DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE
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FOR US POSTAL SERVICE DELIVERY:
Office of Laboratory Animal Welfare
6700B Rockledge Drive, Suite 2500 – MSC 6910
Bethesda, Maryland 20892-7982
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

DATE: June 1, 2022

TO: Michael M. Gottesman, M.D.
Deputy Director for Intramural Research, NIH

FROM: Director
Division of Compliance Oversight, OLAW

SUBJECT: Animal Welfare Investigation (ORS-DVR #17-22) - Animal Welfare Assurance A4149-01 [Case 16U]

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your May 13, 2022 memo regarding an incident of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the Office of Research Services/Division of Veterinary Resources. According to the information provided, OLAW understands that on February 12, 2022, a veterinary technician was microchipping rat pups and using a 4-chamber anesthesia machine as a staging area. The technician had used the machine before but only typically used 2 to 3 chambers at a time and did not fully understand the proper use of the machine. The technician thought oxygen was flowing in all four chambers but failed to turn on the 4th chamber oxygen/ISO switch thus preventing oxygen flow to that chamber resulting in the death of rat pups.

The contract lead trainer, and to two additional trainers, reviewed how the machine worked with the technician. The contractor is currently working on revamping its training and sign-off processes. The involved technician and others on their team have received refresher training

The actions taken to resolve the issue and prevent recurrence were appropriate and accepted by OLAW. The plans for retraining are also accepted by OLAW. We suggest that the usefulness of warning signage posted on the machine be considered by the ACUC. 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: 2022.06.01 08:41:53 -04'00'

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

cc: Dr. Stephen Denny
Dr. Richard Wyatt
Dr. Joanne Smith, Chair, ORS ACUC

A4149 - 164

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

National Institutes of Health
Bethesda, Maryland 20892
www.nih.gov

May 13, 2022

TO: Brent C. Morse, D.V.M.
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare

FROM: Deputy Director for Intramural Research, NIH

SUBJECT: Animal Welfare Investigations - Assurance D16-00602 (DVR 17-22)

This correspondence conveys the results of an animal incident investigation by the NIH Office of Research Services Division of Veterinary Research (DVR) ACUC in accordance with Assurance D16-00602 and PHS Policy IV.F.3. The incident involved the failure to appropriately conduct anesthesia monitoring on neonatal rats as outlined in the ACUC approved animal program operating procedures.

The event was first reported to the NIH Office of Animal Care and Use by the DVR ACUC Chairman on March 18, 2022.

Please contact me or Dr. Stephen Denny, Director, Office of Animal Care and Use, if additional information or clarifications are required.

Michael M. Gottesman -S
Digitally signed by Michael M. Gottesman -S
Date: 2022.05.16 10:41:56 -04'00'

Michael M. Gottesman, M.D.

Attachment

cc: Dr. Wyatt
Dr. Smith
Dr. Denny

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

To: Michael M. Gottesman, MD
Deputy Director for Intramural Research, NIH

From: Joanne Smith
Chair, ORS Animal Care and Use Committee

Subject: NIH DVR Animal Incident Report

In accordance with Animal Welfare Assurance # D16-00602 and PHS Policy IV.F.3., the ORS ACUC provides this report of an incident that occurred involving the care and use of animals in biomedical research.

Incident Summary:

This incident, involving death of rat pups due to incorrect use of an anesthesia machine, occurred on 2/12/22 and was reported by the Facility Veterinarian to the ACUC Chair and the AV on 2/14/22. The ACUC Chair subsequently notified OACU.

A subcommittee interviewed the responsible veterinary technician and their supervisor on 2/23/22.

The committee learned that a veterinary technician was microchipping rat pups and using a 4-chamber anesthesia machine as a staging area. They had used this machine before but only typically used 2 to 3 chambers at a time. They were not used to having to anesthetize so many pups at one time. Due to the large litter size, they utilized all four chambers, using the fourth chamber as a staging area. The technician thought oxygen was flowing in all 4 chambers and turning on the switch started the delivery of Isoflurane. They did not have the 4th chamber oxygen/ISO switch on because they did not want the pups in the 4th chamber to yet be exposed to Isoflurane. They did not realize that the 4th chamber not getting oxygen led to death in pups placed in the 4th chamber. The veterinary technician reported the incident to a co-worker who later talked to the contract lead trainer and to two additional trainers who reviewed how the machine worked with the technician.

It was determined that the rat pup deaths were due to inappropriate use of the 4-chamber anesthesia machine as a staging area, and inappropriate monitoring of the animals. Review with the contract management and technician involved revealed that adequate training and veterinary sign off would have helped prevent the issue. The SOP for use of this unit does state that the oxygen and anesthetic are delivered together.

Corrective Actions:

The contractor is currently working on revamping its training and sign off processes. The involved technician and others on their team have received refresher training

ACUC Review:

The ACUC reviewed this incident at a full committee meeting on 3/15/22 and concluded that the incident was reportable due to accidental harm to animals and inadequate training. The committee feels that the actions proposed will prevent the occurrence of a similar incident in the future.

Sincerely,

Joanne M. Smith -S Digitally signed by Joanne M. Smith -S
Date: 2022.03.25 11:06:25 -04'00'

Chair, ORS Animal Care and Use Committee

Wolff, Axel (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Wednesday, May 18, 2022 7:14 AM
To: Denny, Stephen (NIH/OD) [E]
Cc: OLAW Division of Compliance Oversight (NIH/OD)
Subject: RE: D16-00602 NIH Animal Incident Report (DVR 17-22))

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

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

From: Denny, Stephen (NIH/OD) [E] <stephen.denny@nih.gov>
Sent: Monday, May 16, 2022 3:23 PM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Subject: D16-00602 NIH Animal Incident Report (DVR 17-22))

Dear OLAW/DCO,

The attached documents from the NIH Institutional Official and the NIH National Institute Office of Research Services Division of Veterinary Services (DVR) ACUC address an animal incident involving the failure to appropriately conduct anesthesia monitoring on neonatal rats as outlined in the ACUC approved animal program operating procedures. The event was first reported to the NIH Office of Animal Care and Use by the DVR ACUC Chairman on March 18, 2022.

If you have any questions please contact me via email or at the phone number listed below. Thank you, Steve

STEPHEN DENNY, DVM, MS, DACLAM, DACVPM | Director, Office of Animal Care and Use | NIH Bethesda Campus, Building 31/Room B1C37 | Phone: (301) 435-2188 | ***NIH . . . Turning Discovery Into Health*** |