AN INTERNATIONAL ORGANIZATION DEDICATED TO PROTECTING THE RIGHTS OF ALL ANIMALS

June 12, 2024

Roxanne Mullaney, D.V.M. Deputy Administrator Animal and Plant Health Inspection Service U.S. Department of Agriculture

Via e-mail: <u>Roxanne.C.Mullaney@usda.gov</u>

Dear Dr. Mullaney:

Thank you in advance for your time. I'm writing on behalf of People for the Ethical Treatment of Animals—PETA entities have more than 9 million members and supporters globally—to request that the U.S. Department of Agriculture's (USDA) Animal and Plant Health Inspection Service (APHIS) investigate multiple safety violations in which a registered research facility failed to abide by federal Animal Welfare Act (AWA) regulations. Personnel working with monkeys held in colonies managed by the University of Washington (UW; 91-R-001) and the affiliated Washington National Primate Research Center (WaNPRC) at both sites—Seattle (Site 001) and Mesa, Arizona (Site 002)—have reported numerous safety incidents in the last three years and identified dangers to both animals and staff.

We're particularly concerned, as between 2021 and 2023, the primate center in Seattle and its breeding facility in Mesa reported to UW's Group 1 Safety <u>Committee</u> hundreds of safety incidents, 75 of which we believe may have violated AWA regulations. These incidents involve the incorrect handling of animals, personnel being bitten and scratched by macaques due to poor training, and personnel injuries resulting from the poor use and organization of equipment and stored materials. As such, these instances should also have been reported to the USDA. However, we have seen no indication that this has occurred. Note that we have also included as an enclosure a list of all 255 safety incidents and institutional "resolutions" of these incidents, which illustrate not only apparent serial violations of the AWA but also a staggering disregard for worker health and safety.

UW's Apparent Violations of Regulations

UW's Group 1 Safety Committee reports from 2021 to 2023 indicate that the WaNPRC as well as the university's breeding facility located in Mesa, Arizona, likely violated multiple Animal Welfare Regulations (AWR).

• 9 CFR § 2.32(a): "It shall be the responsibility of the research facility to ensure that all scientists, research technicians, animal technicians, and other personnel involved in animal care, treatment, and use are qualified to perform their duties. This responsibility shall be fulfilled in part through the provision of training and instruction to those personnel."



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- 9 CFR § 2.38(f): "Handling of all animals shall be done as expeditiously and carefully as possible in a manner that does not cause trauma, overheating, excessive cooling, behavioral stress, physical harm, or unnecessary discomfort."
- 9 CFR § 3.1 (b): "Housing facilities and areas used for storing animal food or bedding must be free of any accumulation of trash, waste material, junk, weeds, and other discarded materials. Animal areas inside of housing facilities must be kept neat and free of clutter, including equipment, furniture, and stored material, but may contain materials actually used and necessary for cleaning the area, and fixtures or equipment necessary for proper husbandry practices and research needs."

As of 2023, UW's Group 1 Safety Committee consisted of 32 individuals with 11 alternates. Of these members, the primate center had two representatives, Sulgi Lotze and Melinda Young, and one alternate, Matt Hamlin. PETA has identified 75 instances reported to the safety committee that appear to violate at least one of the AWRs, which are all outlined in the enclosed table.

Disease Risk

As PETA has <u>exposed</u> and <u>reported</u> to APHIS, UW's macaque colony is riddled with multiple infectious agents—including trypanosomiasis (Chagas disease), coccidioidomycosis (Valley fever), Campylobacter, Shigella, Salmonella, Yersinia, Cryptosporidium, MTBC (tuberculosis), and cholera. In addition, macaques are natural carriers of herpes B, a zoonotic virus transmitted through bites, scratches, or bodily fluids with <u>a mortality rate as high as 80% in humans</u>. This deadly pathogen is apparently present in the UW's colonies.

As evidenced by safety incidents reported to the committee that include bites, scratches, accidental needle pokes, eye splashes, and injuries from contaminated equipment, the risk of disease transmission to WaNPRC personnel is extremely high. It appears that Seattle primate center personnel regularly require herpes B antiviral prophylaxis—in some cases, repeatedly.

2023-09-063: SEA WNPRC employee finished the morning cleaning, removed their boots and shook them, causing a splash of liquid to possibly hit their eye. IP did not report incident as they were already on prophylactic medicine after a possible exposure the previous week. When he mentioned it the next day, he was told to report it to his medical team and the faculty vet.

The way in which disease risk to personnel is handled, as evidenced by the following safety incident reports, appears to be inadequate.

<u>2022-04-050</u>: SEA WANPRC employee was seeing the health nurse, and mentioned they had had gastrointestinal symptoms for more than a week; checking with doctor to see if related to any NHP exposure.

Resolution: Supervisor notes say that if the GI issues are related to the monkeys in clinical isolation for GI pathogens, the exposure likely occurred before the monkeys were isolated. Suggests changing gloves more often between rooms, even when not under clinical isolation and wash hands more thoroughly when leaving the facility. ... *Matt said that virtually everyone who works in the units gets ill at some point in their first 6 months, due to meeting*

staph and shigella for the first time and being around aerosolized fecal matter. [Emphasis added.]

<u>2021-03-054</u>: VPR person was bit by the squirrel monkey when trying to weigh her. They were holding a marshmallow on the top of the weigh box and try[ing] to see the ID number on her chest.

<u>Resolution</u>: No supervisor comments. Melinda will check. *Matt mentioned that squirrel monkeys are tiny, and deceptively cute. Their bites don't need a scrub clean.* [*Emphasis added.*]

Incidents: A Result of Poor Training and/or Understaffing?

Despite a declining animal census, it appears that UW has been unable to fill critical veterinary staff positions. This is evidenced by UW's Human Resources job board, which shows that a <u>senior</u> <u>veterinarian position</u> at the Mesa primate facility has been open since November 2023 and that multiple <u>animal technician</u> positions have been open since 2022. Many of the incidents reported are noted to be the result of poor training, violating 9 CFR § 2.32(a), and inadequate staffing, causing personnel to rush through tasks and, in turn, endangering themselves and the animals in their care.

2023-10-091: SEA WNPRC employee was attempting to unlock a Group 5 Seattle-style cage when the NHP inside reached through for the IPs hair cap, scratching their forehead. It was scrubbed 30 minutes later when scratch was noticed, and IP went to the ER.

<u>Resolution</u>: Supervisor notes IP was a trainee without full training on how close to get to a *cage*. For future training, animal awareness and proper space from animals will be addressed explicitly and sooner in the training. [*Emphasis added*.]

2022-10-022: SEA WNPRC employee shifted four juvenile NHP into the same pen to clean the other enclosure, not knowing that door was not secured. Seeing the four had noticed the open door, IP rushed to close it. *As they had not used the transfer door before, they did not know how to latch it*. Attempting to fasten it in a hurry, they pushed back their fogged up face shield. One of the animals bit at IP's glove and then let it snap back in place, causing fluid to hit IP's right eye. IP secured the lock and went to the eye wash for 15 minutes. Co-workers waited during the eyewash, and one walked IP to the ED. IP will switch to goggles. [*Emphasis added*.]

2022-08-022: SEA WNPRC employee was head-stabilizing a NHP in a chair when NHP thrashed head and dragged left canine along base of employee's thumb, causing 3cm laceration. IP washed per protocol and went to the ED. Incident happened on the Thursday, IP was hospitalized on Friday night/Saturday morning.

<u>Resolution</u>: Supervisor notes the IP is transferring to this lab from another lab at the Primate Center, and the procedure techniques are different. IP was only wearing nitrile gloves on the injured hand. Recommends adding more Kevlar gloves to the lab's supply, wearing both nitrile and Kevlar on both hands, learning to hold the NHP head from behind and having another person assist.

It also appears that equipment is not properly being maintained and stored, violating AWR 9 CFR § 3.1 (b) and presenting further danger to staff and animals.

2022-08-046: SEA WNPRC employee was moving a dirty cage when the wheel fell off, the cage tipped toward them, and they swung the cage into the wall to prevent it falling, which strained their back/hip. Suggests moving out of the way instead of trying to catch it in future.

In the incident below, an improperly stored tool fell on a veterinarian, seemingly during a procedure, which could have severely injured the animal undergoing surgery.

<u>2021-12-016</u>: AZ WANPRC vet had a crowbar fall onto their head, causing ~ 2 cm open wound that required staples to close. The wound was scrubbed for 15 minutes prior to going to urgent care. The crowbar was dislodged when a co-worker pulled a glove from the shelf, as they got ready to assist.

Poor Handling Puts Animals at Risk

Numerous safety issues reported at the university's primate facilities involve improper handling of animals, resulting in the animals undergoing undue stress, potential risk, and violating 9 CFR § 2.38(f).

2023-08-143: SEA WNPRC was working with infant rhesus monkey. Two others entered the room, stressing the infant who bit IPs finger as she was being returned to cage. Neither glove was broken, but the finger was bloodied. IP cleaned the wound per exposure protocol, but feels there was no exposure.

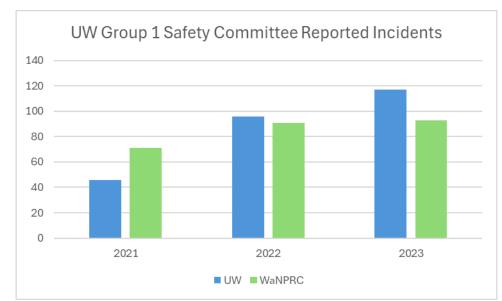
2023-04-046: SEA WNPRC employee was returning a monkey to [a] cage after a procedure, when [the primate] jumped off the table. IP strained their wrist when carrying the monkey in the correct fashion back to their home cage. IP feels holding a moving 16kg animal while waiting for someone else to unlock the cage caused the sprain; recommends leaving the cage unlocked.

<u>2021-07-026</u>: SEA WANPRC employee bitten on right hand/third finger while feeding NHP. Treated at ER with follow-up by Employee Health.

<u>Resolution</u>: Supervisor thinks employee was rushing and not being cautious enough; there is also a lot of activity in the room which may have stressed the animal. Suggests more caution and not getting close to the animals.

Comparison With Other Incidents at the University

The number of incidents at the WaNPRC and its Mesa breeding facility are particularly concerning when compared to other reported incidents from the UW campus. The Group 1 Safety Committee consists of 32 departments at the university, meaning that the primate center comprises roughly 3% of the committee. However, incidents at the primate center account for 61% of reported incidents in 2021, 49% of reported incidents in 2022, and 44% of reported incidents in 2023.



Incidents reported by UW's Group 1 Safety Committee by year. WaNPRC represents one of the 32 reporting units.

Request: Investigate and Issue Penalties as Appropriate

To uphold your mission to protect the health and welfare of animals in the U.S., we urge you to initiate an immediate investigation into the repeated safety issues at UW's primate center. Where appropriate, we ask that citations be issued for the university and that civil and/or criminal penalties be considered through the U.S. Department of Justice.

Thank you for your time and consideration.

Sincerely,

Lisa Jones-Engel, Ph.D. Senior Science Advisor, Primate Experimentation

cc: <u>AC.Complaints@usda.gov</u> <u>seattle@Lni.wa.gov</u>

Enclosures

Table of Apparent AWR Violations List of Safety Incidents Involving WaNPRC, as Reported to the Group 1 Safety Committee

Apparent Violations of Animal Welfare Regulations at the University of Washington's National Primate Research Center

9 CFR § 2.32(a) - "It shall be the responsibility of the research facility to ensure that all scientists, research technicians, animal technicians, and other personnel involved in animal care, treatment, and use are qualified to perform their duties. This responsibility shall be fulfilled in part through the provision of training and instruction to those personnel."

2023-11-072: SEA WNPRC employee was grabbed by a male macaque, tearing the disposable lab coat and leaving a bruise. Skin was not broken, area scrubbed for 15 minutes. Based on the information Employee Health explained the IP could decide to go to the ED or not; IP chose not to. Suggests wearing a real or thicker lab coat.

2023-11-073: SEA WNPRC employee was putting a new needle on a syringe (to do a blood transfer) and stuck themselves.

2023-11-097: SEA WNPRC employee was closing a laparotomy when the needle dragged; they applied pressure and the needle slipped, hitting their other thumb.

2023-10-091: SEA WNPRC employee was attempting to unlock a Group 5 Seattle-style cage when the NHP inside reached through for the IPs hair cap, scratching their forehead. It was scrubbed 30 minutes later when scratch was noticed, and IP went to the ER.

2023-09-026: SEA WNPRC employee was observing an animal when it reached through the bars and scratched through both glove layers.

2023-09-030: AZ WNPRC employee was handing out treatments when an animal bit their finger. IP notes that bites are always a risk when handing out medication in a group enclosure.

<u>2023-09-054</u>: SEA WNPRC student employee was changing the cover on the surrogate when an infant bit their hand. IP washed but did not report to ER for treatment. Later they declined medical follow-up other than B-virus lab work.

2023-09-059: SEA WNPRC employee gave themselves a needlestick with a suture needle while closing an incision. They pushed the needle forward and it came out to poke a finger on the IP's other hand. IP suggests reviewing procedures while working with sharp objects, slow down & use forceps properly.

2023-08-066: SEA WNPRC employee found the wrong bedding pan had been put in cage, making it difficult to remove, which left enough time for the NHP to scratch their hand through the mesh flooring.

2023-08-100: SEA WNPRC employee was moving too fast when uncapping a syringe and poked themselves.

2023-08-130: SEA WNPRC employee had their collarbone scratched as infant NHP climbed up while being weighed.

2023-07-064: AZ WNPRC employee was recapping needle of tuberculin when they poked their right thumb.

2023-04-015: IP was bitten by a monkey when attempting to fasten the other monkey partnered in the cage. The double gloves were not broken, but the bite caused a hematoma under the nail and 2 small cuts. They washed per protocol and went to the ED for usual follow up.

<u>2023-04-031</u>: SEA WNPRC employee 'scabbed' fingers on the squeeze bars when trying to retrieve a zip tie from the enclosed animal.

2023-04-068: SEA WNPRC employee was swapping out cage side doors when the door handle swung down, and crushed their finger. Recommends instructing people new to this kind of cage where to safely put fingers.

<u>2023-03-026</u>: SEA WNPRC employee was attaching a sign to a cage when an NHP scratched their hand through their glove. IP did not realize until later that the scratch had happened; they then followed washing protocol and went to the ER for tests.

2023-03-065: SEA WNPRC NHP scratched employee's hand while employee unlocked cage door. IP suggests being more attentive of animal, and possibly distracting the animal away from what IP's hand is doing.

<u>2023-03-115</u>: AZ WNPRC employee got a needlestick to finger as they uncapped a syringe.

<u>2023-01-002</u>: SEA WNPRC employee was pulling out a cage to clean the floor when a NHP reached out and scratched their hand, tearing two glove layers. IP scrubbed the area for 15 minutes with an exposure kit sponge, reported the incident and went to the ER. Suggests wearing thicker gloves.

2022-12-045: SEA WNPRC employee's inner glove broke when NHP reached out grabbed their hand. Outer glove was intact. They have discussed using an object such as a dustpan to block the gap to prevent the animals reaching out, or having another person there to distract the animal. They will also look into getting glove liners.

2022-12-104: SEA WNPRC employee was handing frozen mango treats to a pair of rhesus macaques when one grabbed their right hand, ripping both layers of gloves off. There was no apparent skin breakage. IP showed the hand to supervisor, who recommended cleaning with alcohol and then using the Herpes scrub kit. At that point, some blood was noticed and IP proceeded with the scrub kit and went to the ER. IP notes proper animal care & PPR were used, and that they may add extra layers of gloves.

Group 4: 2022-10-069: Basso Lab personnel was attaching a lock when the NHP reached out, pulled the IP's left pinky into the cage and bit it. IP pulled their hand back, lost balance, tripped on the touchscreen rig cable. They braced their fall with their left hand and forearm. IP noticed bleeding from a cut on the palm of the hand, although the glove was intact. IP did the glove test, and then scrubbed for 15 minutes. The bit finger was fine, with no cuts or bruising; their wrist was stiff but otherwise fine after the fall. PPE was adequate for the bite, but not the fall.

2022-11-001: SEA WNPRC employee gave NHP a treat while cleaning its cage; the animal grabbed roughly, breaking through the two pairs of gloves and scratching IPs finger. IP went to ER for treatment.

2022-10-022: SEA WNPRC employee shifted four juvenile NHP into the same pen to clean the other enclosure, not knowing that door was not secured. Seeing the four had noticed the open door, IP rushed to close it. As they had not used the transfer door before, they did not know how to latch it. Attempting to fasten it in a hurry, they pushed back their fogged up face shield. One of the animals bit at IP's glove and then let it snap back in place, causing fluid to hit IP's right eye. IP secured the lock and went to the eye wash for 15 minutes. Co-workers waited during the eyewash, and one walked IP to the ED. IP will switch to goggles.

