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PUBLIC MEETING
BETWEEN U.S. NUCLEAR REGULATORY COMMISSION O350 PANEL
AND FIRST ENERGY NUCLEAR OPERATING COMPANY
OAK HARBOR, OHIO

Meeting held on Tuesday, August 20, 2002, at
2:00 p.m. at the Oak Harbor High School, Oak Harbor, Ohio,
taken by me Marie B. Fresch, Registered Merit Reporter, and
Notary Public in and for the State of Ohio.

PANEL MEMBERS PRESENT:

U. S. NUCLEAR REGULATORY COMMISSION

- Mr. John Grobe, Chairman, MC 0350 Panel
- William Dean, Vice Chairman, MC 0350 Panel
- Anthony Mendiola,
Section Chief PDIII-2, NRR
- Christine Lipa, Projects Branch Chief
- Jon R. Johnson, Deputy Director
Office of Nuclear Reactor Regulation
Washington, D.C.
- Douglas Simkins, NRC Resident Inspector
- Melvin Holmberg, Metallurgist, Region 3

FIRST ENERGY NUCLEAR OPERATING COMPANY

- Lew Myers, FENOC Chief Operating Officer
- Robert W. Schrauder,
Director - Support Services
- J. Randel Fast, Plant Manager
- James J. Powers, III
Director - Nuclear Engineering
- L. William Pearce,
Vice President FENOC Oversight
- Clark Price, Manager - Business Services

1 MR. GROBE: Good afternoon.
2 My name is Jack Grobe. I'm the Chairman of the NRC
3 Oversight Panel for the Davis-Besse Nuclear Power Station.
4 This is our next in a series of monthly meetings, public
5 meetings to discuss between the NRC and First Energy
6 Nuclear Operating Company the status of the Davis-Besse
7 Plant and their approach to activities that are intended to
8 get them to restart Davis-Besse.

9 What I would like to do to start is to introduce the
10 NRC staff that are here today, and then ask Mr. Myers to
11 introduce his staff here on the stage.

12 I would like to point out also that there is a
13 handout available to members of the public out in the area
14 outside the auditorium. If you neglected to pick one up,
15 please pick one of those up.

16 Again, my name is Jack Grobe. On my immediate left
17 we have a special visitor today. His name is Jon Johnson.
18 Jon is the Deputy Office Director for the Office of Nuclear
19 Reactor Regulation in our headquarters office in Rockville,
20 Maryland.

21 On my far left is Mel Holmberg. Mel is Senior
22 Metallurgist for Region 3 Office in the Chicago NRC
23 Office.

24 Tony Mendiola is next to Mel. Tony is the
25 Supervisor of the Licensing Organization that's responsible

1 for Davis-Besse in our headquarters office.

2 Bill Dean is the Deputy Chairman, Vice Chairman of
3 the Oversight Panel. He's the Deputy Director of the
4 Division of Engineering in our headquarters offices in
5 Rockville.

6 On my immediate right is Christine Lipa. Christine
7 is the Branch Chief in Region 3 in Chicago responsible for
8 Davis-Besse.

9 (Noise)

10 We have some competing noise. If you're unable to
11 hear me for any reason, please raise a hand or throw
12 something up here, we can make sure that you hear.

13 In addition up here on the stage is Doug Simpkins.
14 Doug is the Resident Inspector. He works at the
15 Davis-Besse Plant for the NRC.

16 (Off the record/fixing microphones)

17 MR. GROBE: Maybe it's not a
18 mike problem.

19 I was introducing Doug Simpkins. Doug is the
20 Resident Inspector. He works for the NRC here at the
21 Davis-Besse Plant and lives in the community.

22 Also in the audience is Rolland Lickus. Rolland
23 raise your hand back there. Rolland is our State Governed
24 Affairs Liaison out of our Region 3 Office in Chicago.

25 In addition in the audience is Vyka Mitlyng. Vyka

1 is one of our Public Affairs Officers out of the NRC Region
2 3 Office.

3 And Nancy Keller, Resident Office Assistant, here
4 assisting us in the logistic of this meeting.

5 I also want to thank the Oak Harbor High School and
6 particularly Mr. Stucker for facilitating these meetings.
7 He's done an outstanding job.

8 Lew, why don't you introduce your staff.

9 MR. MYERS: With us today in
10 the audience we have Bob Saunders, the President of First
11 Energy Nuclear Operating Company. Raise your hand or stand
12 up. His wife, Carol. My wife, Linda.

13 Gary Leidich is the Executive Director -- or
14 Executive Vice President of the Nuclear Operating Company.

15 Steve Loehlein is with us today. Steve was the
16 person that did the Technical Root Cause Report and also
17 headed the team of Nuclear Management Root Cause.

18 David Gudger is with us. He is in charge of our
19 Corrective Action Group.

20 Tim Chambers is here.

21 Mark McCullough is with us; Containment Health.

22 Dave Baker is Reactor Head. I think he's on
23 schedule.

24 And then Mike Ross is with us today. And he's here
25 as Operation Excellence Plan.

1 Tony Seller, Restart.

2 And then Dave Eshelman is Management Performance.

3 To my left, Jim Powers at the table. Jim is the
4 Director of Engineering. He came to us from the Perry
5 Plant. He's also running the programs reviews and the
6 system reviews.

7 Bob Schrauder next to him. Bob came to us from
8 Perry also. He is the Director of Support and he's here
9 for the Nuclear Reactor Vessel Head Project.

10 And Clark Price is with us today. And Clark is
11 going to give you some status on some of our performance
12 indicators, and Clark is running the Restart Action Plan,
13 if you will.

14 Next to me is Bill Pearce. The last time you were
15 here, you asked for some quality reviews, so we brought
16 Bill with us today.

17 And then Randy Fast is with us also. Randy is our
18 Plant Manager in charge of Containment Health.

19 I'm Lew Myers, Chief Operating Officer of First
20 Energy Nuclear Operating Company.

21 MR. GROBE: Okay, thank you.

22 Sounds like we have the problem solved. That's
23 great.

24 At this time, I would like to turn the agenda over
25 to Christine Lipa. Christine is going to summarize some

1 recent activities and facilitate a discussion of our
2 research checklist, as well as recent inspection plans.

3 Christine.

4 MS. LIPA: Okay, thank you.

5 The couple other things I wanted to mention, Jack
6 mentioned we had handouts in the foyer. The Licensee also
7 brought a handout.

8 And we also have feedback forms that will enable
9 anybody who wants to give us feedback on how this meeting
10 goes, so we can incorporate those feedback items into
11 future meetings.

12 The next thing on the agenda I would like to cover
13 is the summary of the last monthly meeting that we held
14 here in Oak Harbor, as well as the meeting we held last
15 week in the Region 3 Office in Lisle, Illinois.

16 So, we'll go to the next slide.

17 This really just covers a few of the milestones that
18 have taken place since March, with the risk assessment that
19 the First Energy folks submitted in April.

20 The Root Cause Analysis Report that focused on the
21 technical issues were submitted in April, on April 18th.

22 Licensee submitted their Return to Service Plan on
23 May 21. That was revised on July 12. It's been revised
24 again just recently in August.

25 And then, of course, we held a public meeting last

1 week in the Region 3 Office in Lisle, Illinois, and we have
2 handouts that are available on the web page. The Licensee
3 will be summarizing that discussion later in this meeting
4 tonight.

