Dominion Nuclear Connecticut, Inc.
Millstone Power Station
Rope Ferry Road
Waterford, CT 06385

Dominion

JUL 21 2003

Docket Nos. 50-245
50-336
50-423
B18944

RE: 10 CFR 26, Appendix A

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

Millstone Power Station, Unit Nos. 1, 2 and 3
10 CFR 26, Appendix A, Subpart B, Section 2.8(e)(4) Report
Unsatisfactory Laboratory Performance Test

Pursuant to 10 CFR 26, Appendix A, "Guidelines For Drug And Alcohol Testing Programs," Subpart B, "Scientific And Technical Requirements," Section 2.8, "Quality Assurance and Quality Control," Item (e)(4), "Licensee Blind Performance Test Procedures," Dominion Nuclear Connecticut, Inc. (DNC) submits the investigative findings and corrective action taken by our secondary testing laboratory, MEDTOX Laboratories Incorporated (see Enclosure 1), from their investigation of an unsatisfactory performance test. This performance test result is from a Department of Health and Human Services (DHHS) certified laboratory under contract to DNC to perform drug testing as required by 10 CFR Part 26 in support of the DNC Fitness-For-Duty (FFD) Program.

On June 25, 2003, MEDTOX Laboratories Incorporated began processing blind specimen #E068283 (DNC number 030618010M), but was unable to complete the analysis due to an assay failure. MEDTOX Laboratories Incorporated was unable to complete a new analysis due to insufficient remaining specimen volume. Enclosure 1 provides the MEDTOX Laboratories Incorporated report of its investigation, dated July 14, 2003, as required by 10 CFR 26, Appendix A, Subpart B, Section 2.8(e)(4). As stated in this report, this failure is considered a random and unusual occurrence, not indicative of a systematic assay or operational problem. No further corrective actions are planned.

There are no regulatory commitments contained within this letter.

A022

If you have any questions regarding this submittal, please contact Mr. David Dodson at (860) 447-1791 x2346.

Very truly yours,

DOMINION NUCLEAR CONNECTICUT, INC.

FOR: J. Alan Price
Site Vice President - Millstone

BY: Stephen P. Sarver, Director
Nuclear Station Operations and Maintenance

Enclosure 1) Re: Specimen #E068283, Investigation Report on Blind Performance Test Sample Prepared by MEDTOX Laboratories Incorporated, dated July 14, 2003

cc: H. J. Miller, Region I Administrator
D. G. Holland, NRC Project Manager, Millstone Unit No. 1
J. R. Wray, NRC Inspector, Region I, Millstone Unit No. 1
R. B. Ennis, NRC Senior Project Manager, Millstone Unit No. 2
V. Nerses, NRC Senior Project Manager, Millstone Unit No. 3
Millstone Senior Resident Inspector

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Enclosure 1

Millstone Power Station, Unit Nos. 1, 2 and 3

Re: Specimen #E068283, Investigation Report on Blind Performance Test Sample
Prepared by MEDTOX Laboratories Incorporated, dated July 14, 2003

MEDTOX®
LABORATORIES, INC.

July 14, 2003

Bryan Lockett
Fitness For Duty Administrator
Millstone Power Station
156 Rope Ferry Rd, BLDG 532
Waterford, CT 06385

Dear Mr. Lockett:

Pursuant to you letter of July 8, 2003, and in regards to 10CFR26 requiring an investigation as to reporting of the specimen identified as 8353317, the following information is provided.

The above-identified specimen arrived at MEDTOX Laboratories on June 25, 2003 at 0645. At that time the specimen was assigned the accession number of E068283, and was then designated for analysis for the presence of Morphine and 6-Acetylmorphine per the Medical Review Officer request.

The chemical analysis for the presence of 6-Acetylmorphine started on June 25, 2003. The assay was repeated on June 26, 2003 due to an assay failure. Subsequent examination of the specimen, confirmed the presence of 6-Acetylmorphine on June 26, 2003.

Concurrently, testing for the presence of Morphine was initiated on June 26, 2003. The analytical batch for Morphine analysis failed because of assay performance requirements. Unfortunately, there was insufficient specimen remaining in the original container to repeat the analysis. The specimen was rescheduled for re-analysis on June 27, 2003, when at that time it was determined that repeat testing would be unavailable due to insufficient specimen volume remaining in the specimen container to perform the chemical analysis.

The specimen results were reported to the Medical Review Officer on June 30, 2003 as "reconfirmed" the presence of 6-Acetylmorphine and "Insufficient specimen volume to complete Morphine testing".

I have reviewed all of the accumulated data to ensure that all procedures and corrective actions were appropriate. I have also reviewed the relevant laboratory standard operating procedures (SOP) to ensure that appropriate controls are in place to ensure that specimen volume is conserved. It is my assessment that the procedures in place are appropriate and were followed by staff. In addition, the laboratory monitors performance indicators, which include processed volumes, turn-around-time and assay success/failure rate. The assay pass rate routinely exceeds 95%, which indicates that the batch failure described above is not a systematic problem.

While we make every effort to complete requested testing on all specimens, there are occasions when sample volume is not sufficient to do so. This may occur when received sample volumes do not provide enough excess to accommodate additional testing that may be required. Unfortunately, this sample did not contain enough volume to accommodate all of the testing.

In summary, I believe that laboratory standard operating procedures are consistent with the requirements of the Federal Workplace Drug Testing Guidelines and that the SOP is routinely followed in the laboratory. The methods have been developed to minimize specimen volumes required for testing and there are practices in place to conserve specimen volume during the testing process. After review of all information relevant to the testing of the specimen indicated above, I have concluded that this was a random and unusual occurrence not indicative of a systematic assay or operational problem. I do not believe that any additional corrective action is merited.

Should you have any further questions or concerns in regards to this specimen, please feel free to contact either Dr. Jennifer Collins or myself at your earliest convenience.

Sincerely;

Mitchell F. LeBard
Associate Director Forensic Toxicology
Responsible Person