

### DEPARTMENT OF HEALTH & HUMAN SERVICES

#### PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:
Office of Laboratory Animal Welfare
6700B Rockledge Drive, Suite 2500, MSC 6910
Bethesda, Maryland 20892-6910
Hone 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
Taicohoas: (301) 496-7163
Facsimile: (301) 402-7065

October 29, 2020

Re: Animal Welfare Assurance #A3245-01 (OLAW Case 3Z]

Dr. Melur Ramasubramanian Vice President for Research University of Virginia P.O. Box 400301 136 Hospital Drive, Varsity Hall Charlottesville, VA 22904-4301

Dear Dr. Ramasubramanian,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your 26 October 2020 report of an incident of noncompliance with the PHS Policy on the Humane Care and Use of Laboratory Animals at the University of Virginia (UVA Compliance Case #: 2020-F). Your final report supplements the preliminary report sent via email on July 29, 2020. According to the information provided it is understood that a researcher failed to ensure the death of an animal (rat) following CO2 euthanasia, and the animal was found alive in the carcass freezer. The animal was immediately euthanized by the veterinary staff. The related animal activity was PHS funded.

In response to a similar, recent incident in the same vivarium, the IACUC assisted the PI in creating a corrective action plan. The Attending Veterinarian retrained the lab staff to perform euthanasia, decapitation, and cervical dislocation. All euthanized rodents will be decapitated following CO2 euthanasia for at least one year. The animal handlers will practice performing cervical dislocation on appropriately sized rodents following CO2 euthanasia and prior to decapitation. After a period of one year, the PI may petition the IACUC to alter the secondary physical method of confirmation of death (decapitation).

OLAW believes that the corrective and preventive measures put in place by the University of Virginia are consistent with the provisions of the PHS Policy on Humane Care and Use of Laboratory Animals. 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.

Date: 2020.10.29 15:07:05 -04'00'

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

cc: IACUC Contact

# University of Virginia Animal Welfare Compliance Report

PHS Assurance # A3245-01

A preliminary email notification was sent to the OLAW Division of Compliance Oversight by Angela Gamble, Director of the Office of Animal Welfare. Dr. Axel Wolff acknowledged receipt. It was understood that a full report would follow IACUC investigation. This document is a summary of the incident, actions taken, and final resolution.

## UVA Compliance Case #: 2020-F

Nature of Incident(s):	Failure to ensure death of animals after euthanasia procedures
Nature of incident(s).	(rat)
Summary of Incident:	The husbandry staff discovered that a researcher failed to ensure the death of an animal following CO <sub>2</sub> euthanasia, and the animal was found alive in the carcass freezer. The animal was immediately euthanized by the veterinary staff.
	Earlier in the day, a caretaker reported the animal to the veterinary staff for examination and possible treatment. When the veterinary technician came to examine the animal, the animal had already been removed from the cage by the laboratory staff. The caretaker verified that the animal had been removed from the cage and was no longer present. Approximately 20 minutes later, the same caretaker was asked to remove a live rat from the carcass freezer. The animal was identified as the same animal on the veterinary report. The PI responsible was identified.
Action taken by IACUC:	At the next convened monthly meeting, the IACUC reviewed the incident and agreed that it was a significant deficiency.
5. 2	The IACUC was extremely concerned about the significant impact on the animal's health and well-being and that a similar issue had occurred within the past several months in the same vivaria. As a result of the previous issue, this PI was among the PIs mandated to complete required training. The training was specific to accepted methodologies for performing a secondary physical method for confirming death in rodents that have been euthanized following CO <sub>2</sub> inhalation or anesthetic overdose. The training documentation indicated that he retrained the current animal handlers as required. The IACUC was concerned that the retraining the PI provided to his animal handlers appeared to be insufficient to correct the problem.
a)	The IACUC outlined their concerns and created a sub- committee to meet with the PI and his departmental chair.

