



## Inspection Report

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OREGON HEALTH & SCIENCE UNIVERSITY  
3181 S W SAM JACKSON PARK RD., #L335  
PORTLAND, OR 97239

Customer ID: **1046**

Certificate: **92-R-0001**

Site: 002

OREGON HEALTH & SCIENCE  
UNIV./WEST CAMPUS

Type: FOCUSED INSPECTION

Date: 25-JAN-2021

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### 3.80(a)(1)

#### Primary enclosures.

On October 26, 2020 a pair of male rhesus macaques were able to shake their paired-cage enclosure enough to knock one of the enclosures partly off the mount, creating a gap between the units. This allowed both animals to escape into the secondary enclosure, a secured animal room. The escaped animals were not injured, but five still-caged macaques housed in the same room sustained injuries – bites, lacerations, abrasions – requiring veterinary care. All have since healed without evidence of long-term impact to their welfare.

All enclosures must be structurally sound to contain the animals. While the enclosures were brand new and an upgrade from the enclosures they replaced, the large male macaques exposed a design flaw. This NCI has since been corrected by adding a bounce-limiting stabilizing bar that keeps the enclosures securely on their mounts.

### 3.85 Critical Employees.

A January 31, 2020 incident was reported where a juvenile macaque was found trapped under a stainless-steel trough drain cover. The husbandry technician had not properly secured the drain cover after cleaning and sanitizing. The animal was returned to his social group after a few weeks of fully successful treatments for his injury.

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Prepared By: GWYNN HALLBERG

USDA, APHIS, Animal Care

Date:

02-FEB-2021

Title: VETERINARY MEDICAL  
OFFICER

Received by Title: IACUC Representative

Date:

02-FEB-2021



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An August 13, 2020 incident was reported where two rhesus macaques were present in a four-unit cage when a husbandry technician put it into an automatic cage washer and started the wash cycle. The husbandry technician had mistakenly pulled the clean rack of cages holding the two monkeys from the housing room to put into the cage washer. Upon the technician's return to the housing room, the mistake was realized. The washer was immediately shut down and the cage unit removed. Veterinarians were immediately called to provide medical care, however the injuries to both animals were fatal.

A root cause analysis conducted after each of these incidents determined insufficient training and/or supervision resulted in both accidents. The NCIs were corrected prior to inspection by upgrading policies and procedures to prevent such occurrences in the future.

This inspection and exit interview were conducted with representatives from the IACUC and with veterinary staff.

Additional Inspectors:

NAOMI SISIMOUR, VETERINARY MEDICAL OFFICER

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**Species Inspected**

Cust No	Cert No	Site	Site Name	Inspection
1046	92-R-0001	002	OREGON HEALTH & SCIENCE UNIV./WEST CAMPUS	25-JAN-2021

Count	Scientific Name	Common Name
000000	NONE	NONE
000000	Total	