2.38(f)(1) Repeat

Miscellaneous.

There have been four incidents of medication dosing errors involving non-human primates (NHPs) and one incident of the incorrect divider placement for NHPs that were reported to the ACUC and OLAW since the last inspection in August 2021. These incidents could have been prevented if the personnel followed established procedures:

- July 2021: the incorrect divider with mesh was put in place allowing two non-human primates (NHPs) to contact each other through the divider and one lost the tip of its tongue. (Affected animal was appropriately treated and recovered).
- Sept 2021: an overdose of midazolam was given to a NHP because the concentration available was different than what the infusion machine was set for.
- August 19-27, 2021: A NHP was given an overdose of a diabetes medication because the newly acquired medication was 200mg/ml and what was used prior was 50mg/ml.
- October 07, 2021: Antibiotics were at times given to the incorrect animal because the orders were written under the ID of its social partner, however some technicians knew which was the correct animal while others didn't and followed the written orders.
- January 6, 2022: one NHP had missed its daily treatments of a glucoregulatory medication and liver function support medication and a different NHP received it because the last 2 digits of the ID were verified but not the complete.
Handling of research animals must be done as carefully as possible.

3.75(c)(1) Critical
Housing facilities, general.
In August 2021 a NHP was found to have its hand stuck between the perch and the wall. Staff removed it and it was treated by staff veterinarians which included amputation of two digits. Records indicate it was appropriately treated and monitored for recovery. Staff also report the perch involved and all perch fixtures of this design were evaluated and reinforced as necessary to prevent further recurrence. This incident was reported to OLAW and the ACUC.

In December 2021 an enrichment device had been modified from its original design for use in a non-human primate enclosure. The enrichment device originally had a sheath with a bungie to attach to the enclosure, however the sheath became detached and when repaired it was modified to be held up with the two chains. The two chains used to suspend it within the enclosure had enough space that a macaque was able to get its head between the chains and then couldn't get back out. The facility found it caught and immediate CPR attempts were noted to be unsuccessful.

Note: The facility reports all enrichment devices of this design were removed to prevent further occurrence and noted retraining of staff on appropriate enrichment device usage and device repair procedure/reporting would be put in place. This incident was also reported by the facility to the USDA veterinary medical officers by the attending veterinarian in December 2021 and also was reported to OLAW and the ACUC.

These two incidents involving furniture-type fixtures had a serious adverse effect on the involved animals and did not provide for the safe activity for the NHPs that use them. Ensure that all furniture-type fixtures or objects remain sturdily constructed and strong enough to provide for the safe activity and welfare of nonhuman primates that use them.

Prepared By: SCOTT WELCH
Title: VETERINARY MEDICAL OFFICER
Date: 05-JUL-2022

Received by Title: Attending Veterinarian
Date: 05-JUL-2022
Maintain correct from this day forward.

This inspection of the non-human primates under LVSC was conducted with facility representatives from 4/5-4/7/2022

Additional Inspectors:

DAWN BARKSDALE, VETERINARY MEDICAL OFFICER
GWENDALYN MAGINNIS, Nonhuman Primate Species Specialist
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