A3196-3A

UCLA
UNIVERSITY OF CALIFORNIA,
LOS ANGELES

ROBERTO PECCEI
Vice Chancellor for Research

Box 951405
Los Angeles, CA 90095-1405
phone: 310-825-7943
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August 15, 2006

Axel V. Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
Rockledge 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

RE: Final Report - Suspension of Principal Investigator Mai N. Brooks, M.D.

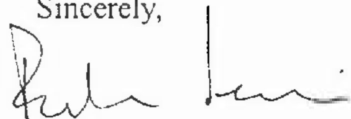
Dear Dr. Wolff:

I am writing to provide you with a final report regarding the suspension of the above named investigator's rights to conduct research at UCLA. As the preliminary report of January 17, 2006 noted, effective December 1, 2005, the University suspended Dr. Brooks' privilege to conduct research for a period of four years.

At the time of the suspension, Dr. Brooks was named as the Principal Investigator of record for one research protocol using laboratory animals which received funding from National Institutes of Health (NIH) grant #P50 AT00151-03. At the request of Dr. Brooks, the Chancellor's Animal Research Committee (ARC) approved the appointment of another qualified investigator to act as Principal Investigator of record for the aforementioned animal use protocol. There have been no further updates on this matter.

If you have any questions or concerns, please do not hesitate to contact me at (310) 206-6308.

Sincerely,



Roberto Peccei
Vice Chancellor for Research

cc: Dr. William H. McBride, Chair, ARC
Judith L. Brookshire, Director, OPRS
Kathy Wadsworth, Associate Director, Animal Subjects Research

A 3196-3A

Hi Ms. Wadsworth,
Thank you for this preliminary report. We look forward to receiving the final report upon completion. Please notify the funding component about the suspension as well as the change in investigators.

Axel Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight
OLAW

From: +EXTERNAL EMAIL FOR ARC [mailto:ARC@OPRS.UCLA.EDU]
Sent: Thursday, January 19, 2006 12:01 PM
To: Wolff, Axel (NIH/OD) [E]
Cc: William McBride (E-mail); Brookshire, Judith; Wadsworth, Kathy
Subject: Preliminary Report of Suspension

Dear Dr. Wolff,

Attached is a preliminary report regarding the suspension of an investigator's privilege to conduct research at UCLA.

Please do not hesitate to contact me if you have any questions.

Kathy
****
Kathy Wadsworth
Associate Director-Animal Subjects Research
Office for the Protection of Research Subjects
University of California, Los Angeles
Phone: (310) 825-5227
Email: kwads@oprs.ucla.edu

<<OLAW preliminary report - Brooks.pdf>>

MEMORANDUM

OFFICE FOR PROTECTION OF RESEARCH SUBJECTS
Chancellor's Animal Research Committee
1401 Ueberroth Building
169407
Phone: (310) 206-6308
Email: arc@oprs.ucla.edu
Website: http://www.oprs.ucla.edu/animal

January 17, 2006

Axel V. Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
Rockledge 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

RE: Preliminary Report - Suspension of Principal Investigator Mai N. Brooks, M.D.

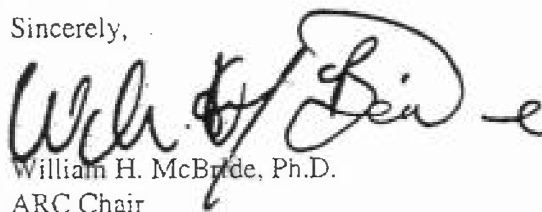
Dear Dr. Wolff,

On behalf of the Chancellor's Animal Research Committee (ARC), I wish to provide you with a preliminary report regarding the suspension of the above named investigator's rights to conduct research at UCLA. Effective December 1, 2005, the University suspended Dr. Brooks' privilege to conduct research for a period of four years.

A review of our animal care and use database revealed that at the time of the suspension, Dr. Brooks was named as the Principal Investigator of record for one research protocol using laboratory animals. The research received funding from National Institutes of Health (NIH) grant #P50 AT00151-03. An amendment was subsequently submitted to the ARC and approved to appoint another qualified investigator as Principal Investigator of record for the animal use protocol. Dr. Brooks was not named as a co-investigator or personnel for any other animal use project at UCLA.

