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

June 9, 2023

Re: Animal Welfare Assurance
A3304-01 [OLAW Case 4C]

Dana L. Director, Ph.D.
Vice President of Research Administration
and Senior Staff Officer
Oregon Health and Science University
3181 SW Sam Jackson Park Rd. – (b) (4)
Portland, OR 97239

Dear Dr. Director,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your June 5, 2023 letter reporting an adverse event involving a nonhuman primate at Oregon Health & Science University, following up on an initial telephone report on May 8, 2023. According to the information provided, OLAW understands that an infant rhesus monkey sustained an accidental injury from a sliding door as technicians were attempting to capture the mother and baby. The technicians were attempting to direct the pair into a transfer box which was holding up the sliding door, but the mother charged the box, the door fell, and the baby was injured.

The immediate action taken following the injury consisted of transporting the infant to the veterinary hospital where it was diagnosed with an untreatable spinal/shoulder injury and was euthanized. The mother was also examined and no injury was identified. Following a root cause analysis, it was concluded that the accident occurred as a result of the sliding door coming down if the transfer box holding it up is removed (which occurred when the mother ran against it). The Institutional Animal Care and Use Committee (IACUC) implemented preventive measures which now require two people to use the transfer box and door slide, with one person controlling the door pulley and cable. The standard operating procedure was updated with this new method and an engineering solution to address the sliding door is under consideration.

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

Sincerely,

(b) (6)

Axel Wolff, M.S., D.V.M.
Deputy Director
Office of Laboratory Animal Welfare

cc: IACUC Chair
Robert Gibbens, D.V.M., USDA-APHIS-AC

A3304-4C

OHSU

OHSU Research & Innovation Office
(b) (6)

Dana Director, PhD
Vice President of Research
Administration & Senior Staff Officer

director@ohsu.edu
www.ohsu.edu/research

Mail code: L335
3181 S.W. Sam Jackson Park Rd.
Portland, OR 97239-3098

June 5, 2023

Brent Morse, DVM, DACLAM
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare (OLAW)
National Institutes of Health
6700B Rockledge Drive, Suite 2500, MSC 6910
Bethesda, MD 20892
olawdco@mail.nih.gov

Dear Dr. Morse:

Oregon Health & Science University (OHSU), in accordance with Assurance D16-00195 (A3304-01) and PHS Policy IV.F.3., provides this report of a serious deviation from the provisions of the *Guide*. This was first reported to you on May 8, 2023, via a telephone voice message from (b) (6)

The incident, which occurred on May 4, 2023, involved a Rhesus macaque female, nine years of age, and her two-day old infant. The animals were members of a socially housed breeding group of 52 animals including adult females, adult males, juveniles and infants. None of the animals were assigned to specific research trials at the time of the adverse event.

Two husbandry technicians were attempting to capture the dam with her infant using cooperative capture techniques. The animals had been isolated from the rest of the group. The standard practice of cooperative capture, a refined technique over netting, allows the animal to voluntarily enter a transfer box placed in unthreatening positions within the enclosure. This cooperative capture technique may be employed by a single husbandry technician, however on the day of the event, two technicians were available to encourage the animals to move to the transfer box. Both husbandry technicians stood within the primary enclosure and maintained distance from the animals to allow them to voluntarily enter the transfer box. Three of four commonly used locations for the box were attempted without success. In the fourth location, the transfer box was placed to block the doorway of the vertical slide so the animals could enter the box as they attempted to go through the vertical slide.

The transfer box was placed in the doorway as training prescribed. The female monkey aggressively and unexpectedly charged the box and

dislodged it from the doorway allowing the vertical slide to fall. At that moment, the infant either fell from its grasp on the female, or the female dropped the infant. The vertical slide impacted the infant and wounded the animal.

The technicians immediately alerted the hospital staff that an injured animal was being transported for emergency medical attention. The animal was admitted to the hospital within ~2.5 minutes and examined immediately. The veterinarians diagnosed an untreatable injury to the infant's shoulder and spine and euthanized the animal. The female macaque was admitted to the hospital and examined but no injuries from the incident were detected.

