Taylor R. Randall, President,
University of Utah,
Via email: teresa.kehl@utah.edu

7/31/24

President Randall,

I am writing to you today to insist that your office take action to remove University of Utah staff who have clearly violated the Animal Welfare Act, as admitted in two University of Utah reports.. These violations are the subject of a Federal Complaint against the University of Utah which I filed with the United States Department of Agriculture on 7/29/24. That complaint is available here: https://saenonline.org/news-media-news-2024/University-of-Utah-Federal-Complaint-7-29-24.html

Using the Freedom of Information Act I obtained two files in which the University of Utah admits the negligence which caused two deaths. The first report is dated 6/4/24 and reveals the unnecessary death of a dog which should have been prevented:

"The animal was approximately 14 days' post-recovery from the first survival surgery where a lateral thoracotomy procedure was performed. . . . On March 22, 2024, the animal presented in lateral recumbency with significant salivation and regurgitation. The animal received carprofen and buprenorphine prior to euthanasia. Point of care ultrasound revealed moderate to marked free pleural effusion. With a working diagnosis of pyothorax, euthanasia was recommended due to guarded prognosis. On post-mortem examination, a septic effusion (pyothorax) was found within the pleural space. A single surgical gauze was found adhered to the left lateral thoracic wall."

This report admits the negligence of the surgeon who performed the procedure. Any first year vet tech student knows that during surgery, before the incision is closed the gauze sponges are counted. And if there is a discrepancy, a full check is made. Why did it take the death of a dog to cause the University of Utah to put in place what should have been a very basic procedure?

The second report is also dated 6/4/24 and it admits that a monkey died of strangulation while in University of Utah care. The report states: ***"On April 18, 2024, a young adult male rhesus macaque was found dead in his home enclosure. This animal was experimentally naive and in the earliest phase of acclimation to a standard aluminum neck collar placed two weeks prior. The area veterinarian was immediately contacted and examined the case within minutes of the initial notification.***

Veterinary examination confirmed the side yoke of the animal's collar had become attached to a standard metal alloy non-locking (straight) carabineer used to suspend a primate hammock from the ceiling of the enclosure. The cause of death was determined to be asphyxiation secondary to hanging strangulation."

1081-B State Route 28 #280 Milford, OH 45150 513-575-5517 www.SAENonline.org

Both of these incidents were preventable and are clear examples of negligence. This monkey and this dog are dead because University of Utah staff did not take basic actions to prevent these deaths.

If the gauze had been removed from the dog's abdomen, and the device for hanging the hammock had been removed from the enclosure, then neither of these animals would be dead.

The death of the dog following the botched surgical procedure is an indictment not only of the surgeon who left the gauze within the dog's abdomen, but also of the animal care staff who did not diagnose the life threatening infection until it was too late. I find it difficult to believe that an animal passes a physical exam on 3/21/24, apparently showing no signs whatsoever of illness. Yet, on the next day the dog has collapsed, is vomiting and hyper salivating. One would expect that if a prothorax had developed the dog's temperature would have been elevated on 3/21/24. Who performs a physical exam on an animal in the weeks immediately following surgery and doesn't take a temperature?

In any case, the final responsibility for the death of this dog is with the befuddled surgeon who left gauze within the dog's abdomen. This person has shown an amazing level of incompetence, and should never be allowed to perform surgery on an animal again, and should be removed from employment at the University of Utah.

Similarly, the individual responsible for leaving the hammock hanger in the monkey's cage while the animal is being accommodated to wearing a collar, should be terminated as well.

If they are not terminated, the surgeon will likely kill more dogs, and the primate caretaker's carelessness could lead to additional issues such as an escape.

President Randall, the website of the University of Utah claims that the facility is ***"committed to responsible and ethical research and follow rigorous guidelines to meet the highest standards of animal welfare."***

Any University of Utah claim regarding ***"rigorous guidelines"*** or following ***"the highest standards of animal welfare"*** is clearly fallacious. If rigorous guidelines were followed, then a dog wouldn't have died because a forgotten surgical gauze caused a pyothorax. Neither do facilities that follow the ***"highest standards of animal welfare"*** allow monkeys to be hung by the neck until dead.

If the University of Utah wants to maintain any pretense of living up to the lofty statements on the website, then those who are responsible for the deaths of these two animals must be fired.

This level of incompetence must not be tolerated, these bunglers must be fired!

I look forward to hearing from you in the near future about the fate of this facility.

