AN INTERNATIONAL ORGANIZATION DEDICATED TO PROTECTING THE RIGHTS OF ALL ANIMALS

PETA

PEOPLE FOR THE ETHICAL TREATMENT OF ANIMALS

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Jacquelyn Tubbs, DVM
Acting Director
Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health

Dear Dr. Tubbs:

I am writing on behalf of People for the Ethical Treatment of Animals (PETA) to expand on our December 10, 2025, complaint regarding animal welfare concerns at the University of Massachusetts Chan Medical School (UMass Chan; Animal Welfare Assurance D16-00196, A3306-01). In that complaint, PETA provided documentation from an insider indicating systemic deficiencies in veterinary oversight, animal care, and institutional compliance, and requested that OLAW investigate the institution's animal care and use program.

Since submitting that complaint, PETA has reviewed records obtained from UMass Chan, including IACUC meeting minutes and noncompliance records. These materials raise further concerns regarding the institution's repeated animal welfare failures, including recurring euthanasia-related noncompliance and other incidents suggesting persistent deficiencies in oversight and compliance.

Continued Euthanasia Failures

Among the most troubling issues identified in these records is a recurring pattern of euthanasia-related noncompliance spanning multiple years. Between 2023 and 2024, UMass Chan reported numerous euthanasia-related incidents to OLAW, including Cases 3O, 3U, 3V, 3Z, 4A, and 4B. These incidents involved failures to ensure death following carbon dioxide overdose, failures to perform required secondary physical methods, animals found alive after they had been presumed dead, live mice discovered in carcass bags and freezers, and improper euthanasia of neonatal mice. These incidents occurred despite prior retraining, heightened oversight, and other corrective measures intended to prevent recurrence.

Following these repeated euthanasia-related noncompliance incidents, OLAW expressed concern that the recurring failures could reflect a programmatic deficiency within UMass Chan's animal care and use program and requested that the institution conduct a root cause analysis to identify the factors contributing to the repeated violations. In response, UMass Chan conducted a program-wide review of these incidents and concluded that the

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euthanasia failures represented isolated lapses in judgment rather than a systemic deficiency within the animal care and use program. The institution reported that it would implement additional measures to reinforce compliance, including enhanced euthanasia training, refresher courses, annual compliance meetings, and other programmatic improvements. Based on the information provided, OLAW accepted UMass Chan's assessment and concluded that appropriate actions had been taken to investigate, correct, and prevent recurrence of the noncompliance.

Despite UMass Chan's conclusion that the incidents reflected isolated lapses in judgment rather than a programmatic deficiency, and despite the corrective measures the institution represented would prevent recurrence, additional euthanasia-related incidents continued to occur.

For example, the December 2025 IACUC meeting minutes document that approximately 50 mice were euthanized using carbon dioxide without the required secondary physical method and that cage-density limits were exceeded during euthanasia procedures conducted on November 19, 2025. The IACUC imposed corrective actions, including suspension of the individual researcher from animal work for six months, but declined to suspend the protocol.

Then, according to the February 2026 IACUC meeting minutes, an Animal Care staff member reported concerns that a researcher had failed to perform the required secondary euthanasia method following carbon dioxide euthanasia of mice on January 23, 2026. Although the institution ultimately determined that the animals had died from prolonged carbon dioxide exposure, the incident nevertheless resulted in retraining and additional oversight.

Significantly, these incidents occurred after UMass Chan's root cause analysis and after the institution had repeatedly assured OLAW that corrective actions had been implemented to address euthanasia-related deficiencies. At a September 2025 IACUC meeting, the committee specifically discussed prior euthanasia failures and adopted a purportedly "no-tolerance" position under which future failures to euthanize animals would result in protocol suspension and repeated offenses would lead to permanent revocation of animal research privileges. Yet additional euthanasia-related incidents were reported only weeks later, but the IACUC failed to suspend the protocols on which these incidents occurred.

Additional Animal Welfare Failures

The pattern of noncompliance at UMass Chan extends beyond euthanasia. Records reviewed by PETA document continuing failures involving water deprivation, animal deaths, inadequate monitoring, analgesia noncompliance, and other animal welfare concerns.

> **Repeated Failures to Provide Food or Water**
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> UMass Chan’s records also document a longstanding pattern of failures to provide animals with food or water. In 2021, eight newly weaned mice were left without food and subsequently euthanized, and 15 other newly weaned mice were found without either food or water (OLAW cases 3F and 3G). In 2023, failure of an automated watering connection resulted in the deaths of 12 litters of mice (OLAW case 3T).

Multiple incidents involving failures to provide animals with adequate access to food or water occurred in 2024. In one case, 20 mice were placed on a rack without functioning water connections after being moved from cages supplied with medicated water bottles; despite veterinary intervention, 10 of the animals died from dehydration (OLAW Case 4D). In a separate matter, hamsters were inadvertently left without access to water for approximately 16 hours during a fecal-collection procedure, requiring veterinary evaluation (OLAW Case 4C). Another incident involved a researcher inadvertently leaving five mice without food after experimental procedures; three of the animals were later found dead (OLAW Case 4H). Most troubling, on three separate occasions between June and July 2024, an Animal Care Technician failed to provide water to mice, affecting 56 animals and resulting in the deaths of 34 from dehydration (OLAW Case 4I).

