

NOTABLE (KNOWN) RECENT U.S. BIOLOGICAL ACCIDENTS & RELEASES FROM "HIGH CONTAINMENT" BIODEFENSE LABS¹

1. Lab-acquired Tularemia (3 times), Boston University, Massachusetts (2004)
2. Plague-infected mice "lost," UMDJ, Newark, New Jersey (2005)
3. Lab-acquired E. coli 0157:H7, USDA, Windmoor, Pennsylvania (2002)
4. Anthrax in letters from Ft. Detrick (probable), Maryland (2001)
5. Anthrax-contaminated offices, Ft. Detrick, Maryland (2002)
6. Ebola needle stick, Ft. Detrick, Maryland (2004)
7. Lab-acquired E. coli 0157:H7, USDA, Bethesda, Maryland (2003)
8. Live anthrax shipped as "dead," SRI, Frederick, Maryland (2004)
9. H2N2 flu in test kits, Meridian Biosci, Cincinnati, OH (2005)
10. Thomas Butler Case (30 of 180 vials of plague missing), Texas Tech University
11. Q-Fever exposure, Rocky Mountain Labs, Hamilton, Montana (2005)
12. Faulty aerosol chamber infects 3, IDRI, Seattle, Washington (2004)
13. Live anthrax mishandled, Oakland Children's Hospital, CA (2004)
14. Three of lab workers tested positive for Q-Fever, Texas A&M, (2007)
15. A researcher was infected with the bio-weapons agent Brucella, Texas A&M, (2007)

¹<http://www.sunshine-project.org/> (Note: The Sunshine Project discontinued its operations in February of 2008. The above listing was culled from its pages prior to that date)

SEE ADDITIONAL INCIDENTS ON THE NEXT 5 PAGES

Table E9-4 Examples of Accidents in United States Biosafety Labs from 1978-2007. This is a partial list, since not all accidents/incidents are reported.

Location	Agent	Description	Date	Source
<i>Human Error</i>				
New Hampshire	Vaccinia	Accidental exposure from needlestick	9/2007	CDC, 2008
unknown	<i>Yersinia pestis</i>	Potential exposure when employee stuck self with broken scalpel blade	8/2007	Field, 2007
Maryland	Vaccinia	Accidental exposure from needlestick	8/2007	CDC, 2008
University of South Alabama	<i>Rickettsia prowazekii</i>	Worker drops plate and splashes self	7/2007	Field, 2007
U.C. Davis	<i>Brucella</i>	Potential exposure due to needlestick	7/2007	Field, 2007
University of Iowa	Tularemia	Potential exposure due to needlestick	5/2007	Field, 2007
Iowa	Vaccinia	Accidental exposure from needlestick	5/2007	CDC, 2008
UT San Antonio	Tularemia	Workers entered lab without PPE, unlikely exposure	4/2007	Field, 2007
unknown	<i>Brucella</i>	Researcher ill because of improper decontamination procedures	4/2007	Field, 2007
Pennsylvania	Vaccinia	Accidental exposure from needlestick	10/2006	CDC, 2008

Saint Louis University	Monkey pox	Worker exposed from needlestick	8/2006	CDC, 2008
University of Chicago	Anthrax	Worker exposed to Anthrax after needlestick	7/2006	CDC, 2008
Connecticut	Vaccinia	Accidental exposure from needlestick	3/2005	CDC, 2008
Children's Hospital and Research Center Oakland, CA	Anthrax	Scientists exposed after live anthrax samples accidentally get shipped to the lab	6/2004	CDC, 2008
USAMRIID	Ebola	Accidental exposure from needlestick	2/2004	Kaiser, 2007
unknown	West Nile Virus	Lab worker contacts virus after accidentally cutting finger with scalpel	12/2002	CDC, 2008
unknown	West Nile Virus	Lab worker contracts virus after needlestick	8/2002	CDC, 2008
University of Texas	<i>Anthrax</i>	Cutaneous anthrax of lab worker	4/2002	Field, 2007
USAMRIID	Junin virus	Bone fragment from monkey punctured finger during autopsy	12/1982	Johnson, 2004
USAMRIID	Lassa virus	Accidental needle stick in finger	11/1979	Johnson, 2004
<i>Equipment/Engineering Error</i>				
University of GA	none	Flooding occurred twice of high-containment laboratory after sterilizer failed to shut off	2008	Schneider and Hart, 2008

CDC	<i>Coxiella burnetii</i>	CDC used duct tape to secure facility after air filtration system failed during maintenance	2007	Young, 2008
University of Mississippi Medical Center	Anthrax	Potential exposure from broken flask spill	8/2007	Field, 2007
University of Texas Health Science Center	Anthrax	Potential exposure after fluid discovered in bottom of centrifuge	5/2007	Field, 2007
unknown	<i>Brucella</i>	Potential exposure after cap came off tube	8/2006	Field, 2007
University of Virginia	Tularemia	Potential exposure from cracked tube	8/2006	Field, 2007
University of Kentucky	<i>Yersinia Pestis</i>	Worker exposed after autoclave bag leaked	5/2006	Field, 2007
Tufts University	Botulinum neurotoxin	Potential exposure after broken vial found in centrifuge	4/2006	Field, 2007
unknown	<i>Coccidioides immitis</i>	Potential exposure after broken vial containing agent found in centrifuge	9/2005	Field, 2007
Plum Island		3 hour power failure	12/2003	Santora, 2002
Rocky Mountain Laboratory	<i>Yersinia pestis</i>	Open container fell off shaker	2001	Johnson, 2004

Unknown/Miscellaneous Error

unknown	<i>Coxiella burnetii</i>	Blood tests show potential exposures of 10 people to agents	2007	Field, 2007
unknown	Tularemia	Potential exposure after bitten by infected animal	7/2007	Field, 2007
unknown	<i>Yersinia pestis</i>	Lab worker potentially scratched by infected animal	4/2007	Field, 2007
Lovelace Respiratory Research Institute	<i>Yersinia pestis</i>	Lab worker bit by infected animal	9/2006	Field, 2007
Texas A&M	<i>Brucella</i>	Lab workers infected while cleaning aerosol chamber; failure to report to CDC	2/2006	United States GAO, 2007
Public Health Research Institute at UMDNJ	<i>Yersinia pestis</i>	Infected mice missing	8/2005	Field, 2007
UNC-Chapel Hill	Venezuelan equine encephalitis	Blood test show possible exposure	9/2004	Field, 2007
Medical College of Ohio	<i>Coccidioides immitis</i>	Lab worker contracts coccidioidomycosis, unknown route of exposure	8/2004	Field, 2007
Boston University Medical Center	Tularemia	3 scientists infected with Tularemia over 5 months	2004	Field, 2007

Rocky Mountain Laboratory	<i>Mycobacterium tuberculosis</i>	Skin test converted; cause was likely improperly inactivated samples	2000	Johnson, 2004
Rocky Mountain Laboratory	<i>Chlamydia trachomatis</i>	Worker hospitalized and successfully treated with antibiotics; no specific cause determined	1998	Johnson, 2004
Yerkes Primate Center	Simian Herpesvirus	Exposed research assistant dies	6/1998	Wrobel, 1998
Rocky Mountain Laboratory	<i>Mycobacterium tuberculosis</i>	Skin test converted; no specific cause determined	1996	Johnson, 2004
Yale University	Sabia	Researcher contracts virus and exposes 75 other co-workers	8/1994	Glass, 1994
Plum Island	Foot and mouth disease	Accidental release of virus into holding pens	1978	Margasak, 2008

SOURCE: NRC Staff.

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