



## Inspection Report

Harvard University  
1414 Massachusetts Avenue  
Room 233  
Cambridge, MA 02138

Customer ID: 156  
Certificate: 14-R-0128  
Site: 001  
HARVARD UNIVERSITY

Type: ROUTINE INSPECTION  
Date: 06-APR-2017

### 2.38(f)(1) CRITICAL

#### MISCELLANEOUS.

Handling.

\*\*In February 2016 husbandry staff found 2 *Peromyscus* mice deceased in their primary enclosure and their 3 cagemates were exhibiting signs of illness; veterinary staff were immediately contacted. The 3 sick animals were treated and recovered. Upon being notified and in response to this information, the IACUC and AV immediately looked into the incident.

It was determined that laboratory staff had transferred the 5 *Peromyscus* to a new enclosure 2 days earlier but had failed to add pelleted feed to the food hopper; in addition husbandry staff failed to detect the lack of feed in the enclosure during the daily observations. As a result, the 5 animals did not have food for 2 days.

\*\*In June 2016 husbandry staff found one *Peromyscus* mouse deceased in its primary enclosure; veterinary staff were immediately contacted. Upon being notified and in response to this information, the IACUC and AV immediately looked into the incident.

It was determined that laboratory staff had removed the enclosure from its designated slot on the ventilated rack 2 days earlier but later inadvertently returned it to a different empty slot on the rack that was not equipped with a sipper valve (delivers water to the enclosure); in addition husbandry staff failed to detect the lack of a sipper valve in the enclosure during the daily observations. As a result the animal did not have access to water for 2 days.

Per this Section of the Regulations, the handling of animals by all personnel, including laboratory and husbandry staff, should be done as carefully as possible in a manner that does not cause physical harm, behavioral stress, or unnecessary discomfort.

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09-APR-2017

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10-APR-2017



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The research facility acted promptly to address both of these incidents by conducting an investigation and swiftly implementing appropriate corrective actions to prevent similar incidents in the future. Corrective actions included but were not limited to implementing changes to SOPs related to animal care and husbandry practices and providing additional retraining of laboratory and husbandry staff. No additional incidents have occurred.

This item has been appropriately addressed and corrected by the research facility.

NOTE - Exit briefing held on-site 4/6/17 with facility representatives. Report delivered by e-mail 4/10/17.

\*END OF REPORT\*

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