I wish to assure you that UCLA takes our responsibility very seriously for the care and use of laboratory animals. A final report will be forwarded to you when additional information is known and/or when the matter is resolved. If you have any questions or concerns, please do not hesitate to contact me at (310) 206-6308.

Sincerely,



William H. McBride, Ph.D.
ARC Chair

cc: Judith L. Brookshire, Director, OPRS
Kathy Wadsworth, Associate Director, Animal Subjects Research

AWAS

Full Assurance Agreement Printout

Assurance Number:	A3196-01	Prior Assurance Number:	A1440
Institution Name:	Univ.of California-Los Angeles		
Institution Address:	Los Angeles, CA	Site:	00

Dates:

Conditional Data Due:		AAALAC Status:	1
Effective:	01/25/2002	PHS Grant / Contract #:	
Expiration:	01/31/2007	Last Modified:	10/13/2005 By: sm
AR Reporting Cycle:	1 2006		

Chairman: William McBride, Ph.D.
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Title: Chair, Chancellor's Animal Research Committee
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Phone: (310) 794-7051 Ext:
Fax: (310) 206-1260
Email: wmcbride@mednet.ucla.edu

Official: Dr. Roberto Peccei
Title: Vice Chancellor for Research
Address:
405 Hilgard Avenue
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Fax: (310) 206-6030
Email:

POC: Ms. Kathy L. Wadsworth
Title: Associate Director-Animal Subjects Research
Address:
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Los Angeles, CA 90095-1694
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DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH

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Home Page: http://grants.nih.gov/grants/olaw/olaw.htm

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Telephone: (301) 496-7163
Facsimile: (301) 402-2803

March 3, 2006

Re: Animal Welfare Assurance A3410-01
[OLAW Cases 3B, 3C, 3D, & 3E]

Dr. Roberto Peccei
Vice Chancellor for Research
University of California, Los Angeles
405 Hilgard Avenue
Los Angeles, CA 90024-1405

Dear Dr. Peccei,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your February 28, 2006 letters reporting four instances of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the University of California- Los Angeles (UCLA). According to the information provided, OLAW understands the following about the incidents and the corresponding corrective actions:

1) OLAW Case A3196-3B: Animals underwent surgical procedures although the protocol had expired.

Corrective action: To prevent a recurrence, the investigator proposed improved intra-laboratory communication, increased vigilance, discussion of protocol approval dates at laboratory meetings, and modifying protocol titles to avoid confusion. The Institutional Animal Care and Use Committee/Animal Research Committee (IACUC/ARC) accepted the corrective plan.

2) OLAW Case A3196-3C: Three rats died due to not receiving adequate food and water over a holiday weekend.

Corrective action: The responsible animal caretaker was counseled, put on a performance plan, and received closer supervision. Animal care procedures for weekends and holidays have been modified and include special logs, water bottle filling instructions, and the inclusion of gel packs in cages.

3) OLAW Case A3196-3D: A sick mouse was ordered by the veterinarian to either be treated or euthanized, however the investigator kept the animal alive in the laboratory. It was further determined that the animal was to have tissue harvested, a procedure not covered on the protocol, and that the laboratory was not an approved animal housing site.

Corrective action: The investigator was retrained, agreed to follow IACUC policies, and appointed laboratory staff to carry out Division of Laboratory Animal Medicine (DLAM) requests.

4) OLAW Case A3196-3E: A sick mouse was ordered by the veterinarian to either be treated or euthanized, however this was not performed in a timely fashion. It was further determined that the cage cards did not contain current contact information for laboratory staff.

Corrective action: The mouse was subsequently euthanized by a DLAM technician. The Principal Investigator agreed to have staff correct and monitor the information on the cage cards.

Based on its assessment of these explanations, OLAW has the following comments on the cases (numbers correspond to the cases above):

1) In future noncompliance reports provide a full explanation of the situation, including what happened, when and where, and the species involved. In this case, it would include provision of more detail about the surgery and the types of animals involved.