2022-09-085: SEA WNPRC employee received a needle stick in their index finger when trying to give a subcutaneous injection to an NHP. The syringe with prograf/tacrolimus was in one hand, and when the animal wiggled, the needle grazed their other hand, breaking the glove. The needle had not touched the animal, and IP felt no solution was injected. IP washed the site for 15 minutes and followed up with Employee Health.

2022-08-021: SEA WNPRC was feeding animal with hand near cage when animal bit hand, breaking gloves but not skin. Employee washed the area for 15 minutes to be safe.

2022-08-107: SEA WNPRC employee pricked left 4th digit during blood draw on NHP.

2022-08-119: SEA WNPRC employee was feeding NHPs when an NHP reached through the hopper and scratched the employee's wrist.

<u>2022-07-040</u>: SEA WNPRC employee's hand was bruised by an infant rhesus bite as employee was handing out biscuits.

2022-07-041: SEA WNPRC employee got a needle stick with a needle previously used on NHPs.

2022-07-103: SEA WNPRC employee was removing biscuits from a food hopper when a macaque reached in, scratching gloved left hand and lacerating left index finger. Per protocol, washed for 15 minutes, and reported it to the On Call vet and went to ED for prophylaxis treatment. Suggests removing the hopper, from the cage, and then emptying it.

2022-06-013: SEA WANPRC employee was feeding NHP treats to distract it while IP visualized an incision sit. Agitated NHP grabbed employee's hand, scratching skin through t layers of nitrile gloves. Followed SOP and washed the area, and went to ER. Plans to wear thicker or cut gloves in future.

<u>2022-06-023</u>: SEA WANPRC staff opened a side gate for socialization between two NHP, and one scratched them through two layers of nitrile gloves. No broken skin.

<u>2022-04-074</u>: SEA WANPRC anesthesiologist gave themselves a needle stick during surgery, after injecting propofol into an IVC port. Suggests being more attentive.

2022-03-011: SEA WANPRC employee was talking while checking lixits, when NHP reached through and pulled a finger through cage, and bit it. Washed injury and reported it. Not a macaque bite, so IP did not have to go to ED. Advised by vet to seek medical attention if bite was serious. IP suggests checking work procedures.

2022-01-001: SEA WANPRC was checking locks when an animal reached through and grabbed their hand. Outer glove fine inner glove was torn, and hand scraped. IP did the required clean of the scrape, while co-worker checked the outer glove. Outer glove passed the water test, so IP did not report for medical follow up.

2022-01-079: SEA WANPRC tech was cleaning a cage pan when animal reached out and scratched their face, reaching under the face shield, and under their mask.

<u>2021-12-045</u>: SEA WANPRC tech was scratched above the protective sleeve by a NHP during a blood draw. IP reported a small tear in the coveralls. They washed the scratches and the alcohol test was done. It appeared the skin was broken, but the IP chose not to go for medical follow up at the time.

<u>2021-12-068</u>: New SEA WANPRC staffer noticed a forearm scratch when removing PPE; believed it must have happened when separating two animals. One animal reached out as the IP was working on the panel lock; IP was focusing on the stiff lock. IP scrubbed the wound and reported it; on-call vet was called.

<u>2021-08-011</u>: New SEA WANPRC employee poked a finger on their left hand while attempting to sedate an animal. Suggests safety training.

<u>2021-07-026</u>: SEA WANPRC employee bitten on right hand/third finger while feeding NHP. Treated at ER with follow-up by Employee Health.

2021-07-047: AZ WANPRC staffer was cleaning a cage when vets and vet techs entered the room to do a transfer; agitated NHP scratched employee's wrist. AP suggests pausing cleaning when a transfer is in progress as there are NHPs who become harder to handle than usual when the vets and vet techs are in the room.

<u>2021-06-029</u>: VPR tech had finger bitten by NHP; bite penetrated glove, although the water test showed the gloves were intact. Used a scrub kit, but not an exposure.

<u>2021-05-014</u>: VPR animal tech removed the feeder box, which left a gap. AP was scratched when an animal grabbed their arm through the gap.

<u>2021-03-064</u>: VPR person had pigtail macaque scratch left hand through gloves. No abrasion present. Used scrub kit anyways to be safe.

<u>2021-03-054</u>: VPR person was bit by the squirrel monkey when trying to weigh her. They were holding a marshmallow on the top of the weigh box and try to see the ID number on her chest.

<u>2021-02-046</u>: VPR staffer was checking lixits (an animal watering device) in a compound group when a small monkey reached through the bars, past the face shield and poked AP in the right eye.

<u>2021-01-038</u>: VPR staffer was in compound trying to distract a monkey with a treat in order to give meds to a second monkey. First monkey bit affected party, but there was no skin break.

<u>2020-12-011</u>: VPR staffer was moving a cage, left their right index finger inside the cage where it was bitten by the squirrel monkey inside; wound bled. IP washed the bite and applied bandage, as required, reported it to the vet on duty.

<u>2020-12-027</u>: VPR staffer was trying to close off contact in the cage to check on a possibly-injured macaque, when right forearm was scratched. Skin not broken, followed the wash protocol.

9 CFR § 2.38(f) – "Handling of all animals shall be done as expeditiously and carefully as possible in a manner that does not cause trauma, overheating, excessive cooling, behavioral stress, physical harm, or unnecessary discomfort."

<u>2023-09-015:</u> SEA WNPRC employee was weighing a pigtail macaque when it turned and scratched the IP's forearm through PPE.

2023-08-143: SEA WNPRC was working with infant rhesus monkey. Two others entered the room, stressing the infant who bit IPs finger as she was being returned to cage. Neither glove was broken, but the finger was bloodied. IP cleaned the wound per exposure protocol, but feels there was no exposure.

<u>2023-07-065:</u> WNPRC employee was receiving & delivering a NHP so was not wearing anything more than scrubs and gloves. Noticed after delivery that they had scratched their arm on the cage, but no visible scratch appeared until after they got home. They called in and the vet determined it counted as an exposure, so they went to the ER for treatment the next day.

<u>2023-04-046</u>: SEA WNPRC employee was returning a monkey to its cage after a procedure, when it jumped off the table. IP strained their wrist when carrying the monkey in the correct fashion back to their home cage. IP feels holding a moving 16kg animal while waiting for someone else to unlock the cage caused the sprain; recommends leaving the cage unlocked.

2022-08-022: SEA WNPRC employee was head-stabilizing a NHP in a chair when NHP thrashed head and dragged left canine along base of employee's thumb, causing 3cm laceration. IP washed per protocol and went to the ED. Incident happened on the Thursday, IP was hospitalized on Friday night/Saturday morning.

2022-07-090: SEA WNPRC employee was using a laryngoscope on a sedated macaque. The animal began to gag as the sponge touched its tracheal surface, and as the mouth closed its canines penetrated the IP's nitrile ppe gloves, lacerating right hand ring finger. Minor bleeding, and bruise.

<u>2021-12-063</u>: AZ WANPRC staffer was bitten twice (calf and knee) by a displeased monkey. Two co-workers were attempting to move two monkeys out of the enclosure and into a box; the angry monkey had been prevented from getting through a gap and back to the colony. IP suggests reviewing work procedure, perhaps using a Group 6 cage (for larger NHP) to avoid issue.

2021-11-089: SEA WANPRC, SOM lab personnel was bitten while working with a mildly-sedated primate. IP washed the area, and went to the ED for treatment and the potential B virus follow up.

2021-09-032: SEA WANPRC vet was scratched by macaque fingernail during routine physical exam. Suggests they wear gown that ties in back when working with infant non-human primates.

2021-04-017: VPR weekend staffer had neck scratched by macaque during weighing. Was wearing appropriate PPE and followed procedures.

<u>2021-03-020</u>: VPR staffer was weighing a partially sedated animal when it briefly awoke and bit onto their wrist. The bite broke through double set of gloves and broke the skin. Suggested they be more aware of animal's consciousness while handling.

9 CFR § 3.1 (b) – "Housing facilities and areas used for storing animal food or bedding must be free of any accumulation of trash, waste material, junk, weeds, and other discarded materials. Animal areas inside of housing facilities must be kept neat and free of clutter, including equipment, furniture, and stored material, but may contain materials actually used and necessary for cleaning the area, and fixtures or equipment necessary for proper husbandry practices and research needs."

2023-11-045: SEA WNPRC employee was splashed when a floor grate fell over from where it was propped against the wall. Water splashed up and under the face shield, they felt the water on their neck and were unsure if it had reached their eyes. They reached out to the vet to see if it counted as a potential exposure and planned to report to the ED for follow up.

<u>2023-07-044</u>: AZ WNPRC employee leaned drain grate against cage during cleaning, and the grate fell onto employee's leg, bruising and cutting calf. IP suggests lighter drain covers and changing SOP to reflect steps for different style grates.

2022-12-046: AZ WNPCR [sic] employee fell after foot fell into the uncovered drain, while carrying the covers they use to protect the tvs during power washing. IP suggests moving the tv covers before the drain grates are removed.

2022-11-088: SEA WNPRC employee slipped in an unidentified puddle and landed on right wrist and hip. Left leg sprawled out while IP tried to catch themselves; reports pain in the associated areas and a bruise on their right wrist.

<u>2022-09-015</u>: AZ WNPRC staffer slipped on floor slippery with hydraulic fluid. Trying to catch themselves in the fall, IP pulled a muscle on the outside of their thigh. Later in the day, slipped on wet cheerios and further aggravated it. Took an OTC anti-inflammatory and returned to work. IP knew the spill was there, and notes that it was appropriately posted. Added they will be more careful and be sure there is adequate bedding down to counteract fluids.

2022-09-017: AZ WNPRC employee also slipped in the fluid reported in 2022-09-015. Caught themselves but tweaked lower back. Not long after, they were pushing a wet-vac down an incline, and when they tried to stop it flipping, more pressure was put on back. IP reported the spill signage had been moved out of sight. They recommend getting a wet-vac for each level so the awkwardly weighted machine does not have to be manipulated on an incline.

2022-08-046: SEA WNPRC employee was moving a dirty cage when the wheel fell off, the cage tipped toward them, and they swung the cage into the wall to prevent it falling, which strained their back/hip. Suggests moving out of the way instead of trying to catch it in future.

2022-05-007: AZ WANPRC employee was walking on wet floor, left leg went into an open gutter and they fell forward, bruising shoulder, arm, and knee.

2022-05-069: AZ WANPRC Employee cut right thumb on metal floor grate.

2021-12-016: AZ WANPRC vet had a crowbar fall onto their head, causing ~2 cm open wound that required staples to close. The wound was scrubbed for 15 minutes prior to going to urgent care. The crowbar was dislodged when a co-worker pulled a glove from the shelf, as they got ready to assist.

2021-11-035: SEA WANPRC tech caught thumb between a cabinet and the wall when packing items from a cabinet. IP reports thumb was slightly swollen and stiff to flex; they took ibuprofen. IP also noted the room was in disarray with extra furniture, equipment, boxes, etc. due to upcoming move. They cleared some of the clutter to remove this kind of hazard, and will be more careful in future.

2021-07-053: SEA WANPRC staffer was walking in vivarium hallway, slipped and fell flat on back. There were no posted signs the floor was wet of slippery; injured back, buttocks, legs.

2021-05-013: VPR animal technician cut finger on macaque cage when opening a stuck squeeze bar latch; difficult to get it unstuck. AP suggested regular maintenance of the cages and stronger gloves.

2021-02-047: VPR staffer suffered a hand laceration and bleeding when the housing cage locking mechanism jammed; AP's hand slipped after the lock opened, hit the cage and tore through two pairs of gloves. Reported the incident, began a chlorhexidine scrub for 15 minutes and went to the UW ER for a blood draw and follow up. Prescribed antiviral, Valacyclovir. Suggested a request for repair be submitted, and noted the locking mechanism is in a tight area, hard to get tools into. Reluctant to lubricate as it does house animals.

Group 1 Safety Committee Meeting Reported Incidents, 2021-2023 Washington National Primate Research Center

December 13, 2023

• <u>2023-11-015:</u> SEA WNPRC person reports that multiple compressed gas cylinders are being stored on the J/K dock, unsecured and with some missing the valve guard. They belong to both Praxair & AirGas and interfere with Primate Center staff using the barrel hoist to lift their 30 gallon cage washing liquids. The vendors should not be using this area as their storage, as there are installed racks to secure cylinders along the wall.

Resolution: Supervisor notes that vendors are either not aware of or not following the rules for storing compressed gases. Feels that someone from Building Management and/or EH&S should communicate with the vendors so that personnel can handle their materials safely. EH&S forwarded to Scott Nelson, John Gunderson and added the HS building email. *Sonia said that this was a good example of when a supervisor should reach out, even if it is not their direct responsibility; contacting building management in this case. Melinda added that it has been resolved—it was a years-long problem and she thinks the OARS report helped push it along.*

• <u>2023-11-017</u>: SEA WNPRC employee was moving a GP4 lab cage when they hit their left hand's middle finger on a clean cage. There was broken skin but no exposure, neither of the two gloves was torn. IP did the 15-minute scrub as a precaution.

<u>Resolution</u>: Supervisor adds IP needed to pay more attention to surroundings and where their hands are when moving cages.

• <u>2023-11-019</u>: SEA WNPRC got a small burn (blistered skin) on the left upper arm due to improper handling of the autoclave arm hit hot metal while unloading trash. IP suggests wearing the provided sleeves to prevent burns.

<u>Resolution</u>: Supervisor suggests making sure the sleeves are in a visible location so they are not forgotten.

• <u>2023-11-036</u>: AZ WNPRC employee was hit by a filled metal water bottle when it fell from the top of a 5-foot fridge. It hit the IP's finger, causing bruising and swelling.

Resolution: Supervisor notes the appliance had just been defrosted and so was lighter than usual. Recommends not placing water bottles on the top. *Sulgi added the bottle also struck the IP's head on the way down, and that the fridge had not been touched by anyone.*

• <u>2023-11-044</u>: SEA WNPRC employee was attempting to detangle their hose, and accidently hit the 'on' button, spraying clean water near their eyes, around their face shield.

Resolution: Supervisor notes the IP was not wearing goggles or safety glasses, because the anti-fog coating on the goggles they were given had worn off. They will provide the IP with new safety glasses and train the IP to put the hose down when untangling. *Melinda added that this report and the next involve the same person -- they mentioned the earlier splash (2023-11-045) when discussing the incident in report 2023-11-044.*

• <u>2023-11-045</u>: SEA WNPRC employee was splashed when a floor grate fell over from where it was propped against the wall. Water splashed up and under the face shield, they felt the water on their neck and were unsure if it had reached their eyes. They reached out to the vet to see if it counted as a potential exposure and planned to report to the ED for follow up.

Resolution: Supervisor notes IP did not report the incident in a timely matter. Met with Melinda to review reporting protocol including notifying supervisor and vet. Provided new anti-fog goggles to replace the ones IP didn't want to wear. IP often feels uncomfortable reporting potential exposures. Recommended spraying grate on the floor if they fear it will fall over again.

• <u>2023-11-063</u>: SEA WNPRC employee was moving a cage and jammed their right forearm between it and the metal doorframe. Slight damage to the skin and slight swelling; after a day the site was still sore and painful.

<u>Resolution</u>: Supervisor notes the hallways are hard to maneuver in and would be better if emptier.

• <u>2023-11-072</u>: SEA WNPRC employee was grabbed by a male macaque, tearing the disposable lab coat and leaving a bruise. Skin was not broken, area scrubbed for 15 minutes. Based on the information Employee Health explained the IP could decide to go to the ED or not; IP chose not to. Suggests wearing a real or thicker lab coat.

<u>Resolution</u>: Supervisor agrees about wearing better protective clothing. *Also, situational awareness.*

• <u>2023-11-073:</u> SEA WNPRC employee was putting a new needle on a syringe (to do a blood transfer) and stuck themselves.

Resolution: Supervisor recommends paying attention to where sharps are in relation to hands, and whenever possible avoid using a needle to transfer blood. *Melinda added that the IP is a FHCC employee, so is listed as the supervisor on the OARS report. As a biosafety incident, both Melinda and Biosafety need to be informed. FHCC is handling the incident for OSHA.*

• <u>2023-11-097</u>: SEA WNPRC employee was closing a laparotomy when the needle dragged; they applied pressure and the needle slipped, hitting their other thumb.

Resolution: No supervisor comments. *Melinda will poke the supervisor.*

November 8, 2023

• <u>2023-10-001</u>: AZ WNPRC employee slipped and fell, landing on their side.

<u>Resolution</u>: Supervisor notes IP was walking fast around a corner on a wet floor; do not rush when floors are wet.

• <u>2023-10-017</u>: VPR employee was setting up chairs & tables in a new office when they suffered a groin injury. Suggests training in how to lift.

