

BU Agent Incident Reporting Summary October to December 2020

**CAMPUS	Date of	Incident Type/Agent Involved	BSL	Transmissible Person to Person	Description	Reportable Incident	Report of Clinical Illness	Agency	Comments/Corrective Actions
BU Medical Campus (BUMC)									
BUMC	11/12/20	Mouse bite to right 3rd finger	ABSL-2		At 10:30 am the trainer at BUASC, called to report that a master's student had a mouse bite at 10:20 am during a training session in a BSL1 setting.	Yes		BPHC	EHS conducted a phone interview with the graduate student. Root cause was attributed to insufficient skills or expertise. The student completed additional sessions with the animal trainer to reaffirm good animal handling and restraint techniques.
BUMC	11/27/20	Mouse bite to left index finger	ABSL-1		A vet tech called ROHP on 11/27/20 to report her coworker was bitten by a mouse at 8:00 am in a ABSL1 facility.	Yes		BPHC	EHS conducted a phone interview with the employee. Root cause was attributed to insufficient skills or expertise. The employee completed additional sessions with the animal trainer to reaffirm good animal handling and restraint techniques.
BUMC	12/7/20	Needlestick to left index finger with needle used to inject cyclophosphamide into non-transgenic mouse	ABSL-2		A Research Associate working at a BU tenant company called to report he sustained a needle stick to his left index finger with a needle he just used to inject cyclophosphamide into a non-transgenic mouse at around 3:10 pm.	Yes		BPHC	EHS reviewed the incident with the employee. The employee reported the needlestick occurred when they went to discard the syringe in the sharps container. The root cause was attributed to not being conscientious. EHS advised the employee to complete the sharps safety training on-line as a refresher.
BUMC	12/23/20	Mouse bite to right index finger during training	ABSL-1		An Animal Science Center Trainer called ROHP at 2:35 pm to report an animal care technician was bitten by a non-experimental (albino CD1 female) mouse today while in animal handling training.	Yes		BPHC	EHS conducted a phone interview with the employee. Root cause was attributed to insufficient skills or expertise. The employee is working towards becoming proficient so work can be performed independently in the future. For now the employee is working closely with the animal trainer to learn best animal handling practices.
Charles River Campus (CRC)									
CRC	10/2/20	Splash of isopropanol to right eye	N/A		ROHP received an email from an environmental health and safety specialist who had been notified by a PI that a student sustained an exposure of isopropanol to the eye.	No		N/A	EHS conducted a phone interview with the student who reported the 00.5% HPLC grade, less than 1mL isopropanol exposure caused by backsplash getting in her eye while cleaning. The eye was irrigated using the eyewash station and the student sought additional medical follow up for an eye evaluation. The root cause was attributed to lack of PPE. Going forward the student will wear safety glasses when performing this task.
CRC	10/13/20	Mouse bite to left middle finger	ABSL-1		A right hand dominant student researcher while in animal handling training wearing double gloves, a surgical mask, gown and shoe covers was bitten on her left middle finger PIP joint today around 4:30 pm.	Yes		BPHC	EHS conducted a phone interview with the student who reported they were in training and that the mouse was non transgenic and did not contain any hazardous agents. The root cause was attributed to insufficient skills and expertise. The student is undergoing more training sessions with the animal trainer to become proficient with techniques.
CRC	10/13/20	Needle stick containing diisopropylamine to right ring finger	N/A		A course facilitator called ROHP 10/13/20 at 6pm to report an undergraduate student working in a chemistry teaching lab sustained a needle stick to his right ring finger.	No		N/A	EHS conducted a phone interview with the student who reported while removing a used 20G needle from a cork ring (contaminated with trace diisopropylamine) he accidentally received a needlestick to his right ring finger. The puncture was washed with soap and water and ROHP was contacted for medical evaluation. The root cause was improper disposal. Going forward, EHS advised student to immediately dispose of sharps after use into a sharps container and avoid re-using needles. The student was instructed to complete the sharps safety training in BioRAFT.

CRC	10/20/20	Left thumb thermal burn	N/A		ROHP received a phone call from a Post Graduate 10/20/20 at 6:00 pm reporting that student in a chemistry teaching lab accidentally touched a hot plate with her left thumb.	No		N/A	EHS conducted a phone interview with the student who reported she was using the hot plate's stir function and had not intended to turn on the heat. When she noticed that her ice was melting more quickly than anticipated, she touched the hot plate to test it and her thumb burned and blistered. She rinsed the affected area and sought medical consultation from ROHP. The root cause was attributed to not being conscientious. To test temperature, EHS recommended putting a drop of water on the hot plate to see if it sizzles and avoid touching and direct contact.
CRC	10/25/20	Laceration to left index finger from scalpel used on cadaver	BSL-2		A student called ROHP on 10/25/20 to report he was dissecting a 90 yo female cadaver when a 30 pound metal door hit him in the shin and then he sustained a small scalpel puncture to his left index finger.	No		N/A	A student was dissecting a cadaver on a metal cadaver table which has two large 30 pound doors to close over the cadaver. When the doors are open (for dissection) the table is designed so that the doors can be pushed underneath the table held back/in place by a metal clip. It was reported that during this incident, the door on the side of the table that the student was standing in front of came unclipped, hit the student in the shin which caused him to jab his left finger with the scalpel he was holding in his right hand. The on-call physician assessed risk factors and reviewed the cadaver medical records. The student followed up with ROHP for medical consultation. The root cause was equipment related. The metal clip is not reliable and can sometimes come undone. The metal cadaver table needs to be replaced with a table that has a better design.
CRC	10/28/20	Mouse bite to right index finger	ABSL-1		An animal handling trainer called ROHP to report an undergraduate student was bitten by a non-experimental mouse today at 11:45 am while in mouse handling training to learn how to draw blood.	Yes		BPHC	EHS conducted a phone interview with the student who confirmed the mouse was categorized as ABSL1, was non transgenic and did not contain any hazardous agents. The PPE, hand washing and reporting to ROHP were all appropriate. The root cause was attributed to insufficient skills or expertise. For proficiency the student will be retrained in mouse handling by the animal trainer.
CRC	11/6/20	Laceration to left hand	N/A		ROHP received a call on 11/6/20 from a lab mate that a PhD student while working in a chemistry lab sustained a laceration to her left hand while trying to open an anaerobic glass tube.	No		N/A	EHS met with the student who reported she was opening a closed glass culture tube containing an ancient bacteria (archaea), also known as methanogen, when the glass accidentally shattered and lacerated her hand in between her left index and middle finger. She described this bacteria as an environmental bacteria that is not pathogenic to humans. Immediately she applied pressure to the wound. BUPD was notified and summoned an ambulance. Medical personnel applied first aid. The student took her own transport to nearby hospital and received two stitches. Post monitoring and removal of stitches was scheduled with BU student health services. She thinks she may have been turning the knob of the glass tube too quickly with pliers. The root cause was attributed to not being conscientious. The lab has ordered cut proof gloves to wear in addition to nitrile gloves when working with the sample tubes.