2) Other animal facilities have implemented a secondary check of animal rooms by a different individual following daily husbandry procedures to ensure completion of tasks.

3) Unless informed to the contrary, OLAW assumes that the cage card discrepancy has also been resolved.

4) OLAW assumes that a policy is in place whereby DLAM staff is authorized to euthanize an animal, based on professional judgment, when required to prevent suffering. Procedures should include provisions to notify investigators, however the severity of the condition may determine the course of action. When PHS-supported activities can specifically be identified, include the relevant grant number.

OLAW understands that UCLA has implemented measures to correct and prevent recurrence of the four noncompliant incidents reported. We appreciate having been informed about these matters and find no cause for further action by this Office.

Sincerely,

Axel Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight

cc: William McBride, Ph.D., IACUC Chair
Judith Brookshire, Director, OPRS
Kathy Wadsworth, Associate Director, Animal Subjects Research

A3176-3B

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PHONE: (310) 825-7943
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E-MAIL: RPECCEI@CONET.UCLA.EDU

February 28, 2006

Axel V. Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
Rockledge 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

Dear Dr. Wolff:

I am writing to provide you with a report of an incident of noncompliance involving a study held by a UCLA investigator. This research project does not receive funding from Federal sources.

The Chancellor's Animal Research Committee (ARC) was informed October 27, 2005 of an incident of noncompliance involving the above referenced protocol. Specifically, veterinary staff from the Division of Laboratory Animal Medicine (DLAM) noted that animals used in this protocol had undergone surgery on October 4, 2005, though ARC approval for the study had expired September 29, 2005.

In accordance with the ARC Policy, Investigating Allegations of Mistreatment or Other Noncompliance Issues[1], the investigator was provided an opportunity to comment on the incident.

The investigator apologized for the incident, stating that "this error may have occurred because of the fact that we have another protocol with [a] similar title that was approved for continuation." To prevent a similar occurrence, the investigator proposed "improved communication between the members of our laboratory and increased vigilance." Additionally, ARC approval dates for ongoing protocols will be discussed at

[1] *"In every investigation, the person(s) against whom the complaint has been raised shall be given notice of the concern and provided an opportunity to address the allegations in writing."*

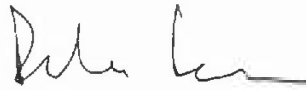
regular laboratory meetings. The investigator also modified the protocol titles "to avoid confusion."

The ARC reviewed the incident at a convened ARC meeting of January 23, 2006 and found the investigator's explanation and corrective action plan to be acceptable.

In accordance with PHS Policy IV.F.3, the ARC requested that this incident be reported to the NIH Office of Laboratory Animal Welfare (OLAW) as a serious deviation from the provisions of the *Guide for the Care and Use of Laboratory Animals*.

If you have any questions or concerns, please do not hesitate to contact me at (310) 825-7943.

Sincerely,



Roberto Peccei
Vice Chancellor for Research

cc: Dr. William H. McBride, Chair, ARC
Judith L. Brookshire, Director, OPRS
Kathy Wadsworth, Associate Director, Animal Subjects Research

DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE
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Bethesda, Maryland 20817
Telephone: (301) 496-7163
Facsimile: (301) 402-2803

March 3, 2006

Re: Animal Welfare Assurance A3410-01
[OLAW Cases 3B, 3C, 3D, & 3E]

Dr. Roberto Peccei
Vice Chancellor for Research
University of California, Los Angeles
405 Hilgard Avenue
Los Angeles, CA 90024-1405

Dear Dr. Peccei,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your February 28, 2006 letters reporting four instances of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the University of California- Los Angeles (UCLA). According to the information provided, OLAW understands the following about the incidents and the corresponding corrective actions:

1) OLAW Case A3196-3B: Animals underwent surgical procedures although the protocol had expired.

Corrective action: To prevent a recurrence, the investigator proposed improved intra-laboratory communication, increased vigilance, discussion of protocol approval dates at laboratory meetings, and modifying protocol titles to avoid confusion. The Institutional Animal Care and Use Committee/Animal Research Committee (IACUC/ARC) accepted the corrective plan.

