Inspection Report

Lovelace Biomedical Research Institute

2425 Ridgecrest Dr SE
Albuquerque, NM 87108

Customer ID: **1072**

Certificate: **85-R-0003**

Site: 001
Lovelace Biomedical Research Institute

Type: FOCUSED INSPECTION

Date: 21-MAY-2025

2.38(f)(1) **Critical**

Miscellaneous.

According to facility correspondence and veterinary records, the facility experienced two separate incidents related to inappropriate handling of non-human primates:
***On 11/12/2024, an animal care technician did not properly fasten the door lock for a primary enclosure, resulting in the escape of two adult, pair-housed cynomolgus macaques into the holding room and a subsequent altercation between the two escaped animals and another, caged adult cynomolgus macaque. Staff discovered the escapes and injuries the following morning: ID# UG1389 sustained lacerations and fractures on the right foot requiring amputation of two toes; ID# 8344164188 sustained lacerations to the face and left hand, and severe trauma to the right hand which required amputation of a finger; ID# 40618 received a skin laceration on the left arm. All animals recovered with veterinary care, and the registrant instituted new procedures, purchased new locks and held training sessions for all staff working with non-human primates at the facility.
Failure to ensure these non-human primates were secure resulted in escapes and serious injuries.
***On 01/28/2025, a clinical staff veterinarian supervised a technical skills and euthanasia training session for veterinary technicians using an anesthetized, six-year old female cynomolgus macaque (ID# 3379843401). At the end of the session, the veterinarian and one of the veterinary technicians confirmed the absence of respiration and heartbeat, but did not perform a secondary, physical method of euthanasia as preferred in the facility's standard operating procedure for Large Animal Euthanasia (SOP# ACL-2112.2). According to the supervising veterinarian, the animal was placed in a sealed bag and and inside a refrigerator to await necropsy, then the veterinarian returned to the procedure room a short distance down the hallway. Necropsy staff removed the animal moments later, and facility correspondence states that the animal "...exhibited signs of respiration and a heartbeat...". Necropsy staff immediately notified the veterinarian, who quickly returned to the necropsy room to administer an additional, effective dose of euthanasia solution. The veterinarian and necropsy staff then confirmed cessation of respiration and heartbeat, and necropsy staff immediately commenced necropsy. The veterinarian stated that the time elapsed between the first euthanasia attempt and successful euthanasia with definitive confirmation of death was only approximately five minutes, and that the animal never exhibited movement, vocalized or showed any further signs of consciousness; however, failure to employ sufficient measures to ensure certain euthanasia prior to placing the animal in a biobag and refrigerator resulted in the animal potentially beginning to revive and could have caused it to experience unnecessary distress and discomfort or pain. Following this incident, the registrant revised their Large Animal Euthanasia SOP to require application of a secondary, physical method of euthanasia and delivered training to all veterinary staff involved with large animal euthanasia.

Prepared By: TAMILA STOTT
USDA, APHIS, Animal Care

Date: 10-JUN-2025

Title: VETERINARY MEDICAL OFFICER

Received by Title: Attending Veterinarian

Date: 10-JUN-2025

Inspection Report

The registrant must continually ensure that all employees who work with non-human primates are trained and capable of performing tasks as expeditiously and carefully as possible, to avoid trauma, behavioral stress, harm and discomfort, as well as prevent escapes and ensure proper euthanasia.

CORRECTED BEFORE THE TIME OF THIS INSPECTION ON 5/21/2025

3.10(a) **Repeat**

Watering

Facility records and OLAW correspondence document two separate incidents involving loss of water access to a total of five adult beagle dogs:

***On 03/16/2025 one two-year old beagle dog (ID# GSH-3) was placed overnight in an indoor, climate-controlled kennel with a drinking tube supplied by a water line that appeared to be properly connected, but was not. The problem was detected the following morning by husbandry staff, and the dog received water immediately. Veterinary staff promptly examined the animal and gave subcutaneous fluids to compensate for mild dehydration; no further veterinary intervention was needed.
***On the evening of 01/31/2025, four adult beagle dogs housed in a climate-controlled kennel (ID numbers CMJCCE, CMJCDT, TV09 and TW09) did not have overnight access to water; these animals were shifted to the opposite sides of their runs by building facility staff to perform maintenance activities, and those sides of the runs did not have a water source. This issue was discovered by the assigned animal technician the following morning and immediately reported to the on-call veterinarian, who promptly examined the dogs. The veterinarian found the dogs' health parameters to be within normal limits, with no signs of dehydration.
Failure to provide continual access to water can result in discomfort and serious dehydration. The facility must ensure that potable water is made continuously available to all dogs, unless excepted by the attending veterinarian or excepted as provided under section 3.17(a).

This inspection and exit interview were conducted with the attending veterinarian and facility representatives.

Prepared By: TAMILA STOTT
USDA, APHIS, Animal Care
Date: 10-JUN-2025

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United States Department of Agriculture
Animal and Plant Health Inspection Service

Customer: 1072
Inspection Date: 21-May-2025

Species Inspected

Cust No	Cert No	Site	Site Name	Inspection
1072	85-R-0003	001	Lovelace Biomedical Research Institute	21-MAY-2025

Count	Scientific Name	Common Name
000006	*Canis familiaris*	DOG ADULT
000000	*Macaca fascicularis*	CRAB-EATING MACAQUE / CYNOMOLGUS MONKEY
000006	**Total**	