Resolution: Supervisor notes the IP had previous work lifting heavy objects, and that they should work with a teammate. *Dian added that the IP has a preexisting physical condition and that it and the lifting incident was not reported to their supervisor in a timely manner. The IP was given modified work, is seeing their doctor (may have surgery later) and was reminded to fill out an OARS report. She notes that there is still some resistance across campus by some to filling out the reports; there persists the feeling that the reporting person might get in trouble. Sonia linked to the EH&S page with incident reporting posters that can be printed out and posted.*

• <u>2023-10-059</u>: AZ WNPRC employee missed their footing as they stepped from an enclosure and fell onto their left knee and rolled their left wrist. When they finally stood, they had an ache in their wrist and a knee that hurt when they walked.

<u>Resolution</u>: Supervisor notes inappropriate footwear (crocs), Wear footwear with good tread and take care on slippery surfaces.

• <u>2023-10-062</u>: AZ WNPRC employee was bent over while pulling on a sliding door when they felt a sharp pain in the left neck and shoulder.

<u>Resolution</u>: Supervisor feels it was the body position when using the shift door; stretch before working and position oneself as to not put strain on neck and shoulder.

• <u>2023-10-091</u>: SEA WNPRC employee was attempting to unlock a Group 5 Seattle-style cage when the NHP inside reached through for the IPs hair cap, scratching their forehead. It was scrubbed 30 minutes later when scratch was noticed, and IP went to the ER.

<u>Resolution</u>: Supervisor notes IP was a trainee without full training on how close to get to a cage. For future training, animal awareness and proper space from animals will be addressed explicitly and sooner in the training.

October 11, 2023

• <u>2023-09-015</u>: SEA WNPRC employee was weighing a pigtail macaque when it turned and scratched the IP's forearm through PPE.

Resolution: No supervisor comments. Melinda will follow up.

• <u>2023-09-024</u>: SEA WNPRC employee was removing their goggles after the washdown of the macaque rooms when they felt a drip of liquid which might have entered an eye. After consultation, it was determined it might have been an exposure so the IP used the eyewash station and then went to the ER for treatment.

Resolution: Supervisor feels more training in how to remove goggles was needed (lean forward when taking off goggles and hair covers to prevent drips). *Melinda said that the supervisor has been working with Employee Health to discuss what counts as an exposure with the IP.*

• <u>2023-09-026</u>: SEA WNPRC employee was observing an animal when it reached through the bars and scratched through both glove layers.

<u>Resolution</u>: Supervisor suggests wearing the thicker PPE gloves, maintaining a distance, and being conscious of animal actions when close to animals

• <u>2023-09-030</u>: AZ WNPRC employee was handing out treatments when an animal bit their finger. IP notes that bites are always a risk when handing out medication in a group enclosure.

<u>Resolution</u>: No supervisor comments. Sulgi will remind the supervisor, and that a good rule of thumb is 'don't put fingers inside the mesh'.

• <u>2023-09-054</u>: SEA WNPRC student employee was changing the cover on the surrogate when an infant bit their hand. IP washed but did not report to ER for treatment. Later they declined medical follow-up other than B-virus lab work.

Resolution: Supervisor added the age of the animal was the biggest contribution; there is a need to change practices as the animals age. They will be curtailing activities with animals this age, and PPE practices will be revised to be sure proper gloving protocols are followed. EH&S biosafety followed up and reports the IP was rushing with their final animal at the end of their shift. The infant was not cooperating, but IP went ahead anyway. The injury was more a scratch than bite, with no bleeding. EH&S discussed not rushing, patience, and what to do in future if injured.

• <u>2023-09-059</u>: SEA WNPRC employee gave themselves a needlestick with a suture needle while closing an incision. They pushed the needle forward and it came out to poke a finger on the IP's other hand. IP suggests reviewing procedures while working with sharp objects, slow down & use forceps properly.

<u>Resolution</u>: Supervisor notes a lapse of attentiveness and rushing; the need to maintain safe use of instruments and not rush.

• <u>2023-09-063</u>: SEA WNPRC employee finished the morning cleaning, removed their boots and shook them, causing a splash of liquid to possibly hit their eye. IP did not report incident as they were already on prophylactic medicine after a possible exposure the previous week.

When he mentioned it the next day, he was told to report it to his medical team and the faculty vet.

Resolution: Supervisor feels root causes were lack of training on boot removal, and the IP being unsure about steps to take with a second exposure. Plans training about all of this, including an explicit set of instructions about responding to exposure. *Melinda believes this is the same IP in 2023-09-024*.

September 13, 2023

• <u>2023-08-013:</u> AZ WNPRC employee cut thumb on the pressure washer hose clamp.

<u>Resolution</u>: Supervisor suggests replacing the hose clamps with ones that so not have sharp edges.

• <u>2023-08-030</u>: SEA WNPRC employee cut finger on glass while snapping open a new bottle of cyclosporine, an immunosuppressive agent.

<u>Resolution</u>: Supervisor thinks it was a faulty bottle, and suggests using ampule breakers, which have been ordered.

• <u>2023-08-051</u>: SEA WNPRC employee smashed finger between a cage and a doorway, while overcorrecting for a turn. No broken skin or ripped gloves, but finger was swollen & bruised.

<u>Resolution</u>: Supervisor notes that cages should be moved with hands away from the cage frames. Make sure staff are trained to do this, and to know the secure places on the cages to properly maneuver them.

• <u>2023-08-066</u>: SEA WNPRC employee found the wrong bedding pan had been put in cage, making it difficult to remove, which left enough time for the NHP to scratch their hand through the mesh flooring.

<u>Resolution</u>: Supervisor plans to get the proper-sized pans back from off-site storage, and discussions are being had about evaluating policies re: working around large aggressive animals, and considering moving the NHP to a wash down facility that does not require close contact during daily cleaning.

• <u>2023-08-074:</u> AZ WNPRC employee slipped while pressure washing, and the stream hit their left wrist.

Resolution: Supervisor reminded IP to be aware of, and avoid the water stream.

• <u>2023-08-085</u>: SEA WNPRC employee pulled a muscle in their neck/back while sanitizing in the tight animal housing quarters. Originally occurred at the end of July, missed work time during August with severe pain. Feels more space is necessary for taller employees.

<u>Resolution:</u> *Melinda added the belated supervisor comment that it was not practical to redesign the area, but the IP and others should have spatial awareness.*

• <u>2023-08-087</u>: AZ WNPRC employee noticed a pain in their wrist while locking and unlocking in B building. Subsequently feels pain when squeezing/turning wrist.

<u>Resolution</u>: Supervisor thinks the locks may need to be oiled, remembering to stretch hands & wrist.

• <u>2023-08-092</u>: SEA WNPCR hit in the head by a swinging side gate arm while trying to lock side gate.

<u>Resolution</u>: Supervisor notes that the NHP likes to play with the side gates when a person is working on them, so better training on Group 6 cages and animal awareness.

• <u>2023-08-100</u>: SEA WNPRC employee was moving too fast when uncapping a syringe and poked themselves.

<u>Resolution</u>: No supervisor comments. *Melinda added they may have needed the capping tool and training*.

• <u>2023-08-127</u>: AZ WNPRC employee was on the first day working without a stairs restriction. After climbing stairs for several hours, their previously-injured ankle was sore, left knee was swollen and right hip was painful. IP plans to ask doctor if there are stretches they can do before working stairs, and if they should restrict the amount of stairs at this point of their recovery.

Resolution: Supervisor notes they are awaiting medical evaluation.

• <u>2023-08-130</u>: SEA WNPRC employee had their collarbone scratched as infant NHP climbed up while being weighed.

Resolution: Supervisor notes inadequate PPE around neck, and need to provide more comprehensive PPE when handling awake infants. *Melinda added they are ordering new neck guards and have them used.*

• <u>2023-08-143:</u> SEA WNPRC was working with infant rhesus monkey. Two others entered the room, stressing the infant who bit IPs finger as she was being returned to cage. Neither glove was broken, but the finger was bloodied. IP cleaned the wound per exposure protocol, but feels there was no exposure.

Resolution: Supervisor notes too many stressors in the room; remind people to not enter a room when someone has an animal out. *Melinda added they had recently come up form Oregon, which was a added stressor*.



• <u>2023-07-010</u>: SEA WNPRC employee accidently poked abdomen through lab coat & scrubs with 3 ml syringe containing acyclovir. None injected, IP scrubbed the area with surgical scrub for 15 minutes. IP feels they were rushing.

Resolution: Supervisor suggests slowing and being extra careful when handling sharps. *Melinda noted it was a clean needle, and they had the IP call employee health.*

• <u>2023-07-012</u>: SEA WNPRC employee was re-filling a bucket that had previously held cleaning tools and solution, when water splashed into their eye up under the face shield. IP rinsed the eye for 15 minutes before going to the ER for treatment.

Resolution: Supervisor notes the IP was not wearing goggles as they tend to fall down & fog. Suggests adding a cincher to fit better, and provide anti-fog wipes. Adds that typically in that location buckets are not filled by hose, and so additional training will be given.

• <u>2023-07-017</u>: SEA WNPRC employee cut finger with glass while opening a new bottle of tacrolinus, an immune-suppressive drug.

<u>Resolution</u>: Supervisor added comments later. *Melinda noted that it was likely an ampule where the neck is snapped. SOP is to hold the ampule with gauze for protection. She added that the IP had 2nd incident this week.*

• <u>2023-07-038</u>: SEA WNPCR employee stood from retrieving dust pan from the floor and hit head on an overhead water pipe. Suffered disorientation, blurred vision & ringing in ears as well as a lump. Woke up the following day vomiting, and went to hospital for concussion. IP wonders if the pipe could be covered.

<u>Resolution</u>: Supervisor thinks that lack of awareness of space was the root cause. As the surfaces must be sanitized, padding might be impractical. IP was doing end of day procedures while trying to finish to get transportation. Take time as needed and be aware of ones surroundings.

Melinda noted the importance of seeking care immediately rather than waiting. Sonia sent the link to EH&S concussion focus sheet.

• <u>2023-07-044</u>: AZ WNPRC employee leaned drain grate against cage during cleaning, and the grate fell onto employee's leg, bruising and cutting calf. IP suggests lighter drain covers and changing SOP to reflect steps for different style grates.

Resolution: No supervisor comments. Sulgi will prompt them.

• <u>2023-07-061</u>: AZ WNPRC employee was pressure washing cages when their thumb and hand became painful, followed by swelling and stiffness.

<u>Resolution</u>: No supervisor comments. *Sulgi mentioned that they are looking into vibration gloves due to the repetition of this as a problem. She added that swapping*

people out during the task would help. Sonia wondered if this had been addressed in the ergonomics report AZ WNPRC had done? Melinda said that various things re: power washing had been discussed, but this might be a good subject for further discussion.

• <u>2023-07-064</u>: AZ WNPRC employee was recapping needle of tuberculin when they poked their right thumb.

Resolution: Supervisor notes a failure to follow established procedures for safely recapping needles; there is a specific device which should be used. Scheduled refresher training for all vet staff at department meeting. *Melinda noted that the IP should not have been using two hands. Per Sulgi, the supervisor in Arizona has ordered more and different styles of re-cappers.*

• <u>2023-07-065</u>: WNPRC employee was receiving & delivering a NHP so was not wearing anything more than scrubs and gloves. Noticed after delivery that they had scratched their arm on the cage, but no visible scratch appeared until after they got home. They called in and the vet determined it counted as an exposure, so they went to the ER for treatment the next day.

<u>Resolution</u>: Supervisor notes there is a procedural step between the vivarium and the transport vehicle which requires taking off PPE. Adding a clean set of arm guards or a lab coat may have helped. Will check the crates for sharp edges and make additional PPE available.

<mark>July 12, 2023</mark>

• <u>2023-06-011:</u> AZ WNPRC employee had thumb and pointer finger numbness. Suggests something be added to hold the trigger down.

Resolution: Supervisor notes the continuous use of hand; suggests changing hands and hand position when using the pressure washer. *This was a new employee with a new task; IP has since left. Sulgi notes that the pressure washers have a trigger lock, but that there is constant vibration, which is why switching hands is important.*

• <u>2023-06-032</u>: AZ WNPCR employee strained back while power washing.

<u>Resolution</u>: Supervisor note the IP twisted while pulling on a stuck water pressure hose, and should have stepped out of the cage to reposition the hose.

• <u>2023-06-048</u>: SEA WNPRC smashed their finger between a cage and the wall when the cage wheel got stuck. There was a gash and bruising.

<u>Resolution</u>: Supervisor suggests wearing thicker/stronger gloves when handling cages. Also don't rush and be aware of surroundings.

• <u>2023-06-074</u>: AZ WNPRC experiencing itchy hives/welts, eventually having to leave work. IP believes it is contact dermatitis from either the Wexcide detergent or the germicidal bleach used in cleaning, and in washing scrubs. Hopes the scrub service due to begin will help.

<u>Resolution:</u> No supervisor comments. *Melinda says there is currently not a laundry service contract in place. Sulgi mentioned that it happened again today to the IP, and she will make sure the IP goes to Urgent Care.*

<mark>June 14, 2023</mark>

• <u>2023-05-004</u>: AZ WNPCR employee was crouching lower than normal while spraying under the cages, due to close proximity. When they stood up, their back pocket caught on feeder, straining back.

<u>Resolution</u>: Supervisor states the cages were too far away from the wall, and they need to be pushed back.

• <u>2023-05-007</u>: AZ WNPRC employee walked into a cage, stood up to begin shoveling and struck head on the left wall bench.

Resolution: Supervisor notes IP was rushing and so inattentive to surroundings.

• <u>2023-05-014</u>: SEA WNPRC employee was drawing blood with a vacutainer on a sedated monkey; as they tried to adjust the subcutaneous positioning, the needle came out and poked the IPs thumb.

Resolution: Supervisor suggests being extra attentive when handling sharps.

• <u>2023-05-023</u>: SEA WNPRC employee with a severe onion allergy entered a room where the animals had been given onions for enrichment and had an immediate physical reaction. Left and went to car to take diphenhydramine.

<u>Resolution</u>: Supervisor says they will no longer order onions again in the workplace, and notified the department that orders their produce.

Maija asked if the area has epinephrine on hand, as the IP took benedryl, which take longer to work. Allison asked if that was something that could be addressed in onboarding? Is there proactive guidance or does it broach health confidentiality. Helen mentioned that onboarding process is currently being updated, so she might pass this question/thought along. Helen added that epipens are expensive, so there could be cases where someone does not have a personal pen on-hand due to cost. Per Sonia, this is a topic currently under debate; whether epipens can be included in a first aid kit. She added that in the APP (page 8) it references new employees required health & safety orientation, but that does not include anything about the employees specific health hazards. Ryan wondered if the UWPD also carry epipens in their emergency equipment, like the SFD. Allison asked if having a pen might count as a health accommodation for the individual employee? Ryan will bring up the discussion at U-Wide, although it does sound as though it falls back on the individual. • <u>2023-05-034</u>: AZ WNPRC employee was removing poly max plastic from an enclosure wall, when the poly cracked, ripping the IP's gloves and scratching the skin. They immediately used the scratch kit.

<u>Resolution</u>: Supervisor recommends heavier gloves when removing the poly over the latex gloves.

• <u>2023-05-042</u>: AZ WNPRC employee scraped knuckle when replacing a floor grate. Suggests taking time to think about steps.

<u>Resolution</u>: Supervisor notes IP failed to wear Kevlar gloves, although trained to do task while wearing gloves.

• <u>2023-05-062</u>: AZ WNPRC employee was passing out food when some dirty water got swept up into their eye. IP notes they were wearing all proper PPE.

Resolution: No supervisor comments.

• <u>2023-05-078</u>: SEA WNPRC employee hurt their upper and lower back carrying boxes with animals during a sample collection project.

Resolution: No supervisor comments.

• <u>2023-05-082</u>: SEA WNPRC employee developed a rash on both hands after using the Microflex Xceed nitrile gloves. IP had not experienced any problems with other brands, notes they can wear cloth glove liners.

<u>Resolution</u>: Supervisor plans to keep a variety of gloves on hand, so if an employee develops a sensitivity they can switch. Offer glove lines and non-nitrile gloves if allergies persist.

May 10, 2023

• <u>2023-04-011:</u> AZ WNPRC employee began feeling mild discomfort in left heel, with no apparent trigger, and it worsened the next day. The following Monday the IP went to urgent care and the doctor suspected plantar fasciitis. They prescribed ibuprofen, perhaps different shoes with better support and a visit to a podiatrist. The heel continues to improve.

<u>Resolution</u>: Supervisor notes IP stands for multiple hours in insufficient footwear; suggests they sit during procedures when possible, change footwear.

• <u>2023-04-012</u>: SEA WNPRC employee pulled muscles in their back picking up a heavy crate of supplies.

<u>Resolution</u>: Supervisor recommends back support for staff. *Hopefully Dian will have further information*.

• <u>2023-04-015</u>: IP was bitten by a monkey when attempting to fasten the other monkey partnered in the cage. The double gloves were not broken, but the bite caused a hematoma under the nail and 2 small cuts. They washed per protocol and went to the ED for usual follow up.