2) OLAW Case A3196-3C: Three rats died due to not receiving adequate food and water over a holiday weekend.

Corrective action: The responsible animal caretaker was counseled, put on a performance plan, and received closer supervision. Animal care procedures for weekends and holidays have been modified and include special logs, water bottle filling instructions, and the inclusion of gel packs in cages.

3) OLAW Case A3196-3D: A sick mouse was ordered by the veterinarian to either be treated or euthanized, however the investigator kept the animal alive in the laboratory. It was further determined that the animal was to have tissue harvested, a procedure not covered on the protocol, and that the laboratory was not an approved animal housing site.

Corrective action: The investigator was retrained, agreed to follow IACUC policies, and appointed laboratory staff to carry out Division of Laboratory Animal Medicine (DLAM) requests.

4) OLAW Case A3196-3E: A sick mouse was ordered by the veterinarian to either be treated or euthanized, however this was not performed in a timely fashion. It was further determined that the cage cards did not contain current contact information for laboratory staff.

Corrective action: The mouse was subsequently euthanized by a DLAM technician. The Principal Investigator agreed to have staff correct and monitor the information on the cage cards.

Based on its assessment of these explanations, OLAW has the following comments on the cases (numbers correspond to the cases above):

1) In future noncompliance reports provide a full explanation of the situation, including what happened, when and where, and the species involved. In this case, it would include provision of more detail about the surgery and the types of animals involved.

2) Other animal facilities have implemented a secondary check of animal rooms by a different individual following daily husbandry procedures to ensure completion of tasks.

3) Unless informed to the contrary, OLAW assumes that the cage card discrepancy has also been resolved.

4) OLAW assumes that a policy is in place whereby DLAM staff is authorized to euthanize an animal, based on professional judgment, when required to prevent suffering. Procedures should include provisions to notify investigators, however the severity of the condition may determine the course of action. When PHS-supported activities can specifically be identified, include the relevant grant number.

OLAW understands that UCLA has implemented measures to correct and prevent recurrence of the four noncompliant incidents reported. We appreciate having been informed about these matters and find no cause for further action by this Office.

Sincerely,

Axel Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight

cc: William McBride, Ph.D., IACUC Chair
Judith Brookshire, Director, OPRS
Kathy Wadsworth, Associate Director, Animal Subjects Research

A3196-3C

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PHONE: (310) 825-7943
FAX: (310) 206-6030
E-MAIL: RPECCEI@CONET.UCLA.EDU

February 28, 2006

Axel V. Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
Rockledge 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

Dear Dr. Wolff,

I am writing to provide you with a report of an incident of noncompliance involving animals housed in a UCLA animal facility. The incident did not pertain to a specific study, therefore, a particular funding source could not be determined.

The UCLA Franz Hall vivarium manager notified the Chancellor's Animal Research Committee (ARC) on November 25, 2005 of an incident of possible animal neglect over the Thanksgiving weekend, which resulted in the death of three rats. Specifically, research staff observed rat cages in a room for which water and food dispensers were empty.

The Franz Hall vivarium manager provided a detailed report to the ARC, stating that the employee responsible to caring for the animals over the Thanksgiving weekend received a counseling session and written notice regarding the incident. To avoid future incidents, the vivarium manager provided the employee with performance goals and set a re-evaluation date for achieving the goals. The employee was also to be closely supervised until the retraining sessions are completed and the vivarium manager is assured that the employee is able to work unsupervised.

Additionally, the vivarium manager created new techniques to anticipate and prevent future animal care problems in the Franz Hall vivarium:

"Specifically, during the week we have an assignment board where I assign a room to my staff and they sign the board when they have completed it. I will now make a weekend/holiday sheet for feed and water checks. Starting December 1, our daily logs will be room specific and more specialized. While this change was in progress before the incident, I feel this will provide additional reminders for the daily care for a particular room. I have created a weekend/holiday log form. I am also changing our internal 'policy' from filling a bottle if its 'low' to filling a bottle on any cage that is less than 75% full. That is an obvious mark, and ensures a 2 to 3 day water supply in the event of natural disaster. For the upcoming holiday period, I will also place water gel packs in cages with multiple rats as an additional backup source of water."