Sincerely,

Michael A. Budkie, A.H.T.,
Executive Director, SAEN

Attachments: 2 University of Utah Noncompliance reports

A3031-1Q

VICE PRESIDENT FOR RESEARCH
THE UNIVERSITY OF UTAH

June 4, 2024

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

To whom it may concern,

Under provision of IV.F.3 of the Animal Welfare Assurance Policy and as the Institutional Official at the University of Utah (U of U), I am providing OLAW with a full explanation of circumstances regarding an adverse event. This was initially reported to OLAW in a preliminary report emailed to the Division of Compliance Oversight on April 15, 2024.

Name of Institution:	University of Utah
Assurance Number:	A3031-01
OLAW Case Number:	A3031-1Q

On April 10, 2024 the IACUC was notified by the principal investigator of an adverse event. Upon discussion with the IACUC chair, vice chair and the attending veterinarian, it was determined that this event would be reviewed at the next convened IACUC meeting to be held on April 24, 2024. In addition, it was determined that a preliminary report would be sent to OLAW to meet the requirement of prompt reporting. The Institutional Official agreed and a preliminary report was sent to OLAW on April 15, 2024 by the IACUC director on behalf of the IACUC chair.

1. Funding agency: *NIH*
2. Animal species: *Canine*
3. Age of animal(s): *1 year*
4. Number of animals involved in the event: *1*
5. Date(s) that the event occurred: *March 22, 2024*

The animal was approximately 14 days' post-recovery from the first survival surgery where a lateral thoracotomy procedure was performed. The animal was receiving gabapentin following the procedure up to March 21, 2024. The veterinary staff performed a physical exam on March 21, 2024, and there was no indication for additional analgesics at that time.

On March 22, 2024, the animal presented in lateral recumbency with significant salivation and regurgitation. The animal received carprofen and buprenorphine prior to euthanasia. Point of care ultrasound revealed moderate to marked free pleural effusion. With a working diagnosis of a pyothorax, euthanasia was recommended due to guarded prognosis. On post-mortem examination, a septic effusion (pyothorax) was found within the pleural space. A single surgical gauze was found adhered to the left lateral thoracic wall.

The IACUC, at a convened meeting on April 24, 2024, discussed the details of the adverse event and the corrective actions provided by the principal investigator. The following corrective actions were taken by the principal investigator:

1. *Sterile surgical towels will be used in place of surgical gauze where possible. The much larger size of the surgical towels will prevent them from being inadvertently left in the surgical site.*
2. *If surgical gauze is needed while the thoracotomy site is opened, a count of surgical gauze entering the field and prior to closure will be conducted.*
3. *We will also order radiopaque sterile surgical gauze which can be imaged with fluoroscopy if the count is found to be incorrect.*

The IACUC agreed with the corrective actions listed above and additionally required that a protocol amendment be submitted to include that any time there is an open cavity, a gauze/towel count will be conducted (body cavity check- count in and count out). The amendment also clarified the use of radiopaque gauze and the potential use of fluoroscopy if counts did not match. The requested amendment was reviewed and subsequently approved by the IACUC on May 17, 2024.

The IACUC reviewed the details and circumstances in which the event occurred and determined that no non-compliance occurred. The principal investigator assured the IACUC that this will not happen again. The IACUC further determined that the following additional institutional actions will be taken to further mitigate future issues:

1. *The IACUC surgery policy will be updated to specifically include the expectation that items will be counted (tools, gauze, towels- count in and count out) when a body cavity is open.*
2. *This expectation will also be messaged during in-person surgery training provided by the veterinary team.*
3. *A "body cavity check" will be included on the standard large animal anesthesia record template.*

The IACUC determined that the adverse event is serious and was an isolated incident. The IACUC agreed with the corrective actions as provided by the principal investigator and described above. The IACUC determined that this will be reported to OLAW and USDA since the work is federally funded. The principal investigator was requested to report this to the agency that is funding this research.

The IACUC director met with the Institutional Official on May 29, 2024. The corrective actions provided by the principal investigator and the IACUC were discussed and determined to be adequate. The University of Utah is committed to protecting the welfare of animals used in research and appreciates the guidance and assistance provided by OLAW in this regard. Thank you for your consideration of this matter.