<u>Resolution</u>: No supervisor comments. *Melinda reminded the supervisor to complete the comment section. She added that she wasn't sure it was an actual exposure, and Sonia noted that she herself might have adjusted the 'type of incident' to say exposure, even with a near miss, so that the report would get a review by the appropriate people.*

• <u>2023-04-031</u>: SEA WNPRC employee 'scabbed' fingers on the squeeze bars when trying to retrieve a zip tie from the enclosed animal.

<u>Resolution:</u> Supervisor recommends extra caution near NHP. *Melinda will check if it was a scab vs a scrape, and it if was a personal vs personnel root cause.*

• <u>2023-04-032</u>: AZ WNPRC employee caught their foot in the pressure washer hose, scraping their knee, and then tripped on the hose as they stepped back, falling on the same knee.

Resolution: Supervisor recommends being aware of surroundings and not rushing. *Sulgi* mentioned that this was her, and that the pressure washer, which has a sharp front corner had been turned so the sharp edge was exposed. They repositioned it.

• <u>2023-04-046</u>: SEA WNPRC employee was returning a monkey to its cage after a procedure, when it jumped off the table. IP strained their wrist when carrying the monkey in the correct fashion back to their home cage. IP feels holding a moving 16kg animal while waiting for someone else to unlock the cage caused the sprain; recommends leaving the cage unlocked.

Resolution: Supervisor notes that animals can recover unpredictably. Suggests moving the animal to its cage with the propofol IV still attached, and removing the IVC at the last minute outside the housing room. Ask for a second person when transporting animals over 10 kg, and reviewing the safety plan.

• <u>2023-04-047</u>: SEA WNPRC employee was moving cages into the elevator when the door shut on their arm, squashing it against the cage. The door did not open immediately but kept trying to close, leading to a bruised and swollen forearm. Suggests using the door hold.

Resolution: Supervisor will have the elevator shop confirm the elevator safety measures are working correctly, as the doors should not try to close on large object in door. They will also ask that additional time is added to the door cycles and remind staff to use the door hold function.

• <u>2023-04-048</u>: AZ WNPRC employee noticed soreness in left shoulder, which worsened as the day went on.

<u>Resolution</u>: No supervisor comments. *Sulgi said that the IP was going to PT and Melinda added they had been released for full duties.*

• <u>2023-04-068</u>: SEA WNPRC employee was swapping out cage side doors when the door handle swung down, and crushed their finger. Recommends instructing people new to this kind of cage where to safely put fingers.

<u>Resolution</u>: Supervisor adds that training supervisor should use more detailed techniques when training cage work. People should put equipment into safe setup when handling, either locked in place or in the down position.

• <u>2023-04-074</u>: SEA WNPRC employee was squeegeeing detergent water from floor when they walked into the animal cage cable rail bolt, striking their temple and falling. After they collected themselves and allowed the animals to quiet the finished the floor. As the day went on their temple was tender and swollen, but they didn't feel disoriented. IP thinks it was a freak accident; perhaps adding soft covers to protruding bolts.

<u>Resolution</u>: Supervisor says that the room was rearranged to position cages to prevent such an accident, and parts have been ordered to pad the rail ends.

• <u>2023-04-075</u>: Another SEA WNPRC employee's head made contact with the rail holder screw the following morning when working in the room.

<mark>April 12, 2023</mark>

• <u>2023-03-026</u>: SEA WNPRC employee was attaching a sign to a cage when an NHP scratched their hand through their glove. IP did not realize until later that the scratch had happened; they then followed washing protocol and went to the ER for tests.

Resolution: No supervisor comments. *Melinda will ask the supervisor.*

• <u>2023-03-030</u>: SEA WNPRC employee pressed hard on a stuck cage lock, their fingers slipped and hit the contaminated casing around the lock. Their gloves ripped and knuckles abraded. They followed washing protocol, but did not report to the ER until the following day.

Resolution: Supervisor notes the cages that have locks which are difficult to maneuver, and the cages have sharp edges. Suggests moving the animal to alternate caging when possible, where thicker gloves, use alternate tools to open difficult locks and be more aware of force and immediate area of hands. *Melinda added that they are also encouraging staff to wear glove liners*.

• <u>2023-03-053</u>: SEA WNPRC employee and a colleague were moving a cage, when its wheel hit grate. As it started to fall, the IP caught it, and it struck IP's chest and shoulders, causing pain and bruising. All PPE was intact after incident. The IP later inspected the grate, and changed it out for a different piece. Notes that spare grates are available and can be rotated out if worn or compromised.

<u>Resolution</u>: Supervisor notes that moving the Allentown cages with two people allows for greater control. Rushing the process allowed the unit to hit the grate. Suggests taking time, working together. New rail systems are being installed, replacing the grate system for the drains. New smaller cages are being considered.

• <u>2023-03-065</u>: SEA WNPRC NHP scratched employee's hand while employee unlocked cage door. IP suggests being more attentive of animal, and possibly distracting the animal away from what IP's hand is doing.

<u>Resolution</u>: Supervisor will ask veterinary staff to trim the NHP toenails when he is next under sedation. Suggests that staff wear the thicker purple gloves as one of their pairs of PPE.

• <u>2023-03-115:</u> AZ WNPRC employee got a needlestick to finger as they uncapped a syringe.

<u>Resolution</u>: No supervisor comments. Sonia noted that comments were added later; the supervisor said that it was a slip tip syringe which doesn't always click firmly in place, so that the needle can sometimes come off with the cap. They are moving to the Luer lock syringe, which allows a needle to be twisted on and then locked in place.

• <u>Group 4: 2023-03-001:</u> Horowitz lab student was taking a NHP out for weighing when they scratched their arm on the cage door, drawing blood. No animal contact with injury, but IP followed the washing protocol, and after consultation with the veterinarian decided to not go to the ER. Suggests they pay better attention.

<u>Resolution</u>: Supervisor notes there is a sharp door jamb, and the physical plant has been alerted to smooth it out. *Melinda added that she went to look at the door, and covered the sharp edge with tape.*

Resolution: See 2023-04-074.

<mark>March 8, 2023</mark>

• <u>2023-02-004</u>: SEA WNPRC employee was kneeling down to give meds to an NHP, when a movement from an animal above caused a drop to splash into employee's eye. It was likely water from the earlier cage washing. IP was wearing safety glasses, not a face shield, and notes they should wear goggles tighter to face or better goggles.

<u>Resolution</u>: Supervisor recommends wearing a face shield when in a room recently washed down and be aware of surroundings.

• <u>2023-02-010</u>: AZ WNPRC employee slipped and fell on a wet floor, and scratched their arm. This was treated as a potential B virus exposure, and employee was sent to urgent care.

Resolution: Supervisor suggests checking the tread on boots, and replacing if necessary.

• <u>2023-02-011</u>: SEA WNPRC employee was moving sharps waste boxes on the loading dock when the cut their pinky finger on another box. After checking that there were no exposed sharps and that it was indeed a paper cut, they cleaned the wound and resumed work.

Resolution: No supervisor comments.

• <u>2023-02-024</u>: AZ WNPRC employee reported suspected workplace transmission of COVID; was in the breakroom for 90 minutes with a fellow employee who later tested positive.

Resolution: No supervisor comments

• <u>2023-02-094</u>: SEA WNPRC employee smelled smoke and found a piece of toast on fire in an unattended toaster oven. They turned off the oven, ran the bread under water and disposed of it just as the person cooking it (from the Primate Center) arrived back in the room. The involved person noted that they were not the supervisor of the person who left the toast, and would ask supervisors to remind staff to pay attention, not leave appliances unattended or use them incorrectly

Resolution: Supervisor of the person who found the fire filed the report; recommends extinguisher training and training on dealing with small fires. *Melinda will send Sonia the name of the proper supervisor to complete the report. Carmen noted that toaster ovens are problematic, and her surprise that they aren't prohibited. Shannon suggested a fire extinguisher nearby (if there isn't one) and training on how to deal with fire—in this case, unplugging the oven, and leaving the door shut. Sonia added that Scott Nelson could always be contacted.*

Melinda reported after the meeting they are going to pull the toaster oven, and that there is a fire extinguisher in the room.

Per Scott Nelson at Fire Safety: "Toaster ovens are allowed. This is what we evaluate for high amperage equipment which includes toaster ovens: High amperage equipment (drawing more than 1400 watts) should be plugged directly into a wall or floor receptacle rather than a surge suppressor or power strip. Examples include large refrigerators, full size microwave ovens, toaster ovens, and space heaters. The collective load of all equipment connected to 15-amp power strip should not exceed 1400 watts, or 1800 watts for a 20-amp power strip. Add it up ... equipment wattage ratings may be found on product labels. Microwave ovens, toaster ovens, and space heaters should not be used unattended. Regarding space heaters, they are a bit different with the requirements in our Focus Sheet on Space Heaters.

• <u>2023-02-111:</u> AZ WNPRC employee was using a squeegee to push water out of an enclosure. When they drew their arm back, they cut knuckles on the metal animal bench lining.

<u>Resolution:</u> No supervisor comments. *The IP was working in a small space, and was wearing 2 layers of nitrile gloves. Sulgi will remind the supervisor to complete the report.*

• <u>2023-02-112</u>: AZ WNPRC employee's finger got caught in the side of a trashcan and they broke the nail off.

Resolution: No supervisor comments. *Per Sulgi, the IP is not sure just how it happened; they were wearing 2 layers of nitrile gloves. Sonia added that on investigation, it turned out to be an exposure incident, and that the OARS report needs a better description of the incident, as well as the supervisor's comments. Sulgi will talk with them.*

February 8, 2023

• <u>2023-01-002</u>: SEA WNPRC employee was pulling out a cage to clean the floor when a NHP reached out and scratched their hand, tearing two glove layers. IP scrubbed the area for 15 minutes with an exposure kit sponge, reported the incident and went to the ER. Suggests wearing thicker gloves.

Resolution: Supervisor suggests retraining on safer areas to hold cages, and that hands should not be on cages longer than necessary. *Melinda noted that the supervisor is the new Animal Husbandry Trainer*.

• <u>2023-01-011</u>: AZ WNPRC employee believes they cut their finger while wrapping up a hose; they did not notice until later when they saw the blood. Recommends more caution.

Resolution: Supervisor recommends wearing heavy gloves when rolling hoses, covering drains, etc. Slow down and inspect equipment, replace if notice damage. *Per Sulgi, the IP found the injury when they removed their gloves and that the gloves appeared undamaged.*

• <u>2023-01-026</u>: AZ WNPRC employee reports a positive COVID test.

<u>Resolution</u>: Supervisor notes the new strains of COVID are highly contagious, and that there isn't much room for social distancing in the facility. Personnel reminded about boosters and masking recommendations.

• <u>2023-01-027</u>: AZ WNPRC employee tweaked their back throwing a trash bag out of the area so they could then move a mop bucket.

<u>Resolution</u>: Supervisor notes they were rushing; recommends taking extra steps to complete tasks safely. *Sulgi adds that two people were trying to cover the work of four.*

• <u>2023-01-044</u>: AZ WNPRC vet was attempting to move an animal from an enclosure using a jump box; animal entered the box more quickly than expected and IP strained back. IP recommends changing approach to moving animals, using trap and run portable caging as more ergonomic.

<u>Resolution</u>: Supervisor notes that jump boxes are not stabilized, and the operator absorbs all the force of the animal. Recommends using trapping run, especially with larger animals. *Ryan asked the weight of these animals; they range from 1-14 Kg. Sulgi*

explained that the jump boxes are small, heavy carriers with a handle on the top, and that the trap & run is much heavier and has to be forklifted to the upper area. Employees are trained to put their full weight on the box, to keep it from moving. Melinda added that it was one of the areas the ergonomist they hired was looking at, including discussion of having handles in a different place so that two people could manage it.

• <u>2023-01-107</u>: AZ WNPRC employee was walking in front of the enclosure when their ankle gave, turning fully inward. Minimal swelling, but felt it was getting significantly worse. IP reports they were working fast due to staffing shortage and that they need to be more careful where they put their feet.

<u>Resolution:</u> No supervisor comment. *OARS report submitted after Sulgi had a talk with the IP.*

January 11, 2023

• <u>2022-12-015:</u> AZ WNPRC employee reported COVID case, caught from co-worker.

Resolution: Supervisor recommends following masking and distancing protocol. EH&S had notified IP of a potential exposure.

• <u>2022-12-018</u>: SEA WNPRC employee caught their hand on the edge of the feeder box, scratching it through the gloves, drawing blood. Suggest wearing two pairs of the thick gloves.

Resolution: Supervisor recommends being more aware and wearing proper PPE.

• <u>2022-12-025:</u> AZ WNPRC employee reported COVID case, caught from co-worker.

<u>Resolution</u>: Supervisor recommends following masking and distancing protocol. EH&S had notified IP of a potential exposure.

• <u>2022-12-045</u>: SEA WNPRC employee's inner glove broke when NHP reached out grabbed their hand. Outer glove was intact. They have discussed using an object such as a dustpan to block the gap to prevent the animals reaching out, or having another person there to distract the animal. They will also look into getting glove liners.

<u>Resolution:</u> Supervisor reiterated the discussion about blocking the gap. *Melinda added that she is going to order glove liners for the IP.*

• <u>2022-12-046</u>: AZ WNPCR employee fell after foot fell into the uncovered drain, while carrying the covers they use to protect the tvs during power washing. IP suggests moving the tv covers before the drain grates are removed.

Resolution: Supervisor adds getting help with the covers as they are bulky, and waiting to pull the drain lids. *Sulgi added that the drains remain uncovered for several hours while the areas are power washed.*

• <u>2022-12-093:</u> AZ WNPRC employee reported COVID exposure.

<u>Resolution</u>: Supervisor notes that the administration building is old with old filtration/airflow. Emailed reminders went out to staff to stay up to date on vaccines and boosters and that masking is recommended.

• <u>2022-12-104</u>: SEA WNPRC employee was handing frozen mango treats to a pair of rhesus macaques when one grabbed their right hand, ripping both layers of gloves off. There was no apparent skin breakage. IP showed the hand to supervisor, who recommended cleaning with alcohol and then using the Herpes scrub kit. At that point, some blood was noticed and IP proceeded with the scrub kit and went to the ER. IP notes proper animal care & PPR were used, and that they may add extra layers of gloves.

Resolution: Supervisor noted that these animals are in caging that allows for some animal accessibility around the food hopper. These animals will be moved back to the standard facility cage, which allow a person to drop food items into the hoppers from more of a distance. *Melinda added that as this involved the rhesus monkeys, EH&S will do a review, with a report to NIH. She repeated the need to wear the heavy gloves and glove liners.*

• <u>2022-12-114:</u> AZ WNPCR employee was coming back down stairs carrying a net, and slipped on poop, sliding down 3-4 stairs.

<u>Resolution</u>: Supervisor suggests not carrying objects while on stairs; note that IP did catch themselves on railing. *Sulgi added that the stairs do get cleaned regularly*.

December 14, 2022

• <u>Group 4: 2022-10-069:</u> Basso Lab personnel was attaching a lock when the NHP reached out, pulled the IP's left pinky into the cage and bit it. IP pulled their hand back, lost balance, tripped on the touchscreen rig cable. They braced their fall with their left hand and forearm. IP noticed bleeding from a cut on the palm of the hand, although the glove was intact. IP did the glove test, and then scrubbed for 15 minutes. The bit finger was fine, with no cuts or bruising; their wrist was stiff but otherwise fine after the fall. PPE was adequate for the bite, but not the fall.

<u>Resolution</u>: Supervisor discussed the incident with the IP and decided to reassign them away from working with animals in this capacity; IP subsequently resigned.

• <u>Group 9: 2022-10-042:</u> Yazdan Lab personnel was facilitating loads a NHP into a chair when the NHP grabbed at a treat in their hand. The IP later noticed a small red bump during a change to sterile gloves. IP had been wearing double nitrile gloves and a double knit lab coat cuff was pulled down over the top of the gloves. They scrubbed for 15 minutes, and the 4 discarded gloves were found to be undamaged. After consultation, the decision was made that it was unlikely they had an exposure.

<u>Resolution</u>: Supervisor notes it was a near-miss, and that animals can respond to routine activities differently day to day; humans must be vigilant. Primate Center has ordered cut resistant gloves and are waiting on delivery. They will be made available and monitored to see if there are any issues wearing them when caging or using the chairs.

• <u>2022-11-001</u>: SEA WNPRC employee gave NHP a treat while cleaning its cage; the animal grabbed roughly, breaking through the two pairs of gloves and scratching IPs finger. IP went to ER for treatment.

<u>Resolution</u>: Per supervisor, the cage has a feeder box. Always be careful and pay attention to the animals; vet staff should also do regular maintenance nails of animals. Employee is fine, did not miss work.

