

BU Agent Incident Reporting Summary July to September 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	7/1/20	Transgenic rat bites to right wrist and left index finger	ABSL1		A project manager called ROHP at 2:00 pm to report she was bitten by a rat a couple of times around 1:30 pm today. This was a transgenic ABSL1 male rat (transgenic rat model of Alzheimer's disease (TgF344-AD) that over expresses amyloid beta with plaques of Alzheimer's but did not contain any other biological, toxin or chemical agents.	Yes		BPHC	It was confirmed by the researcher that there is no inducible promoter responsible for gene expression and the rat was commercially sourced. No other hazardous materials/ rDNA were introduced to the rat at BU. The root cause was attributed to not being conscientious. The researcher suggested that the rat could have been acclimated by handling more prior to performing the ear punch checks done by the laboratory. This procedure was suggested as a follow up in the future to prevent recurrence.
BUMC	7/8/20	Non transgenic rate bite with no hazardous agents to left middle finger	ABSL1		A Vet tech for the animal science center was bitten by a rat this morning at 9:15 am.	Yes		BPHC	EHS corroborates with the ROHP report from the follow up consultation with the vet tech's manager. He confirmed the rat was not transgenic and did not contain any chemical, biological or other toxic agents. The root cause was attributed to not being conscientious. To prevent recurrence in the future, additional animal handling training was coordinated with the vet tech and animal trainer and included means for assessing the health concerns of these animals. Also, the vet tech was advised to wear an additional pair of heavy duty reinforced gloves in between the 2 layers of nitrile gloves when handling the rats.
BUMC	8/17/20	Two mouse bites over right middle finger knuckle	ABSL1		An animal science trainer called ROHP today at 11:45 am to report a research assistant was accidentally bitten on his right middle finger while being trained on mouse restraints. The researcher was called and reported that he was actually bitten twice.	Yes		BPHC	EHS conducted a phone interview with the researcher and corroborates with the ROHP report. The PPE, hand washing and reporting to ROHP were all appropriate. This mouse was from a ABSL1 laboratory, was non transgenic and did not contain any hazardous agents. The root cause was attributed to insufficient skills or expertise. The research assistant is up to date with all the required online trainings and for proficiency will be retrained in mouse handling by the BUASC animal trainer.
BUMC	8/17/20	Splash drop of perfluorooctanoic acid to face	N/A		A researcher called ROHP at 1:05 pm to report she sustained an exposure to perfluorooctanoic acid (PFOA) C8HFO earlier in the morning around 10:15 am today.	No		N/A	While making a diluted solution of perfluorooctanoic acid, a drop splashed out of the container and onto the researcher's left upper cheek. With EHS follow up, the researcher mentioned she was rushing to get the work done and wasn't mindful at the time of the needed PPE and was not using a fume hood. The root cause was attributed to lack of PPE and inadequate procedure. EHS consulted with the researcher and advised the lab to establish an SOP for preparing these kinds of solutions, and when working with a chemical to use a fume hood and wear eye and face protection.

BUMC	9/22/20	Low risk blood borne pathogen/chemical exposure to left eye	BSL2		ROHP received an email from a BU medical student on 9/22/20 reporting he sustained a splash to his left eye on 9/21/20 at 2:30 pm. The student was in touch with both ROHP and BU Student Health on 9/22/20 and followed up at ROHP today for further examination and counseling.	Yes		BPHC	EHS followed up with the student who described that he was trying to open a microcentrifuge tube with some force and when it opened a few droplets of a reaction mixture splashed into his left eye. The work did not involve cloning or any plasmid which could have replicated in a living system. The root cause was lack of PPE. EHS advised the student to wear safety eye protection and reviewed procedures for reporting incidents.
Charles River Campus (CRC)									
CRC	7/16/20	Right eye exposure to green laser beam	N/A		A Postdoctoral Associate called ROHP on 7/16/20 at 5:35 pm to report he felt an uncomfortable feeling in his right eye yesterday afternoon (7/16/20) around 4:00 pm. He looked around the room and noticed two other staff in the same room doing a separate experiment using a laser. (They were using a digital micromirror device, which has diffraction effects). The on call MD spoke with this scientist who reported the only symptom was a teary eye. No headache, scotoma, could read with other eye closed, no floaters.	No		N/A	The laser system was shut down immediately and the incident was also reported to the building manager. The root cause was attributed to no procedure/inadequate procedure and lack of PPE. Laser Safety staff conducted a complete inspection of all laser setups with PI present. Researchers will submit an SOP for the new laser. Researchers will wear appropriate PPE, and will use barriers to separate laser setups in the same room, and will enclose beams and diffracted light whenever possible. PI will verify that laser inventory in BioRAFT is accurate, and will ensure that all new laser acquisitions are reported to the Laser Safety Officer. The PI and all researchers involved are retaking Laser Safety Training via BioRAFT and additional laser safety inspections will be conducted going forward.
CRC	9/28/20	Drop of dichloromethane to gloved right index finger	N/A		ROHP received a call on 9/28/20 from an undergraduate student at 7:10 pm reporting a drop of liquid dichloromethane, an organic solvent got on the glove of a student's left index finger while in a teaching lab. The on call physician spoke with the student who reported the finger was itchy with mild discoloration. Symptoms subsided after washing. The student was counseled to seek medical attention if symptoms worsened and to follow up with ROHP this morning.	No		N/A	EHS followed up with the undergraduate student who confirmed she was working in a fume hood using a pipette to transfer dichloromethane when she sustained a drop on her gloved hand. The root cause was attributed to insufficient skills or expertise. EHS discussed the procedure and recommended the student to position the receiving container very close to the original container when transferring liquids using a pipette.
CRC	9/30/20	Clean needle stick to right middle finger	N/A		A teaching fellow called ROHP at 2:00 pm to report an undergraduate student in an organic teaching lab while wearing one pair of gloves was preparing to draw up a liquid compound when he accidentally stuck the tip of his right middle finger with a clean needle as he removed the cap around 1:50 pm. The student reports the needle was clean and did not yet contain any chemicals or other agents.	No		N/A	EHS conducted a follow up phone interview with the undergraduate student. The student reported it was his first time using a needle and syringe. He verified the needle was clean and had accidentally received a needlestick while removing the needle from the sheath. The root cause was attributed to individual untrained. EHS recommended to avoid using force when unsheathing a needle in the future and suggested the student complete the online Sharps Safety Training in BioRAFT.

National Emerging Infectious Disease Laboratory (NEIDL)									
		No incidents							
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