United States Department of Agriculture
Animal and Plant Health Inspection Service

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Inspection Report

University Of Washington
Box 357160
Seattle, WA 98195

Customer ID: **1016**
Certificate: **91-R-0001**
Site: 001
UNIVERSITY OF WASHINGTON

Type: ROUTINE INSPECTION
Date: 28-FEB-2014

2.31(c)(7)

INSTITUTIONAL ANIMAL CARE AND USE COMMITTEE (IACUC).

At the time of the inspection, a guinea pig was discovered dead in its enclosure. A review of the animal's records showed that it had undergone a major operative procedure three days earlier, and whereas the protocol called for pain medication to be given at the time of the surgery, and then "every 8-12 hours for 48 hours post-surgery", the animal had only received one additional dose at 12 hours.

Unapproved significant changes to the protocol could result in unanticipated pain and distress, and put the animal's welfare at risk. Any significant changes to the approved protocol must be reviewed and approved by the IACUC.

To be corrected from this time forward.

2.32(a)

PERSONNEL QUALIFICATIONS.

For a ten month period beginning in November 2011, a member of a research team failed to give a second protocol-required post-surgical dose of pain medication to thirty rabbits. This incident was identified, reported and corrected by the IACUC, and there was no serious animal welfare impact documented.

A cohort mortality report for Protocol # 3339-01 states that on 2/5/13, a rabbit undergoing a surgical procedure exhibited "an increased respiratory rate and abdominal breath pattern" at 1.25 hours into the procedure. At this point, the research team doubled the concentration of the inhaled anesthetic. The respiratory rate continued to increase, and the surgeon, who was the same person involved in the above-mentioned incident, administered an additional dose of the injectable anesthetic drug combination (85% for drug A, and 200% for drug B of the original dose given preoperatively). At approximately 2.5 hours into the procedure, the animal continued to decline, and the surgeon called Vet Services, who arrived and determined that the rabbit had died.

The anesthetics administered during this incident were not in accordance with the protocol or the training on anesthetics. For a second time, the Veterinary Staff, the IACUC and the Principal Investigator attempted to communicate the problem and retrain the individual involved.

Prepared By: DIANE FORBES, D V M USDA, APHIS, Animal Care **Date:** 03-MAR-2014

Title: VETERINARY MEDICAL OFFICER 5053

Received by Title: PROGRAM MANAGER **Date:** 03-MAR-2014

Failure to verify that research members are adequately qualified to comprehend and implement procedures according to protocol could jeopardize the health and well-being of the animals. The research facility should ensure that members of the research team are qualified to perform their duties.

To be corrected from this time forward.

2.32(c)(1)(2)

PERSONNEL QUALIFICATIONS.

During the inspection, a research assistant was observed carrying a large male macaque which was sedated. After weighing the animal, the assistant placed it on its side on a cart, released the animal, turned her back and took several steps across the hallway to open a door. The animal appeared semi-conscious, and could have fallen to the floor if it had moved. A review of the Non-Human Primate sedation and anesthesia training module revealed that there was no specific instruction on this handling issue.

All personnel handling animals must receive appropriate training on proper animal handling, so as to minimize the risk of injury in order to safeguard animal health and well-being.

To be corrected from this time forward.

2.38(f)(1)

MISCELLANEOUS.

Handling. The IACUC reported that in 2013, a rabbit was found to have a fractured pelvis that resulted in paralysis and euthanasia. Staff was unable to explain how the injury occurred, although the animal had been handled the previous day for restraint training by a technician, as part of a research protocol, and the necropsy suggested that the injury had occurred the previous day.

On the day of inspection, it was observed that in one room thirteen out of fourteen macaques had collars with chain links attached that measured approximately four to eleven inches in length, with the final link measuring one to two inches in diameter.

Animals should be handled in a manner that minimizes the risk of injury. Any fall or injury should be reported promptly by personnnel, so as to be treated in a timely manner in order to minimize pain and distress. Dangling chains attached to animals pose a risk of catching on something in the enclosure, which could result in serious injury. Measures should be taken to minimize the risk of injury in order to safeguard the health and well-being of the animals.

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Handling issues surrounding the rabbit incident are to be corrected from this time forward. Macaque handling and equipment issues to be reviewed, with corrections completed by April 1, 2014.

Inspection conducted from 2/25/14 - 2/28/14.

Exit interview conducted with facility representatives.

Additional Inspectors

Smith Pamela, Veterinary Medical Officer

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Customer: 1016
Inspection Date: 28-FEB-14

Species Inspected

Cust No	Cert No	Site	Site Name	Inspection
1016	91-R-0001	001	UNIVERSITY OF WASHINGTON	28-FEB-14

Count	Scientific Name	Common Name
000008	*Cavia porcellus*	DOMESTIC GUINEA PIG
000228	*Eptesicus fuscus*	BIG BROWN BAT
000024	*Macaca fascicularis*	CRAB-EATING MACAQUE / CYNOMOLGUS MONKEY
000120	*Macaca mulatta*	RHESUS MACAQUE *MALE
000458	*Macaca nemestrina*	PIG-TAILED MACAQUE *MALE
000004	*Muscardinus avellanarius*	HAZEL DORMOUSE
000028	*Oryctolagus cuniculus*	EUROPEAN RABBIT
000002	*Papio anubis*	OLIVE BABOON
000009	*Saimiri sciureus*	COMMON SQUIRREL MONKEY
000006	*Sus scrofa domestica*	DOMESTIC PIG / POTBELLY PIG / MICRO PIG
000887	**Total**	