AFFIDAVIT

I, C. JAMES MAHONEY, D.V.M.S., Ph.D., being duly sworn on oath, make the following statement:

1. I make this statement freely without promise of reward to or from anyone. My address is 11 Rea Court, Monroe, New York.

2. My name is C. James Mahoney. I earned my veterinary medical degree from Glasgow University in 1965, a Master of Science degree from the University of Wales in 1967 and obtained my Ph.D. in Physiology from London University in 1972. For over 35 years I have provided clinical veterinary care to nonhuman primates, starting my career at the primate colony of the Royal College of Surgeons of England, in London, in 1967. I completed my postdoctoral fellowship at the federal Oregon Regional Primate Research Center from 1972 to 1973, and directed a research unit at the federal Wisconsin Regional Primate Research Center from 1973 to 1977. For 20 years, from 1977 to 1997, I was senior veterinarian at the Laboratory for Experimental Medicine and Surgery in Primates (LEMSIP), which was affiliated with New York University until it closed in December 1997. I have been on the faculty of New York University School of Medicine since 1977, becoming full professor in 1992. Currently I provide clinical care, consultations and psychological enrichment guidance to various sanctuaries throughout the United States, Europe and Africa that have chimpanzees (many of whom were involved in biomedical research) and other nonhuman primates as president of the Sanctuary Support Program.

3. I have authored or co-authored over 30 papers that have been published in peer-reviewed scientific journals, as well as medical book chapters and scientific conference abstracts. For over 20 years, I served as a peer reviewer for the scientific publication *Journal of Medical Primatology*. For approximately four years, I served as a peer reviewer for the scientific publication *American Journal of Primatology*.

4. During my tenure at LEMSIP, I was directly responsible for the clinical care of over 200 chimpanzees and 300 monkeys involved in biomedical research. My responsibilities included all aspects of clinical care, from routine physicals to performing emergency surgery on chimpanzees. I was also LEMSIP's Deputy Director for three years, and its Acting Director for two years. Consequently, in addition to my extensive clinical experience, I also have experience operating a large chimpanzee facility.

5. I have been asked by In Defense of Animals (IDA) to comment on alleged circumstances surrounding the deaths of two chimpanzees, Rex (identification number CA0147, date of birth September 7, 1986) and Ashley (identification number 1396, date of birth July 9, 1986). Rex died on December 30, 2002; Ashley died on September 16, 2002. These deaths occurred at the Alamogordo Primate Facility (APF), a chimpanzee holding facility operated by Charles River Laboratories under contract with the National Institutes of Health (NIH). The APF is located on Holloman Air Force Base in New Mexico, at the facilities previously operated by the Coulston Foundation (TCF). The NIH contracted with Charles River after the NIH took ownership of 288 chimpanzees from TCF.

6. At least 36 of the 288 chimpanzees transferred from TCF to NIH ownership originated from LEMSIP. I personally oversaw the transfer of 99 chimpanzees from LEMSIP to TCF in 1996 through 1997.

7. Before commenting on the alleged circumstances surrounding the deaths of Rex and Ashley, I must make clear this caveat: I have no way to independently verify the information provided me by IDA. I must also emphasize that all of my comments and opinions must be read in the context of this caveat. For the purposes of this affidavit, I am assuming that the Charles River APF documents I have been provided – e.g., necropsy reports, histopathology reports, clinical records, etc. – are true and correct copies.

OVERVIEW

8. Both Rex and Ashley demonstrated clear clinical signs of severe medical problems before they died. Despite this, in both instances, Charles River APF animal care personnel (i.e., veterinarians and caretakers) made the conscious and deliberate decision to abandon the chimpanzees and depart the facility, leaving Rex and Ashley in the hands of night security guards who had absolutely no training, background or experience in any aspect of animal care. In both cases, animal care staff recognized the gravity of Rex's and Ashley's conditions by ordering security to double the frequency of monitoring, and to report any changes to the on-call veterinarian. In Rex's case, the veterinarian caring for him, according to the information given me, was actually heard to state that she had been told, presumably by senior staff, that she and the caregiver could not stay beyond their workshifts and continue to provide Rex with care, because that was now the responsibility of Charles River APF security personnel.

