



Inspection Report

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

Type: ROUTINE INSPECTION
Date: 25-JAN-2017

3.83 CRITICAL

WATERING.

The research facility self-reported an adverse event that occurred on 08 JAN 17 involving the death of a nonhuman primate. While performing unrelated rounds and treatments, a veterinary technician found an eight-year-old pigtail macaque that was lethargic, and contacted the veterinarian on call. The veterinarian determined that the animal was severely dehydrated. The water line to the cage was not connected. Veterinary treatment was initiated, however, the animal later died during treatment. Animal husbandry logs indicated that twice daily lixit checks had been performed every day prior to the incident to ensure the lixits were functioning properly and food consumption logs had been normal. However, the clinical condition and necropsy findings were consistent with the animal not having water for at least 48-72 hours. No other animals were affected.

The research facility initiated corrective actions prior to this inspection including completion of documented retraining of care staff, initiating disciplinary action for the involved employee, and revision of their policy such that any schedule changes for husbandry activities like cage cleaning rotation must be approved by a veterinarian instead of the supervisor. Additionally, the Institutional Animal Care and Use Committee (IACUC) reviewed the events and issued a letter of reprimand to the affected facility; the IACUC will be further investigating this incident at the next scheduled meeting. The facility will also be establishing a process for annual re-certification of animal care staff and incorporate that into their standard operating procedures.

The provision of potable water and reliable processes to assure such provision are absolutely critical and fundamental to the health and well-being of animals. The facility must assure that employees are trained and effectively complete critical care tasks, including re-certification of animal care employees.

Correct from this time forward.

3.84(b)(2)

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Inspection Report

CLEANING, SANITIZATION, HOUSEKEEPING, AND PEST CONTROL.

The research facility self-reported that the cages housing six nonhuman primates, which included the animal that died on 08 January 2017, had not been changed or sanitized for 17 days prior to the adverse event that contributed to the death of the pigtail macaque. Instead of completing the scheduled regular sanitization on 06 January 2017, the immediate area supervisor had decided to wait until 09 January 2017 for a scheduled specialized sanitization process. Had the affected animal's cage been changed within the required two week period, the disconnected water line would have been discovered by facility staff, thus averting the incident.

Completion of regularly scheduled sanitization of cages at a frequency of at least once every 2 weeks is necessary for the health and well-being of the animals.

The research facility had instituted corrective actions prior to the inspection including retraining of the supervisory and care staff and revision of their policy such that any schedule changes for husbandry activities like cage cleaning rotation must be approved by a veterinarian instead of the supervisor. The facility will also be establishing a process for annual re-certification of animal care staff and incorporate that into their standard operating procedures.

Correct standard operating procedure by 28 February 2017.

This inspection and exit briefing were conducted with the facility representatives.

Additional Inspectors

Michael Schnell, Veterinary Medical Officer

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