



FPL Energy
Seabrook Station

FPL Energy Seabrook Station
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March 30, 2006

Docket No. 50-443

SBK-L-06047

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555-0001


Seabrook Station
Licensee Event Report (LER) 2006-001-00 for
Inadequate Pre-employment Screening Results in Unauthorized Access

Enclosed is Licensee Event Report (LER) 2006-001-00. This LER reports an event that occurred at Seabrook Station on January 31, 2006. This event is being reported pursuant to the requirements of 10 CFR 73.71(a)(4).

Should you require further information regarding this matter, please contact Mr. James M. Peschel, Regulatory Programs Manager, at (603) 773-7194.

Very truly yours,

FPL Energy Seabrook, LLC



Gene St. Pierre
Site Vice President

cc: Director, Division of Nuclear Security, Office of Nuclear Security and Incident Response
S. J. Collins, NRC Region I Administrator
G. E. Miller, NRC Project Manager, Project Directorate I-2
G. T. Dentel, NRC Senior Resident Inspector

ENCLOSURE TO SBK-L-06047

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0101, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME Seabrook Station	2. DOCKET NUMBER 05000 443	3. PAGE 1 OF 3
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4. TITLE
Inadequate Pre-employment Screening Results in Unauthorized Access

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV. NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
01	31	2006	2006	- 001 -	00	3	30	2006	N/A	05000
									FACILITY NAME	DOCKET NUMBER
									N/A	05000

9. OPERATING MODE 1	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: (Check all that apply)									
10. POWER LEVEL 100	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)						
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)						
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input checked="" type="checkbox"/> 73.71(a)(4)						
<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)							
<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER							
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A							

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME James M. Peschel, Regulatory Programs Manager	TELEPHONE NUMBER (Include Area Code) 603-773-7194
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

14. SUPPLEMENTAL REPORT EXPECTED <input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On January 31, 2006, at 1612 it was determined that a non-supervisory, station contract employee was incorrectly granted unescorted access to the protected area. A review of pre-employment screening records from March 2005 related to fitness for duty records revealed that the employee's pre-access drug test revealed levels of marijuana metabolites that were higher than the allowed levels per 10 CFR 26. The test was incorrectly classified as negative by the site Medical Review Officer (MRO). A one-hour report (EN# 42297) was made to the NRC at 1708 on January 31, 2006. The individual's site access was suspended and the Medical Review Officer was suspended.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Seabrook Station	0500-0443	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
		2006	- 001	- 00	

17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

I. Description of Event

On January 31, 2006, during the annual audit of access authorization and fitness for duty programs, it was determined that a non-supervisory, station contract employee was incorrectly granted unescorted access to the protected area. During a review of the drug and alcohol test results at Seabrook Station, an independent technical specialist discovered that a test conducted on February 25, 2005 was reported by the laboratory on March 2, 2005 as a diluted specimen containing a confirmatory presence of marijuana with a level of 16 ng/ml. This value is above the NRC cut off level of 15 ng/ml for a marijuana confirmatory test. The Medical Review Officer (MRO) directed an observed sample be conducted. The observed test was conducted on March 7, 2005 and returned as a negative test. The MRO ruled the overall tests as negative. With the tests being negative and the remaining elements of the access process in place, the individual was granted unescorted access on March 10, 2005. As a result of the audit review by the technical specialist, the first test being ruled negative was in error. A one-hour report (EN# 42297) was made to the NRC at 1708 on January 31, 2006, the individual's protected area access was suspended and the Medical Review Officer was suspended.

II. Cause of Event

The cause of the event was inadequate understanding by the Medical Review Officer of the specific guidance for declaring a drug test positive, including appropriate cutoff levels and level of detection (LOD) testing.

III. Analysis of Event

10 CFR 26, Appendix A, specifies initial screening cut off levels for each of the five drugs tested. If there is a presence of illegal drugs, an additional step is taken to test the drug in question to a more stringent screening method called Gas Chromatography/Mass Spectrometry (GC/MS), which has lower cut off levels assigned to each drug panel. For marijuana, the initial screening cut off level required by the NRC is 100 ng/ml; however, FPL/FPLE Seabrook applies a stricter standard of 50 ng/ml. The cut off level for a marijuana confirmatory test (GC/MS) is set by the NRC at 15 ng/ml, which FPL/FPLE Seabrook applies.

During an interview conducted by the FPL Medical Review Officer with the Seabrook MRO on February 6, 2006 it was evident that the Seabrook MRO may not have had a full understanding of the cut off levels. The Seabrook MRO stated that he routinely consulted the Fitness for Duty staff regarding threshold levels. Additionally, an uncontrolled copy of a cancelled procedure was still in place in the Medical Office. The cancelled procedure lists the initial drug screening cut off levels (marijuana metabolites – 50 ng/ml) but does not list the specific levels for a confirmatory test. If the MRO solely relied on this procedure, he may have been misled into thinking that the cut off level was 50 ng/ml instead of the required 15 ng/ml for confirmatory tests.

IV. Corrective Action

The corrective actions taken for this event include:

- The FPL MRO will review Seabrook tests requiring MRO review.
- The individual was denied protected area access based on an interview conducted by the FPL MRO since there was no medical explanation for the positive results.
- A work review of the involved individual was conducted for the period of 3/11/05 to 2/1/06 with no adverse issues identified.
- A 100% review of the 2005 tests conducted at Seabrook (2,541 total), to include a review of all negative results. The results determined that there were no additional issues identified that would have impacted unescorted access.

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		2006	- 001	- 00	

17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

IV. Corrective Action (Continued)

- A 100% review was conducted of 2004 diluted and positive tests as a result of one issue identified during the 2005 test review. No further issues were identified.
- Standardized the process for all positive and dilute specimens and documented in appropriate procedure.
- Revised Fitness for Duty procedure to provide the MRO with instructions for handling all non-negative specimens.
- Removed all uncontrolled manuals/procedures from the Medical Office.
- Reviewed procedure usage and use of controlled document requirements with fitness for duty and medical office personnel.

V. Additional Information

None

Similar Events

A review of the Condition Reporting System identified an instance where all regulatory requirements were not met prior to granting unescorted access to the Protected Area. An individual had not completed enhanced Behavior Observation Training per NRC Order EA-02-261, Order for Compensatory Measures Related to Access Authorization. A review of the associated root cause evaluation determined that this condition is not related nor would the corrective actions have precluded this event.

Manufacturer Data

None