9. Rex, who was 16 years old, had been ill for three months and had lost almost 19 percent of weight. He had failed to wake up from anesthesia for physical examination the day *prior* to, and on the day of, his death. This fact alone indicated the severity of his condition. Animal care staff described his status as a "death watch." He repeatedly vomited the day he died, and animal care staff stayed in his cage and manually removed the vomit from his mouth with a vacuum suction device. Charles River APF made the willful decision to actually remove this life-supporting care and have animal care staff leave the facility, despite Rex's grave condition, and despite the possibility that he could have awakened. If Rex awakened, it is quite possible that he could have choked on his own vomit; if that occurred, the night security guard, even if he discovered Rex before asphyxiation, could not have provided the chimpanzee with any care. Given Rex's grave condition, it is also possible if not likely that he was given other life support measures, such as oxygen and/or an indwelling intravenous (IV) catheter, both of which are standard and universally accepted veterinary procedures in such dire cases. Such measures would have had to be removed once the animal care staff departed, since the night security guard had no training in such life support. There appears to be no indication that euthanasia was discussed, despite Rex's "death watch" status and failure to awaken from the previous day's anesthesia. Night security, who had been told to double the normal observation schedule by the veterinarian caring for Rex, found him dead several hours after animal care staff departed the facility. The Charles River APF necropsy report showed the presence of vomit in his mouth and trachea when he died.

10. Ashley, also 16 years old, had been attacked from all sides by all 11 of her adult cage mates in a cage that, according to the U.S. Department of Agriculture (USDA), should contain a maximum of only 6 adult chimpanzees. During the attack she sustained a bite wound to her perineal sexskin that bled continuously throughout the day. Ashley suffered from a pre-existing condition called thrombocytopenia (abnormally low platelet count) which, according to the Charles River APF Clinical Notes, could have caused Ashley to clot "very, very slowly," with anemia as a possible outcome. In the afternoon, during one five-minute period of observation, Ashley was seen to be first standing on her head, then shaking violently and continuously (most likely from shock, I would presume). Despite knowing the trauma she had suffered, her pre-existing blood condition, and her obvious clinical symptoms, Charles River APF made the willful decision to have animal care personnel abandon Ashley and leave the facility. Night security, who had been told by the veterinarian caring for her to double the normal frequency of observation, found Ashley dead several hours after animal care staff departed the facility. The Charles River APF pathology report indicates trauma as the apparent cause of death, and also provides evidence – sizable petechiae throughout the small intestine – consistent with shock. There is no indication that Charles River APF measured how much Ashley bled during the day, despite thrombocytopenia's known association with abnormal bleeding, and the fact that Ashley had been previously treated for abnormally excessive bleeding during her menstrual cycles.

11. If this information is true, I find the circumstances in both cases almost beyond words. It is incomprehensible to me how anyone, let alone animal care professionals, could leave chimpanzees in such obvious medical distress in the hands of night security guards who had not even basic training, background or any experience in animal care. That both chimpanzees died only hours after Charles River APF made the conscious, willful decision to abandon Rex and Ashley to the wholly unfit night security guards only reinforces my professional and personal outrage. That Charles River APF left a bleeding, traumatized, violently shaking chimpanzee who was exhibiting signs of shock and an unconscious, vomiting chimpanzee who had been sick for three months in the hands of an untrained night security guard is simply unconscionable. As a former chimpanzee facility director, I can attest to the fact that basic standards of animal care are not only a moral obligation but also a legal requirement. That Charles River APF made the conscious, willful decision to actually withdraw life-supporting care, in the form of vomit removal, is shocking to me. *Rex was found dead with vomit in his mouth and trachea.* Even more shocking to me is the allegation that the Charles River APF senior staff prevented animal care staff from continuing to care for Rex because that was to be night security's responsibility.

