On January 26th I was attempting to diagnose a problem on my GCMS, I wanted to make sure the problem wasn't the sample I was running, so I went to put the sample on Jonathan's GCMS. While loading the sample I also thought that I should run an alprazolam sample on my instrument to see what my instrument would do on a different method and with a high molecular weight compound. I noticed that the sample on the sequence list above the sample I had just put on Jonathans instrument was alprazolam (and was the only sample in the sequence, all other lines were blanks), so I was going to use that vial to run on my instrument. I noticed in the sequence log that the sample was L2H-222396 item 1, and that is was in location 18. I located the vial in location 18, and written on the vial was L2H-222403 7.2. At first I thought he must have mistyped or given an incorrect vial location, I looked at every sample vial on the tray and none of them had 222396 written on the vial. I then went to look for the folders for each case, L2H-222396 had a few spectra for item 1 in it, it looked like he was having trouble getting the sample to come out, I then checked the folder for 222403, and item 7.2 was alprazolam. I compared the spectra in the case folder from 222403 7.2, to the spectra from 222396, and determined that the spectra were the same. I called analyst Haley Yaklin over to show her what I had noticed and asked for her opinion. She agreed that it looked bad, and we agreed to give him the benefit of the doubt and to wait and see what Jonathan did with the spectra he had generated for 222396 before saying anything to management.

The next time I looked for the folder for 222396 it was in admin review, so I pulled it out and notified Severo of what I suspected had happened.

Andrew Gardiner

Cushes Jan