J. Barnie Beasley, Jr., P.E.
Vice President

Southern Nuclear Operating Company, Inc.
40 Inverness Center Parkway
Post Office Box 1295
Birmingham, Alabama 35201

Tel 205.992.7110
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SOUTHERN COMPANY
Energy to Serve Your World℠

NL-03-1267

June 23, 2003

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555-0001

Southern Nuclear Operating Company
Report of Unsatisfactory Performance Testing

Ladies and Gentlemen:

In accordance with 10 CFR Part 26, Appendix A, paragraph 2.8, Southern Nuclear Operating Company (SNC), the licensed operator for the Joseph M. Farley Nuclear Plant, the Edwin I. Hatch Nuclear Plant and the Vogtle Electric Generating Plant, requires that blind performance test specimens be submitted to a Department of Health and Human Services (HHS) certified laboratory for testing. On May 5, 2003, specimen C030186 was received at Doctors Laboratory, Inc. in Valdosta, Georgia as a blind specimen from the corporate office of SNC in Birmingham, AL. The blind performance specimen had been prepared and certified by ElSohly Laboratory as spiked with Phencyclidine (PCP).

The specimen in question was received and tested by Doctors Laboratory, Inc. on May 5, 2003. The specimen was screened as negative for all analytes. SNC notified Doctors Laboratory, Inc. on May 9, 2003 that a false negative blind performance error had occurred and requested re-testing and an immediate investigation.

Doctors Laboratory, Inc. re-tested the specimen and reported a positive result for PCP on June 3, 2003, with a memo detailing the investigation and the resulting disciplinary actions taken. Human error by an employee-in-training was the cause of the false negative.

The findings of Doctors Laboratory, Inc. are enclosed. The investigation shows no evidence of any systematic failure or fault that might be considered likely to produce the sort of error observed in the testing of this specimen.

SNC has utilized Doctors Laboratory, Inc. since August 2001. The laboratory reports high proficiency performance scores on HHS proficiency testing and nothing in the report indicates additional corrective action is required. Therefore, SNC submits this letter to satisfy the reporting requirements of 10 CFR Part 26 Appendix A, paragraph 2.8.

A022

Should you have any further questions, please advise.

Sincerely,

J. B. Beasley, Jr.

JBB/ANP

Enclosure: Doctors Laboratory, Inc. Report dated June 3, 2003.

cc: Southern Nuclear Operating Company
Mr. J. D. Woodard, Executive Vice President
Mr. J. W. Averett, Vice President – Administrative Services
Document Services RTYPE: CGA02.001

DOCTORS LABORATORY, INC.

RONALD R. ZIMMERMAN, D.O.
Chief Pathologist
SUPRANEE DER, M.D.
Cytopathologist
FRANK J. RAVELO, M.D.
General Pathologist
DAVID R. DAHLENBURG, M.D.
Oncology Specialist
CURTIS R. LIU, M.D.
Hematopathologist
MANOJKUMAR PATEL, M.D.
Dermatopathologist

ROY H. TRUCKS
Chief Executive Officer

BYRON S. DAVIS, M.D.
Chairman of the Board

RONALD R. ZIMMERMAN, D.O.
Medical Director

June 3, 2003

Billie Rooks
Southern Nuclear
40 Inverness Ctr. Pkwy.
Birmingham, AL 35242
205.995.6092

Dear Ms. Rooks:

Our investigation into the discrepant results for the specimen collected on chain of custody 120883, our laboratory number O5640763, patient number C030186, is complete. The specimen was incorrectly reported as negative. The correct result is PCP positive.

A review of the records yielded the following: The specimen was received in the laboratory on 5/5/2003. The initial testing indicated the specimen was reactive for PCP and was sent for confirmatory testing. The result of the GC/MS testing showed the presence of internal standard (indicating a valid extraction) without PCP. The specimen was reported as negative, a false result.

After you notified DLI that the specimen was a blind quality control sample, the specimen was retrieved from long term storage, thawed, and sent for confirmation. The result of this analysis was a positive PCP.

These findings allowed the location of the error to be determined as occurring during aliquoting for confirmation. The person who performed the aliquoting was a new employee, with the company for less than two months. The person checking the work was a long term employee. The person who assigned the new employee to this sensitive position is an experienced team leader. All the above personnel will receive disciplinary action.

Sincerely,

Leon Glass, Ph.D.