Nebraska Public Power District

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January 24, 1991

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

Gentlemen:

Subject: Report of False Positive Drug Test Result
Cooper Nuclear Station
NRC Docket No. 50-298, DPR-46

The District herewith provides its 30-day followup report regarding its investigation into the false positive drug test result verbally reported to the NRC Operations Center on December 24, 1990. This report was made as a result of the identification of a false positive drug test result which occurred during an actual "for-cause" drug test.

10 CFR 26 Appendix A requires the prompt reporting of false positive test results occurring during the administration of a licensee's Blind Performance Quality Assurance (QA) program. 10 CFR 26 Appendix A provides no guidance regarding the reporting of an actual false positive drug test result. Notwithstanding this ambiguity in the applicable regulations, the District determined that a false positive drug test result, regardless of the mechanism of discovery, was an event which appeared to meet the intent of the 10 CFR 26 Appendix A reporting requirements. Therefore, the District verbally notified the NRC of its occurrence. In a later verbal communication with the NRC - Region IV on December 26, 1990, this position was confirmed.

On January 11, 1991, the District conducted an unannounced investigation of the incident at the Nichols Institute for Substance Abuse Testing (NISAT) lab in San Diego, CA. District and contract personnel reviewed applicable documentation and conducted interviews with NISAT personnel. This investigation concluded that the incident was apparently caused by an administrative error which resulted in a switching of drug test results between the District's specimen and another specimen.

The investigation further concluded that this error was, in part, due to bypassing the immunoassay (EMIT) test portion of the process, at the request of the District's Medical Review Officer (MRO). The District employee being tested was administered a "for-cause" test as a result of review of previous drug test results which indicated potential adulteration of the specimen. As a result, this "for-cause" specimen was collected under direct observation and the lab was instructed to bypass the initial screen (EMIT) and conduct only the confirmatory gas chromatography/mass spectrometry (GC/MS) test. In processing the specimen in this manner, the lab 1) was operating outside its

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procedures, and 2) did not have initial screen test results for comparison to the GC/MS test results. Therefore, by operating outside its procedures, the lab was exposed to a greater potential for administrative error, and by bypassing the EMIT test, the lab lacked the data to compare and verify the GC/MS results.

Both the District and NISAT have undertaken corrective actions to address this concern. The District is revising its procedures to require those specimens which are being handled under "special processing," i.e., those suspected of being adulterated or diluted, to undergo both an immunoassay and GC/MS analysis. This will ensure that 1) two test results are available for comparison for each specimen tested under the "special processing" procedure, and 2) that the District will not instruct the testing facility to operate outside its own procedures. These steps will reduce the potential for similar administrative errors occurring in the future with any lab contracted. The District is currently in the process of refining its FFD program implementing procedures and will include this procedure revision in that effort.

The following corrective actions were discussed with NISAT:

- NISAT indicated it will require use of both EMIT screens and GC/MS on all future analytical requests.

- NISAT indicated it will retain the detachable labels used to follow GC/MS processing on additional Chain of Custody sheets reflecting the position of the specimen in the auto-sampler.

- NISAT has budgeted to provide bar code specimen bottles with the accession (test) number. This will remove a potential for human error in transferring test results to record.

If implemented, these corrective actions should reduce the potential for similar administrative errors occurring during the processing of specimens provided to them by any and all other clients. The District will contact NISAT to obtain a formal written and signed commitment detailing corrective actions taken and/or planned to address this incident and prevent recurrence. NISAT's response will be included as part of the District's followup report discussed below.

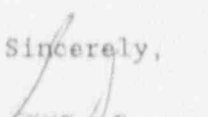
At this time, the District is not prepared to provide the detailed investigative report of this incident; in particular, as discussed above, the District has not yet obtained from NISAT a formal commitment to perform the corrective actions discussed during the investigation. Additionally, District

review of its contractor's investigation report revealed some discrepancies which must be resolved to ensure transmittal of complete and accurate information. Therefore, the District will provide the detailed report by March 1, 1991. This report will address the report elements specified in 10 CFR 26 Appendix A.

Finally, several mitigating facts are relevant to this discussion. First, the District no longer contracts with NISAT for drug testing. The District now contracts with Clinical Reference Laboratory (CRL) in Lenexa, KS. This lab currently uses a bar coding procedure for transferring specimen data to record. The District will review CRL's procedures during its next audit to ensure adequate controls are in place to protect against the administrative error experienced in this reported incident with NISAT. Secondly, the test which resulted in a false positive was for benzodiazepines. Although this drug is in the District's panel of drugs, this drug is not in the NRC required panel of drugs identified in 10 CFR 26 Appendix A. Lastly, the specimen whose results were inadvertently switched with the District's specimen was not from an employee of a nuclear facility. Therefore, no safety concerns exist in that respect.

The District will provide a followup report to this letter by March 1, 1991. Please contact me if you have any questions.

Sincerely,



G. R. Horn
Nuclear Power
Group Manager

GRH/MJB

cc: Regional Administrator
USNRC - Region IV

NRC Resident Inspector
Cooper Nuclear Station