12. The two cases involving Ashley and Rex indicate a fundamentally twisted attitude on the part of the senior staff of Charles River APF towards the most basic care and needs of animals. Their consciously determined and deliberate actions show a singular lack of compassion, are profoundly offensive to me as a veterinary clinician and a human being, and in my opinion violate the most basic precepts of veterinary standards and simple human decency. Although many of the details surrounding Rex's and Ashley's deaths are profoundly troubling to me, they are almost inconsequential compared to the incomprehensible and willful Charles River APF *policy* of leaving these chimpanzees, who were totally helpless and dependent on the staff for basic care and sustenance, in the hands of a night security guard. I believe that the element of intent – of making conscious, deliberate decisions to abandon these gravely sick and injured chimpanzees – moves these cases far beyond negligence into the realm of willful cruelty.

MORE DETAILED DESCRIPTIONS AND COMMENTS

13. The following descriptions and comments are based on copies of various Charles River APF records (i.e., clinical notes, necropsy reports, etc.) and verbal descriptions supplied to me by IDA.

CASE OF ASHLEY

14. On September 16, 2002, Ashley, a sixteen-year-old female, part of a social group containing 12 adult chimpanzees, was attacked by her cage mates and received a bite wound on her perineal sexskin. In a Clinical Diagnostic Summary, dated September 17, 2002, Ashley was described as having been attacked *from all sides* by her 11 cage mates. Clinical signs noted were, "Delayed clotting time: Blood loss – about 1 drop per minute. Had formed a sizable clot antemortem over the sex skin laceration. . . ." The time of this observation was not noted.

15. It is significant that the History section of the Gross Necropsy Report further describes the attack on Ashley as having occurred "while suspended in a cargo net."

16. Ashley was removed from the social group and housed alone in a treatment cage. It was alleged that she continued to bleed throughout the day. After several hours of bleeding, she appeared to be in a weakened condition, and was observed sitting somewhat backward in the cage, her side leaning against the cage wall. A large amount of blood had collected beneath her and was spread over the internal surfaces of the cage. Subsequently, while still bleeding from the bite wound, Ashley was seen during one 5-minute period of observation to be first standing on her head, then shaking in a continuous and violent manner.

17. However, continued observation of Ashley was subsequently handed over to a night security guard, who had received no training in animal care. The security guard was instructed to double the frequency of monitoring rounds from every two hours to hourly intervals, and report by telephone to the on-call veterinarian any change in Ashley's condition. The security guard found Ashley dead in her cage some hours later (6:10 P.M., according to the official records).

18. The Charles River APF records provided to me give no indication that any attempt was made to clinically determine the extent of Ashley's hemorrhage. If that is the case, it would be extremely troubling, for at least two reasons. The first is that Ashley had thrombocytopenia that made excessive bleeding more likely, and clotting more difficult. The Clinical Notes written by veterinarian Dr. Kelly Avila state, "Because of the lack of platelets, Ashley may clot *very, very* slowly. Anemia is a possible outcome" (my emphasis added). The second reason is that the Charles River APF records indicate a specific amount of blood loss. If there had been no attempt to determine clinically such loss, then the amount specified in the Charles River APF records would have no scientific validity. The amount specified – which is extremely small – could consequently mask the actual extent of the hemorrhage.

19. One method for clinically determining the extent of Ashley's hemorrhage could have included collecting extravasated blood on absorbent paper sheets or gauze material, then weighing the

material for an estimate of the hemorrhage. This is a common method of determination employed in human hospitals and emergency clinics.

20. There is also no indication from the records I have been provided that Ashley was examined under tranquilization to determine, by blood sample, how much blood she had lost, and whether she might require intravenous blood transfusion or administration of a blood plasma expander or replacement electrolyte solution. Again, this failure, if true, would be disturbing in light of her pre-existing thrombocytopenia.

