



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 2, 2022

Re: Animal Welfare Assurance
A3413-01 [OLAW Case 3H]

Michael R. Blackburn, Ph.D.
Executive Vice President and
Chief Academic Officer
University of Texas Health Science Center-Houston
7000 Fannin St., UCT-1732
Houston, TX 77030

Dear Dr. Blackburn,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your February 7, 2022 letter reporting an instance of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals within the animal care and use program at the University of Texas Health Science Center at Houston. Your letter supplemented the information contained in an initial telephone report to this office on January 31, 2022. According to the information provided, OLAW understands that between December 29, 2021, and January 7, 2022, due to a mechanical failure of a light timer, approximately 1,020 non-breeding, naive mice housed in 204 cages in a single housing room were subjected to an 8-hour light cycle during the weekday and a 4 to 6-hour light cycle during the weekend instead of the traditional 12-hour lights on and 12-hour lights off cycle. This non-traditional light cycle is not approved on the affected protocols. No clinical consequences were noted during the daily checks of the animals. All mice were moved into a housing room with a functional light timer on January 7, 2022. A new light timer was ordered and installed, and the mice were returned to the housing room on January 11, 2022. The new light timer has been functioning normally, and no further problems have been noted.

Preventive actions include husbandry staff taking a more proactive approach to resolving future issues, including moving animals if required and, pushing critical issues to upper management more quickly. Additionally, husbandry staff has been counseled on the importance of maintaining animal environments in accordance with the recommendations of the *Guide* to prevent future non-compliance. Facility operations and maintenance staff have been counseled to be more proactive and to instigate communication with husbandry managers to determine if facility issues have been corrected. Multiple light timers have been procured to remain in inventory for quicker repairs.

The animals involved in this incident were supported by NIH funding. No significant costs associated with this event were identified, and funds will be returned if associated costs are identified.

OLAW appreciates the consideration of this matter by the University of Texas Health Science Center at Houston, which was consistent with the philosophy of institutional self-regulation. Based on the information provided, OLAW agrees that appropriate corrective and preventive actions were taken. We appreciate being informed of this matter and find no cause for further action by this office.

Page 2 – Dr. Blackburn
March 2, 2022
OLAW Case A34143-3G

Sincerely,

Brent C. Morse -S Digitally signed by Brent C. Morse -S
Date: 2022.03.02 07:54:48 -05'00'

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

cc: IACUC contact

February 7, 2022

Brent Morse, D.V.M., DACLAM
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
Rockledge One, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

Re: Assurance A3413-01

Dear Dr. Morse,

The Animal Welfare Committee (AWC), the Institutional Animal Care and Use Committee for the University of Texas Health Science Center at Houston (UTHealth) provides this report of a mechanical failure resulting in animals being exposed to a non-traditional light cycle. In accordance with Assurance A3413-01 and PHS Policy IV.F.3.a, a preliminary report was made by the (b) (6) (b) (6) to you on January 31, 2022.

On January 13, 2022, the AWC received a report of a mechanical failure resulting in animals being exposed to a non-traditional light cycle. Between December 29, 2021, and January 7, 2022, approximately 1,020 non-breeding, naïve mice housed in 204 cages in a single housing room were subjected to a non-traditional light cycle. More specifically, the non-breeding, naïve mice were exposed to an 8-hour light cycle during the weekday and a 4- to 6-hour light cycle during the weekend instead of the traditional 12-hour lights on and 12-hour lights off cycle. This non-traditional light cycle is not approved on the affected protocols. A light timer failure resulted in the manual control of the lights during the aforementioned date range. No clinical consequences were noted during the daily checks of the animals. All mice were moved into a housing room with a functional light timer on January 7, 2022. A new light timer was ordered and installed, and the mice were returned to the housing room on January 11, 2022. The new light timer has been functioning normally, and no further problems have been noted.

Preventive actions include husbandry staff taking a more proactive approach to resolving future issues, including moving animals if required and pushing critical issues to upper management more quickly. Additionally, husbandry staff has been counseled on the importance of maintaining animal environments in accordance with the recommendations of the *Guide* to prevent future non-compliance. Facility operations and maintenance staff have been counseled to be more proactive and to instigate communication with husbandry managers to determine if facility issues have been corrected. Multiple light timers have been procured to remain in inventory for quicker repairs.

Brent Morse, D.V.M., DACLAM
Re: Assurance A3413-01
February 7, 2022
Page 2 of 2.

The animals involved in this incident were supported by NIH funding (1R21AG067282-01A1, 5R01NS115886-02, 5R01NS108779-04, 5R01NS103592-04, 5F31NS118984-02, 1R21AG070860-01A1, and 5R01NS102452-05). No significant costs associated with this event were identified and funds will be returned if associated costs are identified.

The AWC Protocol Deviation Subcommittee has investigated the incident, evaluated the corrective action plan, and determined that the incident has been successfully resolved.

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

Sincerely,

(b) (6)

Michael R. Blackburn, Ph.D.
Executive Vice President and Chief Academic Officer

MRB/tsl

cc: Dr. Juan Herrera, IACUC Chair

(b) (6)

AWC Office

Wolff, Axel (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Wednesday, February 23, 2022 8:05 AM
To: (b) (6)
Cc: OLAW Division of Compliance Oversight (NIH/OD)
Subject: RE: OLAW Response to Final Reports - Case A3413-01

Thank you for these reports. We will respond soon.

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

From: (b) (6)
Sent: Friday, February 18, 2022 12:23 PM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>; OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Cc: Blackburn, Michael R <Michael.R.Blackburn@uth.tmc.edu>; Herrera, Juan <Juan.Herrera@uth.tmc.edu>; (b) (6)
(b) (6) Animal Welfare Committee, GM <awc@uth.tmc.edu>; (b) (6)
(b) (6)
Subject: [EXTERNAL] OLAW Response to Final Reports - Case A3413-01
Importance: High

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.

***Sent on behalf of Michael R. Blackburn, Ph.D.,
EVP & Chief Academic Officer / Institutional Official, UTHealth—***

Good Morning, Dr. Morse,

I have attached three PDFs concerning the above-referenced.
Please advise if you have any issues with receiving the attachment.

Thanks and regards,

(b) (6)



Initial Report of Noncompliance

By: BCM

Date: 2/2/2022

Time: Voicemail

Name of Person reporting: (b) (6)

Telephone #: (b) (6)

Fax #:

Email:

Name of Institution: Univ. of Texas Health (Houston)

Assurance number: A3413

Did incident involve PHS funded activity? yes

Funding component: ?

Was funding component contacted (if necessary):

What happened?: Room light time malfunctioned. 6-8 hours of light instead of 12. No health issues. Five protocols PHS funded.

Species involved: Mus musculus

Personnel involved: ?

Dates and times: Dec 29, 2021 – Jan 6, 2022

Animal deaths: no

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

New timer installed and new timers ordered for other rooms. Better communication within program has been initiated.

Projected submission to OLAW of final report from Institutional Official:

< 60 days

OFFICE USE ONLY

Case #