• <u>2022-11-015</u>: SEA WNPRC was lifting a frozen carcass from the necropsy room freezer and reinjured their lower back. Cannot lift or bend over easily.

<u>Resolution</u>: No supervisor comments. *Melinda noted that the IP works alone and at night. It is a chest freezer, and so have to reach down. She asked if they could put something in the bottom to raise the level.*

• <u>2022-11-019</u>: SEA WNPRC employee strained back muscle, resulting in a doctor visit, a day after having done multiple cage cleanings. Unsure what motion caused the pain, but not felt until next day

Resolution: Supervisor said that the employee did not return to work and resigned, so the supervisor did not have a chance to talk with them. They should have filed an injury report ASAP. *Ryan noted that AZ WNPRC had its ergonomic assessment done. Melinda said the plan is for both facilities to use the best practices that will be culled from the 47 pages of recommendations they received.*

• <u>2022-11-021</u>: SEA WNPRC employee was giving an injection when the animal moved; the needle bent at an angle and the IP gave self a needle prick.

<u>Resolution</u>: Supervisor suggests squeezing animal tight enough to avoid sudden movements while giving injections. Melinda said the IP did not notice that the needle had bent. She added that Biosafety is doing an investigation.

• <u>2022-11-032</u>: SEA WNPRC vet tech was giving the NHPs their morning treatments when one reached out, knocking over some cups and spilling medications. IP moved quickly to pick them up, slipping and falling to floor holding the tray. They landed knuckles first, and heard a popping sound. There is now discomfort with the middle knuckle. IP would like shoe covers with a better grip and traction

<u>Resolution</u>: Supervisor notes the environment is wet and slippery, animals behave unpredictably. Will look into better shoe covers. *Sonia observed there seemed to be more biscuit-related slips—were they washing the pens when food was still there?*

• <u>2022-11-087</u>: As SEA WNPRC employee was changing out the ringers bags they slipped, hitting their right shoulder on the edge of the cage.

<u>Resolution</u>: Supervisor notes missed step, loss of balance; be extra careful. *Melinda* added that the IP was walked to the ED, but declined to wait to be looked at; they would be seeking medical care on their own.

• <u>2022-11-088</u>: SEA WNPRC employee slipped in an unidentified puddle and landed on right wrist and hip. Left leg sprawled out while IP tried to catch themselves; reports pain in the associated areas and a bruise on their right wrist.

Resolution: No supervisor comments. *Melinda will poke the supervisor*.

• <u>2022-11-094</u>: SEA WNPRC employee slipped in aisle while changing pens; caught themself by grabbing the front of a nearby pen, so only fell halfway. The floor was wet and their boot tread was filled with monkey biscuit mush.

<u>Resolution</u>: No supervisor comments. *Melinda notes that the IP says they now wash down an area first, the clean their boots before entering.*

• <u>2022-11-099</u>: SEA WNPRC cut their hand on the corner of a metal edged wooden ruler when returning it to a drawer; the ruler caught on something in the drawer and cut the IPs palm.

<u>Resolution</u>: Supervisor says inattention and an old metal ruler. Replace with a new plastic one, and reorganize the drawer.

November 9, 2022

• <u>2022-10-022</u>: SEA WNPRC employee shifted four juvenile NHP into the same pen to clean the other enclosure, not knowing that door was not secured. Seeing the four had noticed the open door, IP rushed to close it. As they had not used the transfer door before, they did not know how to latch it. Attempting to fasten it in a hurry, they pushed back their fogged up face shield. One of the animals bit at IP's glove and then let it snap back in place, causing fluid to hit IP's right eye. IP secured the lock and went to the eye wash for 15 minutes. Co-workers waited during the eyewash, and one walked IP to the ED. IP will switch to goggles.

Resolution: No supervisor comments. *Melinda will remind them.*

• <u>2022-10-026</u>: SEA WNPRC employee's feet slipped on wet floor. As they tried to balance themselves, their upper arm hit the floor and their head touched the sharps container. They will try to pay more attention to wet floors.

<u>Resolution</u>: Supervisor says both the spray disinfectant on the IP's booties and the wet patch on the floor added to the slipperiness. Employee knew to squeegee after cleaning, due to the slope of the room. Signs should be posted as reminder. Recommends being aware of movements in wet environment, squeegee the water, ensure signage in place and

switching out shoe covers rather than spraying them with disinfectant. *Melinda added that the standard procedure is to not wear shoe covers on boots.*

• <u>2022-10-065</u>: AZ WNPRC employee has a pre-existing right shoulder injury from pressure washing; they were trying to use left arm for daily tasks, and now has pain in left shoulder.

<u>Resolution</u>: No supervisor comments. *Melinda noted that the ergonomist had flown down, taken videos (including the pressure washing) and provided their assessment. The team was due to meet the week of Nov 14th to discuss the report.*

• <u>2022-10-073:</u> SEA WNPRC had a pair of subcontractors from Summit Anesthesia doing maintenance on a portable anesthetic machine. One accidently dropped a half-full bottle of the anesthetic Sevoflurane, breaking the bottle and spilling the liquid. They covered the spill with a towel and exited the room, notifying the spill team. The spill was cleaned, the glass put in the sharps container and the team returned to work.

<u>Resolution</u>: No supervisor comments. *Melinda said that they were discussing better* ways to handle things, and to handle bottles. This bottle was empty and dropped as it was being removed from the machine, so no liquid spilled. Ryan asked is extra PPE was worn when doing this maintenance; Melinda said as they were subcontractors, she did not know.

October 12, 2022

• <u>2022-09-015</u>: AZ WNPRC staffer slipped on floor slippery with hydraulic fluid. Trying to catch themselves in the fall, IP pulled a muscle on the outside of their thigh. Later in the day, slipped on wet cheerios and further aggravated it. Took an OTC anti-inflammatory and returned to work. IP knew the spill was there, and notes that it was appropriately posted. Added they will be more careful and be sure there is adequate bedding down to counteract fluids.

<u>Resolution</u>: Supervisor says that not enough sawdust was down, and IP walked through and not around the area. Facilities are still waiting on a part to fix the leaky hydraulics. *Per Sulgi, the fix has finally happened.*

• <u>2022-09-017</u>: AZ WNPRC employee also slipped in the fluid reported in 2022-09-015. Caught themselves but tweaked lower back. Not long after, they were pushing a wet-vac down an incline, and when they tried to stop it flipping, more pressure was put on back. IP reported the spill signage had been moved out of sight. They recommend getting a wet-vac for each level so the awkwardly weighted machine does not have to be manipulated on an incline.

<u>Resolution</u>: Supervisor notes IP walked through and not around the area even with sawdust down; and they should have asked for help and/or pulled the shop vac instead of pushing. *Sulgi added that the signage/cones had been moved away and is unsure why.*

• <u>2022-09-029</u>: AZ WNPRC employee had pain in left shoulder, radiating down to ring finger and pinky, with occasional numbness and tingling. It occurred after power washing, and is worsening.

<u>Resolution</u>: Supervisor says too much pressure washing or possible improper handling of equipment; suggests using other arm, stretching beforehand, let coworkers do the task if having issues. *Melinda added that an ergonomist is going to the AZ facility in 2 weeks to look into these issues*.

• <u>2022-09-034</u>: SEA WNPRC employee was in Magnuson HSC building elevator with an older, unmasked man who was coughing and not covering their cough. IP tested positive for COVID three days later. IP suggests wearing KN95 or N95 at work and indoors.

Resolution: Supervisor agrees with masking and social distancing. EH&S forwarded to alert contact tracers. *Caroline wondered about adding masking signage to the elevators in health care facilities. Fieta wondered just what was meant when 'extra' COVID precautions were mentioned. Sonia assumes it is the signage, staff training, extra cleaning, classroom filters, and the like.*

• <u>2022-09-039</u>: AZ WNPRC employee pushed too hard on a cage that had stuck in the drain area and felt a pain in their back. They finished the days work, and reported the injury the next day to Concentra.

Resolution: Supervisor says the cage was heavy and IP should have asked another person for help. *Sulgi noted that it was at the end of the day and there was no other person available.*

• <u>2022-09-051</u>: SEA WNPRC tripped on broken curbing when leaving work after an overtime shift; injured left ankle.

<u>Resolution</u>: No supervisor comments. *Melinda has since finished it, and notes the the IP resigned without ever returning to work.*

• <u>2022-09-085</u>: SEA WNPRC employee received a needle stick in their index finger when trying to give a subcutaneous injection to an NHP. The syringe with prograf/tacrolimus was in one hand, and when the animal wiggled, the needle grazed their other hand, breaking the glove. The needle had not touched the animal, and IP felt no solution was injected. IP washed the site for 15 minutes and followed up with Employee Health.

<u>Resolution</u>: Supervisor offered different options/sites of administering SQ injections safely.

September 14, 2022

• <u>2022-08-008</u>: SEA WNPRC employee has heel bursitis and suspects wearing work boots after being off work for a long stretch contributed. Recommends more supportive boots that are suited to working in the cold I-Wing.

<u>Resolution</u>: Supervisor notes the IP was pushing to complete tasks that had built up over vacation and may not have been prepared for the physical load, and not taking breaks. Take breaks, stretch; new boots have been ordered.

• <u>2022-08-016</u>: SEA WNPRC staffer was cleaning tools after a necropsy and punctured finger with rat tooth forceps. Scrubbed for 15 minutes, went to the ER & started taking Acyclovir while they wait for the test result from EHC.

<u>Resolution</u>: Supervisor suspects inattention and recommends care and concentration. *Per Melinda, the tools had been soaking in cleaning solution for a while, and it was an abundance of caution.*

• <u>2022-08-021</u>: SEA WNPRC was feeding animal with hand near cage when animal bit hand, breaking gloves but not skin. Employee washed the area for 15 minutes to be safe.

<u>Resolution</u>: Supervisor notes it was a near miss, and that the employee should keep body parts away from the cages.

• <u>2022-08-022</u>: SEA WNPRC employee was head-stabilizing a NHP in a chair when NHP thrashed head and dragged left canine along base of employee's thumb, causing 3cm laceration. IP washed per protocol and went to the ED. Incident happened on the Thursday, IP was hospitalized on Friday night/Saturday morning.

Resolution: Supervisor notes the IP is transferring to this lab from another lab at the Primate Center, and the procedure techniques are different. IP was only wearing nitrile gloves on the injured hand. Recommends adding more Kevlar gloves to the lab's supply, wearing both nitrile and Kevlar on both hands, learning to hold the NHP head from behind and having another person assist. *Melinda added that it is now an L&I claim, due to the hospitalization, with a potential fine for the lack of PPE on both hands. Sonia noted that it warrants a serious EH&S serious investigation and a formal root cause analysis. Group 1 should receive a copy & reports when the EH&S investigation is done.*

• <u>2022-08-027</u>: AZ WNPRC employee cut their finger on an animal bench while they were cleaning in a cage.

<u>Resolution</u>: Supervisor suggests checking the bench for any rough areas and smoothing them. Recommends personnel take more care.

• <u>2022-08-043</u>: SEA WNPRC; during an NHP's TB test, NHP movement resulted in used needle grazing employee's finger, puncturing gloves but not skin. Scrubbed for 15 minutes, declined a visit to the ER.

<u>Resolution</u>: Supervisor recommends being more careful with hand placement during procedure; make sure animal is properly sedated.

• <u>2022-08-044</u>: SEA WNPRC employee burned their arm on the autoclave as they removed sanitized trash.

Resolution: Supervisor notes the autoclave bar is higher up and shorter staff have a hard time raising it without bumping the bar. Recommends cover sleeves and care. Feels a step stool might be too unstable. *Same autoclave in 2022-06-042 & 2022-08-109*.

• <u>2022-08-046</u>: SEA WNPRC employee was moving a dirty cage when the wheel fell off, the cage tipped toward them, and they swung the cage into the wall to prevent it falling, which strained their back/hip. Suggests moving out of the way instead of trying to catch it in future.

<u>Resolution</u>: Supervisor says it was equipment failure; couldn't find the missing mut to determine if it was loose or damaged.

• <u>2022-08-047</u>: SEA WNPRC; after sedating an NHP, the employee found a bleeding abrasion on their thumb, probably from animal cage ripping glove.

<u>Resolution</u>: Supervisor says the equipment may be sharp, environment may be small and/or dark. Recommends inspecting the cage.

• <u>2022-08-067</u>: SEA WNPRC; when animal shifted, employee stuck right thumb with needle they just used on infant macaque foot stick blood draw. IP suggest perhaps using retractable needles.

<u>Resolution</u>: Supervisor agrees with recommendation and continuing to train animals to minimize sudden movements. *They have changed the kind of needle used*.

• <u>2022-08-103:</u> AZ WNPRC employee bent over to retrieve an item off a treatment cart and strained their back.

<u>Resolution</u>: Supervisor notes the bowl was a little heavy, but not awkwardly so, and the reach did not involve an awkward body position, but a bend and lift. Recommends not placing heavy or awkward items on the bottom shelf. *Melinda will check the IP did the back training*.

• <u>2022-08-107</u>: SEA WNPRC employee pricked left 4th digit during blood draw on NHP.

Resolution: Supervisor notes inattention.

• <u>2022-08-109</u>: SEA WNPRC husbandry employee was removing items from the autoclave when they burned their arm on the autoclave bars. Recommends providing thermal sleeves.

Resolution: No supervisor comments. *Melinda says sleeves have been ordered.*

• <u>2022-08-119</u>: SEA WNPRC employee was feeding NHPs when an NHP reached through the hopper and scratched the employee's wrist.

<u>Resolution</u>: Supervisor notes inadequate PPE—that longer gloves would have prevented the scratch; recommends cloth sleeve covers.

August 10, 2022

• <u>2022-07-017</u>: AZ WNPRC employee was walking to turn off water, with a fogged face shield. Stepped on a garbage can lid on the floor, it slid underfoot, and IP landed hard in the splits position, bruising and straining groin, buttocks, legs.

<u>Resolution</u>: No supervisor comments. *Per Sulgi, the lid should not have been in the colony area.*

• <u>2022-07-021</u>: AZ WNPRC occupational health employee fell, bruising elbow and hand. Per the IP, they were outside in 103F heat, adjusted their face shield as they walked, and misstepped moving from sidewalk to lower pathway, falling forward. IP suggested not adjusting a face shield while walking, and that perhaps they need to go to Arizona more often to acclimate to the heat.

Resolution: Supervisor note the IP was not familiar with the site. Recommends marking the change in elevation with paint and going more slowly when touring visitors around. *Melinda added that this was her, she was hydrated & in proper shoes, and that it was just a misstep. Sulgi added that they have now painted step edges.*

• <u>2022-07-022</u>: AZ WNPRC employee was cutting avocados when their knife cut through fruit/pit and cut left index finger. IP forgot about the cut gloves, and recommends a general reminder and signage might help.

Resolution: Supervisor recommends wearing protective gloves.

• <u>2022-07-039</u>: SEA WNPRC employee and co-worker removed a wooden crate from an autoclave and placed it in the trash cart. IP put their hands on the cart handle, the crate shifted and crushed fingers on their right hand. Cut and abrasions.

<u>Resolution</u>: Supervisor suggests paying better attention to hand placement when dealing with heavy objects; expects things to shift even when you think they won't.

• <u>2022-07-040</u>: SEA WNPRC employee's hand was bruised by an infant rhesus bite as employee was handing out biscuits.

<u>Resolution</u>: Supervisor notes IP was not wearing adequate PPE, and should have used the available scratch resistant gloves.

• <u>2022-07-041</u>: SEA WNPRC employee got a needle stick with a needle previously used on NHPs.

<u>Resolution:</u> Supervisor feels IP should examine equipment before use, allow time for set up, and re-read the sharps SOP, and communicate with others about the presence of sharps. *Melinda noted that the needle used was the size of one used for insulin, and that the IP forgot it was in the equipment.*

• <u>2022-07-050</u>: AZ WNPRC employee's neck stiffened up after pressure washing. Tried stretching, and went on to spot shoveling the downstairs colony. When finished, their neck was worse. Painful to move neck down, or to the right, with pain going down arm.

<u>Resolution</u>: No supervisor comments. *Melinda says that they are going to work with an ergonomist on prevention of these kinds of injuries. The IP is seeing a PT.*

• <u>2022-07-067</u>: SEA WNPRC employee was spraying beneath the Macaque room grates and felt droplets splashing into eyes. After replacing the grates IP used the eye wash station, and taken to ED for exposure. IP feels the PPE was inadequate for biohazard room washdowns, as the splashes can come from any angle. IP also thinks the grates are an increased health risk for humans and animals as waste and excess moisture accumulate on surfaces that require direct handling to clean. Notes other rooms in Animal Research Care Facility have installed modified railing that allows for discontinuation of grates.

