

BU Agent Incident Reporting Summary March to June 2020

**CAMPUS	Date of Incident	Incident Type/Agent Involved	BSL	Transmissible Person to Person	Description	*Reportable Incident	Report of Clinical Illness	Agency Reported To	Comments/Corrective Actions
BU Medical Campus (BUMC)									
BUMC	4/29/20	Drop of Phenol Chloroform to left wrist	BSL2		ROHP received a telephone call at 7:45 am that a right hand dominant Research Study Technician working on the medical campus in ABSL2 sustained a drop of Phenol Chloroform on her left wrist while pipetting this morning around 7:30 am.	No		N/A	EHS conducted a phone interview with the researcher to follow up and corroborates with the initial ROHP report. The researcher had rolled up her lab coat sleeves prior to pipetting 500 micro liters of phenol chloroform into eppendorf tubes for a DNA extraction, when she noticed a sting and a small red spot on her left wrist. She washed the affected area for more than 15 minutes and reported the incident to ROHP for further medical evaluation. At the time of the incident she was wearing one pair of gloves and a lab coat that had rolled up sleeves while working inside a chemical fume hood. The researcher confirmed with EHS that there were no other biological or hazardous agents involved (the pipette had not been exposed to mouse tails in the eppendorf tubes). The skin was intact with no blistering. The root cause was attributed to lack of PPE and not being conscientious. EHS reminded the researcher to always wear a lab coat when working with hazardous chemicals per the lab's Chemical Hygiene Plan and door placard signage. Rolling up sleeves was strongly discouraged.
BUMC	5/7/20	Mouse bite to right 2nd finger	ABSL2		On 5/7/20, a veterinary technician presented at ROHP with a mouse bite which had occurred 10 minutes earlier. While transferring a mouse to a location where it was to be euthanized, (holding it by its tail), the mouse turned and bit her on her right 2nd finger through her single gloved hand. The mouse was a BSL1 breeding mouse and had not been exposed to biological hazards or to toxins. This occurred in the barrier area, 670 Albany, 8th floor. The mouse was not harmed during this incident.	Yes		BPHC	EHS conducted a phone interview with the employee and corroborates with the initial ROHP report. The employee confirmed the accidental bite occurred during a routine transfer. The BSL1 breeding mouse was reported to have no hazardous agents and was directly purchased from an outside vendor. The root cause was assigned as "Other", as the mouse itself was the attributing factor. The employee is highly experienced and had completed all appropriate trainings and followed through appropriately with notifying ROHP of the incident.
BUMC	6/4/20	Mouse bite to tip of left thumb	ABSL1		An animal care technician was bitten by a mouse early this morning. While working in the barrier facility, and while removing a BSL1 breeding mouse from its housing in order to perform a health check, the mouse bit the ACT on the tip of his left thumb. The ACT was wearing a single pair of gloves at the time. The ACT returned the mouse to its housing and scrubbed the wound for 15 minutes. The mouse was not harmed as a result of the incident. The mouse had not been exposed to hazardous biological material.	Yes		BPHC	EHS conducted a phone interview with the employee and corroborates with the initial ROHP report. At the time of the incident, the PPE was appropriate. This mouse was directly purchased through an outside vendor and did not contain any hazardous agents. The employee reported that the bite was likely attributed to this particular mouse being an aggressor, therefore the root cause was assigned as "Other". The employee washed the affected area appropriately and notified ROHP and has over one year of animal handling work experience at BU.

BUMC	6/16/20	Percutaneous exposure to left 5th finger	ABSL1		<p>An animal science staff manager called ROHP at 2:10 pm today to report a researcher accidentally stuck his finger with a needle containing a CCL3 agent, Tamoxifen and was used on a ABSL1 transgenic mouse. There was no injection of Tamoxifen.</p> <p>The right hand dominant Research Assistant while wearing two pairs of gloves, sleeve covers, a coverall suit and N95 working with a fume hood, accidentally stuck his left 5th fingers as he attempted to give an intraperitoneal injection of Tamoxifen (he had .5ml in the syringe at the time) to a SMPD3/ CX3CricreER transgenic mouse. The researcher confirmed there were no biological agents, viruses or bacteria involved with this mouse. He reports the mouse kicked the needle causing it to prick his finger through the gloves.</p> <p>This researcher irrigated the site for 15 minutes, was evaluated and counseled in ROHP. His Tdap vaccination is up to date.</p> <p>A report will be sent to BPHC.</p>	Yes		BPHC	<p>EHS followed up with the researcher and ASC manager independently and corroborates with the initial ROHP report. Two commercially purchased transgenic mouse lines were crossed to generate a new breed of mice. These mice were not subjected to rDNA or other biological hazardous agents exogenously. Also, this transgene was reported by the PI to have little to no risk to humans. No transduced cells were added to the animal prior to the accidental needlestick. In speaking with the researcher, he reported that he was fairly new to procedurally injecting mice with substances and was referred to the animal trainer for additional support. The root cause was attributed to insufficient skills or expertise. EHS provided the hyperlink to the sharps safety training on BioRAFT and asked the researcher to complete this course. In addition, he followed up with the animal trainer to review techniques for injecting materials into rodents. It was advisable that these skills become proficient prior to administering hazardous agents like tamoxifen.</p>
Charles River Campus (CRC)									
None									
National Emerging Infectious Disease Laboratory (NEIDL)									
NEIDL	6/8/20	Head trauma with scalp laceration	Mechanical room		<p>A facilities research support staff reports he turned quickly and accidentally hit his head on a low lying pipe in the mechanical room around 2:05 pm. No biologics were involved with this incident. This staff did not lose consciousness but did sustain a 3/8" scalp laceration, was seen in ROHP. ROHP will follow up with this research support staff 6/9/20 and again 6/10/20.</p>	Yes		OSHA	<p>EHS followed up with this employee to discuss the incident. He reported he had bumped his head on some overhead piping in the 3rd floor mechanical space near the air compressors and received a head laceration that required immediate attention. ROHP assessed the wound and then advised on going to the BMC emergency room. At the emergency room, the employee received four staples. Additional follow up was scheduled with the ROHP office. The incident was attributed to lack of PPE. This person and the NEIDL Facilities department have been educated on the PPE requirements for this space (bump cap) and will follow this requirement going forward.</p>
Other - Collaborating Laboratory		No incidents							

* Indicates if incident is reportable to local, state or federal agency (e.g. Centers for Disease Control, National Institutes of Health, Boston Public Health Commission, etc.)

** Campus Location

BUMC - Boston University Medical Center

CRC - Charles River Campus

NEIDL - National Emerging Infectious Disease Laboratories

Other - work done at collaborating laboratories