

**Florida
Power**

CORPORATION
Crystal River Unit 3
Docket No. 50-302

April 24, 1991
3F0491-06

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

Subject: Unsatisfactory Blind Performance Testing Incident

Dear Sir:

On March 26, 1991, Florida Power Corporation's (FPC) National Institute of Drug Abuse certified laboratory, Doctors & Physicians Laboratory, submitted its investigative findings of an unsatisfactory blind performance test conducted on March 18, 1991. The laboratory initially reported the result of the blind performance specimen test as negative when, in fact, the specimen contained amphetamines. The concentration in the specimen was reported to be below the 1000 ng/ml cutoff level. This incident is categorized as a "false negative." Pursuant to 10 CFR Part 26, Appendix A, Subpart B, Section 2.8(e)(4), FPC is submitting the attached laboratory report of unsatisfactory blind performance testing incident.

Upon FPC's request, the laboratory investigated the error, retested the specimen, and confirmed the specimen as positive. The initial screening performed on the specimen only shows that amphetamines are present in that specimen. A second screening is then performed to determine if methamphetamines (the active ingredient found in illegal drugs) are also present. The investigation determined two possible causes for the false readings: (1) the second screening test reported a false negative reading or (2) the aliquot set aside for further testing was removed in error by the laboratory's screening technician and a negative urine specimen was placed in the rack for the second screening test. The laboratory suspects the second possibility is a more likely cause of the error than the first.

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In the future, the laboratory will review the aliquot logs from the initial screening and confirm them with the bar coded test tubes to verify the specimen was in the correct position and was labeled with the correct bar code.

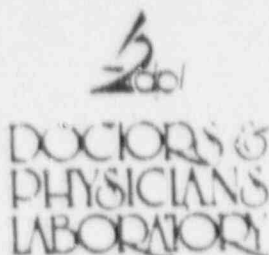
Sincerely,

Sary Boldt for
P. M. Beard, Jr.
Senior Vice President
Nuclear Operations

PMB/GMF

Attachment

xc: Regional Administrator, Region II
NRR Project Manager
Senior Resident Inspector



March 26, 1991

A. F. Sanchez, M. D.
Florida Power Corporation
P. O. 219
Crystal River, FL 32629

RE: SS# 256-23-5353
LAN # 8059393

Dear Dr. Sanchez:

We were in receipt of the above mentioned sample on 18 March 1991. The sample was logged in and an aliquot submitted to EIA testing. The sample was part of batch #031891N3 and was given a processing number on that batch of sample #44. It screened negative for cocaine, opiate, PCP, and THC but positive for amphetamine, (see enclosure).

As part of our routine; all presumptive amphetamine positives go to Abbott TDX testing. This was the case in this matter. The sample was removed from the EIA ring and placed in a further testing aliquot rack for TDX testing. The specimen was given position #9 in the TDX rack along with a blind QC, negative QC and a medium QC specimen. The specimen in position #9 did not screen positive on the TDX as the cutoff is 1000 and specimen #9 read 13.56, therefore the case was signed out as negative.

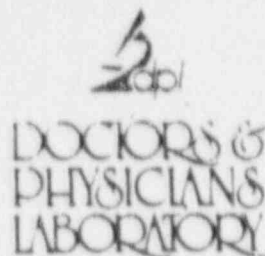
Upon initiation of this investigation, the sample was re-aliquoted for EIA on 19 March 1991 in Batch #031991A3. It again screened positive by EIA and was sent for further testing on the Abbott TDX on 19 March 1991. The position it held on this screen was #8. This screen demonstrated a value of 3366, clearly above the 1000 threshold for amphetamines. The sample was therefore taken to GC/MS and amphetamine was confirmed as positive at a concentration of 2106 ng/mL.

Analyst: J. L. Smith
Technician: M. J. Smith

Upon review of the above data, there are only two possible answers of which only one is likely or more probable than the other. They are:

Deputy Medical Director
Florida Department of Health

1. The Abbott TDX reported a false negative.
2. The EIA aliquot used for further testing was removed in error by the screening technician and a negative urine placed in the TDX run. This seems more likely and more probable than the 1st choice.

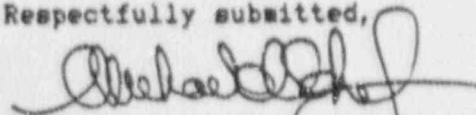


Dr. Sanchez letter continued

We are now reviewing the further aliquot logs from EIA & confirming them with the bar coded test tubes to verify the sample is in the correct position and bears the correct barcode.

I believe that this is the most plausible answer, since we have instituted the log, this problem should be alleviated with the check procedure.

Respectfully submitted,



Michael I. Schaffer, Ph.D., D.A.B.F.T.
DOCTORS & PHYSICIANS LABORATORY, INC.

MIS/jb

Enclosure

cc: Thomas Techman, M. D.
Kathe Russell

William H. Shultz, M.D.
Thomas M. Techman, M.D.

Diplomates American
Board of Pathology