5 Just to go over what we covered at last month's
6 public meeting here in Oak Harbor, is the next slide. It's
7 a summary of that meeting and we focused on the Licensee's
8 Return to Service Plan and their 7 Building Blocks.

9 I wanted to point out that the transcript, this
10 meeting tonight is being transcribed, by the way, but also
11 the transcript for that July 16th meeting is available on
12 our website, with more detailed discussion.

13 Here is some of the highlights of what we talked
14 about last month. We talked about the Licensee's efforts
15 on the reactor head resolution. They purchased the Midland
16 head, cleaned it, moved it here and are preparing to
17 install it, by opening the containment.

18 Then we also talked about the Containment Health
19 Plan. One of the things in there was that the Licensee had
20 expanded the scope of their efforts in looking at
21 containment health and looking at other compliments besides
22 those affected by boric acid in the containment. Looking
23 at the vessel liner in terms of integrity of the vessel
24 liner; also looking at the containment air coolers.

25 Then we talked about the System Health Assurance

1 Plan and the progress that they've made. And looking at
2 their programs, they gave us a sense of where they're
3 headed with what types of things they're looking at in
4 those programs. And we do plan some future inspections on
5 all of these plans, but at the public meetings we discussed
6 their progress and the systems that they were focusing on
7 and what else they were planning to do, and what they were
8 doing with those findings.

9 Again, that's what Clark Price is planning to talk
10 with us about later, the various findings that come out of
11 these reviews.

12 And then we also talked about Management and Human
13 Performance Excellence Plan, and that was really a big
14 focus of the meeting that was held last week in the Region
15 3 Office, was to understand what this months of effort in
16 looking at the root cause and trying to determine what it
17 really was, what the root causes were and what the plans
18 are for corrective action.

19 We really didn't focus too much on the last two of
20 the Building Blocks at last month's meeting. So, that
21 covers the first two items on today's agenda.

22 The third item on today's agenda is a discussion of
23 NRC Restart Checklist. We did discuss this last month and
24 there have been a few changes, but we'll just go through
25 the, for your reference.

1 The first page is basically unaffected from what you
2 saw last month. This was issued, by the way, on August
3 16th by the NRC. The Licensee has a copy of it. This will
4 be available on our website.

5 The second page is not too much change, but I did
6 want to talk about Item 6, which is what we call Licensing
7 Issue Resolution. And this covers various license
8 amendments and relief requests that are formal documents
9 between the Licensee and the NRC that cover very specific
10 items. And we have six of them listed between this page
11 and the next page.

12 And right now, these are the ones that we've
13 identified that are necessary for restart, but we're still
14 working with, with NRC and with the Licensee to ensure that
15 we have a common understanding of which particular ones do
16 need to be resolved before we start, and if there are any
17 new ones.

18 Then on the third page of the checklist, there is a
19 new item here, which is number 7. All along we had planned
20 to do this piece, but we thought it was appropriate to
21 include it as part of the restart checklist.

22 Item 7 is a Confirmatory Action Letter Resolution in
23 March and it was revised in May. And that has very
24 specific items on it that the Licensee has agreed to do
25 before restart.

1 As part of our O350 process, we will be assessing
2 each of those items, and closing each of those items. And
3 one of them in particular that we've added to the checklist
4 here is verification that all the Confirmatory Action
5 Letter Items are resolved. One of those include a public
6 meeting to discuss Readiness for Restart.

7 Okay. On the next item under agenda, Item 3 is a
8 status of the NRC inspections. And, recently we completed
9 the Augmented Inspection Team Follow-up. And just to
10 explain this a little bit. Back in April here, we had an
11 exit of the Augmented Inspection Team findings. And that
12 was, we had that exit here in April and their report was
13 issued on May 3.

14 Then I did find a lot of findings, a lot of
15 observations. It was summarized as several missed
16 opportunities for the Licensee to have identified the
17 condition over the years before it was identified in March
18 of 2002.

19 So, that report was issued in May. It's Report
20 2002-03. That's available on our website.

21 So, what we did as part of the follow-up for that,
22 we held an Augmented Inspection Team Follow-up Inspection.
23 And we had, the exit meeting for that inspection was held
24 August 9th. It was not a public meeting. So, that's why
25 we're discussing the results today. And those results will

1 be documented in Inspection Report 2002-08, which will be
2 on our website. It's still being prepared right now.

3 And in that report, the results that we have will be
4 considered as unresolved items until our risk assessment is
5 complete. And our risk assessment is one of the items that
6 we have been working on in NRC.

7 The next slide.

8 On the Augmented Inspection Team result is a little
9 more detail of the results of that inspection and numerous
10 apparent violations in five areas. And I'll go through
11 those five areas and I'll give you some examples, but I
12 just wanted to a little bit before we got into that,
13 explain the way this inspection works is the inspector goes
14 to the plant, reviews the documents, gathers the facts,
15 tries to put those facts together and then has an exit
16 meeting with the Licensee. After that, they come back to
17 the regional office and those findings go through the
18 management review.

19 So, we're in the management review phase. So, the
20 findings are still considered preliminary until the report
21 is signed off.

22 All the items that we looked at as part of this
23 Augmented Inspection Team Follow-up are considered directly
24 related to the Vessel Head Degradation Issue. So, the
25 significance is being worked together.

1 In accordance with our Inspection Manual 0612, which
2 is our guidance for regular inspection reports, all of
3 these issues, even though some of them appear to be
4 noncompliances or violations, will be characterized as
5 unresolved items. They're apparent violations whose
6 significance has yet to be determined.

7 When our significance determination process or risk
8 determination is completed, we will be able to issue those
9 violations and they will no longer be resolved --
10 unresolved items.

11 So, let me get into some of the examples. The first
12 one is an apparent violation of Technical Specifications,
13 which requires that there be no pressure boundary leakage;
14 and obviously because there were leakage, there was leakage
15 at the cracks in the nozzles, that is pressure valve
16 leakage, that is a violation of Technical Specifications.

17 The next area of violation was the adequacy of
18 corrective actions. And there were several apparent
19 violations of 10 CFR 50 which is a Code of Federal
20 Regulations, Regulation B16 for inadequate corrective
21 actions.

22 And the examples are numerous missed opportunities
23 to have identified the condition of the degradation of the
24 reactor vessel head, and some of the examples include the
25 deferral of the surface structure modification that would

1 have permitted access for adequate cleaning and inspection
2 of the vessel head.

3 Also inadequate corrective action for the radiation
4 monitor plugging that was going on inside the containment.
5 And the containment air cooler bin found that was going on
6 in the containment.

7 The next area of apparent violation is in
8 procedures, following procedures. And there were several
9 examples of procedures that were not being followed in the
10 boric acid, specifically the Boric Acid Corrosion Control
11 Procedure and the Corrective Action Procedure.

12 The fourth area was adequacy of procedures. And the
13 inspectors found problems with the Boric Acid Corrosion
14 Control Procedure regarding its adequacy. One example is
15 that focus was only on bolted connections and did not in
16 all cases require documentation of engineering
17 evaluations. It did refer to engineering evaluations that
18 needed to be done, but it did not require documentation.