Following these repeated failures, the incident was discussed during a fully convened IACUC meeting on August 5, 2024. The committee approved revisions to multiple water-related SOPs, including procedures governing rodent watering systems and ventilated rack changeouts, instituted additional daily water-line checks, and required retraining of animal care personnel.

Nevertheless, comparable failures continued in 2025. The USDA cited the university after two ferrets were left without water for approximately 24 hours after a technician failed to reconnect the water line to their enclosure following a cage change. On November 17, 2025, five mice died after two cages were found without water, and in December 30, 2025, four more mice died after their cage was left without a water valve.

The recurrence of these incidents after equipment changes, SOP revisions, checklists, monitoring measures, and repeated retraining raises serious questions about UMass Chan's ability to identify and correct failures in basic husbandry before animals are harmed or killed.

Deficiencies in Monitoring, Recordkeeping, and Veterinary Communication
Records obtained by PETA also document recurring shortcomings in animal monitoring, medical recordkeeping, and communication with veterinary staff. In OLAW Case 3P, personnel failed to obtain required weekly weights for 15 mice over a two-week period even though those measurements were necessary to assess humane endpoints. As a corrective measure, the protocol was amended to include more relevant monitoring criteria and humane endpoints. [

Similar problems continued into 2024. In OLAW Case 3S, a post-approval monitoring audit and USDA inspection identified multiple protocol deviations involving pigs, including failures to document required postoperative and daily monitoring, administration of drugs outside the approved protocol without documented veterinary consultation, and breakdowns in communication with veterinary staff. One pig experienced progressive clinical deterioration and died shortly after veterinary

assessment, and another animal did not receive timely veterinary care because concerns were not communicated to the attending veterinarian.

Additional monitoring deficiencies were identified in OLAW Case 4J, in which a ferret underwent a CT imaging procedure without anesthetic-depth monitoring at the frequency required by the approved protocol.

Deficiencies in monitoring and recordkeeping persisted in 2025. In April 2025, the IACUC discussed a recent incident where mice were reportedly found in declining condition or dead following anesthesia, but no procedure card was present, and anesthesia and analgesia records were incomplete.

In October 2025, the IACUC discussed deficient anesthesia-monitoring records and a xylazine dosage miscalculation caused by the use of a stock solution at a different concentration.

Failures to Provide Required Analgesia

UMass Chan's records further document repeated failures to provide analgesia in accordance with approved protocols. In OLAW case 3Y, tail tissue was collected from 188 mice without the required anesthesia and/or analgesia. An earlier matter involving three pigs concerned the omission of a required postoperative dose of buprenorphine following survival surgery (OLAW Case 2P).

Similar noncompliance continued in 2025. In the May 2025 IACUC meeting, it was noted that a laboratory performed surgery under the wrong protocol using a different analgesic regimen than the one approved for the animals. In October 2025 the IACUC found that buprenorphine had been administered to mice every 24 hours rather than every six to eight hours for 48 hours, as required by the approved protocol. In a separate incident reported during the December 2025 IACUC meeting, it was reported that tail biopsies were performed on mice older than 29 days without analgesia because their ages had been documented incorrectly.

Unauthorized Procedures and Deficient Protocol Oversight

Records obtained by PETA also identify repeated instances in which personnel performed procedures that had not been approved or did not comply with the applicable protocol. In OLAW case 3I, 25 mice received IDH inhibitor injections before IACUC approval had been obtained. In OLAW case 3W, ten mice received an unapproved immunoglobulin G injection during an experiment in which nine animals later died. In OLAW case 3X, a calculation error resulted in six mice receiving a cocaine dose above the approved limit; two died immediately and the remaining four were euthanized.

The IACUC meeting minutes reveal additional serious animal welfare and compliance concerns in 2025. The January 2025 IACUC meeting minutes describe a case in which a nonsurgical procedure was conducted on cows at a location that had not been reviewed or approved by the IACUC (OLAW Case 4G). The May 2025 IACUC meeting minutes

document the results of an IACUC investigation that substantiated multiple violations, including the performance of non-survival calcium-imaging surgery during a voluntary cessation of surgical activities, adrenalectomies conducted before IACUC approval and outside an approved location, and failures to ensure that personnel were appropriately trained and qualified (OLAW Case 4E).

It would appear that these recurring incidents do not stand in isolation. Rather, they reinforce the concerns raised in PETA's December 10, 2025, complaint, which identified apparent deficiencies in veterinary care, humane endpoint implementation, euthanasia practices, staffing, personnel competency, and overall program oversight. **Taken together, the continued occurrence of similar failures calls into question whether UMass Chan's corrective actions have been effective and whether the institution is capable of maintaining compliance with the Public Health Service Policy on Humane Care and Use of Laboratory Animals. The repeated emergence of the same categories of violations after multiple rounds of retraining, policy revisions, enhanced oversight, sanctions, and a formal root cause analysis suggests a broader failure of institutional and programmatic oversight.**

Accordingly, PETA respectfully requests that OLAW conduct a comprehensive review of UMass Chan's animal care and use program and consider whether continued eligibility for a Public Health Service Animal Welfare Assurance is warranted. Given the institution's extensive history of reportable noncompliance, repeated euthanasia failures, and apparent inability to prevent recurrence despite years of corrective actions, we urge OLAW to evaluate whether suspension or revocation of UMass Chan's Assurance is necessary to protect animal welfare and ensure compliance with PHS Policy.

Sincerely,

Katherine V. Roe, Ph.D.
Chief Scientist
Laboratory Investigations Department