



DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:
Office of Laboratory Animal Welfare
Rockledge One, Suite 360
6705 Rockledge Drive - MSC 7982
Bethesda, Maryland 20892-7982
Home Page: <http://grants.nih.gov/grants/olaw/olaw.htm>

FOR EXPRESS MAIL:
Office of Laboratory Animal Welfare
Rockledge One, Suite 360
6705 Rockledge Drive
Bethesda, Maryland 20817
Telephone: (301) 496-7163
Facsimile: (301) 402-7065

June 27, 2018

Re: Animal Welfare Assurance
A3145-01 [OLAW Case 2B]

Dr. Mark Chance
Vice Dean for Research
Case Western Reserve University
School of Medicine
10900 Euclid Avenue
Cleveland, OH 44106-4988

Dear Dr. Chance,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your June 22, 2018 letter reporting an instance of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at Case Western Reserve University. According to the information provided, OLAW understands that a guinea pig had been inadvertently wrapped in bedding, sent through the autoclave, and died.

The corrective action consisted of recommending termination of the technician responsible, retraining all staff working in this area, requiring caretakers to count all animals before and after changing cages, updating the standard operating procedure (SOP) to include animal counting, and distributing the SOP.

Based on its assessment of this explanation, OLAW understands that measures have been implemented to prevent recurrence of this problem. OLAW concurs with the actions taken by the institution to comply with the PHS Policy.

Sincerely,

(b) (6)

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

cc: IACUC Chair



SCHOOL OF MEDICINE
CASE WESTERN RESERVE
UNIVERSITY

Mark R. Chance, Ph.D.
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June 22, 2018

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

Re: Assurance# A3145-01

Dear Dr. Morse,

I am writing this letter to inform you of an incident that occurred in our Health Sciences Animal Facility on June 1, 2018. During routine husbandry care of animals in our biohazard area, a guinea pig was inadvertently wrapped in bedding material and placed in the autoclave and died as a result. This was an isolated incident on the part of an experienced technician.

The following actions have been taken:

1. The technician is being processed through our HR department with termination recommended.
2. All personnel working in the biohazard area have been retrained with emphasis on animal safety and prevention of adverse events during routine husbandry care.
3. Employees are now required to count all animals before and after each cage changing activity.
4. The relevant SOP was revised to include the new process (#3) and the SOP has been disseminated throughout the biohazard area.

In closing, I want to assure you and your office of Case Western Reserve University's commitment to animal welfare regulations. Please let me know if you have any questions.

Sincerely,

(b) (6)

Mark Chance, Ph.D.
Vice Dean for Research
CWRU SOM IACUC Institutional Official
Charles W. and Iona A. Mathias Professor of Cancer Research
Director, Case Center for Proteomics and Bioinformatics

Ward, Joan (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Monday, June 25, 2018 7:38 AM
To: Tami McCourt
Cc: OLAW Division of Compliance Oversight (NIH/OD)
Subject: RE: ARC Incident Report

Follow Up Flag: Follow up
Flag Status: Completed

Thank you Ms. McCourt for this report. Dr. Wolff will respond soon.

Regards,
 Joan

From: Tami McCourt [mailto:txm9@cwru.edu]
Sent: Friday, June 22, 2018 11:28 AM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Cc: Mark Chance <mark.chance@case.edu>
Subject: ARC Incident Report

Dr. Wolff,

Please find the attached ARC Incident Report from Dr. Mark Chance, the Institutional Official for Case Western Reserve University regarding an operational incident that occurred on June 1, 2018. Please consider this report as our preliminary and final reports combined, as this incident was addressed immediately. Please do not hesitate to let us know if you have any further questions regarding this matter.

Thank you,

Tami McCourt RVT, BTAS, CMAR, CPIA

Director, Research Compliance IACUC

SOM ORA, IACUC

WG78

(b) (6)

tami.mccourt@case.edu

<http://casemed.case.edu/ora/iacuc/training.cfm>