19 The next area is completeness and accuracy of
20 information; and this is 10 CFR 50.9, Federal Regulation
21 50.9 that requires complete and accurate information. And
22 there were several documents that we looked at and there
23 are apparent discrepancies in the accuracy of some of those
24 documents, such as work orders, corrective action
25 documents, and responses to a generic letter and bulletin.

1 And, the scope of this inspection did not focus on or
2 attempt to address the intent. It was mostly focused on
3 whether the document was correct or not.

4 Now, these findings are considered unresolved
5 items. And I mentioned that earlier, because the
6 significance is not completed yet, but also NRC Office of
7 Investigation still has investigations ongoing that relate
8 to some of these issues, so they will not, they will remain
9 unresolved items until that is completed.

10 That's what I have for summary of the NRC
11 follow-up. I'll next turn it over to Mel Holmberg to talk
12 about one of the other inspections.

13 MR. HOLMBERG: Okay, thank you
14 Christine.

15 I'm not sure, can people hear me? I don't hear
16 myself out in the audience. All right, thank you.

17 As Christine said, my name is Mel Holmberg. I'm the
18 Lead Inspector for, associated with the Licensee
19 Containment Health Plan, and what I'll be discussing this
20 afternoon is the results of our NRC review on the
21 Licensee's efforts at determining the extent of condition
22 for boric acid corrosion of components inside containment.

23 Basically, the effort that I will be discussing is
24 an effort of three weeks in length that the NRC conducted
25 reviews of the activities the Licensee conducted inside

1 containment; focused on areas like dissimilar metal welds,
2 some of the containment general area inspections,
3 including components such as the service water piping, some
4 of the containment liner areas, and also review of
5 videotapes the Licensee performed on the reactor vessel.

6 As a result of this inspection, which ended July 26,
7 the NRC identified two findings, which were considered
8 violations of NRC requirements. The first finding was
9 associated with lack of acceptance criteria and
10 requirements to follow inspection plans; and the second
11 finding was associated with inadequate training and
12 certification of inspection personnel.

13 And for the walkdown inspections, the failure to
14 properly certify inspection personnel. Some of the
15 observations that we had in terms of inconsistent methods
16 to track completion of inspections, and some of the
17 observations were where we identified additional components
18 that had evidence of corrosion, led the Licensee to
19 conclusions and our staff's conclusions that these
20 inspections were not entirely effective.

21 As a result the Licensee decided to repeat these
22 inspections, and that effort is currently underway.

23 I'll describe briefly each of the findings. Tell
24 you where they're at right now with those items.

25 The first finding that was identified dealt with

1 lack of acceptance criteria requirements to follow
2 inspection plans. Here, there were three initial plans
3 that were used to actually direct field activities. And
4 these three areas that they focused on were dissimilar
5 metal welds, the reactor vessel and containment general
6 area.

7 However, these plants did not have the same quality
8 assurance program requirements that apply to the safety
9 related procedures, and they also lacked requirements or
10 acceptance criteria; failure to incorporate appropriate
11 acceptance criteria and implement requirements to adhere to
12 the plans is considered a violation of 10 CFR 50, NRC
13 Reg 5.

14 In response to that issue the Licensee has now
15 issued procedures instead of plans and has acceptance
16 criteria for each of the procedures and has begun again to
17 perform the inspections of the containment components.

18 The second finding dealt with inadequate training
19 and certification of inspection personnel. And this issue
20 centers around the standard that the Licensee had selected
21 to train personnel. It's called VT-2 Standard, and that's
22 a term that comes from the ASME or the American Society for
23 Mechanical Engineers. And to become a VT-2 inspector, the
24 requirement was to have six hours minimum training and 60
25 hours relevant work experience.

1 I identified in fact neither one of those
2 requirements was met for the inspection personnel that were
3 used to conduct the inspection.

4 And again, this was considered failure to have the
5 required inspection training and hours work experience was
6 considered a violation of 10 CFR 50, NRC Reg 5.

7 Again, to correct this issue, the Licensee has
8 currently developed a new training standard which is, at
9 this point appears to be more rigorous than previous
10 training standard, and their personnel now have specific
11 requirements that need to be met both for written testing
12 and program standards that are being applied.

13 And basically, I will turn it back over to Christine
14 for further comments.

15 MS. LIPA: Okay. Thanks
16 Mel.

17 Couple of other inspections that we have ongoing
18 right now are the inspections of the new vessel head and
19 the co-data package. Also the opening and the closing of
20 containment. And then some other upcoming inspections
21 would be a review of the license and inspection of the
22 Licensee Program Review.

23 We'll also be beginning our inspection of the
24 Management Human Performance Building Block and also
25 beginning review of the Systems Health Building Block. So,

1 those are some other upcoming NRC inspections that will be
2 discussed at the next public meeting.

3 That's all I have for Agenda Item 3.

4 Jack, do you have comments?

5 MR. GROBE: Lew, we provided
6 the results of our inspections in an ongoing fashion from
7 our staff when we were on site through regular interactions
8 with your staff, as well as at the completion of each
9 inspection through an exit interview. I wanted to briefly
10 summarize the results of inspections that have been
11 completed since our last public meeting, and give folks
12 here as well as yourselves a sense of what inspections we
13 expect to have subsequent to the results at our next public
14 meeting in September.

15 So, that's just a brief summary of the activities
16 that the NRC has had underway and expects to begin in the
17 next several weeks.

18 At this point, unless there is any other comments
19 from members of the panel, I would like to turn it over to
20 you and your staff.

21 MR. MYERS: Thank you.

22 Our Desired Outcomes today:

23 One is to, the first is to demonstrate that the
24 Integrated Schedule of activities at Davis-Besse is well
25 underway.

1 Second, to introduce the actions to achieve and
2 ensure sustained Management and Human Performance
3 Excellence at Davis-Besse.

4 We recently did a root cause with the regulator, as
5 they said last week, and we'll discuss those root causes as
6 we go through the report, and other corrective actions as
7 we go forward.

8 Three is to provide indicators that demonstrate our
9 progress to date. A lot of activities going on at the
10 plant and to give you some of our performance indicators.

11 Final, fourth is to demonstrate increased standards
12 of quality oversight of the Quality Oversight Organization,
13 if you will. One of the key things that we've done is we
14 brought Bill Pearce with us today to talk about the issues
15 in our quality area.

16 And then finally, is to provide the status of some
17 of our other Building Blocks as time permits.

18 Next slide.

19 As you remember, at our last meeting, we have, as we
20 got into the Davis-Besse issue, we created six Building
21 Blocks, with the center being the collection of the Restart
22 Action Plan.

23 The Building Blocks consist of the Reactor Head
24 Resolution Plan, the Program Compliance Plan, the
25 Containment Assurance Plan, which is now a total Health

1 Assurance Plan of Containment, the System Health Plan, the
2 Restart Test Plan; we got to restart test all of the
3 activities that we've done during the outage; and finally
4 is Management Human Performance Excellence Plan that
5 restart completed.

6 Responsible for that plan was Bob Saunders, my boss
7 and I was responsible to the plant at the site; and
8 finally, I believe an independent team, Steve Loehlein
9 headed that team, that completed the reports and gave that
10 to us the first of last week.

11 Now, according to the recent, the Building Blocks
12 Report through the Restart Overview Panel that we had
13 yesterday, that panel is now chaired by Leo Karns. I think
14 Leo is with us today in the audience. There he is out
15 there. He is the new chair. He came up the last time, our
16 chairman. So, Leo is taking that function.