Action taken by PI:	The ACUC assisted the PI in creating a corrective action plan. The Attending Veterinarian retrained the lab staff to perform euthanasia, decapitation, and cervical dislocation. All euthanized rodents will be decapitated following CO <sub>2</sub> euthanasia for at least one year. The animal handlers will practice performing cervical dislocation on appropriately sized rodents following CO <sub>2</sub> euthanasia and prior to decapitation.
Action taken by IACUC:	The IACUC discussed the PI's corrective action plan. After a period of one year, the PI may petition the IACUC to alter the secondary physical method of confirmation of death (decapitation). The IACUC communicated this requirement to the PI and also indicated that any future similar issues noted would likely result in the suspension of the protocol.
Decision/Resolution:	The IACUC accepted the revised corrective action plan as submitted by the PI and considered the issue resolved.
Federal Funding:	R01NS104670; R01NS092548
Notification of Final Disposition:	⊠IO ⊠OLAW
Institutional Official: Dr. Melur K. Ramasubramanian	(b) (б)
	Date: 26 Oct 2020

Wolff, Axel (NIH/OD) [E] OLAW Division of Compliance Oversight (NIH/OD) From: Wednesday, October 28, 2020 8:04 AM Sent: (b) (6) To: OLAW Division of Compliance Oversight (NIH/OD) Cc: RE: UVA OLAW Compliance Report Subject: (b) (6) We will send a response soon. Thank you for this report, Axel Wolff (b)(6)From: Sent: Monday, October 26, 2020 4:58 PM To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov> Cc: Wolff, Axel (NIH/OD) [E] <wolffa@od.nih.gov>; Ramasubramanian, Melur K (mkr5a) <mkr5a@virginia.edu>; Subject: UVA OLAW Compliance Report Dr. Axel Wolff, Director of Compliance Oversight Office of Laboratory Animal Welfare National Institutes of Health RKL 1, Suite 360, MSC 7982 6705 Rockledge Dr., Bethesda, MD Dr. Wolff: I attach a compliance report from our IACUC. These is our case 2020-F In this case, the IACUC has investigated thoroughly, taken appropriate action and the committee has determined that this matter are now resolved to their satisfaction. I have reviewed the report and I concur with the committee responses and final determinations. Thank you, (b) (6) For Dr. Melur Ramasubramanian

(b) (6)

### Wolff, Axel (NIH/OD) [E]

From:

OLAW Division of Compliance Oversight (NIH/OD)

Sent:

Friday, July 31, 2020 7:37 AM

To: Cc: Gamble, Angela (adr8s)
OLAW Division of Compliance Oversight (NIH/OD)

Subject:

RE: preliminary notification - UVA (Assurance A3245-01): 2020-F

Thank you for this preliminary report, Ms. Gamble. We will start a new case file.

Axel Wolff, M.S., D.V.M. Deputy Director, OLAW

From: Gamble, Angela (adr8s) <adr8s@virginia.edu>

Sent: Wednesday, July 29, 2020 1:22 PM

To: OLAW Division of Compliance Oversight (NIH/OD) <olawdco@od.nih.gov>

Cc: Gamble, Angela (adr8s) <adr8s@virginia.edu>;

(b) (6)

Subject: preliminary notification - UVA (Assurance A3245-01): 2020-F

Dear OLAW Division of Compliance Oversight,

This is to provide preliminary notification that the University of Virginia IACUC (PHS Assurance #A3245-01) has identified a significant deficiency. The UVA tracking number is 2020-F. The issue is under investigation and review by the IACUC. Specifically, an individual failed to ensure death after performing CO<sub>2</sub> euthanasia in a rat. We are working towards resolution and will send a complete report once the issue has been resolved.

Should you have any questions or concerns prior to receiving our final report, please do not hesitate to contact me.

Sincerely, Angela Gamble

Angela R. Gamble

Director, Office of Animal Welfare

E: adr8s@virginia.edu P: (b) (6)

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