Resolution: Supervisor says that newer employees are still getting used to the work environment, and was in disposable face shield. It was a high stress day, and there may have been rushing. Recommends using hard shell shield or a disposable one with goggles. *Melinda said that she will also ask on the progress of the project to remove the grates.*

• <u>2022-07-090</u>: SEA WNPRC employee was using a laryngoscope on a sedated macaque. The animal began to gag as the sponge touched its tracheal surface, and as the mouth closed its canines penetrated the IP's nitrile ppe gloves, lacerating right hand ring finger. Minor bleeding, and bruise.

<u>Resolution</u>: Supervisor says the NHP was not well sedate, and recommends ensuring the subject is heavily sedated for sensitive sample collection. Melinda said that during their discussion of the incident, the idea of also using a gag or bite block came up.

• <u>2022-07-092</u>: AZ WNPRC employee stood up after treating patients and felt pain in left quad.

<u>Resolution:</u> No supervisor comments. *Possible to use a rolling stool for lower level checks?*

• <u>2022-07-103</u>: SEA WNPRC employee was removing biscuits from a food hopper when a macaque reached in, scratching gloved left hand and lacerating left index finger. Per protocol,

washed for 15 minutes, and reported it to the On Call vet and went to ED for prophylaxis treatment. Suggests removing the hopper, from the cage, and then emptying it.

<u>Resolution</u>: No supervisor comments at the time of the meeting. Sonia checked and the supervisor had written that the IP had a minor cut and was fine. Pay attention to the animal, think safety at all times, remember to remove the hopper if the animal is active.

• <u>2022-07-104</u>: AZ WNPRC animal tech was using a step stool as a chair, pushed it back and it collapsed. They fell over backwards, landing on their tailbone and hitting their shoulder blade on a metal water bottle. They suggest not using a step stool as a chair.

<u>Resolution</u>: No supervisor comments. *Same IP as in 2022-07-017; possibly using the stepstool as still uncomfortable after the first fall. Sulgi says the stepstool was trashed, as a different person had a fall from it. It will be replaced.*

<mark>July 13, 2022</mark>

• <u>2022-06-009</u>: SEA WANPRC employee had an accidental needlestick with syringe containing formulation. Nothing was injected, but had concerns about any residue on the needle.

<u>Resolution</u>: Supervisor notes it as personal negligence, and advises more care and to pay attention. EH&S comments that the OH nurse noted that proper post exposure protocol was followed. No biohazard, and nurse reached out to IP.

• <u>2022-06-013</u>: SEA WANPRC employee was feeding NHP treats to distract it while IP visualized an incision sit. Agitated NHP grabbed employee's hand, scratching skin through t layers of nitrile gloves. Followed SOP and washed the area, and went to ER. Plans to wear thicker or cut gloves in future.

<u>Resolution</u>: Supervisor agrees with glove recommendation; also to limit close contact with research animals, and watch for agitation. *Melinda added that the IP has just moved into a new job as vet tech, and this might be part of the learning process. It might be good to remind staff to be aware when concentrating on a new skill.*

• <u>2022-06-023</u>: SEA WANPRC staff opened a side gate for socialization between two NHP, and one scratched them through two layers of nitrile gloves. No broken skin.

Resolution: Supervisor notes the animal was able to reach out due to cage spacing; they will remind staff that Kevlar gloves are available, to revisit best practices for side gate opening, and review procedures for dealing with a potential or actual bite/scratch. *Lila asked if these lightweight Kevlar gloves would have helped in OARS reports 2022-06-009 and 2022-06-013. Melinda notes that the gloves are available to staff, but not required in the SOP.*

• <u>2022-06-028</u>: AZ WANPRC employee had slow onset of right shoulder and upper back soreness. IP has been icing, and had not yet sought medical help.

<u>Resolution</u>: No supervisor comments at time of meeting. *Melinda says that they are working with an ergonomist to see what might be done to prevent these types of injuries. The IP has gotten PT.*

• <u>2022-06-050</u>: AZ WANPRC employee's neck and shoulders were already tight from the work week, and their right shoulder started hurting when they tried to power-wash overhead.

<u>Resolution</u>: No supervisor comments at time of meeting. *Had an ergonomic evaluation; Melinda says the supervisor has left their job.*

• <u>2022-06-063</u>: SEA WANPRC employee exposed to coronavirus at work.

<u>Resolution</u>: Supervisor says that a non-employee was on campus for a meeting with UW staff, and reported a positive test the following day.

• <u>2022-06-077</u>: SEA WANPRC employee was replacing the scrub pad on a doodlebug floor scrubber, when its plastic teeth abraded thumb through gloves.

<u>Resolution</u>: No supervisor comments at time of meeting. *Melinda noted that perhaps staff should wear the Kevlar gloves with the doodlebug pads.*

<mark>June 8, 2022</mark>

• <u>2022-05-007</u>: AZ WANPRC employee was walking on wet floor, left leg went into an open gutter and they fell forward, bruising shoulder, arm, and knee.

<u>Resolution</u>: No supervisor comments at time of meeting. *Allison asked if it was possible to paint around the gutters. Per Sulgi, the gutters are always open, and the floor is always wet and both are known hazards.*

• <u>2022-05-042</u>: SEA WANPRC employee burned ~2 inches of elbow crook while reaching in to remove trash from hot autoclave.

<u>Resolution:</u> No supervisor comments at time of meeting. *Ryan will follow up with supervisor to get more details; unknown what kind of autoclave and if PPE was worn.*

• <u>2022-05-061</u>: AZ WANPRC Employee was cleaning outdoor enclosure when water dripped from face shield sponge into left eye.

<u>Resolution</u>: No supervisor comments at time of meeting. *Employee got safety goggles, and plans made that all new hires will wear goggles for the first 2 months. They are also trying anti-fog spray on them. Sulgi pointed out that people don't like the goggles because of the fogging and discomfort wearing them.*

• <u>2022-05-069</u>: AZ WANPRC Employee cut right thumb on metal floor grate.

<u>Resolution</u>: No supervisor comments at time of meeting. *Sulgi said these are the grates that cover the gutters in OARS report 2022-05-007; the short ends are sharp and some are old enough that when lifted they also pull up the lower grating. Their facilities people will work on smoothing the sharp edges as they can.*

• <u>2022-05-075:</u> AZ WANPRC employee splashed in right eye by pressure washer. IP suggested wearing safety goggles under face shield.

Resolution: No supervisor comments at time of meeting. *Per Sulgi, the pressure washing by the animal techs is done at all angles so splash happens.*

• <u>2022-05-090</u>: SEA WANPRC potential workplace transmission of COVID. IP suggests reinstating COVID protocols, such as masks worn in the halls, more hand sanitizer stations, disinfecting door handles.

<u>Resolution</u>: No supervisor comments at time of meeting. *Sulgi says that they are emphasizing masking, and that there is a separate lunch area set up.*

May 10, 2022

• <u>2022-04-041</u>: SEA WANPRC employee had water from rag used to clean plexiglass in NHP cage splash into eye. IP suggests wringing out rag more, or safety glasses.

<u>Resolution</u>: Supervisor says the rag was too wet; wring out rag more, or wear safety glasses.

• <u>2022-04-050</u>: SEA WANPRC employee was seeing the health nurse, and mentioned they had had gastrointestinal symptoms for more than a week; checking with doctor to see if related to any NHP exposure.

Resolution: Supervisor notes say that if the GI issues are related to the monkeys in clinical isolation for GI pathogens, the exposure likely occurred before the monkeys were isolated. Suggests changing gloves more often between rooms, even when not under clinical isolation and wash hands more thoroughly when leaving the facility. *Per Melinda, this is the IP from OARS 2022-04-41. Sonia noted that if this did indeed prove* to be related to animal exposure, they would need the test results, as that would entail a different report to OSHA. Matt said that virtually everyone who works in the units gets ill at some point in their first 6 months, due to meeting staph and shigella for the first time and being around aerosolized fecal matter. Melinda added that all new employees are told about potential transmissions (human to NHP, NHP to human) during their orientation, and given a handout.

• <u>2022-04-074</u>: SEA WANPRC anesthesiologist gave themselves a needle stick during surgery, after injecting propofol into an IVC port. Suggests being more attentive.

<u>Resolution</u>: Supervisor comments that at times it is awkward for an anesthesiologist to reach the IV port, with the patient occasionally still moving and the drape in the way.

Proposes an evaluation stage before surgery, where the patient is placed on the table, and the anesthesiologist can locate a place on the fluid line (or add an extension) that will enable them to easily reach the port and give an infusion without a needle.

• <u>2022-04-077</u>: AZ WANPRC employee carrying a sedated animal into a cage, stood up into the metal perch, hitting and bruising their shoulder. Suggest changing the work layout.

Resolution: Supervisor says the root cause was the existing policy for returning a sedated NHP, having to maneuver through an interior door that is not high enough. Recommends using a cart to transport the animal, so the person can navigate the doors more safely. The IP will try this method, and report back if it works better.

<mark>April 13, 2022</mark>

WANPRC ergonomic and NPH injuries were the primary incidents; it might be worth taking a look at ways to reduce them in the Seattle and Arizona facilities. Matt noted that the Seattle ergonomic problems were primarily due to moving very heavy cages, often across uneven surfaces. Arizona had fewer cage incidents as they have the large holding areas. Erin wondered if it would be worth bringing in an outside ergonomist.

Melinda asked about correcting numbers in the report. She noted that the WANPRC person listed as out 180 days for a shoulder injury did leave with an injury but was actually out subsequently due to a different health issue. Erin and Ken Nielsen (from Risk Services) said changes could be made and they will investigate.

• <u>2022-03-008</u>: AZ WANPRC employee was pushing a cage through obstructions in a hallway. The cage rebounded off wall protrusion and caught employee's hand between cage and wall, bruising and abrading hand. Neither glove was broken, and the cage was clean & outside the facility. Recommends a 2nd person to help guide the cage.

<u>Resolution</u>: Supervisor says the employee was hurrying through a chokepoint in the hallway. Recommends slowing down and using safe moving techniques. Help was available, and the obstructions temporary. Discussed moving techniques with employee. Seeking storage spaces for the obstructing cages.

• <u>2022-03-009</u>: SEA WANPRC employee spraying a dirty barrel in pen got splash back in eye.

<u>Resolution:</u> No supervisor comments. *Melinda added that they are working on purchasing different eye PPE.*

• <u>2022-03-011</u>: SEA WANPRC employee was talking while checking lixits, when NHP reached through and pulled a finger through cage, and bit it. Washed injury and reported it. Not a macaque bite, so IP did not have to go to ED. Advised by vet to seek medical attention if bite was serious. IP suggests checking work procedures.

Resolution: No supervisor comment.

• <u>2022-03-049</u>: SEA WANPRC employee has had a sore muscle under right shoulder blade for 3-4 months, presumably from day-to-day job duties. At annual health assessment was told they should report it. IP plans to stretch properly before and after tasks, and to pay attention to lifting, pushing, pulling procedures.

<u>Resolution</u>: Supervisor notes it is a physical job, and agrees with the IPs plans. *Melinda added that the report was filed by the IP on the same day they had their annual visit with the health nurse.*

• <u>2022-03-065</u>: AZ WANPRC staffer employee was pressure washing outside enclosure when they slipped down stairs, causing bruising and/or cutting elbows, hands, buttocks and knees.

<u>Resolution:</u> No supervisor comments. *Melinda and Sulgi had been DM-ing re: this incident. IP slipped while moving pressure washer hose to the upper level. Ryan asked about leaving a second washer on the upper level, but the stairs are inside the compound, so that won't work. He then asked if a dedicated water line could be there, instead, to hook the washer up when needed. Melinda added that they are short-staffed down there.*

• <u>2022-03-077:</u> SEA WANPRC staffer employee was removing stuck food hopper which released suddenly and cut right thumb.

<u>Resolution</u>: Supervisor feels root cause was defective caging. Suggests IP report problem rather than trying to fix it themselves and administer medication via other means.

February 9, 2022

• <u>2022-01-001</u>: SEA WANPRC was checking locks when an animal reached through and grabbed their hand. Outer glove fine inner glove was torn, and hand scraped. IP did the required clean of the scrape, while co-worker checked the outer glove. Outer glove passed the water test, so IP did not report for medical follow up.

<u>Resolution</u>: No supervisor comments. *Per Melinda, protocols were followed. Sonia* added the reminder that closed OARS reports can be reopened by EH&S if additional comments need to be made.

• <u>2022-01-010</u>: AZ WANPRC staffer stepped on rock with right heel when getting off the forklift. The area where the forklift is driven & parked is on dirt and rocks; suggested corrective action would be asphalt or concrete driveway. Meanwhile, will use more caution when stepping off the forklift in the dark.

<u>Resolution</u>: No supervisor comments. *Per Melinda, it was a stone bruise and they did not seek medical attention. They were wearing work boots.*

• <u>2022-01-028</u>: SEA WANPRC having pain in right hand, wrist & fingers since new duties (1.5 years) involving more keyboarding. Reports they had the same problem in 2021-2013 when also had increase in keyboarding, including wrist surgery in 2012. They are making a doctor's

appointment, and reports that they have a laptop, chair and ergonomic mouse at work, and similar home set up; possible a different desk?

<u>Resolution</u>: Possibly re-aggravated or new injury that need to be assed by physician. EH&S has provided resources to mitigate continued aggravation and pain. IP is scheduling an appointment.

• <u>2022-01-035</u>: SEA WANPRC staffer injured shoulder and arm when the heavy cage he was pushing suddenly stuck on the door threshold. Pain and partial immobility overnight; not evaluated medically.

Resolution: They will go over proper pushing and pulling techniques in the cage wash area. *Per Matt, push rather than pull is the best policy. The cages should be loaded into the washers carefully, generally "one wheel at a time" i.e. at an angle rather than directly perpendicular to the wash chamber.*

• <u>2022-01-047</u>: SEA WANPRC staffer tested positive for COVID on Jan 11; potential workplace exposure. IP suggests change/reviewing work procedure.

Resolution: No supervisor comments.

• <u>2022-01-048</u>: SEA WANPRC staffer was spraying a dirty cage floor when the water bounced off floor and under face shield onto face. Some splashed around their eyes, and so they did the 15 minute eye wash to be safe. IP suggested wearing safety glasses under shield.

<u>Resolution</u>: Supervisor agreed with the suggestion of safety glasses. *Melinda notes that there is a new supervisor in Seattle, who is looking into new, different face shields.*

• <u>2022-01-071:</u> AZ WANPRC staffer was unloading chow off the forklift, hit the doorframe with a bag of feed and jammed their wrist. IP suggests wider doors on the feed shed.

<u>Resolution</u>: No supervisor comments. Same IP as in 2022-01-010; Melinda added that the root cause was due to the door size. The IP needed to unload 300+ bags of feed by daisy chaining them off one pallet and restacking them inside the building on a new pallet. The door is being replaced 2/10 and they will now be able to directly place the pallet in the feed storage area. This should be prevent future wrist injuries and be an ergonomic win for the group.

• <u>2022-01-077:</u> AZ WANPRC employee went home due to COVID symptoms, testing positive. Feels only contacts had been coworkers or Concentra office.

Resolution: No supervisor comments.

• <u>2022-01-078</u>: AZ WANPRC employee woke up with COVID symptoms, testing positive. Feels only contacts had been coworkers or Concentra office where they go for PT. **Resolution:** No supervisor comments.

• <u>2022-01-079</u>: SEA WANPRC tech was cleaning a cage pan when animal reached out and scratched their face, reaching under the face shield, and under their mask.

Resolution: No supervisor comments.

• <u>2022-01-080</u>: SEA WANPRC employee has for a month experienced their right arm going to sleep when sleeping at night. Symptoms have progressed, and now has middle and pointer fingers tingling, pain in right wrist and arm, possibly from repetitive motions.

<u>Resolution</u>: No supervisor comments. *Ergonomics issue; Melinda is checking to see if they saw their own doctor, or used employee health.*

January 12, 2022

• <u>2021-12-016</u>: AZ WANPRC vet had a crowbar fall onto their head, causing ~2 cm open wound that required staples to close. The wound was scrubbed for 15 minutes prior to going to urgent care. The crowbar was dislodged when a co-worker pulled a glove from the shelf, as they got ready to assist.

<u>Resolution</u>: A crowbar was stored on the top shelf of a storage rack; storage location was changed.

• <u>2021-12-37:</u> SEA WANPRC employee reported ongoing trouble (since August) with middle fingers locking on tight hand. He was seen by the doctor at EHC and referred to Occupational therapy. He was seen there in December, and an L&I claim filed.

<u>Resolution</u>: OARS report filed for L&I claim. *Melinda reported that this report and* OARS 2021-12-038 involve the same IP; they did not file OARS reports at the time, so it was done later.

• <u>2021-12-038</u>: SEA WANPRC employee contacted EHC with a hive-like rash. IP say doctor referred to Occupational clinic. A L&I claim was filed.

<u>Resolution</u>: OARS report filed for L&I claim. Employee has switched boots and that seems to have helped. They will be given longer gloves and coveralls with feet.

