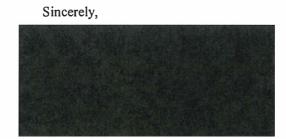
Re: Animal Welfare Assurance A3350-01 [OLAW Case U]

Executive Vice Chancellor
University of New Mexico
Albuquerque, NM

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your December 13, 2018 letter reporting an instance of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the University of New Mexico following up on an initial telephone report on December 4, 2018. According to the information provided, OLAW understands that 13 mice died of asphyxiation in an experimental smoke exposure chamber due to a technician choosing the wrong smoke exposure regimen. The mice had not received adequate air flow which led to their deaths.

The corrective actions consisted of modifying the chamber's software menu to ensure that the correct airflow mode is selected, modifying the standard operating procedures (SOP) to ensure that the pumps and air flow are correct, having staff monitor the mice, and retraining the laboratory staff on the revised SOP. A post-approval monitoring visit to the laboratory confirmed that procedures were being conducted in accordance with the protocol.

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.



cc: IACUC Chair

From: To:

OLAW Coop A 2250 H

Cc: Subject:

ect: OLAW Case A3350-U

Date:

Wednesday, December 26, 2018 11:44:41 AM

Attachments: 3769 001.pdf

[[-- External - this message has been sent from outside the University --]]

Dear

Attached please find

3.5

final response to OLAW Case A3350-U.

If you have any questions, feel free to contact us by phone or by e-mail.

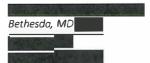
Regards,



Program Specialist

Office of Laboratory Animal Welfare

National Institutes of Health



From: AWAS Application

To: Cc:

10:

Subject: Annual Report Acknowledgement Letter Final - D16-00228

Date: Thursday, January 24, 2019 6:08:19 PM
Attachments: ARAcknowledgeLetter_D16-00228 (1).docx

[[-- External - this message has been sent from outside the University --]]

OLAW - Annual Report Acknowledged

We are pleased to inform you that the Office of Laboratory Animal Welfare (OLAW) reviewed and acknowledged your organization's Animal Welfare Annual Report. Please review the attached document for full details.



PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:

Office of Laboratory Animal Welfare Division of Assurances

Bethesda, Maryland

Home Page: https://olaw.nih.gov

January 24, 2019

FOR EXPRESS MAIL: Office of Laboratory Animal Welfare Division of Assurances

Bethesda, Maryland Telephone:

Re: Assurance D16-00228 (A3350-01) Report to OLAW for CY 2018

Executive Vice Chancellor, Vice Chancellor for Research
University of New Mexico - Albuquerque

Albuquerque, NM

Dear

This notice is to acknowledge that the Division of Assurances, Office of Laboratory Animal Welfare (OLAW) received and reviewed your institution's Annual Report that was submitted in accordance with Part IV.F. of the Public Health Service (PHS) Policy on Humane Care and Use of Laboratory Animals, revised 2015.

The Annual Report to OLAW is a key document in a continuing relationship with the PHS. It contains pertinent information regarding the policies and procedures in place to provide for the appropriate care and use of laboratory animals.

We look forward to receiving your next report for the period January 1, 2019 through December 31, 2019 within 30 days (January 31, 2020) of the end of the reporting period. Please include your Assurance number on your Annual Report and in all correspondence to OLAW.

Thank you for your attention to these matters.

Sincerely.

1/24/2019

X

Signed by: Signed by: Division of A

Program Analyst, Division of Assurances Office of Laboratory Animal Welfare

cc: IACUC Contact Senior Operations Manager, Office of animal Care Compliance From:

AWAS Application

To: Cc:

Subject:

Annual Report Acknowledgement Letter Final - D16-00565

 Date:
 Monday, January 28, 2019 10:20:56 AM

 Attachments:
 ARAcknowledgeLetter_D16-00565 (1).docx

[[-- External - this message has been sent from outside the University --]]

OLAW - Annual Report Acknowledged

We are pleased to inform you that the Office of Laboratory Animal Welfare (OLAW) reviewed and acknowledged your organization's Animal Welfare Annual Report. Please review the attached document for full details.



PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:

Office of Laboratory Animal Welfare

Division of Assurances

Bethesda, Maryland

Home Page: https://olaw.nih.gov

January 28, 2019

FOR EXPRESS MAIL:

Office of Laboratory Animal Welfare Division of Assurances

Bethesda, Maryland Telephone:

Re: Assurance D16-00565 (A4023-01) Report to OLAW for CY 2018

Executive Vice Chancellor, Vice Chancellor for Research

University of New Mexico -

Albuquerque, NM

Dear

This notice is to acknowledge that the Division of Assurances, Office of Laboratory Animal Welfare (OLAW) received and reviewed your institution's Annual Report that was submitted in accordance with Part IV.F. of the Public Health Service (PHS) Policy on Humane Care and Use of Laboratory Animals, revised 2015.

The Annual Report to OLAW is a key document in a continuing relationship with the PHS. It contains pertinent information regarding the policies and procedures in place to provide for the appropriate care and use of laboratory animals.

We look forward to receiving your next report for the period January 1, 2019 through December 31, 2019 within 30 days (January 31, 2020) of the end of the reporting period. Please include your Assurance number on your Annual Report and in all correspondence to OLAW.

Thank you for your attention to these matters.

Sincerely,

cc: IACUC Contact Operations Manager



Office of Animal Care Compliance

February 13, 201 8
Division of Compliance Oversight Office of Laboratory Animal Welfare (OLAW), National Institutes of Health (NIH)
Bethesda, MD Phone: FAX: E-mail:
Attn: , DVM, PhD, Veterinary Medical Officer

RE: Assurance # D16-00228 (A3350-01) – Failure to ensure adequate anesthesia and performing a procedure that is not listed on an approved protocol (protocol deviation)

As per our telephonic report to student rotating through a Principle Investigator's (Pl's) lab observed that a visiting MD from another country, who is currently working towards a PhD degree, performed heart perfusions on five mice. Although the PI laboratory associates thought this procedure was approved, the protocol was only approved for tissue harvest after euthanasia. In addition, the protocol associate failed to ensure an adequate plane of anesthesia before starting the procedure as evidenced by some movement and vocalizations from some of the mice. Upon review with the PI, it was determined that there had been problems with overdosing of mice and subsequently they reduced the initial dose to prevent premature death. Repeated anesthesia doses were administered during the procedure when animals were lightly anesthetized, but unfortunately not before mice were exposed to unnecessary pain or distress.

This incident was discussed in the February 7th, 2019 convened Health Sciences Center (HSC) Institutional Animal Care and Use Committee (IACUC) meeting and a subcommittee of the IACUC (Chair and Vice-Chair), Attending Veterinarian (AV), Animal Resource Facility (ARF) Supervisor, and the Office of Animal Care Compliance (OACC) staff to include the Senior Operations Manager and Compliance Specialist met with the PI on February 8th, 2019 to discuss the incident and action items to remediate the incident. In addition, the same group will meet with the PI and all the lab members on February 22, 2019 to further discuss ongoing remediation process for the incident.



Action items for remediation of the incident:

- 1. The PI will immediately amend the IACUC protocol to include perfusions as "Non-survival Surgery" in addition to tissue harvest after euthanasia.
- 2. The PI will ensure that all lab members know which specific procedures are approved in the IACUC protocol.
- 3. The ARF Supervisor and veterinarian will retrain the PI and all lab personnel on anesthesia methods and dosing.
- 4. The ARF, IACUC, and/or OACC will complete Post-approval Monitoring (PAM) prior to the lab personnel conduction any additional animal procedures. PAM will continue quarterly for the next calendar year in order to ensure both adherence to the approved IACUC protocol and lab member proficiency with animal procedures.