The Committee reviewed the above information at the meeting of January 23, 2006 and determined that this matter had been adequately resolved, with no further corrective action necessary. However, the ARC determined that since the matter involved *"conditions that jeopardize the health or well-being, including natural disasters, accidents, and mechanical failures, resulting in actual harm or death to animals,"* the matter should be reported to OLAW[1].

If you have any questions or concerns, please do not hesitate to contact me at (310) 825-7943.

Sincerely,

Roberto Peccei
Vice Chancellor for Research

cc: Dr. William H. McBride, Chair, ARC
Judith L. Brookshire, Director, OPRS
Kathy Wadsworth, Associate Director, Animal Subjects Research

---

[1] Guidance on Prompt Reporting to OLAW *Notice #: NOT-OD-05-034.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE
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Home Page: http://grants.nih.gov/grants/olaw/olaw.htm

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Office of Laboratory Animal Welfare
Rockledge One, Suite 360
6705 Rockledge Drive
Bethesda, Maryland 20817
Telephone: (301) 496-7163
Facsimile: (301) 402-2803

March 3, 2006

Re: Animal Welfare Assurance A3410-01
[OLAW Cases 3B, 3C, 3D, & 3E]

Dr. Roberto Peccei
Vice Chancellor for Research
University of California, Los Angeles
405 Hilgard Avenue
Los Angeles, CA 90024-1405

Dear Dr. Peccei,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your February 28, 2006 letters reporting four instances of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the University of California- Los Angeles (UCLA). According to the information provided, OLAW understands the following about the incidents and the corresponding corrective actions:

1) OLAW Case A3196-3B: Animals underwent surgical procedures although the protocol had expired.

Corrective action: To prevent a recurrence, the investigator proposed improved intra-laboratory communication, increased vigilance, discussion of protocol approval dates at laboratory meetings, and modifying protocol titles to avoid confusion. The Institutional Animal Care and Use Committee/Animal Research Committee (IACUC/ARC) accepted the corrective plan.

2) OLAW Case A3196-3C: Three rats died due to not receiving adequate food and water over a holiday weekend.

Corrective action: The responsible animal caretaker was counseled, put on a performance plan, and received closer supervision. Animal care procedures for weekends and holidays have been modified and include special logs, water bottle filling instructions, and the inclusion of gel packs in cages.

3) OLAW Case A3196-3D: A sick mouse was ordered by the veterinarian to either be treated or euthanized, however the investigator kept the animal alive in the laboratory. It was further determined that the animal was to have tissue harvested, a procedure not covered on the protocol, and that the laboratory was not an approved animal housing site.

Corrective action: The investigator was retrained, agreed to follow IACUC policies, and appointed laboratory staff to carry out Division of Laboratory Animal Medicine (DLAM) requests.

4) OLAW Case A3196-3E: A sick mouse was ordered by the veterinarian to either be treated or euthanized, however this was not performed in a timely fashion. It was further determined that the cage cards did not contain current contact information for laboratory staff.

Corrective action: The mouse was subsequently euthanized by a DLAM technician. The Principal Investigator agreed to have staff correct and monitor the information on the cage cards.

Based on its assessment of these explanations, OLAW has the following comments on the cases (numbers correspond to the cases above):

1) In future noncompliance reports provide a full explanation of the situation, including what happened, when and where, and the species involved. In this case, it would include provision of more detail about the surgery and the types of animals involved.

2) Other animal facilities have implemented a secondary check of animal rooms by a different individual following daily husbandry procedures to ensure completion of tasks.

3) Unless informed to the contrary, OLAW assumes that the cage card discrepancy has also been resolved.

4) OLAW assumes that a policy is in place whereby DLAM staff is authorized to euthanize an animal, based on professional judgment, when required to prevent suffering. Procedures should include provisions to notify investigators, however the severity of the condition may determine the course of action. When PHS-supported activities can specifically be identified, include the relevant grant number.