CRC	11/20/20	Blood blister on left middle finger after vial removed from liquid nitrogen cryotank	BSL-2		An undergraduate student performing work for course credit reported she sustained a blood blister on her left middle finger 11/20/20. She called our office right away and spoke to the on-call physician who provided guidance.	No		N/A	EHS followed up with the student who reported she was thawing a vial taken from the liquid nitrogen tank, when the vial exploded. There were no burns or abrasions, rather a bruise and formation of a blood blister on the left middle finger. The student followed up with ROHP for medical evaluation and wound care. The root cause was attributed to inadequate procedure. Holding the vials to warm up was discouraged.
CRC	11/30/20	Mouse bite to left index finger and splash of either isopropanol or murine melanoma cells to face or eye	ABSL-2		A PhD student emailed ROHP today to report he was bitten on his left index finger by a mouse.	Yes		BPHC	EHS followed up with the researcher who verified he was wearing gloves, lab coat and face mask at the time of both incidences. The first incident happened on 10/16/20 between 4-5pm. It occurred to the student his face may have been exposed to a small volume of murine tumor cell suspension. The student did not do any first aid and did not follow up with ROHP. On 11/30/20 the student was bitten by a non-transgenic wild type mouse that had not yet been injected with the murine melanoma cancer cell suspension. The root cause was attributed to insufficient skills or expertise. To prevent recurrence in the future, EHS provided student with training resources and reviewed incident steps such as washing the affected area with copious water for 15 minutes and reporting incident to supervisor and ROHP. The researcher was also advised to use eye protection to avoid splashes.
CRC	12/2/20	Thermal burn to right 5th finger	N/A		A PI called ROHP to report an undergraduate student while filling liquid nitrogen to perform RNA extractions sustained a thermal burn to her finger.	No		N/A	EHS followed up with the student who reported she was using a liquid nitrogen fill station at the loading dock and the liquid nitrogen wasn't flowing properly. She had to grip the valve hard causing the glove to compress and sustained a burn to her right 5th finger. Upon examination of the gloves, the student used gloves that should be used for autoclaves. The root cause was lack of PPE and broken equipment. EHS advised wearing cryogenic gloves and face shield as part of task specific PPE needed for work with cryogenic hazards.
National Emerging Infectious Disease Laboratory (NEIDL)									
NEIDL	10/8/20	ABSL2 mouse bite to right index finger	ABSL-2		A researcher notified ROHP that she was bitten by a non-infectious ABSL2 mouse today.	Yes		BPHC	EHS discussed the incident with the employee. The employee was scruffing an ABSL-1 mouse to perform an IP injection of antibodies when the mouse bit the employee's right index finger. The mouse was not infected or administered any hazardous material at the time of the incident and was sourced from a commercial laboratory. The root cause was attributed to inadequate procedure and upon consultation with EHS and ASC the employee will be anesthetizing all mice prior to handling.

NEIDL	10/27/20	Abrasion to right eye	N/A		The ROHP on call physician received a call 10/27/20 at 5:30 pm that a mechanic working in the NEIDL simulation lab sustained an injury to his right eye.	No		N/A	EHS conducted a follow up investigation with the mechanic who reported they were removing a brass pin from a door hinge and when the pin was pulled free it accidentally hit the eye and scratched it. The mechanic irrigated the eye using an eyewash station then sought additional medical follow up for an eye evaluation. The root cause was attributed to lack of PPE. Going forward the mechanic will wear safety glasses when performing this task.
NEIDL	11/18/20	Sterile needle stick to right finger	ABSL-2		A NEIDL research assistant called ROHP at 2:25 pm to report she accidentally stuck her right index finger with a sterile needle in the ABSL2.	No		N/A	EHS conducted a follow up investigation with the employee who reported the accidental needlestick occurred while removing the sterile needle from its package to implant a temperature chip into a mouse. The employee confirmed that the needle had not touched the mouse yet and reports no biological or hazardous agents were involved with this incident. The root cause was attributed to lack of awareness/understanding the procedure. The employee will undergo additional training to review proper hand placement and potential utilization of forceps for this procedure.
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