Sincerely,

Executive Vice Chancellor Vice Chancellor for Research

Cc:
Attending Veterinarian
IACUC Chair

, MS, CPIA, Senior Operations Manager, OACC

OLAW Division of Compliance Oversight (NIH/OD) To: OLAW Division of Compliante Oversight (NIH/OD) Cc: RE: Assurance # D16-00228 (A3350-01) - University of New Mexico Health Sciences Center Subject: Friday, March 1, 2019 11:05:27 AM Date: [-- External - this message has been sent from outside the University --]] Thank you for this report, . We will send a response soon. , M.S., D.V.M. Deputy Director, OLAW From: Sent: Friday, March 1, 2019 11:31 AM To: OLAW Division of Compliance Oversight (NIH/OD) Cc: Subject: Assurance # D16-00228 (A3350-01) - University of New Mexico Health Sciences Center Good morning, , Please see the attached, signed final report as previously discussed. Thank you! , MS, CPIA Senior Operations Manager Office of Animal Care Compliance Albuquerque, NM , fax *****CONFIDENTIALITY STATEMENT -- PLEASE READ******************** This email is an official communication intended for use by the designated recipient(s) only. This email (including any attachments) contains information which is confidential and/or legally privileged under federal/state laws and/or regulations as well as UNM policies. The authorized recipient(s) should keep this communication confidential and not forward it to any person without permission of

the Committee in charge of handling this matter. Any use by parties other than the named recipient(s) is unauthorized and prohibited. If you receive this email in error, please call , notify the sender by email, and delete this email including any attachments.

From:



DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH

OR US POSTAL SERVICE DELIVERY:

Bethesda, Maryland

Home Page: http://grants.nih.gov/grants/olaw/olaw.htm

March 12, 2019

FOR EXPRESS MAIL:
Office of Laboratory Animal Welfare
Bethesda, Maryland
Telephone:
Facsimile:

Re: Animal Welfare Assurance A3350-01 [OLAW Case V]

Executive Vice Chancellor University of New Mexico

Albuquerque, NM

Dear

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your February 13, 2018 letter reporting an instance of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the University of New Mexico, following up on an initial telephone report on February 12, 2019. According to the information provided, OLAW understands that five mice were subjected to a cardiac perfusion although this procedure was not described in the approved protocol. Furthermore, the mice were inadequately anesthetized before the procedure was started.

The corrective actions consisted of amending the protocol to include perfusions, having the Principal Investigator (PI) ensure that laboratory staff is aware of the procedures approved in the protocol, retraining the PI and staff on the appropriate conduct of anesthesia, and placing the laboratory under enhanced post-approval monitoring.

Based on its assessment of this explanation, OLAW understands that measures have been implemented to prevent recurrence of this problem. OLAW concurs with the actions taken by the institution to comply with the PHS Policy.

Sincerely,



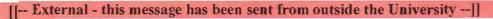
cc: IACUC Chair

From: To: Cc: OLAW Case A3350-V

Subject:

Date: Friday, March 15, 2019 6:36:29 AM

Attachments: 0889 001.pdf



Dear

Attached please find

final response to OLAW Case A3350-V.

If you have any questions, feel free to contact us by phone or by e-mail.

Regards,



Program Specialist Office of Laboratory Animal Welfare National Institutes of Health

Bethesda, MD



Office of Animal Care Compliance

October 11, 2019

Division of Compliance Oversight Office of Laboratory Animal Welfare (OLAW), National Institutes of Health (NIH)
Phone: , FAX: E-mail:
Attn: , DVM, PhD, Veterinary Medical Officer
RE: Assurance # D16-00228 (A3350-01) – Unexpected animal deaths

As per our telephonic report to on 9/18/19, an adverse event occurred on 9/11/19 in which 29 out of 60 mice died unexpectedly after routine tamoxifen injection (26 Cre+ and 3 Cre-). The Attending Veterinarian (AV), ARF Supervisor, and the Office of Animal Care Compliance (OACC) staff met with the PI and a laboratory staff member on 10/1/19 to discuss outcomes of the incident and to consider action items to remediate the incident. It was determined that culture of the tamoxifen solution in corn oil used for the injections did not yield any microbial contamination and pathological assessment was inconclusive. On 10/3/19 the Animal Resource Facility (ARF) Supervisor observed the laboratory staff's injection techniques and confirmed their competency with intra peritoneal injection techniques.

This incident was discussed in the 10/3/19 convened Health Sciences Center (HSC) Institutional Animal Care and Use Committee (IACUC) meeting.