OLAW understands that UCLA has implemented measures to correct and prevent recurrence of the four noncompliant incidents reported. We appreciate having been informed about these matters and find no cause for further action by this Office.

Sincerely,

Axel Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight

cc: William McBride, Ph.D., IACUC Chair
Judith Brookshire, Director, OPRS
Kathy Wadsworth, Associate Director, Animal Subjects Research

A3196-3D

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February 28, 2006

Axel V. Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
Rockledge 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

Dear Dr. Wolff:

I am writing to provide you with a report of an incident of noncompliance involving a UCLA investigator. The investigator receives funding for his research from various Federal sources, including the National Institutes of Health.

The Chancellor's Animal Research Committee (ARC) was notified November 30, 2005 of an incident of noncompliance involving the investigator. Specifically, a veterinarian from the Division of Laboratory Animal Medicine (DLAM) instructed the investigator's laboratory staff on November 15, 2005 to either euthanize a mouse with ulcerative dermatitis that had developed marked abdominal distention, or contact the veterinarian to discuss options. On November 29, 2005, DLAM technicians discovered the animal still alive in a fume hood in the investigator's lab.

When the veterinary technician asked one of the investigator's staff about the animal, it was learned that the animal had been saved to obtain tissues for a separate study on aging. Additionally, it was noted that the protocol referenced on the cage card for the animal was for a breeding colony, and not for an experimental protocol. It was further noted that the ARC had not approved the investigator's laboratory as an animal housing facility.

In accordance with the ARC Policy, Investigating Allegations of Mistreatment or Other Noncompliance Issues[1], the investigator was provided an opportunity to comment on the incident.

[1] *"In every investigation, the person(s) against whom the complaint has been raised shall be given notice of the concern and provided an opportunity to address the allegations in writing."*

The investigator apologized for the incident, stating that his "original intention was to euthanize the mouse and obtain tissue for necropsy, so the mouse was brought to the lab and placed in the fume hood so that it could be sacrificed the following day." The investigator also stated that his "recollection of the animal use guidelines is that it would be acceptable for animals to be housed for periods of less than 24 hours in the lab, prior to sacrifice." He further stated that he decided to euthanize the animal without tissue collection, but "there appears to have been a miscommunication with my research staff about this change of plan, for which I take responsibility."

The investigator provided his assurance that he "recognizes the importance of following the directions of the veterinary staff in the treatment of sick animals and assures [the ARC] that I will be more careful to check that animals are sacrificed in compliance with ARC policy." To avoid reoccurrence of noncompliance, the investigator appointed specific laboratory staff to attend to DLAM requests when he is not available. Additionally, the Committee refreshed the investigator's recollection of the ARC Policy for Maintaining Animals in Study Areas[2].

The ARC reviewed the incident at a convened ARC meeting of January 23, 2006 and found the investigator's explanation and corrective action plan to be acceptable.

In accordance with PHS Policy IV.F.3, the ARC requested that this incident be reported to the NIH Office of Laboratory Animal Welfare (OLAW) as a serious deviation from the provisions of the *Guide for the Care and Use of Laboratory Animals*.

If you have any questions or concerns, please do not hesitate to contact me at (310) 825-7943.

Sincerely,

Roberto Peccei
Vice Chancellor for Research

cc: Dr. William H. McBride, Chair, ARC
Judith L. Brookshire, Director, OPRS
Kathy Wadsworth, Associate Director, Animal Subjects Research

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[2] *"In accordance with the USDA AWARs and PHS Policy, the ARC is required to conduct inspections of all animal facilities, including, but not limited to, areas where animals are maintained for periods longer than 12 hours, at least once every six months. Animals may be housed in study areas provided... Scientific justification for this arrangement is approved by the ARC."* ARC Policy on Maintaining Animals in Study Areas

DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE
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March 3, 2006

Re: Animal Welfare Assurance A3410-01
[OLAW Cases 3B, 3C, 3D, & 3E]

Dr. Roberto Peccei
Vice Chancellor for Research
University of California, Los Angeles
405 Hilgard Avenue
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Dear Dr. Peccei,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your February 28, 2006 letters reporting four instances of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the University of California- Los Angeles (UCLA). According to the information provided, OLAW understands the following about the incidents and the corresponding corrective actions:

1) OLAW Case A3196-3B: Animals underwent surgical procedures although the protocol had expired.