The Attending Veterinarian notified the Institutional Official (IO), the Chair of the Institutional Animal Care and Use Committee (IACUC), and the ACUP Director on the day of the incident. An internal root cause analysis was initiated on May 5th as per standard practice at the Oregon National Primate Research Center. The ACUP Director and Chair of the IACUC initiated an independent investigation which included private interviews with the husbandry technicians, the veterinarians who examined the animals, and the training coordinator. The incident was reported to the IACUC on May 16, 2023.

After careful consideration, the IACUC determined this was an accident that occurred due to physical characteristics of the transfer box and the doorway of the vertical slide. It was determined that human error did not contribute to the cause of the accident. While this capture technique has been used for ~10 years without incident, the root cause of the accident was the ability of the slide to fall to the ground if the transfer box became dislodged. The IACUC voted unanimously to approve the following actions to prevent recurrence.

- Effective immediately following the accident, two trained persons are required when the box and vertical slide technique is used for cooperative capture. One person must stand outside the enclosure and manually control the pulley and cable system that operates the vertical slide. If two trained people are not available, this capture method may not be employed.
- The standard operating procedure (SOP) and training will be updated to include the requirement for a second trained individual to remain outside of the enclosure and manually control the slide pulley and cable system. The IACUC will review these revisions and approve, or require modifications to approve, the SOP. Any IACUC member may call the revised SOP for a Full Committee Review (FCR). If no member calls for FCR, the revised SOP and

training may be reviewed using the Designated Member Review process.

- An engineering solution must be installed before a second person will no longer be required to manually operate the vertical slide pulley and cable system. The engineering solution must prevent the vertical slide from falling to the floor even if the transfer box is dislodged. Regular updates on the design and implementation of an engineering solution will be reported to the IACUC.

OHSU is committed to protecting the welfare of animals used in research and appreciates the guidance and assistance provided by OLAW in this regard. Should you have any questions, please contact (b) (6) (b) (6)

Thank you for your consideration of this matter.

Sincerely,

(b) (6)

Dana L. Director, Ph.D.
Vice President of Research Administration & Senior Staff Officer
Institutional Official
Oregon Health & Science University

cc: Attending Veterinarian
IACUC Chair
Director, Animal Care & Use Program

McCoy, Devora (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Monday, June 5, 2023 12:33 PM
To: (b) (6)
Cc: OLAW Division of Compliance Oversight (NIH/OD)
Subject: RE: Final Report Serious Deviation OHSU A3304-01

Good afternoon (b) (6)

Thank you for sending us this final report and we will send an official response soon.

Best,
Devora

Devora McCoy, BS, MBA (pronunciation)
Program Analyst
Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health

Phone: 301-435-2390
Email: devora.mccoy@nih.gov

From: (b) (6)
Sent: Monday, June 5, 2023 11:45 AM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Cc: Dana Director <director@ohsu.edu>; (b) (6)
Subject: [EXTERNAL] Final Report Serious Deviation OHSU A3304-01

Please find attached the Final Report from the Oregon Health & Science University of a serious deviation from the Guide for the Care and Use of Laboratory Animals.
Respectfully,
(b) (6)

A3304-4C

Initial Report of Noncompliance

By: (b) (6) Vivian

Date: 5/8/23

Time: 11 45

Name of Person reporting: (b) (6)
Telephone #: (b) (6)
Fax #:
Email:

Name of Institution: Oregon Health & Science U
Assurance number: A3304

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

What happened? May 4 - occurred
Infant macaque injured by slide door
Accident

Species involved: Macaque
Personnel involved: Animal Care staff + supervisors
Dates and times:
Animal deaths:

Projected plan and schedule for correction/prevention (if known): _____
IACUC investigating, report in June

Projected submission to OLAW of final report from Institutional Official:

OFFICE USE ONLY
Case #_____