



### Inspection Report

University of Wisconsin Madison  
DIRECTOR RESEARCH ANIMAL RESOURCES CENTER  
1710 UNIVERSITY AVENUE 396 ENZYME INST  
MADISON, WI 53726

Customer ID: **616**  
Certificate: **35-R-0001**  
Site: 001  
ALL CAMPUS SITES

Type: ROUTINE INSPECTION  
Date: 23-JUL-2024

#### 2.31(d)(1)

##### **Institutional Animal Care and Use Committee (IACUC).**

Incidents were identified by the facility in which procedures were either not approved procedures or the procedures were not conducted in accordance with the written protocol:

- One NHP underwent whole body perfusion (a terminal procedure done under deep anesthesia) on 1/4/2024 and one on 1/11/2024.
- Some NHPs had 13 intraocular injections but the protocol approved amount was 6.
- Some NHPs had large bowel biopsies with a 4-5 day gap between the second biopsy, but the protocol indicated that they would have a 7day gap between biopsies. The veterinarians' evaluation of the procedure was that the difference in days between biopsies did not cause any adverse pain or effects to the NHPs.
- Six starlings did not receive the protocol-indicated analgesia prior to and after vector infusions but they were under deep anesthesia and no adverse effects were reported/observed by personnel and the lab that studies starlings was found to have taken corrective actions to prevent further recurrence.

Principal investigators must ensure that procedures are done in accordance with the approved protocol. While the facility veterinarians found no adverse effects occurred, not following protocol-permitted activity does not allow the IACUC to conduct a review of the appropriateness of the procedure being conducted for the study.

\*\*\*The facility identified these incidents and reported them to the overseeing ACUC and to OLAW as applicable and took corrective action.

\*\*\*Ensure that corrective measures are maintained from 7/26/2024 forward.

#### 2.31(d)(1)(x)                      **Critical**

##### **Institutional Animal Care and Use Committee (IACUC).**

On 8/17/2023 an adult female marmoset underwent a second major survival surgery which was not approved on the protocol. The protocol had approval for multiple types of this surgery on macaques but not for marmosets. Multiple survival surgeries that are not approved on the protocol could cause unnecessary pain in animals and do not ensure that the procedure is necessary for the study. The facility and overseeing ACUC must ensure that principal investigators (PI's) follow their approved protocols.

The facility identified this incident and reported it to the overseeing ACUC and OLAW and took corrective measures.

Correction: Ensure corrective measures are maintained.

**Prepared By:** SCOTT WELCH  
USDA, APHIS, Animal Care  
**Title:** VETERINARY MEDICAL OFFICER

**Date:**  
31-JUL-2024

**Received by Title:** Facility Representative

**Date:**  
31-JUL-2024



### Inspection Report

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**2.38(f)(1)                      Critical                      Repeat**

**Miscellaneous.**

Incidents were identified by the facility in which possible human error caused NHPs to have uncontrolled interaction with other NHPs in the room and cause injury to other NHPs or get injury on 4/10/2024 and 4/9/2024.. Affected animals had injuries that needed sutures. Animals received prompt and appropriate veterinary care. Incorrect handling can allow NHPs to cause injury or get injured as found in these incidents. Ensure that animals are handled as careful as possible to protect their wellbeing.

On 7/12/2023 two NHPs had warming lamps positioned too close to maintain body temperature while under a study procedure and recieved thermal injuries. Using heat lamps too close as in this incident can cause injuries which are painful. The animals received veterinary treatment. The facility implemented corrective action (discontinued lamp use and replaced warming methods with warm air) to prevent further incidents. Ensure corrective actions are maintained.

An incident of not following proper blood draw procedure on 7/20/2023 was found to have contributed to an animal being found in poor health the same day. The affected animal was given prompt veterinary care but due to poor treatment response euthanasia was elected. The employee was retrained and observed by the facility to ensure that blood draw procedures can be done correctly in the future. Ensure blood draw procedures on animals are done correctly by employees and as careful as possible to protect their wellbeing.

Note: These incidents were identified by the facility and reported to the overseeing ACUC and OLAW. Affected animals recieved veterinary treatment.

**3.80(a)(2)(ii)                      Critical**

**Primary enclosures.**

A marmoset's hand was seriously injured on 7/29/2023 when it jumped toward an enclosure door that was closing. The affected marmoset received prompt veterinary treatment. The facility found that the employee had used the equipment properly and followed proper procedure, however that the door was too heavy to stop at the last second to prevent the injury when the marmoset moved toward the door. The construction of these enclosures can cause injury to marmosets if they move to the door right when it is being closed. Ensure that modifications to any of this type of enclosure are sufficient to protect nonhuman primates from injury.

\*\*\*Correct by August 16, 2024.

Note: This incident was reported to the overseeing ACUC and OLAW. The facility has modified the affected enclosure door to help prevent future incidents.

**3.80(a)(2)(iii)                      Critical**

**Primary enclosures.**

On 12/30/2023 a group pen of macaques damaged a door separating them from another group and allowed them to interact with another group of macaques. Six of the fourteen macaques that interacted were injured and wounds needed sutures. To prevent accidental opening, enclosures must be routinely checked for any weakness. The facility secured this enclosure to prevent future opening and checked other enclosure doors of this type to ensure they were secure. Enclosures must contain animals and prevent accidental opening including by the animal.

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Some incidents had nonhuman primates (NHPs) get out of their primary enclosure and interact with other NHP's that caused injury (8/7/2023, 12/22/2023) or get injured with wounds that needed sutures. The facility found in these incidents that an enclosure lock failure likely was the cause of the NHP being able to get out into the room or in with another NHP. Animals that were injured recieved prompt veterinary care. Ensure enclosures are maintained in a manner that contain animals and prevent accidental opening including by the animal.

\*\*\*The facility identified these problems, has taken corrective measures and reported them to the overseeing ACUC and applicable incidents to OLAW. Ensure corrective actions and observations are maintained. Correct from 7/26/2024 forward.

This was an inspection of animals and records covered under LSVC. Inspection and exit interview were conducted with facility representatives.

Additional Inspectors:

DAWN BARKSDALE, VETERINARY MEDICAL OFFICER

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### Species Inspected

Cust No	Cert No	Site	Site Name	Inspection
616	35-R-0001	001	ALL CAMPUS SITES	23-JUL-2024

Count	Scientific Name	Common Name
000200	<i>Macaca fascicularis</i>	CRAB-EATING MACAQUE / CYNOMOLGUS MONKEY
000245	<i>Callithrix jacchus</i>	COMMON MARMOSET
000008	<i>Macaca nemestrina</i>	PIG-TAILED MACAQUE
001573	<i>Macaca mulatta</i>	RHESUS MACAQUE
000115	<i>Sturnus vulgaris</i>	EUROPEAN STARLING / COMMON STARLING
000359	<i>Peromyscus californicus</i>	CALIFORNIA MOUSE
002500	<b>Total</b>	