



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

May 9, 2019

Re: Animal Welfare Assurance
A3544-01 [OLAW Case K]

Dr. Dennis Durbin
Chief Scientific Officer
Nationwide Children's Hospital
700 Children's Drive – W177
Columbus, Ohio 43205-2696

Dear Dr. Durbin,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your May 6, 2019 letter reporting a serious deviation from the provisions of the *Guide for the Care and Use of Laboratory Animals* at the Research Institute at Nationwide Children's Hospital, following up on an initial telephone report on May 2, 2019. According to the information provided, OLAW understands that due to incorrect filling of a food hopper, the rats could not access feed and two animals died. The problem was not noted during nine days of daily health checks by three different technicians. The cage was even changed during this time but the feeder issue was not identified.

The corrective actions consisted of counseling the room technician, noting the incident in the personnel file, retraining, and monitoring. The weekend technicians were counseled, retrained, and received corrective actions. All animal caretakers were counseled by the Attending Veterinarian and the feeder was temporarily modified to alert staff where food is placed and where the water bottle is to be placed. The vendor will be contacted to provide a permanent modification.

Based on its assessment of this explanation, OLAW understands that measures have been implemented to correct and prevent recurrence of this problem. OLAW concurs with the actions taken by the institution to comply with the PHS Policy on Humane Care and Use of Laboratory Animals. Thank you for keeping OLAW apprised on this matter.

Sincerely,

(b) (6)

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

cc: IACUC Chair



NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.™

May 6, 2019

Axel Wolff, DVM
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
Rockledge 1, Suite 360
6705 Rockledge Drive
Bethesda, MD 20892

Dear Dr. Wolff:

The Research Institute at Nationwide Children's Hospital, in accordance with Assurance A3544-01 and PHS Policy IV.F.3., provides this report of noncompliance regarding the death of two rats due to lack of access to the food in the cage. I first reported this incident to you on May 2, 2019 via a telephone call.

This cage of rats was being funded by an internal fund.

On April 1, 2019 the SuperRat cage had the feeder filled incorrectly which caused the death of two of the three rats in the cage. The feed was placed on the side of the feeder that holds a water bottle, prohibiting the rats from reaching the feed. Room log shows that daily observations were performed April 1st – 9th. The dead rats were found on April 9th. In addition to the new room technician, two other technicians observed the animals on April 6th and April 7th (weekend), neither noticed the food issue. The room tech changed the cage bottom only on April 8th and did not notice the incorrect feeder issue.

The following corrective action plan was implemented after the incident:

1. The room tech has had a performance review with her supervisor, which was documented in her file. She is under oversight and is has undergone retraining.
2. The weekend technicians have had a discussion with their supervisor, have been retrained, and received corrective actions.
3. All husbandry technicians had a meeting with AV to go over this situation.
4. AV has taken steps to prevent loading of food into the water bottle compartment of SuperRat feeders. A visual cue (cage card holder) will be added to the water bottle compartment as a temporary solution. The long term solution is to work with the caging vendor to replace the water bottle plate with a feeder cup.

At the IACUC meeting on May 6th, 2019, the IACUC committee reviewed and accepted the corrective action plan. The IACUC committee determined that this was an isolated incident and not a programmatic failure.

Please do not hesitate to contact me if you require further information.

With regards,

(b) (6)

Dennis Durbin, MD, MSCE
Institutional Official
Chief Scientific Officer

Wolff, Axel (NIH/OD) [E]

From: OLAW Division of Compliance Oversight (NIH/OD)
Sent: Tuesday, May 7, 2019 6:22 AM
To: (b) (6)
Cc: OLAW Division of Compliance Oversight (NIH/OD)
Subject: RE: D16-00331 - New Director-The Research Institute at Nationwide Children's Hospital

Thank you for this report, (b) (6) I will send a response shortly.

Axel Wolff, M.S., D.V.M.
Deputy Director, OLAW

From: (b) (6)
Sent: Monday, May 6, 2019 4:20 PM
To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>
Subject: D16-00331 - New Director-The Research Institute at Nationwide Children's Hospital

Please see the attached letter announcing our new Director/Attending Veterinarian for the Research Institute at Nationwide Children's Hospital. If you would like the original signed copy, please let me know and I will send it by FedEx overnight.

If you have any questions, please let me know.





Initial Report of Noncompliance

By: (b) (6)

Date: 5/2/19

Time: 10:10

Name of Person reporting: Dennis Dunbar

Telephone #: (b) (6)

Fax #:

Email:

Name of Institution:

Research Institute at
Nationwide Children's Hospital

Assurance number:

A3544 Ohio

Did incident involve PHS funded activity? ?

Funding component: _____

Was funding component contacted (if necessary): _____

What happened?

New Technician put food into wrong part of feeder, not
noted for 9 days

Species involved: Rat

Personnel involved:

Dates and times:

Animal deaths: 2

Projected plan and schedule for correction/prevention (if known): _____

Plans in HR file, retraining,
mark feeders to identify food area

Projected submission to OLAW of final report from Institutional Official:

OFFICE USE ONLY

Case # _____