• <u>2021-12-045</u>: SEA WANPRC tech was scratched above the protective sleeve by a NHP during a blood draw. IP reported a small tear in the coveralls. They washed the scratches and the alcohol test was done. It appeared the skin was broken, but the IP chose not to go for medical follow up at the time.

<u>Resolution</u>: No supervisor comments. *Melinda notes that supervisors have been working on the floor as they have personnel gaps from Covid quarantining and (in December) the snow.*

• <u>2021-12-046</u>: SEA WANPRC tech's hand was pinned by a (disposable) wooden transport cage while transferring animals. IP did not report the injury, but missed a day of work. Reported the following day with a visibly injured hand; IP says the glove was not torn.

Resolution: No supervisor comments.

• <u>2021-12-054</u>: AZ WANPRC staffer twisted right ankle when tripped on a gravel driveway in the dark. Motion light that would light the area was out; IP will put in work order to fix it.

Resolution: No supervisor comments. Melinda says the IP is still receiving PT.

• <u>2021-12-063</u>: AZ WANPRC staffer was bitten twice (calf and knee) by a displeased monkey. Two co-workers were attempting to move two monkeys out of the enclosure and into a box; the angry monkey had been prevented from getting through a gap and back to the colony. IP suggests reviewing work procedure, perhaps using a Group 6 cage (for larger NHP) to avoid issue.

<u>Resolution</u>: A Group 6 cage was available, but not used. It has an extension the abuts the enclosure to prevent an animal from squeezing through any gap. WaNPRC are working on center-wide guidelines for when jumping animals out of enclosures.

• <u>2021-12-066</u>: AZ WANPRC staffer was bending over, and hit lower back on the long bar perch across the enclosure.

Resolution: No supervisor comments.

• <u>2021-12-068</u>: New SEA WANPRC staffer noticed a forearm scratch when removing PPE; believed it must have happened when separating two animals. One animal reached out as the IP was working on the panel lock; IP was focusing on the stiff lock. IP scrubbed the wound and reported it; on-call vet was called.

<u>Resolution</u>: Staffer was instructed to carefully check hands and arms before starting work and to cover any existing scratches, cuts or nicks with band aids. Also told to wear sleeve covers.

December 8, 2021

• <u>2021-11-003</u>: SEA WANPRC tech foot was caught in an elevator door. They were standing outside the elevator, and the foot was caught about 18 inches off the floor. The IP reports that there was no noise to indicate the door was going to close. When they pushed the call button the other elevator arrived, and nothing happened with the one still holding their foot. IP says foot is ok at this point; work order in 11/01 to fix elevator.

Resolution: per supervisor, the elevator safe guard failed to keep the door from closing on the IP. The elevator seemed to be functioning 11/02. They have requested an update on the issues found and addressed. *Melinda added that the IP was not trying to hold the elevator by sticking their foot out; Allison said that in a meeting she once had with the*

Elevator Shop, they were very firm that you never put any body part in the doorway to try to stop the elevators doors.

• <u>2021-11-016</u>: AZ WANPRC employee was hit by a slow-moving car in the parking lot. EMS were called, and IP transported to hospital. IP was released from the ED, and was to follow up with a specialist the following day.

Resolution: No supervisor comments. Jim Murphy, Animal Program Manager at the Arizona facility who witnessed the accident had an update. Several employees were leaving work at the same time. The IP got to his car, noticed something hanging from the car body and laid down on the ground to investigate. His legs were extending past the car body into the roadway, when a coworker in the car next to his pulled forward, and ran over his legs. Amazingly, nothing was broken. He saw his physician for a follow-up, and as there is still pain, will have an MRI. Jim will take care of the supervisor comments and add his additional information to the OARS report.

• <u>2021-11-035</u>: SEA WANPRC tech caught thumb between a cabinet and the wall when packing items from a cabinet. IP reports thumb was slightly swollen and stiff to flex; they took ibuprofen. IP also noted the room was in disarray with extra furniture, equipment, boxes, etc. due to upcoming move. They cleared some of the clutter to remove this kind of hazard, and will be more careful in future.

<u>Resolution</u>: No supervisor comments. *Matt said that he was the IP in this report and in 2021-11-058, and it was the same thumb in both instances. They have been decommissioning a lab at the Western Ave building, and so packing many boxes. On this day he was moving furniture around to better get at a pile of trash, and pinned his thumb.*

• <u>2021-11-052</u>: SEA WANPRC staffer cut thumb pad on the edge of a paper towel dispenser. Minor cut, but it bled a lot. Wrapped it in paper towels, applied pressure, washed it and applied antibiotics; had to find a band-aid from a different first aid kit. Disinfected the paper towel dispenser. IP recommends replacing the dispenser, which is old and sharp edged; switching to c-fold towels. Also informed the BioSafety specialist about the lack of band-aids in the kit.

<u>Resolution</u>: No supervisor comments. *Matt was in the break room, having made coffee. He was trying to pry the paper towels out of the old dispenser when he cut his thumb. Melinda noted that she has added more band-aids and towels.*

• <u>2021-11-058</u>: SEA WANPRC staffer received minor cut on right ring finger on the blade of a paper tape dispenser. Cut did not bleed, but stung when they used an alcohol wipe. Recommends buying a new dispenser.

<u>Resolution:</u> Supervisor adds equipment was not functioning well, and recommends replacing it. *Melinda says that they replaced the dispenser, but the IP was still having troubles getting it to work correctly. After testing, they finally decided it was due to the IP being left-handed, and ordered another, made specifically for lefties.*

• <u>2021-11-089</u>: SEA WANPRC, SOM lab personnel was bitten while working with a mildlysedated primate. IP washed the area, and went to the ED for treatment and the potential B virus follow up.

<u>Resolution</u>: No supervisor comments. Discussion tabled until later, as EH&S are doing a formal review. *Melinda called this report a place-holder input at the time of injury. The IP has provided a much more detailed explanation of the incident.*

November 10, 2021

• <u>2021-10-026</u>: SEA WANPRC tech was knocked off a footstool when the animal they were boxing moved, causing the box to smack the tech in the sternum. Sternum bruised and sore. IP suggests asking for assistance during this activity -- the NHP had never done this before, but as the handler IP feels they should have taken precautions due to the animal size.

<u>Resolution</u>: Supervisor suggests also using the lift, which has a secured transfer box, and to ask for assistance.

• <u>2021-10-044</u>: WA WANPRC staffer scraped the front of their left shin when moving equipment; noticed the scrape at the end of their shift. Suggests they will pay more attention, slow down and pace themselves.

Resolution: No supervisor comments. EH&S adds that bandages, antibiotics and wipes were provided, and medical attention were recommended. *Matt says this is a strange one, as the person waited several days after the injury to report it, and then waited another few days to go to the doctor. IP had to estimate a date of injury; has had multiple injuries this year Melinda added that she had provided first aid supplies, and that the supervisor had transferred, so she will get someone else to close the report.*

• <u>2021-10-052</u>: WA WANPRC tech had noticed lower back pain in the morning, which escalated after completing a change-out.

Resolution: Supervisor adds that the employee has no previous record of physical injury while at work. The incident was probably due to overexertion in pulling out cages during the cage change out plus physical fatigue for the week work schedule. IP is on lighter duty as requested by her attending physician. *Melinda noted in was a typical injury, and that she found that Oregon has a "Safety in motion" program that the Oregon primate center uses.*

• <u>2021-10-074</u>: AZ WANPRC tech had pants soaked with Wexide when the hose coupler was broken. IP gave the coupler to maintenance, then took a 15-minute shower.

<u>Resolution</u>: Supervisor adds the coupler o-ring was worn and needed replacement. IP stated they did not need to go to Concentra; has a mild red area on her leg just above the knee.

October 13, 2021

• <u>2021-09-015</u>: AZ WANPRC discovered must have hit thumb while changing pigtail macaque cages; after finishing, removed two pairs of gloves to find thumb and nailbed were bloody. Got the herpes B kit, and scrubbed the affected area for 15 minutes with an iodine scrub. The inner glove had a hole, and so reported to clinical staff. Staffer reported to the emergency department. Staffer had worn all the required protective coverings, and suggested they go slower.

Resolution: No supervisor comments. *Melinda will follow up with the supervisor.*

• <u>2021-09-023</u>: AZ WANPRC was born on hands and neck by noseeums/sand flies/midges. Later noticed many insects in front of the AB main entry doors inside and outside the changing area. Find their breeding area?

<u>Resolution</u>: No supervisor comments. *Melinda had talked with the supervisor who was unsure how to complete the OARS report in this case. There had been a lot of rain in AZ, and an insect boom. Employees were told to use insect spray if they were concerned. Carmen asked if the first aid kits included anti-itch ointment.*

• <u>2021-09-032</u>: SEA WANPRC vet was scratched by macaque fingernail during routine physical exam. Suggests they wear gown that ties in back when working with infant non-human primates.

Resolution: Supervisor suggests high necked gowns as PPE. *IP was a new vet unaware of the correct PPE; they were wearing just a lab coat. There is both employee training and diagrams posted showing what specific PPE to wear in each area.*

• <u>2021-09-076</u>: AZ WANPRC staffer slipped and pulled his upper back on the catwalk leaving the roof to the lower level. Suggests he be careful and slow down on wet surfaces.

Resolution: Supervisor says there was moisture on the catwalk, and to use the handrails. *Rain on the outside catwalk, Melinda talked with the supervisor who had originally filed this as a near-miss as there wasn't a fall. It was re-filed.*

September 8, 2021

• <u>2021-08-009</u>: AZ WANPRC stepped to one side to pick up a syringe knocked from their hand by an animal, and slipped on a wet area of the floor. Swung out arm for balance, felt a twinge in the right scapula area, which progressed to a dull ache down the arm. Took Tylenol; the muscles felt knotted and aching several hours later. Will pay closer attention to floors.

<u>Resolution</u>: Supervisor suggests looking into facility shoes with better treads. Reviewed footwear with IP. *The employee also suggested boot brushes to clear the shoe treads*.

• <u>2021-08-011</u>: New SEA WANPRC employee poked a finger on their left hand while attempting to sedate an animal. Suggests safety training.

<u>Resolution</u>: Supervisor notes animal jumped at the last minute. The syringe and needle were too close to her other hand, and so she stabbed herself. They will work to get IP more experience, get help with difficult animals, and try to flag reactive monkeys.

• <u>2021-08-047</u>: SEA WANPRC employee reported lower back pain that travels down their right leg, which worsened during the day. Painful when standing from a seated position, or turning in bed.

<u>Resolution</u>: No supervisor comments. Melinda said that IP was going to check with a doctor, but has not checked back in. *At October meeting Melinda reported the supervisor had left, and that she will ask the next in line.*

• <u>2021-08-050</u>: AZ WANPRC employee was cleaning floor gutters/troughs, when foot slipped, causing them to land awkwardly on the right side of their foot. There was discomfort, and they were going to monitor.

Resolution: No supervisor comment beyond 'wet surface.' *Looking into footwear*.

August 11, 2021

• <u>2021-07-007</u>: SEA WANPRC tech was cleaning necroscopy tools when face and possibly eye were splashed. AP suggested PPE be provided; noted they could have worn splash goggles/safety glasses, but not sure it would have helped.

<u>Resolution</u>: Supervisor added that PPE was not worn correctly—the face shield was slightly raised, which allowed the splash. AP should follow PPE recommendations. *Allison asked if some of these splash incidents could be related to water pressure. Melinda noted that short staffing, long hours and fatigue can also be related.*

• <u>2021-07-020</u>: AZ WANPRC tech was handing a transfer box to coworker inside an enclosure when coworker accidently closed enclosure door on AP's face and arm.

<u>Resolution:</u> No supervisor comments. *Melinda noted they have two new hires starting in August.*

• <u>2021-07-025</u>: AZ WANPRC vet tech was performing dental cleaning on animal when they cut their hand through gloves with the scaler. AP says will pay more attention to hand placement.

<u>Resolution</u>: Supervisor cites inattention, and to remain vigilant when working with animals and equipment.

• <u>2021-07-026</u>: SEA WANPRC employee bitten on right hand/third finger while feeding NHP. Treated at ER with follow-up by Employee Health.

<u>Resolution</u>: Supervisor thinks employee was rushing and not being cautious enough; there is also a lot of activity in the room which may have stressed the animal. Suggests

more caution and not getting close to the animals. *Melinda says the supervisor also suggested cut proof gloves; Matt thinks it is hard to be bitten when feeding and wondered if the AP was engaging with the animal or trying to calm it.*

• <u>2021-07-027</u>: AZ WANPRC staffer has back pain and strain from frequent heavy lifting and carrying. AP suggests change/review work procedures, possible a larger cart to move heavy items and NHPs. Will be using the exercises and stretches the PT provided to increase strength & mobility in the lower back.

<u>Resolution</u>: Supervisor adds that it is a very physical job requiring heavy lifting/ pushing/pulling/carrying, leaving employees prone to physical injuries, ergonomic issues and repetitive motion injuries. Recommends working in teams, utilizing the provided wheeled carts, taking breaks and stretching throughout the day. *Melinda says they have ordered additional carts, and will check on the status of the order*.

• <u>2021-07-028</u>: new SEA WANPRC specialist was cleaning cages and crunching biscuits and felt something hit his eye. Found a splash of fluid inside the left side of face shield and so flushed eyes and followed up with Occupational Health and Emergency. Notes he will be more aware of surroundings, and make sure face shield is between himself and animal.

Resolution: Supervisor added that it seemed the animal may have spit or urinated when employee was cleaning lower cage. *Melinda said that is also could have been APs own sweat*.

• <u>2021-07-047</u>: AZ WANPRC staffer was cleaning a cage when vets and vet techs entered the room to do a transfer; agitated NHP scratched employee's wrist. AP suggests pausing cleaning when a transfer is in progress as there are NHPs who become harder to handle than usual when the vets and vet techs are in the room.

Resolution: No supervisor comment.

• <u>2021-07-053</u>: SEA WANPRC staffer was walking in vivarium hallway, slipped and fell flat on back. There were no posted signs the floor was wet of slippery; injured back, buttocks, legs.

<u>Resolution</u>: Supervisor reports the AT supervisor said the floor had been cleaned with NPD the day before; later a wet cage had been transported in the hallway and the combination of the NPD residue and water from the cage made for a slippery floor. Recommends putting up signage when floors are wet. AT supervisor recommends reviewing the amount of NPD used, so there is less residue. *Melinda notes the AP was wearing shoe covers, and they recommend staff wear safer shoes or boots.*

• <u>2021-07-058</u>: SEA WANPRC employee was pulling clean Allentown cages into hallway, and smashed left hand between two cages.

<u>Resolution</u>: Supervisor says employee was pulling cages from a small area; will work with employee on posture and best way to move these cages. Also, don't move two cages at once.

• <u>2021-07-063</u>: SEA WANPRC employee had pre-existing hand injury which worsened at work, causing pain in right thumb. AP suggests taping the joint to prevent injury, and spacing tasks out.

<u>Resolution</u>: No supervisor comments. *Sonia said EH&S contacted AP who had gone back to PT; they were told they could also see the on-site physician.*

• <u>2021-07-069</u>: AZ WANPRC employee hit middle and ring fingers on exterior door.

Resolution: No supervisor comments. *Melinda will contact.*

• <u>2021-07-083</u>: SEA WANPRC employee was pushing garbage/supply cart when it tilted backwards and scraped wrist. It did not break skin, per alcohol test. AP suggests replacing the cart with one that will not tip, add protective covering to sharp edges or require long sleeves when using this cart.

<u>Resolution</u>: No supervisor comments. *Matt says these particular carts are back-heavy even when empty. Melinda added that their facilities people say the cart was gone over, she will check with them. She thinks the supervisor is going to require long sleeves.*

• <u>2021-07-086</u>: AZ WANPRC employee was pulling down shift door handle when finger grazed an exposed screw, lacerating both glove and skin. AP suggests a maintenance request.

Resolution: Maintenance was notified about the exposed screws and they covered them.

<mark>July 14, 2021</mark>

• <u>2021-06-015</u>: VPR vet tech got a drop of water/cleaner in eye (past goggles) when NPH jumped down onto freshly washed cage door. AP plans to either not wear goggles, or get band to hold them in place.

<u>Resolution</u>: Supervisor noted the wet caging and improperly fitting goggles. Recommends tighter fitting goggles or face shield. *Melinda said they are looking into better fitting goggles*.

• <u>2021-06-019</u>: VPR occupational health specialist arm showed signs of an allergic reaction to the loth sleeve used when handling NHP infants. AP suggests providing alternative sleeve covers in the infant room, or trying a different laundry soap.

<u>Resolution</u>: No supervisor comments. *Melinda says that it was likely a reaction to laundry soap; the AP will wear an arm covering under the protective sleeve.*

• <u>2021-06-029</u>: VPR tech had finger bitten by NHP; bite penetrated glove, although the water test showed the gloves were intact. Used a scrub kit, but not an exposure.