17 That group is a group of very impressive independent
18 individuals. And anybody that don't think they're
19 independent, they could you tell you, come in and sit at
20 one of the meetings. They give us a lot of feedback on
21 some of the things we need to do as management team to
22 restart the Davis-Besse Plant.

23 In fact, what I would like to do is talk about some
24 of the things they've given us already on recommendations.
25 They've given us over 80 recommendations formally. And

1 quite a couple hundred informally.

2 One of the recommendations they gave us was to
3 expand the scope of the Containment Health, to the new
4 Containment Health Plan, not focus just on boric acid, but
5 some of the long term issues that we have in our
6 containment that we're trying to address now.

7 They also gave us some advice on developing
8 procedures and instituting stricter standards on quality.
9 And what we were finding out is these procedures, like the
10 word I use, primary word, prioritize becomes part of our
11 normal ways of doing business at the plant.

12 Finally, they place some, help us place some
13 independent oversight or review boards and subcommittees in
14 place. That can be engineering review boards that were put
15 in place. So, brought in some good talent there.

16 They suggested some specific plants that might be a
17 benchmark for management practices and standards that had
18 similar issues to our Davis-Besse Plant. We've been to
19 those plants and picked up some improvements there that we
20 would talk about later on.

21 And finally, Safety Conscious Work Environment.
22 Something we're all concerned about. I know that I have
23 meetings with the employees, our chairman, and several of
24 the members start coming to the plant and meeting with our
25 employees. And we're really stressing safety conscious

1 work environment. We're looking to be, to be more
2 proactive, looking for issues.

3 And, then finally, the extended root cause to
4 consider what effect some of the things we were finding has
5 on all of our plants. It's important as we go across these
6 issues or find these strengths, that we carry these forward
7 to our other plants.

8 The next slide.

9 At the last meeting we talked about the
10 organization. There has been a couple of changes since
11 that time. Dave Gudger is now in charge of the Corrective
12 Action Program. I think he's with us today. Dave came to
13 us from our Perry Plant.

14 And also you'll see on the slide that I have now
15 taken the duties as Site Vice President and will remain in
16 that position until after restart.

17 The first area that we want to talk about today are
18 the Management Root Causes. We had a meeting with the
19 Regulatory last week in Chicago, four-hour meeting went
20 over Root Causes, and I'll try not to spend that long
21 today, but try to brief you on what we told them.

22 Earlier investigations that we did, both from
23 Augmented Inspection Team and we did our Technical
24 Evaluation Process; both concluded one thing, that
25 management had ineffectively implemented processes and thus

1 failed to detect plant problems as opportunities arose.

2 And you heard that at the end of their investigation, that
3 opportunities to identify these problems were missed.

4 Knowing the history of the plant, we looked back and
5 decided to do the Technical Root Cause that was submitted
6 earlier this year, but we knew that since these missed
7 opportunities were management concerns, and we were going
8 to make management changes, that we had to wait to do our
9 Management Root Cause Reports, so we went ahead and did a
10 Technical Root Cause Report.

11 Before we did that, this strength in our
12 organization brought Gary Leidich in as Executive Director.
13 They promoted me to Chief Operating Officer and Executive
14 Vice President, and Bill Pearce as Vice President FENOC
15 Oversight. So, we wanted to get that out of the way.

16 Then, I was charged to come to the plant and we
17 chartered a Root Cause Team and we wanted to understand why
18 over the period of time, that Davis-Besse personnel failed
19 to identify the corrosion of the reactor pressure vessel
20 head. These were missed opportunities, if you would.

21 We wanted to go back. We had issues before that
22 failed to fix those problems, so it was important that we
23 went and go all the way down to understand the problem.

24 Let me share with you some of the things that we
25 found out. For root cause, there is never one root cause,

1 there is lots of contributing causes, lots of root causes,
2 but we've lumped those in four basic areas that we think,
3 with the exit of the AIT team a couple of weeks ago, were
4 the findings that Christine went over, our report appears
5 very much in line with some of the issues that were brought
6 up there.

7 Lists, our people over time, there is a focus on
8 production, combined with minimum actions to meet
9 regulatory requirements that resulted in the acceptance of
10 the degraded conditions.

11 That sounds real good. Let me tell you what that
12 means. At a nuclear plant or any commercial plant there is
13 also a focus on production. Always a focus on production.
14 That's what we do for a living. But we have to balance
15 that very carefully with nuclear safety and safety concerns
16 and assure that we do an appropriate technical review as we
17 find and fix problems.

18 If you look over about a five year period, what we
19 found is we had some degradation in that process, that we
20 were not thoroughly investigating issues as issues arose.
21 And that's one of the things that caused these missed
22 opportunities to exist.

23 The next area we reviewed was inadequate
24 implementation of the Corrective Action Program. We heard
25 the AIT report that the program was inadequate. Let me

1 tell you, the program did not meet all the bells and
2 whistles of the regulatory process. However, the program
3 was adequate to find and fix the reactor vessel head
4 problem. It was adequate to do that, but we failed to
5 implement the program appropriately.

6 The next area was failure to integrate and apply key
7 industry information and site knowledge and experience and
8 compare the new information to baseline knowledge.

9 The word that comes to mind there is complacency.
10 Davis-Besse over a period of years was an excellent
11 performer. And as time went by and industry experience in
12 specific issues grew, we were complacent and we failed to
13 look at the industry experience and our own requirements,
14 if you will, and improve our programs and processes to look
15 for this issue. In fact, we tend to justify why the issue
16 didn't exist.

17 Some steps in the Boric Acid Corrosion Control
18 Procedure were not followed. If you go to look at the
19 procedure we had in place, there were several times that we
20 had missed opportunities that we were just not clearly
21 following the procedure that we identified.

22 So, we've gone back and really strengthened the
23 procedure to have sign-offs and checklists to make sure
24 that we have a very strong, healthy Boric Acid Procedure
25 Control Program at all of our nuclear plants. It's now a

1 common process at all of our plants.

2 With that, let me go into some of the contributing
3 causes. Some decisions were made without considering the
4 need for safety analysis. What that's got to do, we tend
5 to identify things and put them into our Corrective Action
6 Program, but we did not perform the detail analysis that
7 many times, that we should have. To say, what could be
8 causing this issue? Missed opportunities again.

9 Corrective Action Program was not state-of-the-art.
10 What we find there is some differences, sometimes in
11 improvements, but also that there were times that the
12 programs at our Davis-Besse Plant was not quite the same
13 program as we have at our other plants, nor was it
14 implemented the same way. We'll talk about some of those
15 corrective actions.

16 Now, let me take a few minutes in each one of these
17 areas to talk about the corrective actions, if you will.
18 As we went into this issue, we developed our Restart Action
19 Plan consisting of Building Blocks. The Building Blocks
20 themselves were designed to help us with many of the
21 corrective actions.

22 The System Health Assurance Plan provides a rigorous
23 system review, if you will. We've got people out in the
24 two-step plan looking at our system, that went through the
25 systems, looking at long term issues, looking for system

1 health problems, walkdowns, and we brought in a lot of
2 system expertise, lessons learned from other plants like
3 D.C. Cook, as we're doing this.

