

Tennessee Valley Authority, 1101 Market Street, Chattanooga, Tennessee 37402-2801

June 26, 2009

10 CFR 26.719(c)

US Nuclear Regulatory Commission, ATTN: Document Control Desk Rockville, MD 20852

50-391

## TENNESSEE VALLEY AUTHORITY (TVA) - SUBMITTAL OF REPORT IN ACCORDANCE WITH 10 CFR 26.719 (c)(1) FOR DRUG AND ALCOHOL TESTING ERRORS

In accordance with 10 CFR 26.719 (c)(1), TVA submits the following report regarding an anomaly in a blind specimen provided by TVA's contracted vendor, Quality Assurance Service Corporation (QAS).

## Description of Incident

On May 8, 2009, TVA submitted a "dilute" blind specimen to its Department of Health and Human Services (DHHS) contract laboratory for specimen analysis. On May 12, 2009, TVA's contract laboratory reported the specimen to be an "invalid" rather than "dilute" blind specimen. Because of this unexpected result, TVA's Medical Review Officer (MRO) and Fitness-for-Duty (FFD) Staff contacted QAS which reported to the MRO and FFD Staff that pH levels for the "dilute" specimen were not monitored/controlled as required by contract and 10 CFR Part 26 requirements. QAS's failure to monitor/control the pH level caused an unexpected, but correct, analysis as reported by TVA's contract laboratory.

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## Corrective Actions Taken or Planned

Upon notification of the unexpected results, TVA began an investigation and contacted QAS's Operation Manager. The Operation Manager confirmed that QAS erroneously thought that pH levels did not have to fall within the normal range for dilute specimens and therefore did not monitor the pH levels for this lot of specimens. The required pH levels were specified in TVA's contract with QAS in accordance with 10 CFR 26.185. TVA requested the QAS Operation Manager to provide documentation attesting that the pH levels in question were not controlled for the "dilute" blind specimens as required per the contract. TVA also requested the QAS Operation Manager provide confirmations on pH levels for all remaining lots of blind specimens (adulterated, false negative challenge, positive, etc.).

Five remaining "dilute" blind specimens within this lot were confirmed by QAS to be incorrectly prepared. None of the remaining blind specimens within this lot supplied by QAS, including the five confirmed incorrectly prepared specimens, were submitted to the DHHS contract laboratory for analysis. All blind specimens supplied by QAS to TVA since March 31, 2009 and subsequently submitted to the DHHS contract laboratory were reviewed by the MRO to verify compliance. The MRO verified that in all cases reviewed, the DHHS contract laboratory had tested and reported correct results to the MRO. However, the MRO identified eight positive blind specimens supplied by QAS for use this quarter which were either at or above the two hundred percent cutoff level prescribed by 10 CFR 26.185.

TVA has discontinued obtaining specimens from QAS and initiated a contract with a new blind specimen vendor. Blind specimens have been ordered and received from the new vendor to replace the specimens which were incorrectly prepared by QAS. To ensure blind specimen vendor compliance, TVA's MRO will review and sign off on 100% of TVA's non-negative (positive, substituted, dilute, and adulterated) blind specimen testing results. The MRO review requirement will be procedurally captured in FFD Manual Procedure FFD-11, "Blind Testing and Other Administrative Requirements." TVA will also submit this event as an Operating Experience Report through Institute of Nuclear Power Operations.

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This event was entered in TVA's Corrective Action Program under Problem Evaluation Report (PER) 171219. There are no new regulatory commitments in this letter. If you have any questions about this response, please contact Kevin Casey at (423) 751-8523.

Sincerely,

Fredrick C. Mashburn

Acting Manager, Corporate Nuclear Licensing and Industry Affairs

CC:

M. E. Ernstes

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