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50-335 St. Lucie Plant, Unit 1, Florida Power & Light Co. 05000335
50-389 St. Lucie Plant, Unit 2, Florida Power & Light Co. 05000389

AUTH.NAME AUTHOR AFFILIATION
BOHLKE,W.H. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION
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SUBJECT: Forwards rept of unsatisfactory performance testing,per 10CFR26,discovered in blind performance test specimens submitted to util contract certified lab (CompuChem Labs, Inc).

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P.O. Box 14000, Juno Beach, FL 33408-0420

DEC 16 1992

L-92-342
10 CFR 26

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

Gentlemen:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
St. Lucie Units 1 and 2
Docket Nos. 50-335 and 50-389
10 CFR 26 Unsatisfactory Performance
Testing Incident Report

Pursuant to 10 CFR 26, Appendix A, Section 2.8(e)(4), Florida Power and Light Company (FPL) is submitting to the NRC the enclosed report of an unsatisfactory performance testing incident. FPL submitted blind performance test specimens to FPL's contract Department of Health and Human Services (DHHS) certified laboratory, CompuChem Laboratories, Inc. The enclosed report details the investigative analysis of the unsatisfactory blind specimen result, the identification of the cause, and the corrective action taken by the laboratory to prevent recurrence.

Please contact us if additional information is required.

Very truly yours,

W. H. Bohlke
Vice President
Nuclear Engineering and Licensing

WHB/DMB

Attachments

cc: Stewart D. Ebneter, Regional Administrator, Region II, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant
Senior Resident Inspector, USNRC, St. Lucie Plant

A022

COMPUCHEM LABORATORIES, INC.
a subsidiary of Roche Biomedical Laboratories, Inc.

P.O. Box 12652 3308 Chapel Hill/Nelson Highway
Research Triangle Park, NC 27709
(919) 549-8263

November 30, 1992

Dr. Kendall Green
Medical Review Officer
Florida Power and Light Company
700 Universe Boulevard
Juno Beach, FL 33408

RE: BLIND PT SAMPLE #318-000-5006
RBL #319-743-0101

Dear Dr. Green:

The enclosed report is in response to the memorandum received by Dr. Michael Peat on November 16, 1992 concerning the specimen referenced above.

The enclosures include a description of the analyses and the corrective action plan. If you need additional information, please call me at (800) 833-3984 extension 6703.

Sincerely yours,

Paula S. Childs

Paula S. Childs, Ph.D., D-ABFT
Vice President, Toxicology Operations

Blind Quality Control Sample #318-000-5006

PROBLEM:

The blind quality control sample #318-000-5006 was received at the CompuChem Laboratory on November 14, 1992. The specimen was analyzed and the results were negative. The specimen contained THC. Other samples from the same batch were reported as being positive in the past.

ANALYSIS:

The blind quality control sample identified above was accessioned following receipt (RBL# 319-743-0101, CCN 73254674). The specimen was screened using the standard operating procedure. The results of the analysis indicated that all the drug/metabolite results were less than the cut-off concentrations. The result "NEGATIVE" was transmitted to the Medical Review Officer.

The erroneous report was brought to the attention of Dr. Michael Peat by Ms. Liz Berlau on November 17, 1992. Dr. Peat initiated a review of the data. He also ordered a re-analysis in screening and a confirmation test (GC/MS) for the presence of THC metabolite.

The initial screening data (analyzed on 11/14/92) revealed that the screening result for THC metabolite was less than the cut-off. The repeat screening analysis result was greater than the cut-off (>50 ng/mL). The confirmation test was positive for carboxy-THC at 148 ng/mL. There were no other unusual findings.

An analysis of the data transfer system between the Olympus instrument (screening instrument) and the data review system was conducted. The discrepancy between the initial and re-analysis results can only be explained as the malfunction of the screening instrument to properly dispense enough specimen aliquot during the screening test. There are electronic "level sensors" which detect low volume of aliquot during the sampling process. Should a low volume of aliquot occur, this sensor should sent a "warning flag" to the printer. This printout is reviewed by the analyst/operator, and any specimens with a warning flag are selected for review and re-analysis. However, for this specimen, it appears that if the flag was generated, it was not observed during the technician/operator review of the printout. The error flag is not transmitted to the data review computer network.

CORRECTIVE ACTION:

The program which transmits the Olympus data from the instrument to the data review stations will be modified to include the error

flag(s) from the Olympus. This will allow the data reviewer to observe the error flag status for each specimen. The results of any specimen with an error flag will systematically be placed on "HOLD". The specimen will be scheduled for repeat analysis or further review prior to reporting. This programming change is in the formatting process, and the expected completion date is January 1, 1993.

Respectfully submitted,

Paula S. Childs

Paula S. Childs, Ph.D., D-ABFT
Vice President, Toxicology Operations

TO: Dr Michael Peat

FROM: Liz Berlau, MRO temporary Assistant

DATE: November 16, 1992

SUBJECT: False Negative THC Report

On 11/13/92 a blind sample, number 318-000-5006, was sent from Turkey Point Nuclear Plant containing THC. On 11/16/92 the result, Compuchem Roche number 319-743-0101, was received reporting the speciment to be negative. I request that a report on the problem be made to determine the source of the reporting error.

The blind THC samples from the same batch were reported as being positive in the past.