

Florida Power CORPORATION

Crystal River Unit 3
Docket No. 50-202

November 17, 1992
3F1192-09

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

Subject: 10 CFR 26, "Fitness for Duty"
Unsatisfactory Performance Testing Incident
(False Negative Results)

Dear Sir:

Florida Power Corporation (FPC) is submitting this incident report in accordance with Title 10, Code of Federal Regulations, Part 26, Appendix A, Subpart B, Section 2.8(e)(4). This letter describes the unsatisfactory chemical testing incident, the investigative findings, and the corrective actions taken. Included as an attachment is the formal report submitted to FPC by our testing lab, Doctors & Physicians Laboratory.

FPC submitted a blind specimen to the testing lab on October 19, 1992. The required tests were made on the sample on October 20, 1992. The error was discovered by FPC's Medical Review Officer on October 21, 1992 when he reviewed the laboratory reports. The blind sample contained Morphine which should have been detected, but was not. FPC requested the laboratory to retest the sample and investigate the error. Upon retest, the laboratory correctly identified the substance as Morphine. The follow-up laboratory investigation revealed that the substance was correctly identified as Morphine during the initial October 20, 1992 testing. Two clerical errors were made by the laboratory. The first clerical error occurred when the positive sample result notation was transcribed to the laboratory computer records as a negative sample. The second clerical error occurred when the certifying scientist reviewing the paperwork incorrectly identified the positive opiate result on the specimen as negative.

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GENERAL OFFICE: 3201 Thirty-fourth Street South • P.O. Box 14042 • St. Petersburg, Florida 33733 • (813) 866-5151

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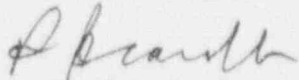
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The laboratory has corrected all the records, counseled the individuals involved in the clerical errors, and made appropriate changes in its procedures to prevent this error from occurring again.

Sincerely,



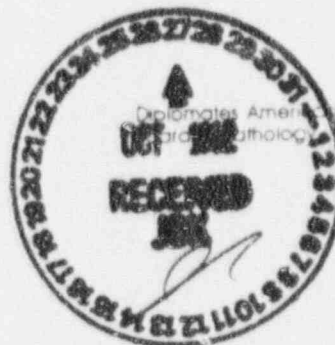
P. M. Beard, Jr.
Senior Vice President
Nuclear Operations

PMB/JWT

Attachment

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

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



October 26, 1992

Jeffrey Kessler, M.D.
Medical Review Officer
Florida Power Corporation
P.O. Box 219
Crystal River, Florida 32629

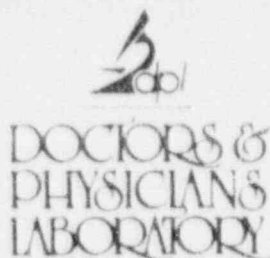
RE: 8102495

Dear Dr. Kessler:

An investigation was held in the matter of the specimen listed above. The results of that investigation follow for your review.

1. Specimen identified with a social security number of 521-21-7457 was received in the toxicology accessioning department via DPL courier on 10/19/92 by Millie Phillips.
2. Millie Phillips logged the specimen into the computer system and Rhonda Stanford labeled and aliquotted the specimen for immunoassay screening.
3. Maryanne O'Toole received the aliquot along with others in Batch 101992A9C. The aliquots were processed on the CHEM1 analyzer and the results of the testing is attached. Specimen 521-21-7457 was given laboratory accession number 8102495, and appeared on the Batch sheet as specimen number 47. The results are clearly identified as positive for opiates as indicated by the circled notation showing PO or positive for opiates with a reading of 37.1 milliabsorbance units for the opiate category, but was missed by the analyst, who made the first clerical error.
4. The results were entered as negative into the laboratory data system, and the paperwork was submitted to the certifying scientist, Kathryn Pearson for review and release of the results.
5. Kathryn Pearson reviewed Batch 101992A9C, and incorrectly identified the positive opiate result on specimen 8102495 as negative. Ms. Pearson, then released the results via the computer to the autodial, and the printer in Toxicology and certified the results as being negative, the second clerical error.
6. Dr. Jeffrey Kessler contacted this author to notify the laboratory of the incorrect identification of the proficiency sample, and advised this author to investigate the

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



Diplomates American
Board of Pathology

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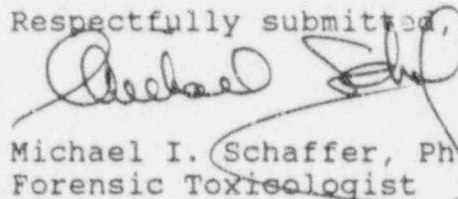
- circumstances surrounding this occurrence and prepare a draft for submission to his offices for his permanent record.
7. This author then set about to investigate the occurrence and noted the findings as listed above.
 8. The laboratory forwarded the specimen to GC/MS for confirmation and released an amended report on this proficiency specimen with a result of the specimen being positive for morphine at a concentration of 815 ng/ml.
 9. The author is submitting all pertinent copies of the missed proficiency sample for your permanent records.

Let me finally say that we are indeed very sorry for initially causing this error as a result of this clerical mistake, and have taken measures to counsel those persons involved, and make provisions to prevent this problem from happening again.

Since specimens identified with the number 8 are consistent with quality control specimens on the Chem 1 analyzer, the analysts as well as the certifying scientists have been cautioned to check very carefully whenever any specimen with the number 8 is analyzed on the Chem 1 analyzer. In so doing any specimen logged in with the number 8 as the first number will be checked very carefully and correctly entered with the appropriate results after a review by the screening analyst(s) and the certifying scientist.

If any of the above submitted information needs further clarification or discussion, please do not hesitate to contact this author at your earliest convenience.

Respectfully submitted,



Michael I. Schaffer, Ph.D., D.A.B.F.T.
Forensic Toxicologist
Co-Director of the NIDA Laboratory

Enclosed