The following action items were decided upon for remediation of the incident:

- 1. Query the vendor regarding any reports of adverse events using their tamoxifen reagent and pharmaceutical grade corn oil vehicle.
- 2. If there have been no reports of adverse events, purchase new tamoxifen reagent and corn oil vehicle from the vendor to use in the next set of experiments.
- 3. Plate an aliquot of the final preparation of tamoxifen in corn oil on bacterial agar to ensure that no bacterial contamination has occurred prior to injecting mice.
- 4. Adjust procedures if indicated and then conduct a pilot with a few Cre + and mice using the new preparations.
- 5. If no adverse outcomes, move forward with the study.



Sincerely,

Executive Vice Chancellor Vice Chancellor for Research

Cc:

Attending Veterinarian
Ph.D., IACUC Chair
, MS, CPIA, Senior Operations Manager, OACC

From: OLAW Division of Compliance Oversight (NIH/OD)

To: ; OLAW Division of Compliance Orersight (NIH/OD)

Cc: Subject:

RE: Assurance # D16-00228 (A3350-01) - Mouse_Injection_Incident_Memo_to_OLAW_10-11-19-signed.pdf

Date: Thursday, October 17, 2019 12:09:04 PM

[[-- External - this message has been sent from outside the University --]]

Thank you for providing this report. We will send an official response soon.

Best regards,

, DVM, DACLAM

Director

Division of Compliance Oversight Office of Laboratory Animal Welfare

National Institutes of Health

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From:
Sent: Thursday, October 17, 2019 1:58 PM

To: OLAW Division of Compliance Oversight (NIH/OD)

Cc: ;

Subject: Assurance # D16-00228 (A3350-01) - Mouse_Injection_Incident_Memo_to_OLAW_10-11-19-signed.pdf

Good afternoon,

Please see the attached Mouse Injection Incident Memo for the University of New Mexico Health Sciences Center OLAW Assurance # D16-00228 (A3350-01).

Thank you!

From: To: Cc: OLAW Case A3350-W

Subject: Date:

Thursday, October 24, 2019 11:04:04 AM

Attachments: 1015 001.pdf

[[-- External - this message has been sent from outside the University --]]

Dear

Attached please find

State of the Colons

final response to OLAW Case A3350-W.

If you have any questions, feel free to contact us by phone or by e-mail.

Best Regards,



T WO

Program Specialist Office of Laboratory Animal Welfare National Institutes of Health

Bethesda, MD

150



DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:
Office of Laboratory Animal Welfare

Bethesda, Maryland

Home Page: http://grants.nih.gcv/grants/olaw/olaw.htm

FOR EXPRESS MAIL,
Office of Laboratory Animal Welfare
Bethesda, Maryland
Telephone:
Facsimile:

October 24, 2019

Re: Animal Welfare Assurance A3350-01 [OLAW Case W]

Executive Vice Chancellor
University of New Mexico
Albuquerque, NM
Dear

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your October 11, 2019 letter reporting an instance of an adverse event within the animal care and use program at the University of New Mexico. Your letter supplements the information provided in a preliminary telephone report made on September 18, 2019. According to the information provided, OLAW understands that on September 11, 2019, after routine injection with a mixture of tamoxifen in pharmaceutical grade corn oil, 29 out of 60 mice died unexpectedly. The animals on this study were supported by NIH funding.

OLAW understands that in attempting to determine the cause and prevent future concerns, a culture of the tamoxifen-corn oil mixture did not yield any microbial contamination and the pathological assessment was inconclusive. The vendor will be contacted to ascertain if other adverse events have been reported by other clients using tamoxifen or corn oil. Additionally, the institution will purchase new tamoxifen reagent and corn oil vehicle, plate an aliquot of the tamoxifen-corn oil mixture on bacterial agar to screen for bacterial contamination, adjust any procedures as needed and conduct a pilot study with new preparations before moving forward with the study pending no adverse outcomes.

OLAW appreciates the prompt consideration of this matter by the University of New Mexico, which is consistent with the philosophy of institutional self-regulation. Based on the information provided, OLAW is satisfied that appropriate steps have been taken to investigate this incident and to attempt to prevent another occurrence. We appreciate being informed of this matter and find no cause for further action by this office.



cc: IACUC Contact