<u>Resolution:</u> No supervisor comments. *Melinda reminded the supervisor to finish the report even if it is not an exposure incident.*

• <u>2021-06-044</u>: VPR tech splashed Wexide on hand above the glove, when overextended the dispenser. Washed hands and changed clothes immediately. No apparent injury from exposure. AP asks if the pump can be affixed to the barrel so this can be avoided in future.

<u>Resolution</u>: No supervisor comment. *Melinda hasn't heard back from the supervisor yet, but that they are looking into chemical handling at that facility.*

• <u>2021-06-052</u>: VPR tech slid halfway down exterior metal stairs on side/buttocks. AP suggested undertaking hazard assessment to check stair front edges are slippery.

<u>Resolution</u>: No supervisor comments. *Melinda wants to do more follow up on the AP's request about slippery edges.*

• <u>Group 4: 2021-06-020:</u> Tech in Fetz Lab splashed eye when running water through feeding device tubing. Potential for saliva exposure, and as device is in close proximity to NHP so risk of NHP virus exposure. AP suggests making sure proper PPE is used in spaces with NHP, even in their absence.

Resolution: Supervisor says lack of eye protection PPE. Remind all personnel who use this area to wear PPE including eye protection. *Melinda said the AP did the virus protocol.*

<mark>June 9, 2021</mark>

• <u>2021-05-005</u>: VPR staffer was scrubbing the floor when NPD mixture and possible animal waste splashed up under face shield into eye. AP recommended finding a face shield that would cover face better.

<u>Resolution</u>: Supervisor suggested wearing safety glasses under the face shield as water/chemical drips and splashes during sanitation. *Per Melinda, AP has a new face shield. Matt also recommends goggles, noting that one can now get prescription inserts.*

• <u>2021-05-013</u>: VPR animal technician cut finger on macaque cage when opening a stuck squeeze bar latch; difficult to get it unstuck. AP suggested regular maintenance of the cages and stronger gloves.

<u>Resolution</u>: Supervisor says to be cautious and careful with hand placement when opening. *Matt suggests also adding an extra barrier (towel, paper towel) between gloves and latch. Ryan asked if there was a tool that would help. Matt mentioned that he uses a tool (essentially an eye hook) to either pop open the cylindrical locks or help pull stuck cotter pins. Melinda suggested getting them for all staff.*

• <u>2021-05-014</u>: VPR animal tech removed the feeder box, which left a gap. AP was scratched when an animal grabbed their arm through the gap.

<u>Resolution</u>: Supervisor says to wear cut resistant sleeves/gloves when dealing with such a gap.

• <u>2021-05-017</u>: VPR animal tech strained shoulder moving boxes with coworker. Suggests changing the work area layout.

<u>Resolution</u>: Supervisor notes the employee was asked to organize boxes of lab coats & other PPE; boxes are medium sized and weigh no more than 30 lbs. No recommendations made.

• <u>2021-05-022</u>: VPR animal tech was boxing animal, and when the animal hit the cage, the AP overbalanced & fell off the moveable 2-step stairs (with protective guardrails), scraping knee and shin.

<u>Resolution</u>: No supervisor comments. *Melinda said they are still doing an internal investigation*. *Did they not use the provided lift? Was it because they were in one of the smaller rooms?*

• <u>2021-05-047</u>: VPR animal tech was adding clean hay when dust or hay blew past face shield into eye. AP developed conjunctivitis. Suggests wearing different face shield.

Resolution: Supervisor suggested wearing goggles and keeping hay close to ground when shaking it out. *Matt noted that people are sometimes reluctant to wear goggles as they fog up. He uses anti-fog wipes on his, and thinks it would be a good fix for others.*

May 12, 2021

• <u>2021-03-010</u>: Medical student was moving a monkey between lab and equipment (possibly the transport chair) tore through double gloves.

Resolution: Recommended using thicker gloves or Kevlar gloves when working with animal & equipment. *Originally routed to Group 4 as a SoM departmental employee, but should have been routed to Group 1 for WANPRC.*

• <u>2021-04-002</u>: VPR technician was moving cage when felt someone behind them. When looked around, missed the door, and pinched hand between cage and door. AP suggests care moving large objects around other people; and that passersby warn that they are near.

<u>Resolution:</u> No supervisor comments. *Matt noted that the I-Wing rooms are quite small, the doors are hard to maneuver with the large cages.*

• <u>2021-04-017</u>: VPR weekend staffer had neck scratched by macaque during weighing. Was wearing appropriate PPE and followed procedures.

<u>Resolution</u>: Supervisor notes the animals are growing, getting bigger & able to jump farther. Suggests that weekend staff stop weighing animals on the weekend unless clinically necessary.

• <u>2021-04-018</u>: VPR technician was picking up trash from the floor, lost balance and hit head on a stationary bar. Cut needed 4 staples to close cut.

Resolution: Recommended to be aware of surroundings, and to take time.

• <u>2021-04-045</u>: VPR technician received 4 spots of NPD (germicidal detergent) through Tyvek PPE when the top came off the bottle. AP recommended different PPE, as the Tyvek didn't stop the liquid. Will also check that the bottle pump threads aren't worn.

<u>Resolution</u>: No supervisor comments. *Melinda pointed out the AP was not wearing Tyvek, but regular spun poly cover-alls. They do have cover-alls that are more moisture resistant, and the AP should have been wearing those, but there weren't any on site. Now have more on site, and the storeroom has been reorganized for both accessibility and additional PPE stock. Supervisor has been contacted about the comments.*

<mark>April 14, 2021</mark>

• <u>2021-03-020</u>: VPR staffer was weighing a partially sedated animal when it briefly awoke and bit onto their wrist. The bite broke through double set of gloves and broke the skin. Suggested they be more aware of animal's consciousness while handling.

<u>Resolution</u>: Supervisor noted inattention to detail/rushing at the end of the day, and recommended they ensure animals are fully sedated before removing from squeeze box. *Melinda assumes the AP did the standard post-bite procedure.*

• <u>2021-03-028</u>: VPR staffer was cleaning the fridge, and hit the bridge of their nose on the freezer door when they stood; did not go to the doctor, did clean the small cut he received. Rushing and not paying attention.

Resolution: Supervisor recommended to slow down and pay attention.

• <u>2021-03-031</u>: VPR person noticed an irritation on right shin, and thinks they must have splashed NPD and Coverage on leg while cleaning the floor with the foamer. There were no coveralls with the moisture-resistant panel available, and were understaffed. Recommends provide safety training & provide PPE; should have not mixed the two chemicals and should all have been more aware of the pH of the process NPD cleaner.

Resolution: The IP found and stocked the better coveralls the next day. The supervisor has ordered new boots for all employees. The IP will redo chemical safety training. *Melinda notes it was both a splash and an improper mix of 2 chemicals. They are revamping their chemical training, targeted at their specific chemicals & use. Some employees work in 3-4 locations, so they want them to have books in all locations. Have*

had difficulty getting PPE the last few months; there are 3 kinds of coveralls, and they needed the moisture resistant ones.

• <u>2021-03-040</u>: VPR staffer was leaving through secondary door after providing treatments and left hand was on the door when the door swung back; hand was slammed between the door and the stopper on the wall.

<u>Resolution</u>: Supervisor recommended pay closer attention and take time to complete tasks. *Melinda added it is possible the second time this kind of incident has happened & that they may need to reposition the door stopper.*

• <u>2021-03-050</u>: VPR person reported having soreness in right knee while cleaning outside downstairs cages; doesn't remember slipping, tripping etc. on the stairs. When the soreness increased, went to Concentra and they said she had a sprain in her knee and to wear a knee brace. Told no stairs or ladders; can kneel and squat occasionally.

Resolution: Supervisor can't pinpoint any specific cause, as AP did not trip or fall on the stairs. Noted that AP did not tell supervisor about the sore knee the next day; had they known, they would have changed the assignments around. Recommended that when soreness happens take NSAIDs if can, ice and stretch-- and let supervisor know of soreness so if possible one can be reassigned to a different task that won't irritate the area that is sore.

• <u>2021-03-053</u>: VPR staffer pulled group 6 cage and hit left ankle—swollen.

Resolution: Improper body posture when pulling cages; might've been too close to the cage. Be aware of body posture and space between cage to allow enough space to prevent getting hit. *Matt noted that these cages are extra large (over 300 pounds) and hard to move. He thinks they should be a 2-person job. Melinda added that the AP is a new hire.*

• <u>2021-03-054</u>: VPR person was bit by the squirrel monkey when trying to weigh her. They were holding a marshmallow on the top of the weigh box and try to see the ID number on her chest.

<u>Resolution:</u> No supervisor comments. *Melinda will check. Matt mentioned that squirrel monkeys are tiny, and deceptively cute. Their bites don't need a scrub clean.*

• <u>2021-03-064</u>: VPR person had pigtail macaque scratch left hand through gloves. No abrasion present. Used scrub kit anyways to be safe.

Resolution: Supervisor notes when transferring animals from one cage to another there is a gap big enough for it to reach out, and animal is already grabby as it is. Use a different method to be able to transfer the animal, such as tower with transfer box attached. *Melinda noted that this counts as a near-miss for them, and reporting it helps tie it to a specific animal.*

• <u>2021-03-067</u>: VPR person injured hand while operating a metal lathe; the material that was being machined had come loose. After performing some first aid to control the bleeding, they went to the ER to get an x-ray and some stitches. Attempting to perform a delicate machining operation on the metal lathe; in hindsight should have paid more attention to how I installed the material in the chuck.

Resolution: Supervisor has discussed the event in detail with the AP and agrees with his assessment of the causes of this accident, and his suggestions for corrective actions. Always remain alert to full implementation of plans, and to pay close attention to securing things. *Per Dian via chat: "Ultimately the staff member did not ensure the metal was properly secured to the work surface. It was lack of detail on preparing for the position and his supervisor spoke to him about this. I also saw him recently and we discussed steps to ensure materials are secure when being machined. He is healing nicely and quite sheepish about the fact that he was not detailed in his preparation for doing this work."*

• <u>2021-03-71:</u> VPR person got blood spatter in right eye (past safety glasses) when an unseen post-surgery seroma burst while they were squeezing animal for sedation. Plans to wear safety glasses closer to eyes instead of further down on nose.

<u>Resolution</u>: No supervisor comments. *Melinda says they have done a lot of research as this is an NHS reportable occurrence, due to the medications the animal is on. AP was wearing older safety glasses, which were loose. They want to make sure there are glasses that fit closely, and have ordered several sizes for AP to try.*

• <u>2021-03-074</u>: VPR staffer felt a burning sensation on top of their wrist and then noticed a large bump there that they had not noticed before. It is unknown if this has appeared due to work or if this is an unrelated condition. They were sent to Concentra today to see the doctor.

<u>Resolution</u>: Supervisor notes that it is unknown at this point if it is work related. Suggested before starting his daily duties try doing some stretching of the hands and wrists, and to follow any recommendations from the doctor. *Melinda says it was diagnosed as a non-work related ganglion cyst*.

March 10, 2021

• <u>2021-02-017</u>: VPR staffer touched right wrist to the bucket lip when pouring undiluted 8100 (a degreaser) and a small amount penetrated the woven cuff of their protective gown. AP suggested easier access to the Material Safety Data Sheets.

<u>Resolution</u>: No supervisor comments. *Melinda noted supervisor might be waiting on information from a clinic visit. Jim Murphy said that staff wear full PPE (polyester long sleeved gown, double glove layers) when doing the task. It just happened to get onto the permeable cuff.*

• <u>2021-02-038</u>: VPR lab person had potential eye exposure from splattering when the drill got caught in gauze. They recommended weather eye-protective goggles under the face shield.

Resolution: Supervisor added the face shield is too long, and would sometimes touch the sterile field; pairing a shorter face shield and couple with eye goggles. *Melinda said she let them know that both goggles and shorter face shields are available. The AP is new, and was learning the job while assisting. They are in the process of hiring a new vet, and so there may be changes made after that.*

• <u>2021-02-046</u>: VPR staffer was checking lixits (an animal watering device) in a compound group when a small monkey reached through the bars, past the face shield and poked AP in the right eye.

Resolution: Supervisor feels it was a freak incident; AP was wearing the PPE correctly. AP immediately flushed eye with saline solution, then with the eye wash for 15 minutes after that. And then again with saline. She will get eye checked. Standing farther away from the cage front was suggested, even though that does make it harder to check levels. *Another new employee; might be a training issue. Sometimes staff just have to learn how far animals can reach. Matt added that a lot of the monkeys treat the lixits and persons as part of a game. It is also possible to toss treats to distract the animals away from the lixit.*

• <u>2021-02-047</u>: VPR staffer suffered a hand laceration and bleeding when the housing cage locking mechanism jammed; AP's hand slipped after the lock opened, hit the cage and tore through two pairs of gloves. Reported the incident, began a chlorhexidine scrub for 15 minutes and went to the UW ER for a blood draw and follow up. Prescribed antiviral, Valacyclovir. Suggested a request for repair be submitted, and noted the locking mechanism is in a tight area, hard to get tools into. Reluctant to lubricate as it does house animals.

<u>Resolution</u>: Changed out the cage, flagged it for repair of side gate locking mechanism. *Matt talked with the affected person; it was one of their 35-40 year old cages, and he was trying to release the divider after separating a pair of animals. The chlorhexidine and an offer of an antiviral are protocol when there is 'dirty cage exposure' around the macaques. They are working on replacing all of these old cages.*

February 10, 2021

• <u>2021-01-009</u>: VPR staffer was cleaning the pans at the bottom of the cage, and the cage occupant urinated on her head; it went through both the head cover and face shield foam guard into both eyes. Employee washed her eyes for 15 minutes and went to the ER for consultation. Now taking prescription meds, returned to regular duties.

<u>Resolution</u>: Supervisor notes this is not normal animal behavior; recommended signage to remind ATs to pay attention when cleaning after this particular animal.

• <u>2021-01-018</u>: VPR staffer was 'jumping' the monkeys out of the enclosure and after lifting the pulley door while opening the sliding door felt a sharp pain in left back side. Has seen a

doctor, is icing her back and taking anti-inflammatories, with lift restrictions (15 lbs). Suggested changing the work area layout/design.

<u>Resolution</u>: Supervisor suggests having co-worker help with doors. They add that the task can lead to working in an awkward position, as it is difficult to operate 2 doors at a time. The area is undergoing construction in January and when finished the ATs will not have to 'jump' the monkeys out of the enclosure when it is to be cleaned.

• <u>2021-01-020</u>: VPR staffer was reaching to open the fire doors when a security guard on the other side pushed the door open. The door struck the affected party in the head, causing dizziness; he was taken to the ER. He suggests that stairway/hallway doors need windows.

<u>Resolution</u>: Supervisor notes SOM could evaluate doors to determine the feasibility of adding windows. *It was suggested this report also be shared with Group 4, as it involves doors in the public hallways in Health Sciences.*

• <u>2021-01-024</u>: VPR staffer was opening the crate door, and crushed hand between the pivoting door latch and the door stop mounted at handle level on the wall. Bruised 4th & 5th fingers on the right hand, full movement in fingers, opted to not go to the doctor. Says will not place hand on that part of door in future.

<u>Resolution</u>: Supervisor says rushing and inattention; pay attention to where hands are when opening & closing the doors.

• <u>2021-01-031</u>: VPR staffer sliced thumb and nail while preparing produce; the knife slipped over the top of the apple.

<u>Resolution</u>: No supervisor comments. Su asked about PPE gloves, and Ryan mentioned that the HUB went through a long process to find cut gloves that were comfortable for their food workers to use. Melinda noted VPR has cut gloves and she'll see they are available during food prep.

• <u>2021-01-038</u>: VPR staffer was in compound trying to distract a monkey with a treat in order to give meds to a second monkey. First monkey bit affected party, but there was no skin break.

<u>Resolution</u>: AP suggests having at least 2 people distribute meds in compounds. Supervisor said that the AP took their eyes off the monkey briefly, and that they will be sure to have two people there during meds. Melinda will follow up.

<mark>January 13, 2021</mark>

• <u>2020-12-011</u>: VPR staffer was moving a cage, left their right index finger inside the cage where it was bitten by the squirrel monkey inside; wound bled. IP washed the bite and applied bandage, as required, reported it to the vet on duty.

<u>Resolution</u>: Supervisor noted IP should pay attention to the animals when doing tasks, and assume are all potentially harmful. Employee is fine. *Matt added that the squirrel*

monkeys don't carry diseases (unlike the macaques, who have the risk of B-virus transmission) so bite doesn't require a hospital visit or prophylaxis routine.

• <u>2020-12-027</u>: VPR staffer was trying to close off contact in the cage to check on a possiblyinjured macaque, when right forearm was scratched. Skin not broken, followed the wash protocol.

Resolution: Skin not broken, so near-miss. Animal's aggressive behavior the biggest factor; in future person could wear a sleeve cover and attempt to distract monkey with treat when working with side gate or lock. *If the skin had been broken, then the prophylaxis regimen would be followed.*