4 So, these System Health Reviews are really
5 strengthening the rigor of looking at our systems, system
6 health.

7 Program Compliance Plan ensures programs meet the
8 industry high standards. We're going back to a large
9 number of our programs. We have a two-phase approach.
10 There is five programs right now that we're doing a very
11 in-depth latent issues review with a large integrated
12 team.

13 On the other programs, we're going through what we
14 call Phase One Review, and we're looking at each and every
15 program to ensure its compliance phase, it has good
16 ownership, and the implementation appears to be adequate.

17 Those two plans, if you will, were designed to help
18 us with recovery of the plant.

19 Finally, Management and Human Performance Excellence
20 Plan will ensure that we have strong and sustained safety
21 focus. What do we mean by that? Well, let me go through
22 the issues, and what I'll do is spend some time with each
23 issue talking about the corrective actions.

24 The first issue that I talked about earlier was
25 Nuclear Safety Focus. Well, we've strengthened our

1 corporate oversight. As I said, my position didn't exist.
2 Bill's position didn't exist as Nuclear Oversight,
3 Executive VP. And then the Executive VP, Gary
4 Leidich's position didn't exist. So, we've really
5 strengthened our corporate oversight of the plant.

6 Now, that was the first thing that we did. Then, we
7 turned around and we wanted to look at the Davis-Besse
8 team. One of the major issues that we had was management
9 involvement in day-to-day activities and leadership. We
10 now have in place a new Senior Team at Davis-Besse that are
11 proven high standard people, with proven industry
12 performance. We think that team will take the plant
13 forward.

14 New Management Observation Program. It's really not
15 a new program. We have a very good computerized Management
16 Observation Program at both Perry and Davis-Besse, and at
17 Beaver Valley plant. We're bringing that program over to
18 Davis-Besse, and we'll start using it as the program here
19 to perform the next bullet, Scheduled Management
20 Observation.

21 It's our intention to have managers in the field
22 observing scheduled work activities each and every week to
23 make sure that we have good ownership, we're following our
24 procedures, and good rigor in activities we perform; both
25 in routine maintenance activities, engineering activities,

1 and last but most important training activities.

2 We've created a case study. That's sort of a simple
3 word. It's not really a case study, it's more than that.
4 We're sitting down with each and every group at our plant
5 and going over this issue in great detail. We're looking
6 at the root causes by group and explain to each group how
7 they affected this issue; how they can prevent it from
8 happening.

9 At the end of that, we're going through the
10 standards of each group and then we're giving a test to
11 each and every employee. At least we'll know what the
12 standards are and we can go on from there.

13 Then, we're reinforcing our safety conscious work
14 environment every day. Now, we have several programs in
15 place, the four stages I'll talk about later; the
16 management review of our employees, what we call town
17 meetings to improve our safety focus at the Davis-Besse
18 Plant.

19 Continuing with Nuclear Safety Focus. We've staffed
20 organizational effectiveness experts, that are now on our
21 staff in helping us with our organization as we go forward;
22 that's employees.

23 Our four C's Meetings are Compliments,
24 Communications, Concerns, and Changes. We had the first
25 meeting a couple weeks ago. We had another meeting today.

1 And we'll close another meeting out on Friday. I did that
2 to meet with our employees individually, let them do a
3 facilitative, bring up their concerns, their issues, their
4 compliments. So, it's anonymous. And then I come back
5 after they do that, and look at the issues independently.
6 And it's sort of an anonymous proactive process to
7 strengthen our safety culture.

8 Ownership for excellence review of all of our
9 managers and directors. Our plan for evaluating the
10 attributes of the managers and directors is through
11 ownership and excellence.

12 We've done this at other plants. We're improving
13 our ownership programs. As we start up and go forward,
14 we'll be performing ownership for excellence reviews of
15 each and every manager and director at our plant.

16 Competency assessment is something we picked up from
17 one of the other plants, that they were building into
18 leadership in action, for each one of our supervisors. All
19 of our key supervisors, we'll do competency assessments on;
20 four different groups as we go prior to start up.

21 That concludes our actions on Nuclear Safety Focus.

22 The next area --

23 MR. GROBE: Lew, before you go
24 on, did I hear you correctly, you said the Ownership for
25 Excellence Review of Managers and Directors and Competency

1 Assessment of Supervisors; that will all be completed prior
2 to restart?

3 MR. MYERS: There is about
4 four groups of people. Ops, I forget the groups, but we'll
5 complete those prior to restart, yes.

6 MR. GROBE: Okay. Is this
7 described in the Building Block on Management and Human
8 Performance Excellence?

9 MR. MYERS: It will be in
10 Management Review Performance Excellence Plan.

11 MR. GROBE: So, that plan is
12 going under revision right now?

13 MR. MYERS: Right.

14 MR. GROBE: I would like to go
15 back, if I could one slide. You indicated that you're
16 reinforcing the safety conscious work environment.

17 You recently completed I believe a study of the
18 safety conscious work environment at the plant. Has that
19 been completed?

20 MR. MYERS: Yes.

21 MR. GROBE: Is that going to
22 be discussed in some of your succeeding slides?

23 MR. MYERS: I can discuss
24 that, if you like.

25 Bill, do you want to discuss that?

1 MR. GROBE: Sure, I think that
2 would be helpful.

3 MR. PEARCE: Okay.

4 MR. MYERS: Go ahead.

5 MR. PEARCE: You want me to do
6 it now?

7 MR. GROBE: Sure.

8 MR. PEARCE: We did a survey, a
9 survey, it's industry standard survey that we've done
10 several times in the past. And what we're trying to do in
11 doing that is understand where are we in the issues of
12 people being able to bring issues forward in the
13 organization, feel comfortable without reprisal, that they
14 can bring issues up and that kind of thing.

15 And of course, what's been seen in the industry over
16 a number of years is when you have this kind of problem,
17 that our employees or all employees kind of get a feeling
18 that, that they can't bring an issue forward as well as
19 they normally can. So, that's why we wanted to do the
20 survey, was to see where are we now in that regard.

21 What we discovered was that we had done a survey in
22 1999, I forget which month, early in 1999, and we had done
23 another one this year in January. And, so now we're doing
24 a third one. All the same survey and all we changed on it
25 was we added a couple of questions because of the issue

1 we're in, but generally the same survey.

2 And what it told us is that we had some issues in
3 1999 that were kind of low range in the area that we're
4 requesting. And at the first of this year before we found
5 the head problem, our ratings were actually pretty strong,
6 good. And now, the one taken in August, we're back to
7 where we were in the ratings in about the 1999 time frame.

8 So, you know, it was good and now it's bad again.
9 Overall, what does that mean? I think it means that, that
10 we have to put together a proactive plan to solicit those
11 issues from employees and make sure that we work a lot of
12 communication and trust issues, so that our folks believe
13 that without any question that we want them to bring issues
14 up; we value the information when we get it; and that we'll
15 act on it without hesitation.

16 And, of course, in that regard, they always have the
17 right if we don't act on it, to go to NRC, which is
18 guaranteed under law.

19 But that's kind of the baseline what we found on the
20 survey, Jack.

21 MR. GROBE: Bill, do you think
22 that, in fact, there was improvement in the safety culture
23 of the organization between '99 and 2001, or do you think
24 that was a fidelity problem in the survey?

25 MR. PEARCE: Well, in my heart

1 looking back at what we've looked at, I would have to
2 conclude that we probably thought even down in the
3 organization that we were in a better condition for those
4 issues than we actually were, and now we've maybe come back
5 more toward reality. I guess that's how I see it.

