Southern Nuclear

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U. S. Nuclear Regulatory Commission
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Washington, D. C. 20555-0001

Joseph M. Farley Nuclear Plant – Units 1 and 2
10 CFR 26.719(c) 30-Day Report
For False Positive Drug Test Results

Ladies and Gentlemen:

On September 21, 2016, a drug screening was performed by LabCorp RTP for Joseph M. Farley Nuclear Plant (FNP). On September 26, 2016, a positive test result was communicated to FNP. A confirmation test by a different lab was requested and positive results were not confirmed. An investigation was initiated and accepted by Southern Nuclear Operating Company (SNC) on November 5, 2016. Therefore, in accordance with 10 CFR 26.719(c), SNC hereby submits the enclosed report.

This letter contains no NRC commitments. If you have any questions, please contact Jamie Coleman at 205.992.6611.

Respectfully submitted,

Ms. C. A. Gayheart
Vice President – Farley

CAG/JMC

Enclosure: 10 CFR 26.719(c) Report

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Enclosure

10 CFR 26.719(c) Report

Description of the incident

On September 21, 2016, LabCorp RTP, a Department of Health and Human Services certified laboratory, conducted urine drug screening on Specimen 0200974406 and reported a positive result for Morphine on September 24, 2016. On September 26, 2016, the positive result was received by Farley Nuclear Plant (FNP). The FNP Medical Review Officer (MRO) conducted an interview with the donor on September 27, 2016 to inquire about the positive test result. The MRO requested that the specimen be re-tested due to information received from the donor. The specimen was sent to Alere toxicology in Gretna, LA for re-testing. Alere conducted retesting on the specimen for Morphine and failed to re-confirm the substance. Labcorp was contacted by Alere Toxicology and informed that Specimen 0200974406 failed to re-confirm the previously positive result. An investigation was consequently initiated by LabCorp to re-analyze the specimen and determine the reason for the inaccurate test result. LabCorp released a corrected report on October 4, 2016 indicating a negative test result for Specimen 0200974406.

Cause

An investigation initiated by LabCorp discovered that Specimen 0200974406 was included in a batch with only two donors. Both of the samples were properly in-processed and both screened positive for opiates on September 21, 2016. Specimen 0200974406 was sent for confirmation testing and was aliquoted. This same specimen was then tested via GC/MS and was reported as positive for Morphine greater than 20,000 ng/mL on September 24, 2016.

The main cause identified by LabCorp for the false positive morphine result was that the Confirmation Aliquoter failed to properly identify the sample in accordance with the standard operating procedure.

Southern Nuclear Operating Company (SNC) obtained the services of an independent toxicology consultant who reviewed the original laboratory report with the incorrect result. The consultant also reviewed:

- Sequence of events leading up to the inaccurate test result.
- Initial GC/MS confirmation Batch Data
- Repeat GC/MS confirmation Batch Data
- Standard Operating Procedures for LabCorp for confirmation aliquoting
- Corrective Action documentation including the investigation letter from LabCorp
- Retraining documents for laboratory personnel

Per the independent toxicologist's review of all of the documentation, the mishandling of the sample occurred when the analyst pipetted one sample twice instead of pipetting the two different specimens that were in the confirmation batch.

Corrective actions that were implemented for the laboratory were found to be acceptable.

Corrective Actions

- LabCorp removed the aliquot technician from performing NRC batch duties.
- The analyst was re-trained on the two box method.
- The analyst was required to complete 10 verification batches prior to returning to duty.
- The Laboratory covered the incident with all aliquot technicians as operating experience focusing on the cause of the incident and actions that could have prevented this from happening.