



M. S. Tuckman
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Duke Energy Corporation

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October 19, 2001

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

Subject: Duke Energy Corporation
Catawba Nuclear Station Units 1 & 2
Docket Nos. 50 -413, 414
McGuire Nuclear Station Units 1 & 2
Docket Nos. 50 -369, 370
Oconee Nuclear Station Units 1, 2 & 3
Docket Nos. 50 -269, 270, 287
Fitness For Duty: Unsatisfactory Laboratory
Performance of a Blind Urine Drug Screen Result

Pursuant to 10 CFR Part 26, Appendix A, 2.8(e)(4), attached is a report of an unsatisfactory performance testing result.

If you have questions or need additional information, please contact Allison Jones-Young at (704) 382-3154.

Very truly yours,

M.S. Tuckman

Attachments

A022

Rec'd
11/14/02

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xc: L.A. Reyes
Regional Administrator, Region II

C.P. Patel, ONRR

R.E. Martin, ONRR

L.N. Olshan, ONRR

S.M. Shaeffer (MNS)

D.J. Roberts (CNS)

M.C. Shannon (ONS)

US NRC

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bcc: L.F. Vaughn
M.R. Wilder
G.D. Gilbert
L.E. Nicholson
C.J. Thomas
A.D. Jones-Young
W.E. Dukes
A.C. Barnette
S.M. Francis
P.L. Loper

ATTACHMENTS



Duke Energy Corporation

EC020
526 South Church Street
P.O. Box 1006
Charlotte, NC 28201-1006

October 12, 2001

SUBJECT: Unsatisfactory Laboratory Performance of a Blind Urine Drug Screen

A spiked specimen containing methamphetamine was incorrectly identified as Amphetamine by Quest Diagnostics Laboratory in Atlanta, Georgia. The specimen (510518Q) was submitted on 8/22/2001. The specimen report was received at Duke Energy on 8/27/2001. Duke Energy notified Quest Diagnostics of the discrepancy on 8/29/2001. The laboratory's investigation was completed on 9/28/2001.

The specimen originally tested positive for amphetamine. It should have tested positive for methamphetamine. Upon repeat testing of the specimen on 9/17/2001 they correctly identified the specimen.

The laboratory's investigation revealed that during the GC/MS confirmation analysis an error was made in the placement of the specimen on the GC/MS autosampler tray. The laboratory repeated all of the specimens. The laboratory has instituted corrective measures (see letter from Ms. Tvaronza of 9/28/2001 and memo of changes). Their standard operating procedures will reflect the changes.

This type of error has not happened previously. Duke Energy's Nuclear Procurement Quality audited the laboratory on 9/26/2001. There were no findings and no other problems were found. The procedures they have put in place will prevent any recurrence of this type of error.

Sincerely,

A handwritten signature in black ink that reads 'William E. Dukes, Jr.' followed by a stylized flourish.

William E. Dukes, Jr., MD
Corporate Medical Director

Quest Diagnostics Incorporated

3175 Presidential Drive
Atlanta, GA 30340



September 28, 2001

Dr. Gene Dukes
Duke Power
526 South Church Street
Charolotte, NC 28201

Dear Dr. Dukes:

This letter is in response to the laboratory's report on the blind specimen received from Duke Power on 8/24/2001. The blind specimen was identified by requisition number 2033711, participant ID 398422122 and was given an accession number of 510518Q. This specimen was to be reported negative for Amphetamine and positive for Methamphetamine. The specimen was reported as positive for Amphetamine and negative for Methamphetamine.

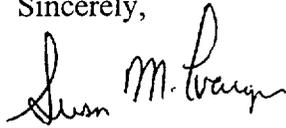
Upon investigation, it was determined that the error in reporting was due to the sample being placed in the wrong position on the GC/MS autosampler tray. Under the laboratory's current operating procedure, a sequence list was printed and the technician was responsible for verifying that the correct samples were in the correct positions on the GC/MS autosampler tray. In this instance, the sequence list was printed and the technician responsible for loading the GC/MS autosampler tray was also the technician who verified that the specimens were in the appropriate positions on the GC/MS autosampler tray. On the sequence list, position 29 was specimen 510518Q and position 30 was specimen 510794Q. In order to troubleshoot the problem, the whole load was re-extracted and analyzed. Upon re-analysis, it became apparent that on the original run, the specimen in position 29 was 510794Q and the specimen in position 30 was 510518Q. Even though the technician followed the standard operating procedure, an error was made in the placement of the specimens on the GC/MS autosampler tray.

In order to prevent this type of error in the future, a technician other than the one responsible for setting up the run, will check and verify the sequence list and the positioning of the specimen vials. In addition, at the completion of analysis before the vials are removed from the GC/MS autosampler tray, a technician will check the sequence list and verify the accuracy of the vial positions. This process has gone from a double check system by one person to a triple check system by two or more people.

Please see the attached memo that was distributed to all confirmation technicians for review and implementation (one technician on vacation). In addition, the standard operating procedure will be edited to reflect these changes.

If you have any questions or concerns, please do not hesitate to contact me at 770/452-1590 ext. 6122.

Sincerely,

A handwritten signature in cursive script that reads "Susan M. Tvarozna". The signature is written in black ink and is positioned above the printed name.

Susan M. Tvarozna
QA Manager

Confirmation Department
Blist Memo

Judy Keller	<u>Judy Keller</u> Signature	<u>9/25/2001</u> Date
Joy Barnard	<u>Joy Barnard</u> Signature	<u>9-26-01</u> Date
Hope Battle	<u>Hope Battle</u> Signature	<u>9/25/01</u> Date
Denise Glasford	<u>Denise Glasford</u> Signature	<u>9-26-01</u> Date
Annie Johnson	<u>Annie Johnson</u> Signature	<u>9/25/01</u> Date
Donna McCain	<u>Donna McCain</u> Signature	<u>9/28/01</u> Date
Elizabeth Newton-Cohen	_____ Signature	_____ Date
William Ofsa	_____ Signature	_____ Date
Angelique Payne	_____ Signature	_____ Date
Kay Shoemo-Watson	<u>Kay Shoemo Watson</u> Signature	<u>9/25/01</u> Date
Darlyne Smith	<u>Darlyne Smith</u> Signature	<u>9/28/01</u> Date
Candace Stevens	<u>Candace Stevens</u> Signature	<u>9-25-2001</u> Date
Linda Walston	<u>Linda Walston</u> Signature	<u>9-26-01</u> Date
Ellean White	<u>Ellean White</u> Signature	<u>9-29-01</u> Date

Effective 9/25/2001, the protocol for loading and checking of samples on the autosampler is as follows:

1. The person loading samples onto the autosampler must have another person check the positions of the samples, as indicated on the Blist.
2. If no one is available in the technical area, call the Certifying Scientists (ext.6139) to help. If no one is available in the certifying area, load the run, start it and the person who follows will have to check.(This may be the situation on weekend evenings)
3. The person who interprets the data must also check the position of the samples on the autosampler, as indicated on the Blist, before removing the samples from the tray. The data interpreter must still continue to check vials for injections.

4. If a load needs to be moved from one instrument to another, the person moving the load must get another person to check the new Blist.
5. Techs cannot check their own Blist.
6. If this procedure is not followed, disciplinary action will be taken.