United States Department of Agriculture
Animal and Plant Health Inspection Service

Inspection Report

Washington University
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Campus Box 8106
Saint Louis, MO 63110

Customer ID: **1444**
Certificate: **43-R-0008**
Site: 004
WASHINGTON UNIVERSITY

Type: ROUTINE INSPECTION
Date: 07-MAR-2017

2.33(b)(4) CRITICAL

ATTENDING VETERINARIAN AND ADEQUATE VETERINARY CARE.

***In September 2016 the facility self-reported an incident to the Office of Laboratory Animal Welfare (OLAW) and USDA. The facility suspended a protocol as a result of inadequate intraoperative monitoring, as approved in the study protocol, and subsequent failure to identify a malfunctioning heating pad that may have contributed to the unexpected death of a rabbit undergoing a non-survival surgical procedure. According to anesthesia records, there was a period of approximately 4 hours in which no temperature was recorded while the animal was under anesthesia for this procedure. This is contrary to the approved protocol which states that a rectal temperature will be monitored and recorded every 15 minutes. Written records indicate that the animal died while under anesthesia and it is recorded that the animal's blood pressure dropped due to hypothermia and hemodilution. It was also noted in the records that the water-heated mat under the animal had turned off, leading to hypothermia.The veterinary staff was not immediately notified of intraoperative problems or of the animal's death. A necropsy was not performed on the rabbit. By monitoring the temperature at more frequent intervals, changes in temperature may be identified and addressed sooner. The facility identified that proper steps to ensure the health and welfare of the animal may not have been taken because records to substantiate those efforts were inadequately maintained. The facility must ensure that proper guidance is provided to principal investigators and their personnel involved in the care and use of animals regarding handling, immobilization, anesthesia, analgesia, tranquilization and euthanasia at all times. The research facility acted promptly to address this incident by conducting an investigation, reporting the incident to OLAW and USDA, and swiftly implementing appropriate corrective actions to prevent future occurrences. Corrective actions taken include, but are not limited to, retraining of all personnel involved, a submitted plan to ensure adequate expertise of the research team performing procedures and amending the protocol to include contacting veterinary staff immediately if complications occur. This item has been corrected by the facility.

The inspection was conducted on March 7-9, 2017 and an exit interview was conducted on March 9, 2017 with facility representatives.

Prepared By: [redacted]
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