Entergy Operations, Inc.
1448 S.R. 333
Russellville, AR 72802
Tel 479-858-4704

Stephenie L. Pyle
Manager, Regulatory Assurance
Arkansas Nuclear One

0CAN041604

April 19, 2016

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

SUBJECT: Unsatisfactory Blind Quality Assurance Drug Testing Samples
Arkansas Nuclear One - Units 1 and 2
Docket Nos. 50-313 and 50-368
License Nos. DPR-51 and NPF-6

Dear Sir or Madam:

On February 1, 2016, Arkansas Nuclear One (ANO) Fitness-for-Duty (FFD) Staff confirmed a sequencing error had likely occurred for a blind Quality Assurance drug testing sample that was purchased from Elsohly Laboratory in Oxford, Mississippi and sent to the Quest Diagnostics Health and Human Services-certified laboratory in Lenexa, Kansas, for analysis.

The ANO FFD Staff completed an investigation pertaining to the blind sample errors on March 24, 2016, and pursuant to the reporting requirements of 10 CFR 26.719(c)(1), the investigation results and corrective actions are documented in the Attachment to this letter.

This report includes no new regulatory commitments.

If you have any questions or require additional information, please contact Robert Jackson, Supervisor, ANO FFD, at 479-858-6875.

Sincerely,

ORIGINAL SIGNED BY STEPHENIE L. PYLE

SLP/mkh

Attachment: Summary of Blind Quality Assurance Sample Error Investigation Report

cc: Mr. Marc L. Dapas
Regional Administrator
U. S. Nuclear Regulatory Commission
Region IV
1600 East Lamar Boulevard
Arlington, TX 76011-4511

NRC Senior Resident Inspector
Arkansas Nuclear One
P. O. Box 310
London, AR 72847

U. S. Nuclear Regulatory Commission
Attn: Mr. Stephen Koenick
MS O8 B1A
One White Flint North
11555 Rockville Pike
Rockville, MD 20852

Attachment to

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Summary of Blind Quality Assurance Sample Error Investigation Report

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Identification of Error:

Two blind Quality Assurance (QA) samples which had been pre-certified with values consistent with dilute samples were submitted to a Health and Human Services (HHS)-certified laboratory. Results for one of the samples was consistent with the Certificate of Analysis (CoA) indicating that the sample was dilute. However, results for the second sample were inconsistent with the pre-certified, dilute values. This sample reported results were consistent with a non-dilute sample.

Investigation:

Upon receipt of these results, the following actions were initiated:

1. The Arkansas Nuclear One (ANO) Medical Review Officer was informed of the error.
2. The remaining aliquot of the errant sample was submitted to the laboratory to validate the previous results. The results from the re-submitted sample were consistent with pre-certified, dilute values.
3. The remaining Entergy fleet plants were notified of the event.

Conclusion:

At the Quest Diagnostics HHS-certified laboratory in Lenexa, Kansas (Quest) specimen aliquotting is normally performed via an automated process. However, in this specific case, a manual aliquotting step was performed. The event was caused by a human error in performing this manual aliquotting step. Manual aliquotting is an infrequent performed activity, accounting for <1% of specimens processed.

Confirmatory testing following a positive screening test is performed from a fresh aliquot of the original specimen. Therefore, the likelihood of a false positive test result caused by an error involving manual aliquotting is remote.

Immediate Actions:

The Quest individual responsible for this error was suspended from performing manual aliquotting of urine specimens pending remediation.

Additional Corrective Actions:

Quest is to provide in-service training to other appropriate processing personnel to include a review of standard operating procedures, designated laboratory practices, and the results of the incident investigation.

Accelerated blind QA sample testing will be performed by ANO Fitness-for-Duty (FFD) personnel over the next 6 months that will include 5 additional tests per month. The 5 tests per month will be in addition to the 30 tests per quarter currently required by the FFD program. This additional testing, along with blind QA samples submitted by other Entergy Nuclear South fleet plants that are submitted to the same Quest HHS-certified laboratory in Lenexa Kansas is intended to increase the likelihood of detection of a recurring aliquot sequencing error.