21. There is also no indication whether any action, treatment or diagnosis was undertaken on the basis of the observation of Ashley's standing on her head, or her continued and violent shaking over at least a five-minute period (most bizarre and profoundly troubling behaviors for a chimpanzee). Such behaviors should have been cause for serious alarm and action, especially taking into account the circumstances known to the animal care staff surrounding Ashley's condition. The shaking (or tremors) could very well have been a sign of shock relating to the physical trauma of having been beaten. Other possibilities include the result of severe blood loss and hypovolemia (extreme fall in circulating blood volume and blood pressure).

22. However, the sizable petechiae noted at necropsy examination throughout the small intestine suggest that Ashley was in a state of shock. A handwritten note attached after the typed Necropsy Report, indicating that 25 ml of pericardial fluid was collected, supports this shock reaction hypothesis. "Trauma" was noted on the Problem List, and in the concluding remarks, the Histopathology Report states, "This chimpanzee apparently died of trauma after being attacked by its cagemates."

23. However, many of these questions and details, disturbing as they are to a clinician like myself, pale in comparison to the shocking allegation that this bleeding, traumatized, beaten and violently shaking chimpanzee was handed off to a night security guard completely untrained in any aspect of animal care. That this same security guard was instructed to double the frequency of observation of Ashley, from two-hour intervals to hourly, and report by telephone any untoward findings to the veterinarian on call, was a sure indication that the Charles River APF animal care staff clearly knew that Ashley's condition was of serious concern and required close monitoring. Incredibly, this recognition did not prevent the animal care staff from abandoning Ashley and departing the facility.

OVERCROWDING

24. The Charles River APF records indicate that Ashley was housed in a social group of 12 adult chimpanzees in an indoor den measuring 15 feet by 11 feet (165 square feet), which communicated with an outdoor run of 242 square feet. Hers was one of three such social groups containing 11 or 12 adult chimpanzees in total. In a memorandum dated March 29, 2000, when the chimpanzee colony was still under the control of the Coulston Foundation, the USDA determined that such dens could "hold a maximum of 6 chimpanzees *unless there are mothers with infants (one such den*" they noted, *"has 11 chimpanzees.)"* (my emphasis added)

25. A group of 12 adult chimpanzees would therefore constitute a condition of overcrowding in the eyes of the USDA, made only worse when the animals would have to be confined to the indoor area during inclement weather or to either the indoor or outdoor areas during daily cleaning procedures of either section (in order to give cleaning personnel safe access to the areas). In my long experience of working with chimpanzees, I can attest to the dangers of overcrowding and the resulting fights it often promotes, even if for only the briefest periods (which sometimes can be measured in just seconds. A bite wound takes only an instant to inflict). I have no information to indicate whether this overcrowding contributed to Ashley's bite injury, but my long experience with chimpanzees prompts me to state that such overcrowding would have made Ashley's severe beating at the hands of her cage mates far more likely.

26. The History section of the Gross Necropsy Report states that Ashley "was attacked by her 11 cagemates while suspended in a cargo net," a device often used as an exercise surface and even as a sleeping platform. This description evokes the disturbing picture of a chimpanzee helplessly "cornered" on a suspended, swaying, woven surface, from which she would not easily be able to get off, surrounded *from all sides* by her 11 cage mates. The physiological effects from this physical beating could easily have surpassed the effects of the bite wound itself. Chimpanzees, especially in gang-fight situations, tend to pound the hapless victim who is the center of their attention repeatedly with the backs of their wrists. It is this trauma to the underlying muscle and subcutaneous tissues that causes the onset of shock. It is also important to understand that chimpanzees are inordinately powerful.

