



Inspection Report

The Johns Hopkins University
Research Animal Resources
459 S Ross Building, 720 Rutland Ave
Baltimore, MD 21205

Customer ID: **81**

Certificate: **51-R-0006**

Site: 003

JOHNS HOPKINS UNIVERSITY, THE

Type: ROUTINE INSPECTION

Date: Jan-28-2015

2.35

RECORDKEEPING REQUIREMENTS.

The minutes of IACUC meetings did not include all activities of the Committee, and Committee deliberations as required. Specifically, adverse events reported to the IACUC were not outlined and there was no indication that the members concurred with the proposed corrections. The Training and Compliance staff generally gives a verbal report to the IACUC. This report is not outlined in the minutes, not formalized and approved, and not available as a written document to reviewers. Omissions of this type do not assure that the IACUC members are provided the proper notification and oversight for the members to assess the research facility's animal program, facilities, and procedures as required. Additionally, failure to include information regarding deliberations of events with significant animal welfare impacts prevents APHIS Officials from evaluating the facilities response and adherence to the Animal Welfare Act. Each research facility shall maintain IACUC records that include minutes of meetings, records of attendance, activities of the Committee, and Committee deliberations. Correct by ensuring that records contain required information from this point forward.

2.38 (f) (1)

MISCELLANEOUS.

A rabbit died after being left in its cage which was sent through the autoclave for disinfection prior to regular cage washing. The autoclave begins with a prolonged vacuum cycle that the facility veterinary staff determined caused the animal to die by asphyxiation. The animal caretaker had failed to notice that an animal was present in the cage. The incident was reported immediately and the following corrective actions were taken: The individual responsible was given a warning, the light levels in the room were increased during cage changes, cages must now be slid out of the rack when transferring animals, and a second person will now check each cage with a light before placement in the autoclave. Staff has been trained on the new procedures. The person handling the cage, and therefore the animal, was in the process of handling. All research facilities must ensure that handling of animals is conducted as expeditiously and carefully as possible in a manner that does not cause trauma, overheating, excessive cooling, behavioral stress, physical harm, or unnecessary discomfort. Corrected by facility before this inspection as indicated above.

Prepared By:

DAVID OELBERG, D V M

DAVID A OELBERG, D V M USDA, APHIS, Animal Care

Title: VETERINARY MEDICAL OFFICER Inspector 1043

Date:

Jan-29-2015

Received By:

Title:

Date:

Jan-28-2015



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3.76 (b)

INDOOR HOUSING FACILITIES.

A room containing four owl monkeys had a relative humidity reading of 21% on Kestral reading during inspection. A review of the January 2015 room log indicated that humidity had been below 20% every day of the month to date (3 weeks). A paper posted at the room boldly showed the target humidity to be 40% with a range of 30 to 70%. Indoor housing facilities as defined in 9CFR section 1.1 must be capable of maintaining humidity levels of 30 to 70%. Due to the small size of these animals, and their native habitat, a 20% relative humidity is not consistent with a level that ensures the health and well-being of the animals housed and is not consistent with generally accepted professional and husbandry practices. Failure to provide appropriate humidity can result in the development of clinical signs including coughing, dehydration, and nose-bleeds. While the facility is currently monitoring for these signs, intervention would only be provided after the animal had felt the effects related to low humidity. Indoor housing facilities for non-human primates must maintain the relative humidity at a level that ensures the health and well-being of the animals as directed by the attending veterinarian. Additionally, humidity must be maintained at levels in-keeping with generally accepted professional and husbandry practices. Correct By: 13 February 2015

3.80 (a) (2) (ii)

PRIMARY ENCLOSURES.

Five of the 34 primary enclosures for macaques at location 13 had perches added to them for enrichment. These extra perches (each cage had a fixed perch) were hung by four(4) chains. Two(2) chains on one end of the perch were 7 links long and the two on the other end were 13 links long. Each link was approximately one inch in length. One of the perches had been flipped over by the primate so that the chains crossed and created four triangular holes. The triangles on the 13 link side were large enough to accommodate the head of the primate. All four triangles could accommodate an appendage and might cause entrapment if the perch was flipped again. This facility had two primate deaths that appeared to be by strangulation in chains and were confirmed as asphyxiation on necropsy. Both of these deaths were reported to OLAW. The first was closed with them 15 January 2014 and the second was closed with OLAW 26 September 2014. Based on this experience, the facility took measures to remove or redesign chain structures in or on primate cages. Long chains were removed or covered in PVC pipe throughout the facility but the Five(5) perches supported by chains at location 13 were not removed or modified. Primary enclosures for non-human primates must be constructed and maintained in a manner so that they adequately protect the animals from injury. While enrichment is important for the behavioral health of primates, chains that can form loops are known to cause injury to appendages and death by strangulation. Although the facility recognized the ongoing risk of chains, they failed to identify potentially hazardous chains in all housing areas for NHPs. The facility removed all identified potentially hazardous chain devices at the time of inspection. Additionally the facility must ensure that all primary enclosures are maintained in a manner to prevent injury to the animals from this point forward.

An exit interview was conducted with facility representatives and the IACUC Chair.

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