Corrective action: To prevent a recurrence, the investigator proposed improved intra-laboratory communication, increased vigilance, discussion of protocol approval dates at laboratory meetings, and modifying protocol titles to avoid confusion. The Institutional Animal Care and Use Committee/Animal Research Committee (IACUC/ARC) accepted the corrective plan.

2) OLAW Case A3196-3C: Three rats died due to not receiving adequate food and water over a holiday weekend.

Corrective action: The responsible animal caretaker was counseled, put on a performance plan, and received closer supervision. Animal care procedures for weekends and holidays have been modified and include special logs, water bottle filling instructions, and the inclusion of gel packs in cages.

3) OLAW Case A3196-3D: A sick mouse was ordered by the veterinarian to either be treated or euthanized, however the investigator kept the animal alive in the laboratory. It was further determined that the animal was to have tissue harvested, a procedure not covered on the protocol, and that the laboratory was not an approved animal housing site.

Corrective action: The investigator was retrained, agreed to follow IACUC policies, and appointed laboratory staff to carry out Division of Laboratory Animal Medicine (DLAM) requests.

4) OLAW Case A3196-3E: A sick mouse was ordered by the veterinarian to either be treated or euthanized, however this was not performed in a timely fashion. It was further determined that the cage cards did not contain current contact information for laboratory staff.

Corrective action: The mouse was subsequently euthanized by a DLAM technician. The Principal Investigator agreed to have staff correct and monitor the information on the cage cards.

Based on its assessment of these explanations, OLAW has the following comments on the cases (numbers correspond to the cases above):

1) In future noncompliance reports provide a full explanation of the situation, including what happened, when and where, and the species involved. In this case, it would include provision of more detail about the surgery and the types of animals involved.

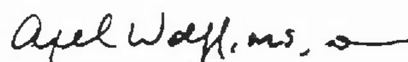
2) Other animal facilities have implemented a secondary check of animal rooms by a different individual following daily husbandry procedures to ensure completion of tasks.

3) Unless informed to the contrary, OLAW assumes that the cage card discrepancy has also been resolved.

4) OLAW assumes that a policy is in place whereby DLAM staff is authorized to euthanize an animal, based on professional judgment, when required to prevent suffering. Procedures should include provisions to notify investigators, however the severity of the condition may determine the course of action. When PHS-supported activities can specifically be identified, include the relevant grant number.

OLAW understands that UCLA has implemented measures to correct and prevent recurrence of the four noncompliant incidents reported. We appreciate having been informed about these matters and find no cause for further action by this Office.

Sincerely,



Axel Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight

cc: William McBride, Ph.D., IACUC Chair
Judith Brookshire, Director, OPRS
Kathy Wadsworth, Associate Director, Animal Subjects Research

A3/46-32

UNIVERSITY OF CALIFORNIA, LOS ANGELES **UCLA**

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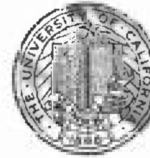

ROBERTO PECCEI
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February 28, 2006

Axel V. Wolff, M.S., D.V.M.
Director, Division of Compliance Oversight
Office of Laboratory Animal Welfare
National Institutes of Health
Rockledge 1, Suite 360, MSC 7982
6705 Rockledge Drive
Bethesda, MD 20892-7982

Dear Dr. Wolff:

I am writing to provide you with a report of an incident of noncompliance involving animals housed in a UCLA investigator's laboratory. This lab receives funding from various Federal sources.