27. Regardless of whether Ashley's bite wound and beating were the result of overcrowding of animals in the social group; whether adequate monitoring was performed to determine her state of anemia or possible hypovolemic shock; and irrespective of what postmortem or histology findings might have shown regarding her severe condition and eventual death, the central and defining point is that Ashley, with a known severe medical condition that made clotting much more difficult, who had also been physically attacked, bitten and traumatized by her cage partners, *was intentionally left in the sole care of a person wholly untrained in animal care* (a night security guard). In my opinion, this constitutes nothing less than gross and intentional negligence ("intentional" in that a conscious decision was made to do so) and outright cruelty on the part of the management of Charles River APF. This violates the basic precepts of the veterinary medical profession – of which I am a proud member – as well as the basic precepts of humane care and human decency.

CASE OF REX

28. Rex, a 16-year-old adult male chimpanzee, was apparently known to be suffering from severe liver and/or kidney failure. He was unconscious, having failed to wake up from anesthesia for a physical examination the previous day, and vomiting continuously. He had lost almost 19 percent of his body weight in the previous three months. He did not eat during the two days prior to his death. The Charles River APF records state, "Physical on day before death revealed icterus, liver mass and enlarged kidneys."

29. No laboratory clinical data, apart from bacteriological results obtained from liver, kidney and lung tissues, have been supplied to me, such as hematology or serum chemistry results, nor any

official description of how Rex's case was handled clinically. Charles River APF necropsy findings indicate that Rex was severely ill from a widespread septicemia.

30. Apparently, an animal caretaker or technician stayed in the cage with the unconscious Rex throughout much of the day on which he died, frequently removing vomit from his mouth and throat with the aid of a suction-pump machine. It appears that the caretaker stayed with Rex continuously, and did not leave the cage after each occasion of aspirating the vomit. Also, the situation was described to animal care personnel as "a death watch," since Rex was expected to die.

31. I have been unable to determine whether any other type of life support was provided Rex, apart from the aspiration of vomit from his mouth and trachea. I strongly suspect, however, that Rex would have been provided other types of life support, such as oxygen and/or an indwelling intravenous (IV) catheter to enable infusion of electrolyte solutions. It may well be that oxygen therapy through a nasal tube was also provided because of his history of vomiting, which would likely have interfered with his normal breathing. These are standard and universally accepted veterinary procedures in such dire cases.

32. The IV would be intended not only to give life support, but also would provide a rapid and easy access to Rex's bloodstream to administer emergency drugs, such as cardiac or respiratory stimulants, in the event Rex suffered cardiac or respiratory arrest or depression. Just as importantly, the IV would have enabled the administration of an overdose of barbiturates if animal care staff had decided to humanely kill (euthanize) Rex.

33. If my assumption is correct that additional life support measures were utilized, other than just mechanical removal of vomitus from his mouth and trachea, these measures also would have *had* to be removed from Rex once the animal care staff departed for the night. This is because Rex was left in the hands of a night security guard totally untrained in any aspect of animal care, including the management of life-support procedures.

34. Just as with Ashley, regular, trained animal care staff left the premises in the late afternoon, handing over the observation of Rex to a night security guard who was completely untrained in the care of animals, healthy or otherwise. *However, the veterinarian caring for him, Dr. Avila, was actually heard stating that she had been told (presumably by senior Charles River APF staff) that she and the caretaker could not stay beyond their workshifts and continue to provide Rex with care because that was now the responsibility of the security guard.*

35. This allegation alone, if true, would in my opinion prove beyond any doubt that Charles River APF committed willful and unconscionable cruelty against the unconscious, totally dependent Rex.

36. Just as with Ashley, the security guard was instructed to double the frequency of periodic observation to every hour and report by telephone any adverse findings to the veterinarian on call. This is clear indication that Rex's condition was considered dire by the animal care staff – who nevertheless left the facility after allegedly being prevented from staying with Rex by the Charles River APF senior staff. It must be emphasized that Rex apparently never recovered

from anesthesia given to him for his physical examination the previous day. This, alone, indicates that he was in a serious medical condition. He may have awakened in the intervals between the night guard's hourly rounds, but we will never know.

37. It is important to note that the security guard was not instructed to sit in the cage with Rex but simply to observe him hourly. Consequently, there was no way for regurgitated stomach contents to be removed from Rex's mouth and throat if he continued to vomit.

