

LICENSEE EVENT REPORT (LER)

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

Estimated burden per response to comply with this mandatory information collection request: 50.0 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If 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.

FACILITY NAME (1) Davis-Besse Unit Number 1	DOCKET NUMBER (2) 05000346	PAGE (3) 1 OF 4
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TITLE (4)
Minimum Licensed Operator Shift Staffing Deficiency Due to Inadequate Evaluation of Temporary Medical Condition

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
09	21	1999	1999	-- 004 --	00	10	21	1999		05000
									FACILITY NAME	DOCKET NUMBER
										05000

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

LICENSEE CONTACT FOR THIS LER (12)

NAME D. L. Miller, Senior Engineer - Licensing	TELEPHONE NUMBER (Include Area Code) (419) 321-7264
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

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

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

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On September 21, 1999, Davis-Besse Nuclear Power Station personnel identified in a Condition Report that the respiratory requirements of a Senior Reactor Operator (SRO) had not been appropriately coupled to the medical qualification requirements for performance of licensed duties. On August 8, 1999, the licensed operator was injured away from work. On August 17, the licensed operator took a biennial medical examination as required by 10CFR55.21, Medical Examination. At the medical examination, the operator was unable to pass spirometry testing. On August 31, Nuclear Operations Training received summary documentation of the licensed operator's physical results. On September 1, the operator was removed from Fire Brigade duties but remained on licensed operator duties. On September 4 and 5, the SRO stood watches in the Control Room. Since this licensed operator did not meet the required minimum medical qualification, there was no qualified SRO in the Control Room as required by Administrative Technical Specification 6.2.2.c. Since this condition is prohibited by the plant's Technical Specifications, it is reportable as a Licensee Event Report in accordance with 10CFR50.73(a)(2)(i)(B). The apparent cause of occurrence is that written communication and procedural guidance, for medical conditions affecting licensed duties, is inadequate. The relationship between spirometry testing and performance of licensed duties was not understood. Failure to remove the operator from licensed duties had no safety significance. The operator was removed from licensed duties pending further medical evaluation.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Davis-Besse Unit Number 1	05000346	1999	-- 004 --	00	2 OF 4

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

Description of Occurrence:

On September 21, 1999, Davis-Besse Nuclear Power Station (DBNPS) personnel identified in a Condition Report (1999-1568) that the respiratory requirements of a Senior Reactor Operator (SRO) had not been appropriately coupled to the medical qualification requirements for performance of licensed duties. On August 8, 1999, the licensed operator was injured in an accident while engaged in a non-work related activity, away from work. As a result of this injury, the operator was not able to report to work as scheduled during the week of August 9. On August 9, the operator had been scheduled to take a biennial medical examination as required by 10CFR55.21, Medical Examination. This medical examination was rescheduled to August 17, 1999. At the rescheduled medical examination, the operator was unable to pass spirometry testing in accordance with the requirements of ANSI/ANS-3.4-1983, American National Standard Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants.

At the DBNPS, the operator medical examinations are performed at an on-site Health Center. After completion of all the required medical examinations and tests, the results are reviewed by the designated medical examiner. The results of the licensed operator's examination were summarized on a DBNPS Health Clearance form, which identified that the operator did not pass the biennial exam. Specifically, the Health Clearance form denoted that the operator had not met the requirements of ANSI/ANS-3.4-1983, DBNPS respirator qualification and DBNPS Fire Brigade qualification. In the comment section of the Health Clearance form, it was documented that repeat spirometry testing was needed and a referral to a specialist for additional testing may be needed. After the Health Clearance form was completed, it was forwarded to Nuclear Operations Training in accordance with procedure NT-OT-07001, "Licensed Operator Requalification Program."

On August 31, 1999, the Supervisor-Nuclear Operations Training received, reviewed and signed the Health Clearance form. Based on the comments on the form, the training supervisor thought further evaluation was to be performed prior to final dispositioning of the medical examination. On September 1, 1999, the licensed operator was removed from Fire Brigade duties but remained on licensed shift duties. This decision was based on the understanding that Control Room licensed duties did not require respirator qualification. The connection of the failed test to performing licensed duties was not clearly understood. On September 4 and 5, the licensed operator stood watches, as the Control Room SRO, to satisfy minimum staffing requirements for Administrative Technical Specification 6.6.2, Facility Staff.