6 MR. MYERS: Let me answer that
7 too. You go look at the plant back in the last survey
8 we've done, just completed a very long run. The
9 performance has been outstanding. The employees felt good
10 about the status of the plant at that time.

11 When you go through an event like we're going
12 through now, the question is how did we get here. You
13 know, we trusted different groups. We trusted management.
14 We trusted everybody to keep us out of the situation. This
15 is our livelihood. How did we get here? It puts a
16 terrible stress on an organization.

17 So, the results that I'm seeing now, I would expect
18 to see. What we've got to do now is understand these
19 faults and move forward, be very proactive.

20 MR. GROBE: The word that's
21 often used in describing, what I think you're describing is
22 complaisant. Is that what you're sensing, that the
23 organization had become complaisant and tolerated lower
24 standards and that's why you were ranked higher in your
25 survey?

1 MR. PEARCE: Yes.

2 MR. MYERS: That's a good
3 analysis.

4 MR. GROBE: There was a
5 condition report initiated earlier this month and I'll just
6 read this. This is a description of the condition
7 identified. Says, based upon interviews conducted as part
8 of the Phase 2 Detailed Review and Corrective Action
9 Program, hesitancy to document our organization, human
10 performance and problematic issues on our condition reports
11 due to a fear of retaliation, as well as other reasons,
12 including the boomerang effect, continues to exist.

13 Could you help me understand what that means, and
14 why it continues to exist four or five months after a
15 shutdown of the plant?

16 MR. MYERS: Well, I think if
17 you look at some of our employees, it's hard to tell your
18 managers that you have problems with them, and there is
19 probably some hesitancy to do that, to right the management
20 issues or complaints that are management issues.

21 That's one of the reasons I started the Four C's
22 Program, anonymous way for a group of people to get
23 together and complain back to me if they want to; I can
24 come and address that issue.

25 So, it's difficult for people to do that. And then,

1 often when you do write something like that, it's a
2 boomerang effect. What happens, you wind up trying to
3 solve the problem, puts more work on you, you're already
4 working hard already.

5 I think that's the argument under the times, that's
6 probably an appropriate CR, and it's driven us, it's
7 driving us to take some actions to communicate better, be
8 more proactive in that area.

9 MR. GROBE: So, the corrective
10 action you laid out hereto, reestablishment of some
11 standards, new managers, your observation program having
12 managers in the field, case study, the four C's meetings,
13 these things will turn around this condition report
14 document in early August?

15 MR. MYERS: Sure.

16 MR. PEARCE: Jack, that's part
17 of it. Right now, we're formulating exactly what we're
18 going to do. As you know, we just had the survey completed
19 within the last week. And we're formulating exactly where
20 we're going from here. What are the additional actions
21 that we need to take going forward beyond what some of the
22 things we had already put in place. And I think that
23 certainly it's going to change some of the things we do
24 going forward.

25 I've already worked on power plants, so I know we're

1 going to do some things differently. We're not prepared to
2 present that today, but the next meeting we could, if you
3 wish.

4 MR. GROBE: Okay. The, one of
5 the artifacts of this kind of a situation that you've got
6 yourself into, is a number of issues or deficiencies or
7 concerns or problems that may not have gotten documented.
8 How are you trying to identify those, unearth them, get
9 them out of the drawers and into the systems?

10 MR. MYERS: You know, if you
11 look, one of the things we found consistently is our, from
12 a plant material condition standpoint, our people have
13 documented their concerns, CRs at a very, fairly low rate.
14 So, from a plant standpoint, that's sort of what we're
15 saying. Now, from a management standpoint, this is a
16 process of a lot of clearing.

17 Now to answer that question, how we look at those
18 things. There is Program Reviews that we're doing and a
19 System Reviews. As we go through the Program Reviews and
20 the System Reviews, we're specifically looking for those
21 long term latent issue type problems that's been laying
22 around, long-term type problems, trying to address those.
23 Meeting with the system engineers, and we have some outside
24 vendors in.

25 So, we're looking for those type of long-term

1 material condition issues as we go through this. They're
2 problematic.

3 Let me add this too. In general, the overall
4 material condition of the Davis-Besse plant as we walk the
5 system down, is in general good. You know, we are finding
6 a lot of, several hundred CRs that were written.
7 Generally, when you walk our plant down, you look at the
8 material condition, it's pretty good.

9 MR. GROBE: In addition to the
10 structured reviews you have, are you also asking all the
11 staff to lift the carpet and bring the issues back out from
12 underneath?

13 MR. MYERS: Let me go to my
14 next slide.

15 MR. GROBE: Okay.

16 MR. MYERS: The next area of
17 corrective action, if you will, concerns our Corrective
18 Action Program.

19 For the audience, what is Corrective Action Program?
20 That is the program that is sacred to us as managers of our
21 plant that we use to identify and fix our problems; for the
22 material condition problems, procedural problems, or
23 program problems, it's our, it's our life's blood for
24 documenting, finding and fixing our problems.

25 One of the things we're doing now, is that program

1 appeared to have some, at least some problems of
2 implementation as we went looking back on the record,
3 vessel head events. So, prior to even doing the root
4 cause, we decided that was one of the programs we were
5 going to do the Latent Issues Review on.

6 So, we've had a group of industry experts in here
7 and they're finalizing a report now where they spent time
8 going back and looking at our Corrective Action Program and
9 the health of that program. So, that's coming to
10 completion.

11 We're improving, one of the things in the management
12 performance area, the criteria for categorizing our CRs
13 that were really, was not effectively implemented.

14 And, let me explain that. We let people write CRs,
15 condition reports, on just about any issue. The required
16 program is very limited from a regulatory standpoint, but
17 we allow our people to write condition reports on broken
18 trucks, if they want to.

19 And, as we take, as we generate these CRs, every
20 morning we review the CRs to ensure that they're properly
21 categorized. Are they conditions adverse to quality of our
22 plant or are they just nonconforming conditions, or
23 nonquality conditions, or are they just management issue
24 type of conditions. So, we categorize those, the CRs that
25 are written each and every day; except on the weekends.

1 What we found as we went through the Management
2 Human Performance Review, was we had not properly
3 categorized several of the CRs that we looked at.

4 For example, you know, condition reports that were
5 written on containment coolers were not, not at high level,
6 not considered condition adverse to quality. It should
7 have been classified higher. We didn't do that well.

8 So, what we're doing now, we've already reviewed the
9 criteria. Every morning at the morning meeting, we're
10 going over the CRs that are generated, and we're
11 effectively implementing the corrective actions
12 categorization.

13 Bill is monitoring that. I monitor that.

14 Existing longstanding conditions are now being
15 reviewed as significant conditions adverse to quality.
16 What we mean by that? Well, as we go through the program
17 reviews, as we go through system reviews, we're looking for
18 longstanding issues, things the system is telling us, this
19 has been around for five years, ten years, hasn't worked
20 well.

21 So, we'll take those issues and we'll try to
22 reclassify those as appropriate, not every one of them, as
23 a significant issue adverse to quality. And what that will
24 do is give a detailed management review of root cause, if
25 you will, to make sure that the strong corrective action is

1 effected.