38. In other words, at least one important form of life support was consciously, intentionally and deliberately removed from Rex. Vomitus was, in fact, found in Rex's mouth and trachea (the main "wind pipe" of the respiratory system) at necropsy examination. If, as I suspect, Rex had been provided other life support, such as oxygen and/or IV infusion – normal provisions given such severely ill animals – these, too would have had to be removed by the trained animal care staff before they departed the facility. The nighttime security guard, the sole guardian remaining, was not trained to administer such treatment, or any treatment for that matter.

39. This decision by Charles River APF constituted not negligence or thoughtless oversight, but a heinous and deliberate abdication of responsibility. I am especially outraged, as a veterinary professional and as a human being, if it is true that the Charles River APF senior staff actually ordered animal care staff not to stay and instead to remove life support measures and abandon Rex to an untrained security guard.

40. There is no way to determine whether Rex might have regained consciousness, even if only for a brief moment, simply because no human being was constantly in attendance to him. This is extremely important. No consideration seems to have been given by Charles River APF to the possibility that if he did regain consciousness, he could regurgitate stomach contents, which would cause him to choke to death or die from asphyxiation. This would, in my opinion, constitute extreme cruelty. It was also a very real possibility given his repeated vomiting. According to the Necropsy Report, Rex's mouth and trachea did contain ingesta at the time of his death. Rex could have indeed suffered this almost unimaginable cruelty, since he was abandoned by the animal care staff, and was monitored only once per hour by the night security guard. What is certain, however, is that leaving Rex so unguarded and uncared for while he was in such extremis was absolutely unconscionable, and violated the most basic precepts of acceptable, humane and compassionate care, let alone basic human decency.

41. The trained animal care staff of Charles River APF had three options by the time the working day was drawing to a close: (1) They could stay and continue to give Rex life support until he either recovered or died; (2) They could humanely euthanize him, if his condition seemed hopeless; or (3) They could go home, leaving him to possibly die, perhaps even an unpleasant, cruel death, in the hands of an untrained security guard. If the information provided to me is true, it is clear what option Charles River APF chose.

42. As with Ashley, the medical details surrounding Rex's condition, though important, are almost inconsequential compared to the central and defining point that Rex, who had been sick for three months, had failed to wake up from anesthesia the previous day, and was unconscious and vomiting, *was nevertheless intentionally left in the sole care of a person wholly untrained in*

animal care (a night security guard). To make matters even more heinous, Charles River APF actually removed life support measures while senior staff allegedly prevented animal care staff from staying with the Rex beyond their workshifts with the unbelievably callous and cold-blooded remark that Rex was now security's responsibility. In my opinion, this constitutes gross and intentional negligence as well as incontrovertible and willful cruelty.

SUMMATION

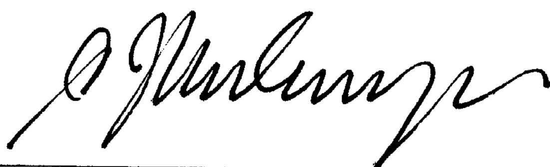
43. The two cases involving Ashley and Rex indicate a fundamentally twisted and despicable attitude on the part of the senior staff of Charles River APF towards the most basic care and needs of animals.

44. Although many of the medical details surrounding Rex's and Ashley's deaths are profoundly troubling to me, they are almost inconsequential compared to the incomprehensible and willful policy displayed by Charles River APF of leaving these chimpanzees in the hands of a night security guard.

45. If these allegations are true, then Charles River APF has committed willful, deliberate and despicable cruelty on chimpanzees in extremis who were totally dependent on them for the most basic care and sustenance.

I have read this statement and declare under oath, pursuant to 28 U.S.C. Section 1746 and under penalty of perjury, that the foregoing statement is true and correct to the best of my knowledge.

Executed this 11th day of July, 2003



C. James Mahoney, D.V.M.S., Ph.D.