



Inspection Report

Lovelace Respiratory Research Institute
2425 Ridgecrest S E
Albuquerque, NM 87108

Customer ID: **1072**

Certificate: **85-R-0003**

Site: 001

LOVELACE RESPIRATORY RESEARCH INSTITUTE

Type: ROUTINE INSPECTION

Date: Jun-17-2015

2.31 (d) (1) (viii)

INSTITUTIONAL ANIMAL CARE AND USE COMMITTEE (IACUC).

On 5/22/2015 during an IACUC approved activity (Protocol 15-057), a device used to measure pulmonary function was connected to an anesthetized dog (ID#1689v) via endotracheal tube while the device was still attached to house air. This caused the dog's lungs to overinflate in approximately 5 seconds or less, leading to respiratory arrest and death. The technician connecting the device was not trained to perform this task nor directed by anyone to connect the device. The principal investigator (PI) was present but did not see the technician act until the effect on the dog was detected.

Personnel involved in animal activities need to be qualified and trained in any procedures they may perform to ensure that they will be conducted correctly in order to minimize pain and distress to the animals.

The IACUC shall determine that personnel conducting procedures on the species being maintained or studied must be appropriately qualified and trained in those procedures.

This incident was self-reported to APHIS by the IACUC Chair and an internal facility investigation was initiated within a week after the incident occurred.

Corrections have been initiated by the Principal Investigator, in consultation with the IACUC, which include adding safety equipment to the device setup and documenting all the steps required to conduct this activity safely.

Final corrective actions should be reviewed and approved by the IACUC to ensure that all personnel are qualified and trained appropriately before conducting procedures.

3.80 (a) (2) (iii)

PRIMARY ENCLOSURES.

Three nonhuman primates (NHPs) were able to escape from their primary enclosures due to the accidental opening of the enclosures.

--On 3/18/2015, a female Rhesus macaque (ID#RA1021) was able to escape from the primary enclosure

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during a transfer between a transport enclosure and the primary enclosure. The transport enclosure was being supported by the leg of one of the technicians, the primary enclosure door became stuck open, the NHP was able to jump back into the transport enclosure, and escape between a gap between the two enclosures. The NHP was able to be recaptured without injury after approximately 10 minutes and securely placed into the primary enclosure. A frame is available at the facility that allows the transport enclosures to be held securely against the primary enclosure door but this procedure area did not have one on hand nor had the technicians been trained to use the transport enclosure with the frame prior to this incident.

--On 3/27/2015, a Rhesus macaque (ID#RQ9087) was able to escape from its primary enclosure after just being transferred from a transport enclosure. One of the technicians involved in the transfer accidentally opened the primary enclosure door, prior to it being locked, which allowed the NHP to escape. The NHP was able to be recaptured without injury after approximately 9 minutes and securely placed into the primary enclosure.

--On 5/9/2015, a Cynomologus monkey (ID#1110608) was able to escape from its primary enclosure after releasing a C-clamp from a metal panel on the cage door. The panel should have been secured by an appropriate lock and not by a C-clamp but this was not identified by the staff prior to the animal's escape. The NHP was able to be baited with food items back into its primary enclosure without injury.

Accidental opening of NHP enclosures poses a risk of injury to the animals and personnel should the animals escape or become caught in the process of opening the enclosure.

Primary enclosures must be constructed and maintained so that they contain the nonhuman primates securely and prevent accidental opening of the enclosure, including opening by the animal.

Corrective measures have been implemented by the research staff in consultation with the IACUC including developing a training program for staff involved in the transferring of NHP's using the transport enclosure and frame, adapting the enclosures so that transport enclosures and restraint devices can be more securely used, and checking all enclosures for appropriate locks or other security measures prior to moving animals into enclosures.

On June 17-18, 2015, a focused inspection was conducted with facility representatives and AC VMO, Tracy Thompson, DVM, to review the self-reported incident and to follow-up on citations from the previous inspection.

Exit interview conducted with facility representatives on June 19, 2015.

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