United States Department of Agriculture
Animal and Plant Health Inspection Service

LNAVARRO

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Inspection Report

Emory University
Mailstop 1599-001-1be
1599 Clifton Road Ne, 4th Floor
Office Of Research Admin
Atlanta, GA 30322

Customer ID: **896**
Certificate: **57-R-0003**
Site: 003
YERKES REGIONAL PRIMATE RESEARCH CENTER

Type: ROUTINE INSPECTION
Date: 06-SEP-2017

2.38(f)(1) CRITICAL REPEAT

MISCELLANEOUS.

An incident involving a vole who underwent surgery was reported during the month of November 2016 and was found dead in his cage.The cage had a "special care" sign and it appears that due to miscommunication between the investigator and facility personnel the animal was not properly fed.
Corrective actions included retraining personnel and implementing a log when the animals are fed by the investigator.
An incident involving a NHP on July 2017 in which a technician took the animal to necropsy for euthanasia when the animal identification code was mistakenly entered to the necropsy schedule.
Corrective actions to prevent incorrect animal codes to enter the necropsy schedule had been implemented by double checking (necropsy supervisor and technician) and lab confirmation that the animlas entering the necropsy schedule are correct.
An adverse event was reported on August 2017 in which a NHP underwent a planned donor nephrectomy and 7 days later had to be referred for surgery again to remove a gauze sponge from the abdomen.
Corrective actions were implemented by halting surgeries until radio frequency implanted gauze sponges have been procured to be used in future surgeries to avoid human error counting the gauze sponges.

This inspection and exit interview were conducted with the facility representative and facility personnel.

Prepared By: NAVARRO LUIS, D V M

NAVARRO LUIS, D V M USDA, APHIS, Animal Care

Title: VETERINARY MEDICAL OFFICER 6025

Date:
07-SEP-2017

Received By:

Title:

Date:
07-SEP-2017