

DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH

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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) 480-3387

August 13, 2020

Re: Animal Welfare Assurance #A3012-01 (OLAW Case 11]

Dr. William Wasilenko Senior Associate Dean for Research Eastern Virginia Medical School 721 Fairfax Avenue-Fairfax Andrews Hall, (b) (4) Norfolk, VA 23507

Dear Dr. Wasilenko,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your August 6, 2020 letter reporting an instance of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at Eastern Virginia Medical School. According to the information provided, OLAW understands that on July 22, 2020, three mice were placed in the same cage housed in an IVC housing unit. Two different veterinary technicians (vet techs) were responsible for checking the animals once a day on July 22-27, 2020. During those daily checks, the animals appeared to be healthy, however, the technicians did not inspect the water lixit to ensure that it was functioning properly. On July 28, 2020 at approximately 9:00 a.m., two of the three mice were found dead. The third mouse appeared to be dehydrated. The Attending Veterinarian (AV) was contacted immediately upon discovery of the mice. CompMed staff discovered that the lixit was covered, meaning the mice had been without access to water. The third mouse responded to supportive treatment. The CompMed staff assumed full responsibility for the adverse situation. It was noted that this activity was not funded by the PHS.

Corrective actions included refresher training for the entire staff on July 29, 2020. During the session, CompMed staff were retrained on how to properly intake and process new arrivals and on how to properly conduct daily health checks on rodents. At the time of the incident, the intake SOP included priming the water lixit prior to placing a cage in the housing unit. Following the incident, the SOP was revised to state that non-functional lixits should be repaired immediately. If that is not possible, the cage slot should be labeled as unusable until the repair ls completed.

OLAW appreciates the prompt consideration of this matter by Eastern Virginia Medical School, which was consistent with the philosophy of institutional self-regulation. Based on the information provided, OLAW is satisfied that appropriate actions have been taken to investigate this incident, correct the noncompliance, and prevent recurrence. OLAW concurs that the incident warranted reporting. We appreciate being informed of this matter and find no cause for further action by this office.

Sincerely,

Brent C. Morse -S Morse -S

Digitally signed by Brent C. Morse - S

Date: 2020.08.13 09:21:49 -04'00'

Brent C. Morse, DVM Director Division of Compliance Oversight Office of Laboratory Animal Welfare

cc: IACUC Contact



August 6, 2020

Brent C. Morse, D.V.M., DACLAM
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare (OLAW)
National Institutes of Health (NIH)
Rockledge 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, Maryland 20892-7982

Dear Dr. Morse:

RE: Reportable Incident

Eastern Virginia Medical School (EVMS), Norfolk, Virginia
Animal Welfare Assurance Number D16-00007 (formerly A3012-01)

I am writing to inform OLAW of an incident reported to the EVMS Institutional Animal Care and Use Committee (IACUC) Office on July 29, 2020. This report is submitted in accordance with document NOT-OD-05-034, Guidance on Prompt Reporting to OLAW under the PHS Policy on Humane Care and Use of Laboratory Animals, which states that reportable situations include "conditions that jeopardize the health or well-being of animals, including natural disasters, accidents, and mechanical failures, resulting in actual harm or death to animals." The investigator's research is supported by private industry funds.

Upon arrival to the EVMS Division of Comparative Medicine (CompMed) animal facility on July 22, 2020, three mice were placed in the same cage housed in an Optimice® IVC housing unit. Two different veterinary technicians (vet techs) were responsible for checking the animals once a day on July 22-27, 2020 as per the CompMed standard operating procedure (SOP) for its ultra-barrier housing location. During those daily checks, the animals appeared to be healthy; however, the technicians did not inspect the water lixit to ensure that it was functioning properly. On July 28, 2020 at approximately 9:00 a.m., two of the three mice were found dead. The third mouse appeared to be dehydrated as evidenced by poor skin turgor and hunched posture; however, its behavior was assessed as bright, alert, and responsive (BAR). The Attending Veterinarian (AV) was contacted immediately upon discovery of the mice. Food had been eaten from the hopper and feces were found in the cage; however, the CompMed staff discovered that the lixit was covered (i.e., a lixit cover), meaning the mice had been without access to water. The two deceased mice were necropsied. Due to decomposition and cannibalization, the necropsies were not diagnostic; however, the findings were compatible with dehydration.

Upon consultation with the AV, the surviving mouse was administered warm saline, and DietGel® and HydroGel® were placed in the cage. Also, its cage was moved to a new location in the housing unit where the water lixit was appropriately primed and confirmed to be in proper working condition. The mouse responded well to treatment and is part of the investigator's existing rodent colony.

Research

The CompMed staff assumed full responsibility for the adverse situation and refresher training was scheduled for the entire staff on July 29, 2020. During the session, CompMed staff were retrained on how to properly intake and process new arrivals and on how to properly conduct daily health checks on rodents. At the time of the incident, the intake SOP included priming the water lixit prior to placing a cage in the housing unit. Following the incident, the SOP was revised to state that non-functional lixits should be repaired immediately. If that is not possible, the cage slot should be labeled as unusable until the repair is completed.

I, along with the IACUC and the CompMed staff, sincerely regret the unexpected deaths; however, we believe that the corrective action plan outlined above is sufficient to prevent a reoccurrence, to the extent possible.

Please do not hesitate to contact me should you have questions and/or concerns regarding this matter.

Sincerely,

(b) (6)

William Wasilenko, Ph.D.
Vice Dean for Research and Institutional Official
EVMS Office of Research
855 W. Brambleton Avenue
E. V. Williams Hall, (b) (4)
Norfolk, Virginia 23507
(b) (6)
wasilewi@evms.edu

WJW/cbh

cc: Principal Investigator

Frank A. Lattanzio, Ph.D., IACUC Chair

Mario C. Rodríguez, D.V.M., M.S., CompMed Attending Veterinarian

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Wolff, Axel (NIH/OD) [E]

Wolli, Axel (Mill)	D) [1]
From: Sent: To: Cc: Subject:	OLAW Division of Compliance Oversight (NIH/OD) Monday, August 10, 2020 7:10 AM (b) (6) OLAW Division of Compliance Oversight (NIH/OD) RE: EVMS #D16-0007 - REPORTABLE INCIDENT
Thank you for this repor	rt, (b) (6) We will send a response soon.
Axel Wolff, M.S., D.V.M. Deputy Director, OLAW	
Cc: Wasilenko, William (b) (б)	ompliance Oversight (NIH/OD) <olawdco@od.nih.gov> I. <wasilewj@evms.edu>; Lattanzio, Frank A. <lattanfa@evms.edu>; (b) (6)</lattanfa@evms.edu></wasilewj@evms.edu></olawdco@od.nih.gov>
Dear Dr. Morse:	
	ident a Medical School (EVMS), Norfolk, Virginia e Assurance Number D16-0007 (formerly A3012-01)
copy of the report will b	ent on behalf of William J. Wasilenko, Ph.D., Vice Dean for Research and Institutional Official. be sent to the Principal Investigator under separate cover. Please do not hesitate to contact me have questions about or require additional information regarding this report.
Kindest regards,	
	(b) (6)