



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

October 11, 2018

Re: Animal Welfare Assurance
#A3165-01 [OLAW Case 1C]

Dr. James J. Tomasek
Vice President for Research and
Dean of Graduate College
University of Oklahoma Health Sciences Center
1000 Stranton L. Young Blvd., [REDACTED]
Oklahoma City, OK 73111

Dear Dr. Tomasek,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your September 26, 2018 letter reporting an adverse event within the animal care and use program at the University of Oklahoma Health Sciences Center. Your letter supplements information provided by your designee in a September 20, 2018 telephone prompt report to this office. According to the information provided, OLAW understands that on August 5, 2018 a cage of mice was found without food. Four of the five mice were dead and the fifth mouse was given food and the PI and Attending Veterinarian were advised. It was determined that animal care staff had not accomplished the prescribed twice-a-day cage checks. These animals were not supported with PHS funds.

Corrective and preventive actions included: group training of the facility animal care staff regarding husbandry expectations; verbal and written counseling of individuals; reassignment of the responsible staff member; counseling of the facility manager, and; discussion of the incident with the PI.

The prompt consideration of this matter by the University of Oklahoma Health Sciences Center was consistent with the philosophy of institutional self-regulation. OLAW concurs that the incident warranted reporting. Although this activity was not PHS funded, the application of the standards of the PHS Policy across the animal care and use program reduces any potential appearance of a double standard. Based on the information provided, OLAW is satisfied that appropriate actions have been taken to investigate this unfortunate incident, make corrections, and prevent recurrence. We appreciate being informed of this matter and find no cause for further action by this office.

Sincerely,

[REDACTED] (b) (6)

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

cc: IACUC contact



The University of Oklahoma

Health Sciences Center

OFFICE OF THE VICE PRESIDENT FOR RESEARCH

September 26, 2018

Brent Morse, DVM
Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
RKL 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892
morseb@mail.nih.gov
olawdco@mail.nih.gov

Dear Dr. Morse:

The University of Oklahoma Health Sciences Center (OUHSC), in accordance with Assurance D16-00104 and PHS Policy IV.F.3., provides this final report of an incident reported on September 20, 2018, involving a non-PHS funded project. The University's final report is as follows:

On August 5, 2018, animal care staff discovered a cage of mice without access to food; four of the five mice in the cage had died. The animal care staff removed the deceased mice and placed food in the cage for the surviving mouse. The Principal Investigator and the Attending Veterinarian were then advised.

The Director of Comparative Medicine and the Attending Veterinarian performed an investigation and concluded animal care staff had not accomplished the prescribed twice-a-day cage checks. On September 12, 2018, the Director of Comparative Medicine reported to the IACUC the details of the investigation and corrective measures engaged. In summary:

- Facility animal care staff received group training by the Attending Veterinarian and the facility manager regarding husbandry expectations.
- Individuals who had performed sub-optimally received written counseling statement and verbal counseling with the facility manager.
- The staff member responsible for overseeing the daily room checks was reassigned to other duties.
- The facility manager received counseling by the Director of Comparative Medicine.
- The Attending Veterinarian and the facility manager met with the Principal Investigator to discuss the incident.

The IACUC acknowledged the conclusions drawn by Comparative Medicine regarding this incident, found the corrective measures to be appropriate, and determined the matter closed.

Brent Morse, DVM
September 26, 2018
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The University is committed to protecting the welfare of animals used in research. If you have any questions regarding this report or the IACUC's actions, please contact me at the number below or Eric Howard, PhD, IACUC Chair, at Eric-Howard@ouhsc.edu.

Thank you for your consideration of this matter.

Sincerely,

(b) (6)

James J. Tomasek, Ph.D.
Vice President for Research
David Ross Boyd Professor of Cell Biology

CC: Eric Howard, PhD, IACUC Chair
Ron Banks, DVM, Director of the Division of Comparative Medicine
Sandra Nettleton, Director of Compliance

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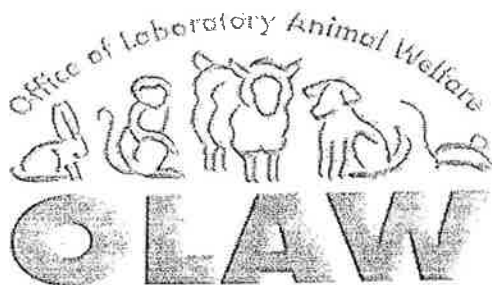
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Initial Report of Noncompliance

By: [Signature]

Date: 9/20/18

Time: 2:00

Name of Person reporting: [Redacted] (b) (6)

Telephone #: [Redacted] (b) (6)

Fax #: [Redacted]

Email: [Redacted]

Name of Institution: U. of OK - HSC

Assurance number: A3185

Did incident involve PHS funded activity? No

Funding component: [Redacted]

Was funding component contacted (if necessary): [Redacted]

What happened? Cage of 5 mice (4 dead) w/no feed. Cage was changed 5 days prior and room had been checked.

Species involved: [Redacted]

Personnel involved: [Redacted]

Dates and times: Early August

Animal deaths: [Redacted]

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

Training
Reprimands, reassignment

Projected submission to OLAW of final report from Institutional Official: [Redacted]

OFFICE USE ONLY

Case #: [Redacted]