2 We've strengthened the review board. It's called
3 the Corrective Action Review Board. And what happens there
4 is, the causes, when we try to find and fix problems, go to
5 that board, make sure that we've done a good job of
6 reviewing for root causes if need, or parent causes or
7 whatever.

8 We now have a Director. In fact, it's our Plant
9 Manager, Randy Fast. He's the chairman of that board. So,
10 we've strengthened the management ownership of the board.

11 As we move forward, we will routinely for the next
12 year or two, anyway, perform assessments categorization.
13 You know, we think we got a categorization, could step
14 down, but we can't afford to step back. We're reviewing
15 every CR at the morning meetings every day.

16 Now, repeat conditions are being evaluated for the
17 significant conditions adverse to quality. One of the
18 things, containment air coolers, became the norm; became
19 the norm. Write a condition report; write a condition
20 report. And none of them high priority.

21 So, as we look for repeat conditions, we'll be
22 really strengthening on the ownership of those and try to
23 classify them as inappropriate, significant conditions
24 adverse to quality.

25 Require the use of formal cause determination

1 techniques for root cause and basic cause evaluations to
2 ensure analytical rigor is applied. If you go look at all
3 the CRs, we write thousands of CRs a year, there is only a
4 handful that are really significant issues and get detailed
5 root causes. Typically, we do apparent causes or basic
6 causes and what we find is we haven't done a good job of
7 training people to do those type of evaluations. So, we'll
8 be strengthening that area.

9 Define and implement training for cause
10 evaluations. That's to get the root causes and evaluations
11 consistently performed at each of our sites.

12 Improve guidance on reviews for effectiveness of
13 corrective actions. If you take the corrective action,
14 it's important to spend some time and you go back and make
15 sure those corrective actions really solve the problem.
16 Were effective and we're strengthening that process and in
17 fact we're providing guidelines for effectiveness reviews.

18 Implement an effective site-wide equipment trending
19 program. We typically do engineering reports on our
20 systems, probably on a quarterly basis. We're going to
21 strengthening our process to look for trending of
22 degradation. We do an adequate job at any rate.

23 Technical rigor, the next area, if you will.

24 MR. GROBE: Lew, before you go
25 on, did you have a question?

1 MR. DEAN: I'm sorry. I
2 wanted to get back to a question that related to the
3 surveys and the meeting you had with your staff. Is that
4 reinforcing some of the things that you saw on the survey,
5 safety conscious work environment survey in terms of --

6 MR. MYERS: Yes.

7 MR. DEAN: Can you describe
8 the global perception that you see on the part of the
9 staff?

10 MR. MYERS: Well, in the
11 meeting that I had, it's very independent so far. Our
12 staff will tell you they know their performance has
13 declined. They see that now. They openly tell me that.
14 They openly tell me the management bottom had decayed away,
15 which is exactly what we saw on the root cause, you know,
16 where we looked at managers to see how the containment is
17 doing, is relevant.

18 They also tell me that once you get talking to them,
19 they're not the least bit shy. And they tell me, we
20 haven't done a very good job of communicating to them.
21 Also they found things out through the newspaper before
22 they find out from us. And we're trying to strengthen that
23 communication in our newsletters and online television
24 system.

25 One of the things we did last week as a result of

1 that was, for feedback, is prior to going to meet with NRC
2 on the root cause, the day before, right before we left, we
3 had an all hands meeting with a couple hundred employees to
4 go over the results of the management review before we did
5 it with you; and to talk about the safety culture survey we
6 had just completed.

7 So, we did that last week. So, each one of those
8 areas that they give us, we try to address.

9 MR. DEAN: Thank you.

10 MR. GROBE: You described your
11 corrective actions for nuclear safety focus and now
12 corrective action program. That's a fairly broad set of
13 corrective action going forward. Two questions. One, the
14 Corrective Action Review Board.

15 Randy, you're fairly new to the organization. You
16 chaired that. Are there other members of the Corrective
17 Action Review Board that are either independent or new to
18 the site?

19 MR. FAST: We have some
20 engineers, but we also have some oversight, so both the
21 quality comes in to monitor those meetings, as well we have
22 independent assessment that provides feedback to us about
23 the things that they see as we review the significant
24 conditions of first quality, and the reports.

25 MR. GROBE: Like I said, this

1 is a, this is going to be a good going forward. Have you
2 queried the staff about issues or concerns that they've had
3 in the past that they did not bring up, because of this
4 problem with corrective action program, and safety focused
5 concerns?

6 MR. MYERS: I would say that
7 we're doing that now. All those details brought in place.

8 One of the things we chartered, is an action from
9 the Restart Oversight Panel, is Buzz Galbraith, our
10 Chairman, and Jere Witt, from the county, is starting some
11 individual independent meetings with our employees, and
12 giving us feedback as a management team at the Restart
13 Oversight Panel.

14 That's another action we're getting ready to take.
15 I just looked at the charter for that action today.

16 MR. GROBE: Okay. That's
17 probably something that before our next public meeting is
18 to spend some time out at the plant talking with the
19 staff.

20 MR. MYERS: Good.

21 MR. GROBE: Finding out what
22 they're thinking.

23 MR. MYERS: We would invite
24 that.

25 The next area is Technical Rigor. What do we mean

1 by that? That's a level of detail that we go into when
2 we're solving problems.

3 It appeared to be problems there. So, one of the
4 things we found was that we were given mixed messages on
5 some of our standards. At the FENOC level we have
6 policies, our business plans. Our business plans
7 specifically say that our priorities are the following:
8 Safety first, people second, reliability third, and finally
9 cost. That's our priorities in that order.

10 We found there is documents at our Davis-Besse Plant
11 that don't support some of the, policies that don't support
12 our business plan in FENOC's vision. We've come back and
13 made a list of all of those policies and procedures. One
14 of the things we do at FENOC, we went and we have completed
15 already and approved a Nuclear Operating Procedure that now
16 makes it a requirement that any time you generate one of
17 these site causes that could be, give you misleading
18 information, that's got to come to the Executive Team to be
19 reviewed and approved by us, for us to generate policy at
20 Davis-Besse.

21 We strengthened that, and we did that by creating a
22 Nuclear Operating Procedure that talks about, and our
23 approval process we talk about. That's complete.

24 We've established an Engineering Assessment Board
25 that reinforces our standards of engineering. And once

1 again, it's built with these type of changes that we have
2 now, rebaseline your standards, if you will. That puts
3 stress on the people in the organization that reinforced
4 the products that we didn't have to. And when that
5 happens, it tends to cause issues. And, that's another
6 reason we have to be sensitive to the issues we discuss
7 while we go.

8 We have established a Periodic System Walkdown
9 Program. You know, let me talk about the engineering a
10 moment. We've established a Periodic Engineering Program
11 Review Process. As we've gone through these reviews of our
12 programs and systems, the question comes to mind, why did
13 we have a procedure in place that our system engineers use
14 all the time for system reviews. They are supposed to be
15 doing routine system reviews and bringing their peers over
16 from the other plants to help them do reviews.

17 So, we've taken the documents and the lessons
18 learned from this issue, and the Buildings Blocks, and
19 we've turned those into, are turning those into permanent
20 processes that will be integral to all of our plants before
21 it's over with. So, the System Review and Program Review
22 is part of the normal culture, if you would.

23 We've rebaselined the standards and expectations
24 into each of our groups. We've already done that with
25 engineering, and we're going to look at rebaseline and

1 making sure those standards are right with us there. That
2 should help us with technical rigor.