During the week of September 13, the Manager-Plant Operations (Acting) was contacted by Operations Training to discuss the approaching physical due date of the licensed operator. After these discussions, Regulatory Affairs-Compliance was requested to assist in determining if failure of spirometry testing only affected respirator qualification or if this failure also affected the operator's qualification to perform licensed duties. After review of the situation, it was determined that the operator was not qualified to perform licensed duties due to the medical condition that was identified during the biennial medical examination.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Davis-Besse Unit Number 1	05000346	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 4
		1999	-- 004 --	00	

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

Description of Occurrence: (Continued)

The operator was removed from licensed duties on September 20, 1999.

Condition Report 1999-1568 was initiated on September 21, 1999, to identify that respiratory requirements had not been appropriately coupled to the medical qualification requirements. A review of the Unit Log completed on September 24, 1999, for the time period of August 17 through September 20, 1999, revealed that on September 4 and September 5, 1999, the individual was designated the shift position of Control Room SRO for two complete shifts. Since this individual did not meet the required minimum medical qualification per ANSI/ANS-3.4-1983, there was no qualified SRO in the Control Room as required by Technical Specification 6.2.2.c. The NRC Senior Resident Inspector for the DENPS was notified of this occurrence. Since this condition is prohibited by the plant's Technical Specifications, it is reportable as a Licensee Event Report (LER) in accordance with 10CFR50.73 (a) (2) (i) (B).

Apparent Cause of Occurrence:

The apparent cause of occurrence is that written communication was inadequate in that procedural guidance for temporary medical conditions affecting licensed duties does not exist. Procedure NT-OT-07001 provides general guidance for medical conditions that can cause a permanent change in the medical qualification of a licensed operator. There is no guidance that discusses the specific minimum capacities required for the medical qualification of a licensed operator to perform licensed duties as described in ANSI/ANS-3.4-1983. No written guidance exists for evaluation or administrative control of temporary medical conditions. Since no written guidance existed, there was uncertainty on the decision point for removing a licensed operator from licensed duties. There is no clear written guidance on who is responsible for removing a licensed operator from licensed duties.

Inadequate training is also an apparent cause in that training personnel, operations management and licensed operators do not possess the knowledge or a general understanding of the minimum medical capacities to perform licensed duties.

Inadequate verbal communication also contributed to the untimely revocation of the licensed operator's qualification to perform licensed duties after failing spirometry testing. Notification from Health Services to the Nuclear Operations Training was performed upon identifying the medical condition, but the ramifications of the licensed operator's condition relative to performance of licensed duties was not clearly understood.

Inadequate work practices contributed in that procedures were not followed correctly. Nuclear Operations Training did not notify Plant Operations management of the medical condition when the Health Clearance form was received on August 31, as required by NT-OT-07001.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Davis-Besse Unit Number 1	05000346	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	4 OF 4
		1999	-- 004 --	00	

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

Analysis of Occurrence:

Failure to remove the operator from licensed duties had no safety significance. Three SROs were on site on September 4 and 5, which is greater than the TS Minimum Shift Crew Composition of two SROs. The required Control Room SRO position could have been relieved by one of the other two qualified licensed SROs, if required. Spirometry testing for which the licensed operator should have been removed from licensed duties was only marginally below the required minimum capacity. There were no other medical criterion for which the licensed operator failed to meet the minimum required capacities.

Corrective Actions:

The licensed operator was removed from licensed duties on September 20, 1999, pending further medical evaluation.

Interim guidance with regard to minimum medical qualifications to perform licensed duties will be provided to licensed operators by November 10, 1999.

Procedure NT-OT-07001 will be revised, or a new Nuclear Training policy or procedure will be prepared. This guidance will clarify minimum medical requirements, decision making and management responsibilities for temporary medical conditions. The appropriate revised documents will be approved by February 28, 2000.

The minimum required medical standards for performance of licensed duties will be incorporated into licensed operator requalification training plans by February 28, 2000.

Training on the revised procedures and/or policies will be completed by March 31, 2000.

Failure Data:

Within the past three years there have been no other Licensee Event Reports for failure to meet the required minimum shift staffing requirements.

NP-33-99-004-00

CR 1999-1568