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) 402-7065

January 7, 2019

Re: Animal Welfare Assurance
#A3290-01 (OLAW Case 1S)

Todd R. Evans, Ph.D.
Associate Dean for Research, WCM
Weill Medical College of Cornell University
1300 York Avenue, LC-708
New York, NY 10065

Dear Dr. Evans,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your December 20, 2018 letter reporting several non-compliances with the PHS Policy on the Humane Care and Use of Laboratory Animals at Weill Cornell Medicine. According to the information provided it is understood that:

For incident #1, a cage of 2 recently weaned mice was found without feed and water. One mouse was dead and the other dehydrated. The cage had been created by a laboratory staff member. The related activity is PHS-funded.

Corrective and/or preventive measures included the PI addressing the issue with the lab staff including ensuring that food and water are available and accessible. The animal care staff was also retrained and corrective actions implemented.

For incident #2, a member of the Veterinary Services requested that a mouse with vaginal prolapse be euthanized promptly by an animal user (AU). The mouse was subsequently found on a euthanasia rack instead of being euthanized immediately as per Institutional policy. The related activity is PHS-funded.

Corrective and/or preventive measures included the PI addressing the lab about the need to adhere to the euthanasia guidelines. The AU was required to retake online training addressing euthanasia procedures.

For incident #3, a dead mouse was found in a basket used for aerosolizing M. tuberculosis after autoclaving. It was not determined if the animal died as a result of autoclaving. The PI was from another institution and the protocols were approved by that institution's IACUC.

Corrective and/or preventive measures included the IACUC requiring the PI to develop, present, and implement a process to ensure the incident will not be repeated. An SOP was developed detailing the procedure to be conducted by two people and that the animals be counted before and after aerosolization. A training session was held for all ABSL-3 personnel conducting this procedure.

OLAW believes that the corrective measures put in place by Weill Cornell Medicine are consistent with the provisions of the PHS Policy on Humane Care and Use of Laboratory Animals. We appreciate being informed of these matters and find no cause for further action by this office.

Sincerely,

(b) (6)

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

cc: IACUC Contact

A3290-15

Weill Cornell Medicine

Institutional Animal Care and Use Committee
1300 York Avenue, Box 5
New York, NY 10065

Telephone: 646-962-2981/2
Email: iacucadmin@med.cornell.edu

445 East 69th Street, Olin Hall Rm-423
New York, NY 10065

December 20, 2018

Brent Morse, DVM
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
Rockledge 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

Re: Assurance # D16-00186

Dear Dr. Morse:

We are writing to report incidents of non-compliance that occurred within the animal care and use program at Weill Cornell Medicine. The incidents were presented to and discussed by the IACUC during the months of November and December. The incidents and resolutions are as follows:

Incident #1
A cage of 2 recently weaned mice, which had been created by a laboratory staff member, was found without feed and water. One mouse was dead and the other dehydrated. The veterinary staff reported that the mice appeared small and may not have been able to reach the drinking water.
Resolution: The animal care staff assumes primary responsibility for ensuring all cages have food and water. The PI was informed that their staff member should have ensured that food and water was provided and was accessible to the weanlings when the cage of newly weaned mice was created. The PI addressed the issue with their laboratory. The animal care staff was retrained and corrective action implemented. (National Heart, Lung, & Blood Institute 4 R00 HL125899-03)

Incident #2
A member of the Veterinary Services staff identified a mouse with a vaginal prolapse and requested the animal user (AU) euthanize the mouse promptly and supply a foster dam for the nursing pups. The AU responded that the mouse would be euthanized by the time requested. The mouse was subsequently found on a euthanasia rack in violation of Institutional policy restricting mice with clinical issues being placed on the rack as they should be euthanized immediately.
Resolution: A letter was sent to the PI reminding them of Institutional policy. The PI addressed the lab about the need to adhere to the euthanasia guidelines. The AU was required to retake the online training course addressing euthanasia procedures. (National Inst of Arthritis & Musculoskeletal & Skin Diseases 7 R01 AR070234-02)

The following incident occurred in WCM facilities, but the PIs is an MSK investigator and the protocols were approved by the MSK IACUC.

A331

Incident #3
A dead mouse was found in a basket used for the aerosolization of M. tuberculosis after autoclaving for decontamination. It could not be determined if the animal died during aerosolization or as a result of decontamination.
Resolution: The IACUC required the PI to develop, present, and implement a process to ensure this incident will not be repeated. An SOP detailing the procedure being conducted by two people and that the animals be counted before and after aerosolization was provided to the Committee for review. A training session was held for all ABSL-3 staff conducting this procedure.

We believe that these issues have been adequately addressed and that the procedures implemented should prevent recurrence. Should you have any questions or concerns, please contact me at (b) (6) or the IACUC Chairman, Dr. Andrew Nicholson, at (b) (6)

Sincerely,

(b) (6)

Todd R. Evans, Ph.D.
Institutional Official
Associate Dean for Research
Weill Cornell Medicine

Morse, Brent (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Wednesday, January 02, 2019 11:34 AM
To: (b) (6) OLAW Division of Compliance Oversight (NIH/OD)
Cc: Andrew C. Nicholson; Todd R. Evans
Subject: RE: WCM IACUC Incident Report (#D16-00186)

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

Best regards, Brent Morse

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

From: (b) (6)
Sent: Wednesday, January 02, 2019 10:43 AM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Cc: Andrew C. Nicholson <nicholso@med.cornell.edu>; Todd R. Evans <tre2003@med.cornell.edu>
Subject: WCM IACUC Incident Report (#D16-00186)
Importance: High

Dear OLAW:

Please find a WCM IACUC incident report attached and let me know if any further clarifications are required.

Best regards,
(b) (6)

(b) (6)

Weill Cornell Medicine