AN INTERNATIONAL ORGANIZATION DEDICATED TO PROTECTING THE RIGHTS OF ALL ANIMALS

PETA FOUNDATION

PEOPLE FOR THE ETHICAL TREATMENT OF ANIMALS FOUNDATION

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Washington Department of Health Veterinary Board of Governors
P.O. Box 47852
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Dear Dr. Andrea Sanchez-Chambers:

I am writing on behalf of People for the Ethical Treatment of Animals (PETA) —PETA entities have more than 9 million members and supporters globally—in regard to the death of an adult male rhesus macaque at the Washington National Primate Research Center (WaNPRC) on June 26th.

On July 27th during the monthly meeting of the University of Washington's IACUC, the UW Attending Veterinarian, Dr. Christine Cruzen (VT60919454), reported the death of an adult male rhesus macaque assigned to an experimental protocol at the WaNPRC. A transcript of Dr. Cruzen's description of the events resulting in this animal's death during what should have been a routine sedation and debridement of tissues surrounding his cranial implant is attached to this complaint and you can view a recording of Dr. Cruzen addressing the IACUC here (00:11:08-00:15:31). The apparent failure of UW veterinarians to have in place standard operating procedures (SOP) for anesthesia induction, monitoring and training and supervision of technicians resulted in fatal barotrauma for this monkey. We urge you to investigate this matter with the same rigor that you would at a small veterinary clinic, and issue fines if you determine wrongdoing.

As stated during the meeting, on June 26th, the rhesus macaque was anesthetized with injectable ketamine and propofol, intubated and maintained on room air. Propofol is a well-known respiratory depressant and best practice SOPs expect that animals sedated with this drug should be in areas with equipment capable of providing artificial ventilation, administering supplemental oxygen, and instituting cardiovascular resuscitation. None of these resources were apparently available in the procedure area where the technicians sedated and debrided tissue around the monkey's cranial implant. Within 15 minutes of receiving injectable ketamine and propofol, the animal reportedly began experiencing poor oxygenation and a rapid irregular heartbeat. The veterinary technician then reportedly requested to switch the monkey to inhalation anesthesia. A

to the monkey's lungs. A veterinarian was apparently not present at this time and had to be called when the monkey stopped breathing. No emergency equipment was reportedly available in the procedure space and the monkey reportedly had to be taken into another area that had an anesthesia ventilator. He then reportedly went into cardiac arrest and could not be resuscitated.

During all anesthetic procedures, it is vital that emergency equipment, including an ambu bag, two sources of oxygen, laryngoscopes, properly sized endotracheal tubes, and a crash cart with proper medications, is readily available and has been tested to ensure it is in proper working order. Technicians running anesthesia must be able to properly set up, check, and troubleshoot all necessary equipment prior to use, and a veterinarian must be immediately available in case of emergency.

This incident seems to demonstrate that WaNPRC fails to have a proper SOP in place for providing safe anesthesia and monitoring. Charlotte Hotchkiss, DVM, Ph.D. (VT60036030) is WaNPRC's Associate Director and Veterinary Supervisor. Thea Brabb, DVM, Ph.D. (VT00003556) is Chair of the Department of Comparative Medicine which oversees UW's Veterinary Services department which is responsible for the care of over 100,000 animals at UW. According to Dr. Christine Cruzen, Veterinary Services provided the personnel involved in this incident. The space this procedure was performed in apparently lacked the necessary respiratory support and emergency response equipment, staff were apparently not properly trained in the use of anesthetic equipment, and once the monkey began to show symptoms of respiratory and cardiac distress, immediate access to a veterinarian was apparently not available.

Given the apparent violation of RCW 18.130.180(4), we urge you to impose sanctions under RCW 18.130.160 with the facility being fined, immediate review and adjustment of their anesthesia SOP (particularly in regard to proper equipment being readily available during anesthetic procedures, staff trained in use of said equipment, and veterinarians being contacted as soon as abnormalities are noted) with review by the board before implementation, and mandatory continuing education in anesthetic equipment as well as anesthesia monitoring for the individuals involved. Thank you for your immediate attention to this matter.

Sincerely,

Robert Mason Payne,
DVM Wildlife
Veterinarian
Captive Animal Law Enforcement | PETA Foundation

TRANSCRIPTION of the UW July 27, 2023 IACUC meeting (00:11:08-00:15:31)

On June 26 an adult male rhesus died while under anesthesia. The animal was on study and was under anesthesia for a procedure to debride around his cranial implant. The anesthesia was being performed by veterinary services. The animal was initially sedated with ketamine and the administered propofol for anesthesia. Both of these are injectable anesthetic agents. He was also intubated to protect the airway, but was breathing room air. Approximately 15 minutes after the induction of anesthesia the animal began to experience poor oxygenation based on peripheral SPO2 monitoring which is a measure of oxygenation in the tissue that we can obtain from a little clip on them as well as a rapid irregular heartbeat. Due to these vital signs a veterinary technician requested to transition the animal to inhalant anesthesia with oxygen support. Another technician went to quickly retrieve a portable anesthesia machine to bring to this procedure space. The animal was attached to the anesthesia machine and immediately stopped breathing. A veterinarian was called and the animal was taken to an area that had an anesthesia ventilator. Unfortunately, the animal went into cardiac arrest and was unable to be resuscitated. Upon immediate review of the incident the portable anesthesia machine that was used had been recently donated to vet services and had not previously been used by them. When it was initially brought from the storage space it did not have a breathing circuit attached to it which was not noticed until taking the elevator to the procedure space. Due to the urgency of the situation the technician leak tested and pressure tested the machine while someone went to run and grab a circuit to attach to it. She then attached the circuit to the machine and then attached it to the animal. It was later discovered that this machine was not function properly with this type of circuit and resulted in elevated pressures rapidly developing within the tubing. Evidence of barotrauma was confirmed at gross necropsy confirming the increased pressure as the cause of death for this animal. All of the staff involved in the incident had been appropriately trained. All anesthetics and dosages used were verified to be correct and the anesthesia machine had been serviced by a commercial vendor within all of the recommend timeframes. The machine has since been removed from use and will be discarded because it is not functioning properly.

Additional preventative measures that are being taken by the primate center include a change in procedure that specifies that all leak and pressure checks must be done with the circuits attached. To facilitate a more rapid emergency response, procedure spaces will be set up with emergence kits that include intubation supplies and ambu bags which are bags that can attach directly to the tube that can kind of temporarily breathe for the animal until you can get to a machine that will ventilate them. In addition any new or donated machines will be fully evaluated by a veterinarian in addition to the commercial vendor maintenance prior to use and if machines are obtained that are different from the existing stock they will require machine specific training for all users prior to storage in any common use storage area. I wanted to note that this event actually occurred during our AAALAC site visit and it was reported to our site visit team while they were onsite. The team elected to meet with all of the involved staff they reviewed the surgical and anesthesia records of the affected animal and they reviewed our proposed corrective and preventative actions at that time. They acknowledged the unfortunate nature of the events but they were very complimentary of the emergency response by the vet staff, our internal investigation and our response to the incident. They were particularly impressed by the compassion of the staff involved as well as the compassion that the PI exhibited to the staff following the incident. This has also been reported to the USDA and OLAW. Is there any additional discussion, questions or actions that the committee would like to take in response to this incident?