Home Office

Report of ASRU Investigation into compliance

Ref: C30(1)

Date published: September 2014

In the 2013 Animals in Science Regulation Unit Annual Report, ASRU set out details of plans to start publishing anonymised reports of substantial investigations upon their completion.

The publication of such investigations may be triggered by a number of factors including, but not limited to:

- an exposé making allegations in the public domain;
- a cluster of non-compliances or 'near misses' triaged by an inspector to ASRU management;
- a non-compliance apparently involving significant animal harm;
- a published paper that appears to describe unjustified pain, suffering or distress; and,
- concern raised by inspectors or others that a particular procedure may not optimally implement the 3Rs.

Such publication would be over and above the reporting of summary details of all cases of non-compliance in the ASRU Annual Report. This has routinely taken place for several years and will continue.

We believe such early publication of these investigations is in the interests of transparency and openness. We believe that this will also help ensure that all stakeholders can learn from the outcomes of these investigations as early as possible and enable them to address any potential weaknesses in their own management systems, creating a cycle of continuous improvement. These reports will also provide the public with an insight into this important aspect of ASRU's work.

Report of ASRU Investigation into compliance

Nature of the incident:

Failure of an air-handling unit resulted in loss of ventilation and temperature control to a building housing rats and mice. There was a delay in contacting engineering staff so that the time taken to resolve the situation was prolonged and the temperature and humidity in the animal rooms increased to unsuitable levels.

Discovery: How was the incident discovered?

The incident was self-reported by telephone by an administrator acting on behalf of the establishment licence holder.

Adverse animal welfare costs: The following unexpected adverse animal health or welfare costs arose as a result of the incident?

On the day of the incident and the 3 days afterwards 787 animals died and 345 animals were culled for welfare reasons.

Immediate action: The following actions were taken to prevent additional animal welfare costs?

Animals whose health or welfare was giving cause for concern were culled.

Faulty parts were replaced the same day. Temporary air-handling units were provided as back-up for this building and another where there had been power failures with no animal welfare consequences. The air-handling units to both these areas have subsequently been replaced with new ones.

A major review of all critical systems is being carried out. Management is considering longer term solutions to overcome the previous shortcomings in investment in facilities and maintenance. Revised call-out procedures were instituted immediately and a fundamental review of how engineering and maintenance duties are provided has been undertaken.

Section(s) of ASPA or of a licence condition considered to be breached:

ASPA	
PEL	Standard conditions 4 (3), 4(4) and 5
PPL	
PIL	

ASRU-I investigation:

VISITS AND INVESTIGATION INTERVIEWS

The Inspectorate carried out seventeen interviews (seven face-to-face and ten by telephone) with thirteen individuals (including the relevant licence holders and named persons) on two days on site and telephone calls on several further days. A meeting of the AWERB was also called to review the situation, listen to staff concerns, and make local recommendations.

For all major issues there was agreement between the accounts of the staff. The salient points from these discussions were:

i. The failures in both areas are believed to have been precipitated by stress on the heating and ventilation (HVAC) systems during an unusually hot period of weather (ambient temperatures rose to >30ºC).
ii. In one area the high external temperatures resulted in more banks of chillers going into operation with overload of the power supply causing a fuse to blow. This happened on three consecutive days. On each occasion the problem was solved without any observable welfare consequences.
iii. The seriousness of the welfare consequences in the other area was almost certainly increased by the delay in contacting an engineer.
iv. After the incident the call-out policy was immediately revised and the guard is now provided with a list of people who may be called for each area. This is updated weekly to accommodate absences.

EVIDENCE OF EACH INCIDENT OF NON-COMPLIANCE

The investigations identified a number of areas where there were shortcomings including:

- call-out procedures;
- facilities, maintenance and investment;
- lack of resilience and contingency plans;
- staffing, training, and the general lack of resources.

It was concluded that Standard conditions 4 (3), 4(4) and 5 of the Establishment Licence (PEL) had been breached.

Standard Condition 4 (3) The PEL holder failed to maintain an environment appropriate for the health and well-being of the animals. As a consequence at least 1,132 rats and mice are known to have died.

Standard Condition 4 (4) The PEL holder failed to provide and maintain installations and equipment suitable for the species. At least 1,132 rats and mice are known to have died as a result of the failure of the installations.

Also, the environmental conditions have been such that they have not assured that the minimum number of animals would be used under project licences and that these animals would experience the minimum degree of pain, suffering, distress and lasting harm. Evidence for this was that, in addition to the deaths, 68 genetically altered mouse pups from 8 litters were missing, assumed cannibalised by their

mothers.

Standard Condition 5 The level of engineering support and the knowledge, familiarity and expertise of the engineering maintenance staff was such that there was a lack of oversight of routine maintenance which contributed to the failures.

There was no evidence that the deaths and suffering which occurred as a result of the failure of the HVAC system were related to animal technician staffing levels.

Considerations for recommendation to the Secretary of State.

- Mitigating circumstances

The incident was self-reported. There has been a detailed local internal investigation and several meetings with key staff involved to improve local practices and prevent similar incidents from occurring. An immediate change was instituted to the call-out procedure. A major review of all critical systems and equipment was initiated immediately and the most senior management have attended site and participated in the investigations. They have pledged that funding will be available to make good any deficiencies and to assure appropriate staffing (or, where appropriate, contractor support) including the necessary expertise for engineering and maintenance. Immediate repairs were effected and subsequently some replacement equipment was installed.

- Compliance history of the people or place

Since 2010 there have been two other non-compliances at this establishment.

- Attitude of the people involved

The incident was promptly self-reported and the establishment kept the Inspectorate informed of the facts through phone calls, e-mails and reports. All parties have been helpful and co-operative throughout the investigation and have expressed regret for what happened. Once the relevant issues were identified the establishment responded very quickly to resolve the immediate situation.

Outcome:

A written reprimand was sent to the Establishment Licence holder and two special conditions were added to the Establishment Licence requiring, within one month, the following actions to be completed and reported to the Home Office:

- a list of measures taken to remedy the immediate issues which caused the failure; and
- an action plan detailing other measures being taken to ensure that all facilities authorised under the Establishment Licence would operate in accordance with ASPA and any associated Home Office Codes of Practice, and would be maintained in such a way that ongoing compliance would be assured.

The action plan was to be prioritised, unequivocal and with clear deadlines. Adherence to it is being monitored during inspections. The Secretary of State also wrote to the Chief Executive Officer of the parent company to reinforce the concerns.