United States Department of Agriculture
Animal and Plant Health Inspection Service

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Inspection Report

Snbl Usa Ltd
6605 Merrill Creek Parkway
Everett, WA 98203

Customer ID: **11124**
Certificate: **91-R-0053**
Site: 001
SNBL USA, LTD

Type: ROUTINE INSPECTION
Date: 01-NOV-2016

2.31(e)(5)

INSTITUTIONAL ANIMAL CARE AND USE COMMITTEE (IACUC).

***Three IACUC protocols (91516-19 utilizing beagles) and (72316-16 and 28916-19 utilizing cymnomolgus macaques) did not have a complete description of the method of euthanasia. Although the facility is following the AVMA guidelines for euthanasia in practice, the protocols as approved state “exsanguination” for euthanasia.

***Another protocol (94916-02) utilizing swine did not have an appropriate description of the method of euthanasia. The protocol states “euthasol will be administered to develop a surgical plane of anesthesia prior to exsanguination." Euthasol is not an anesthetic agent, and thus the statement is not an appropriate description for the method of euthanasia. All four protocols did refer back to a SOP entitled "Euthanasia of Laboratory Animals;" however, the SOP does not provide sufficient explanation to support the protocols as written.

***A fifth protocol (99016-124) utilizing rhesus macaques indicated euthanasia with euthasol "to effect." It did not reference the SOP, and did not provide a complete description of the method of euthanasia.

The IACUC must assure that all proposals to conduct an activity involving animals have a complete description of the method of euthanasia. IACUC approval of activities where an incomplete or inappropriate description of euthanasia is present indicates the IACUC may not be conducting a thorough review of the protocols and thus might lead to an animal welfare issue.

Correct by: December 2, 2016

2.33(b)(3)

ATTENDING VETERINARIAN AND ADEQUATE VETERINARY CARE.

During the inspection, a number of macaques were identified with stereotypic behaviors, including alopecia consistent with aberrant grooming. Several of these animals did not have any observation or treatment plan listed

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Date: 23-NOV-2016

in their medical records. Seven stereotypies were observed during the inspection, and three had not been noted/recorded by the facility. All were cynomolgus macaques and were identified as 143-523 (female), 120-327 (male), and 160-223 (male).

Two of the animals did have alopecia noted in their records. These animals had moderate/severe alopecia and were identified as 143-418 (female cynomolgus) and 150-099 (male rhesus). However, the facility's treatment plan was only to add an extra toy to their enclosure (150-099) or increase foraging enrichment (143-418).

The remaining two animals were observed to be either back-flipping (143-635 female cynomolgus) or pacing/spinning (150-184 male rhesus). The facility had recorded those animals as having alopecia only. At the time of the inspection, the environmental enhancement coordinator observed the two animals; however, the facility stated the animals were not exhibiting this aberrant behavior when the coordinator was in the room. The facility's correction for the alopecia was only to add an extra toy to their enclosure.

While these animals were covered by and received standard care according to the facility environmental enhancement plan, and while the plan has been substantially improved and augmented, animals for which this plan has not been effective were not identified. The facility in consultation with a facility-designated veterinarian must assure that a system of observation of animals is regularly conducted to identify animals with medical or special environmental enhancement needs. Careful observation and referral for special evaluation and treatment of these animals with consultation with the attending veterinarian or other designated veterinarian is required to assure optimal psychological and physical well-being of these animals.

Correct from this point in time forward.

2.38(f)(1) CRITICAL

MISCELLANEOUS.

***During a toxicity study, two cynomolgus macaque infants were placed with incorrect dams following infant handling training, resulting in the death of one of the infants. The facility concluded the most likely cause of death was maternal neglect.

The facility self-reported the incident to USDA, APHIS, AC and has implemented corrective actions to further prevent this type of incident from reoccurring. The corrective actions include improved animal identification; having only one dam/infant pair sedated per technician; and dam/infant rechecks by a second technician prior to returning the animals to the home cage. In addition, retraining has been conducted for all staff on proper animal/cage

identification and dam/infant behavior. The corrective action involving revision of the standard operating procedure was identified to be completed by 11/15/16; this target date was established by the facility prior to this inspection.

***The facility also self-reported an incident with a male cynomolgus macaque that was found dead in its home cage. The animal was found with a chain from an enrichment foraging device around its neck causing apparent asphyxiation. The total length of the chain and connector clip was approximately 9 inches in length.

The facility instituted the following corrective actions: These foraging devices were promptly removed from all primate cages within the facility until a full assessment of the issue could be made; all other hanging manipulanda within the facility were also inspected to make sure none were capable of causing similar issues; ensured all hanging devices used within the facility have chains with connecting links that are no longer than 6 inches in total length; and the foraging device vendor was contacted. According to the facility, they had not had any other reported incidents with these devices, but will be putting out a technical note as a precaution when used with primates.

***A review of the IACUC minutes during the inspection included a discussion of improving the reporting of animals that are difficult to handle. They further recommended that facility guidance be revised to reflect how to properly use a bite bar, and possibly include guidance on the improper use of the bite bar. They stated that tapping an animal with a bite bar will aggravate an already aggravated animal and that it is not acceptable to do so. They also mentioned the training program includes instruction to step away from a procedure if an animal is not cooperating, and identified that this instruction needs to be given more priority during training.

The use of a bite bar to tap an animal would be considered inappropriate handling under any circumstances. Appropriate availability and training of personnel is required to assure that handling of all animals is done as expeditiously and carefully as possible in a manner that does not cause trauma, overheating, excessive cooling, behavioral stress, physical harm, or unnecessary discomfort. Physical abuse shall not be used to train, work, or otherwise handle animals.

A system of evaluation and monitoring of enclosures and attachments to them, such as toys or chains to secure portions of the enclosures, must be in place to prevent any inadvertent injury to animals housed. Appropriate training of personnel must be provided to assure proper use of the bite bar and include guidance if an animal is not cooperating during handling. Additionally, the revision of the sedation SOP must be completed by the target date.

Correct by: December 15, 2016

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The inspection was conducted on 1 - 2 NOV 2016. The inspection and exit briefing were conducted with the facility representatives.

Additional Inspectors

Michael Schnell, Veterinary Medical Officer

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Inspection Date: 01-NOV-16

Animal Inspected at Last Inspection

Cust No	Cert No	Site	Site Name	Inspection
11124	91-R-0053	001	SNBL USA LTD	01-NOV-16

Count	Species
000064	Dog Adult
001203	Crab-eating/long-tailed macaque/cynomolgus monkey
000064	Rhesus macaque *Male
000036	Domestic Pig
001367	**Total**