Sincerely,

(b) (6)

Erin Rothwell, Ph.D.
Vice President for Research
Institutional Official

cc. Regional Director USDA Animal Care Western Region

Associate Vice President for Research Integrity & Compliance

IACUC Chair

IACUC Vice Chair

Attending Veterinarian

U of U IACUC Office Files

A3031-1R

VICE PRESIDENT FOR RESEARCH
THE UNIVERSITY OF UTAH

June 4, 2024

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

To whom it may concern,

Under provision of IV.F.3 of the Animal Welfare Assurance Policy and as the Institutional Official at the University of Utah (U of U), I am providing OLAW with a full explanation of circumstances regarding an adverse event. This was initially reported to OLAW in a preliminary report emailed to the Division of Compliance Oversight on April 23, 2024.

Name of Institution:	University of Utah
Assurance Number:	A3031-01
OLAW Case Number:	A3031-1R

On April 19, 2024 the IACUC was notified by the attending veterinarian of an adverse event. The IACUC chair and vice chair determined that this event would be reviewed at the next convened IACUC meeting to be held on May 22, 2024. In addition, it was determined that a preliminary report would be sent to OLAW to meet the requirement of prompt reporting. The Institutional Official agreed and a preliminary report was sent to OLAW on April 23, 2024 by the IACUC director on behalf of the IACUC chair.

1. Funding agency: *NIH*
2. Animal species: *Rhesus macaque*
3. Age of animal(s): *Young adult*
4. Number of animals involved in the event: *1*
5. Date(s) that the event occurred: *April 18, 2024*

On April 18, 2024, a young adult male rhesus macaque was found dead in his home enclosure. This animal was experimentally naïve and in the earliest phase of acclimation to a standard aluminum neck collar placed two weeks prior. The area veterinarian was immediately contacted and examined the case within minutes of the initial notification.

Veterinary examination confirmed the side yoke of the animal's collar had become attached to a standard metal alloy non-locking (straight) carabineer used to suspend a primate hammock from the ceiling of the enclosure. The cause of death was determined to be asphyxiation secondary to hanging strangulation. Post mortem radiography of the neck region found no evidence of injuries associated with the cervical vertebrae or surrounding soft tissue. Gross abnormalities in this region were limited to skin depression and light focal bruising associated with the tissue that had been in direct contact with the collar. The neck region was otherwise normal (e.g., non-erythematous, non-swollen, free of diffuse hemorrhage/bruising). The remainder of the post-mortem exam was normal.

The IACUC, at a convened meeting on May 22, 2024, discussed the details of the adverse event and the corrective actions provided by the attending veterinarian. The following corrective actions were taken by the attending veterinarian:

1. *All existing and potential new enrichment for nonhuman primates is (already) routinely reviewed and approved by the area veterinarian prior to use. Macaques with collars will no longer be issued suspended enrichment that has the potential to become attached to a collar.*
2. *The area veterinarian will provide appropriate training to animal care staff and research personnel involved in the husbandry, care and experimental procedures involving collared macaques.*

VICE PRESIDENT FOR RESEARCH
THE UNIVERSITY OF UTAH

The IACUC, with input from the veterinary team, discussed and determined that the event represents an unusual case wherein widely used, species-appropriate research equipment (i.e. aluminum collars required for pole and collar training to facilitate awake chaired experiments) and enrichment (hammocks and fastening devices) resulted in the death of an animal.

The IACUC discussed that there are no published reports citing greater rates of injury or death secondary to use of structural or non-structure enrichment with collared versus non-collared animals and that it is not standard for research facilities to make special exemptions or distinguish between various forms of enrichment issued to collared animals. The IACUC discussed the use of locking carabineers. The IACUC determined that because the animals possess opposable thumbs and routinely unlock carabineers with locking features, replacement of 'non-locking' with 'locking' carabineers would not reduce the potential for reoccurrence of this event.

The IACUC determined that the corrective actions are appropriate to prevent recurrence and that this was an unfortunate adverse event that occurred under unusual circumstances (i.e., use of standard species appropriate enrichment). Further, no non-compliance occurred. The IACUC unanimously voted to approve the corrective actions as described above and that this adverse event will be reported to OLAW and USDA since it is federally funded and meets OLAW reporting criteria. The principal investigator was requested to report this to the agency that is funding this research.

The IACUC director met with the Institutional Official on May 29, 2024. The corrective actions provided by the attending veterinarian were discussed and determined to be adequate to prevent reoccurrence. The University of Utah is committed to protecting the welfare of animals used in research and appreciates the guidance and assistance provided by OLAW in this regard. Thank you for your consideration of this matter.

Sincerely,

(b) (6)

Erin Rothwell, Ph.D.
Vice President for Research
Institutional Official

cc. Regional Director USDA Animal Care Western Region

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