The Chancellor's Animal Research Committee (ARC) was notified December 9, 2005 of an incident of noncompliance involving failure to treat or euthanize an animal. Specifically, a veterinarian from the Division of Laboratory Animal Medicine (DLAM) spoke with the investigator's laboratory staff at 9:26 a.m. on December 6, 2005 regarding an urgent request to euthanize a sick animal in their lab. The person the veterinarian spoke with at that time had not yet undergone appropriate training, and was therefore unable to carry-out the DLAM request. However, the staff informed the veterinarian that she said would alert the principal investigator of the urgent DLAM request. The veterinarian also followed-up with an email to the Principal Investigator to euthanize the animal within the hour.

By 3:00 p.m. that afternoon, a DLAM technician discovered that the animal had not yet been attended to and was in a severely moribund state. The DLAM technician subsequently euthanized the animal at that time.

When the veterinarian later questioned the investigator about the incident, it was learned that the contact person listed on the cage card had left UCLA "several months ago." Additionally, the other cage cards did not contain current contact information for the responsible lab staff.

In accordance with the ARC Policy, Investigating Allegations of Mistreatment or Other Noncompliance Issues[1], the investigator was provided an opportunity to comment on the incident. The investigator acknowledged that an incorrect contact was listed on the cage card of the symptomatic mouse. To prevent recurrence of noncompliance, the investigator will instruct his staff to "monitor the names on the cards and correct any mistakes as soon as possible."

The ARC reviewed the incident at a convened ARC meeting of January 23, 2006 and found the investigator's explanation and corrective action plan to be acceptable.

In accordance with PHS Policy IV.F.3, the ARC requested that this incident be reported to the NIH Office of Laboratory Animal Welfare (OLAW) as a serious deviation from the provisions of the *Guide for the Care and Use of Laboratory Animals*.

If you have any questions or concerns, please do not hesitate to contact me at (310) 825-7943.

Sincerely,

Roberto Peccei
Vice Chancellor for Research

cc: Dr. William H. McBride, Chair, ARC
Judith L. Brookshire, Director, OPRS
Kathy Wadsworth, Associate Director, Animal Subjects Research

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[1] *"In every investigation, the person(s) against whom the complaint has been raised shall be given notice of the concern and provided an opportunity to address the allegations in writing."*

DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH

FOR US POSTAL SERVICE DELIVERY:
Office of Laboratory Animal Welfare
Rockledge One, Suite 360
6705 Rockledge Drive - MSC 7982
Bethesda, Maryland 20892-7982
Home Page: http://grants.nih.gov/grants/olaw/olaw.htm

FOR EXPRESS MAIL:
Office of Laboratory Animal Welfare
Rockledge One, Suite 360
6705 Rockledge Drive
Bethesda, Maryland 20817
Telephone: (301) 496-7163
Facsimile: (301) 402-2803

August 23, 2006

Re: Animal Welfare Assurance
A3196-01 [OLAW Case 3A]

Roberto Peccei, Ph.D.
Vice Chancellor for Research
Office of the Chancellor
University of California-Los Angeles
405 Hilgard Avenue
Los Angeles, CA 90024-1405

Dear Dr. Peccei,

The Office of Laboratory Animal Welfare (OLAW) acknowledges receipt of your August 15, 2006 letter reporting an instance of noncompliance with the PHS Policy on Humane Care and Use of Laboratory Animals at the University of California, Los Angeles (UCLA) that was submitted supplemental to a January 17, 2006 memorandum signed by Dr. McBride sent via e-mail as an initial report to this Office on January 19, 2006. According to the information provided, OLAW understands that the university suspended a researcher's privilege to conduct animal research at UCLA for a period of four years effective December 1, 2005. It is further noted that the suspended PI was working on a protocol supported by grant #P50 AT00151-03 and that the UCLA Animal Research Committee (ARC) has approved an amendment appointing a new PI for that protocol.

Please be advised that the appointment of a new PI must be reported to the funding agency if not done so already.

OLAW appreciates being informed of this matter and finds no cause for further action by this office.

Sincerely,

Brent C. Morse, DVM
Animal Welfare Program Specialist
Division of Compliance Oversight
Office of Laboratory Animal Welfare

cc: Dr. William McBride, IACUC Chair