3 The next area we talked about is Procedure
4 Compliance. You know, that's an area that people have been
5 storing away for years. It seemed like it went away too
6 far to the right. We've established a training program to
7 applicable Boric Acid Inspectors.

8 If you go look at, we talked a little while ago
9 about VT-2 qualifications. What we really found when we
10 looked at VT-2 qualifications, I think that most people
11 use, is that we really did not train the people
12 adequately.

13 So, we went back and created our own training,
14 training program for Boric Acid Inspections. And we
15 believe that that's going to be a program that will take
16 off here at our sites and be recognized as a leader in the
17 industry before it's over with.

18 Reinforce the standards and expectations for
19 procedure compliance and the need for work-practice rigor.
20 That gets back to the management observations. As we
21 scheduled these management observations and risk work, on
22 training, we expect to see a strong enforcement of
23 procedure implementation and stress the need for good rigor
24 on the procedures.

25 The next area is implement the Management

1 Observation Program with weekly schedules. It's not
2 something we've really done at other plants. We have
3 Management Observation Programs, but we haven't scheduled
4 each and every manager.

5 To show where we are at our Davis-Besse Plant, we're
6 going to schedule our managers to perform weekly
7 inspections. So, as we look at our weekly work of
8 training, maintenance style, we'll have our managers in the
9 field, and monitor this Management Observation Program.

10 And then Bill and his group are going to provide
11 oversight of how effectively our managers are calling out
12 issues as they see them.

13 Perform independent assessments of procedure
14 compliance. You know, we typically have Assessment
15 Programs, so since this has been such a big issue, we will
16 build that in as self-assessment for the next couple years
17 anyway to make sure we have the right rigor procedure in
18 compliance, because it's not the kind of thing you can lay
19 down. Strength today, then be in compliance; and if you
20 don't stay on it for a couple of years, you won't get back
21 to where you really want to be.

22 Discuss procedure compliance regularly at our
23 morning meetings. What we mean there is we look at all the
24 CRs written. We're looking for our procedure compliance in
25 the morning meetings and we'll receive training and we'll

1 attack those trainings.

2 One of the things we talk about is contributing
3 causes. We'll address some of the contributing causes,
4 we've established the FENOC decision-making process at
5 Davis-Besse, including the hazard analysis.

6 That's a really nice bunch of root cause type
7 words. What that means is we have a doc called Tech 19
8 that we use at both our Perry and Davis-Besse Plants.
9 We're turning that into a nuclear operating procedure. It
10 has a lot of philosophies in it on how to address equipment
11 and plant problems.

12 And if we had had that and used that process as we
13 went through our Corrective Action Program, we would have
14 done a better job of doing safety reviews when need to,
15 doing stronger technical reviews. It forces you through
16 that process.

17 So, we're going to turn that into a nuclear
18 operating procedure and formalize that process at all three
19 of our sites.

20 Perform corrective action procedure benchmark. We
21 now, as I said, we're doing that as we speak. We have a
22 group of experts that are a pretty impressive team of
23 industry, industry experts.

24 We're doing a latent issues review of our Corrective
25 Action Program, and there are some issues with that

1 program. And we're going to strengthen that program, but
2 more important than anything else is implementation of the
3 program.

4 MR. GROBE: Lew, before you go on,
5 the root causes that you've identified, safety focus versus
6 production focus and technical rigor; Christine summarized
7 earlier some violations that came out of our Augmented
8 Inspection Team follow-up inspection; and clearly you can
9 see threads through those violations of procedure
10 compliance, lack of safety focus. That was a fairly narrow
11 inspection, focused primarily on the head degradation.

12 Have you seen procedural compliance concerns in
13 other areas of the plant to cross operations and health
14 visits and engineering and maintenance?

15 MR. MYERS: I would say we've
16 seen a lack of rigor in several areas, yes. For example,
17 you know, we talked about one here, that is operability
18 concerns. The same program implemented the same at all
19 three sites is not the same.

20 So, we need to strengthen those operability
21 concerns. And Mike Cross is working that as we speak. The
22 operation rigor. So, yeah, we seen that pretty much across
23 the board.

24 MR. GROBE: Okay.

25 MR. MYERS: When we did the

1 root cause last week, we talked about management incentive
2 focus from safety, or the lack thereof. You know, I've
3 been a pretty high level person in this organization many
4 years, and I don't think that it's any programs are ever,
5 in fact, I don't even know what incentives are, to be
6 truthful about it, but I notice it never swayed my
7 decision, but it's an issue and it's an issue at the high
8 level we need to address.

9 I know Bob and Gary and myself, we're going to
10 address those issues and make sure that our incentive
11 program is properly in line.

12 Establish policies to support safety. We need
13 strong operational involvement. We need good managers in
14 the field and good decision making. We are strengthening
15 that.

16 You know, in summary, if you look at this issue, I
17 think our First Energy procedure, at one of our large staff
18 meetings in Akron a few weeks ago, in front of every one
19 said it best; said, you know, he has committed to returning
20 the Davis-Besse plant to service in a safe and reliable
21 manner.

22 What we really said was doing the job right the
23 first time. That's what we need to be about; doing the job
24 right the first time. Just find and fix the problem and
25 quit trying to justify the way. We're committed to meet

1 that challenge.

2 That's all I have. Thank you.

3 MR. GROBE: Okay. Questions

4 from the panel members?

5 Bill?

6 MR. DEAN: Lew, relative to

7 the statement here on the next to last slide where you talk

8 about establishing policies, report safety and in

9 particular operations involvement, is there a vision there

10 that you have as an organization relative to how do you see

11 operations fitting within the overall concept of how

12 Davis-Besse is going to operate that may be different than

13 how it's operated in the past?

14 MR. MYERS: Do that again for

15 me, I lost you somewhere.

16 MR. DEAN: The involvement of

17 the operations has in leading the organizations as opposed

18 to perhaps how it might have been in the past.

19 MR. MYERS: You want to

20 comment on that, Randy?

21 MR. FAST: When you benchmark

22 the industry, the best of the best, they're operation

23 driven. License holders of the plants are our operators.

24 It's the eyes and the ears of the plant. The expectations

25 are that they run true to form. They set the standard for

1 the rest of the station, and the station follows
2 operations.

3 That has not been the case at Davis-Besse of late.
4 Part of our Operational Excellence Plan is to clearly
5 communicate to our operations staff their leadership role
6 and then challenge them in assuring the high standards of
7 the plant.

8 In fact, we have one of our high level condition
9 reports. We're just in the final phases of review and
10 approval, and it reinstitutionalizes operation's role in
11 that management process. And to ensure proper buy in, we
12 have a meeting on this, this coming Friday, with all of our
13 shift engineers and our shift managers, so we can clarify
14 roles and responsibilities, and the critical role that they
15 play in ensuring the safeguards of the plant.

16 So, the short story is, operations will be the
17 leader of the future and they will set the standards for
18 proper operation of the plant.

19 MR. DEAN: In your efforts in
20 benchmarking in those organizations, what are some of the
21 steps you need besides clarifying roles and
22 responsibilities? Obviously, there are things that need to
23 be done in order to drain that throughout the organization.
24 Everyone else in the organization has to see organization
25 as well. So, what sort of steps are you talking to ensure

1 that message is seen specifically across the site?

2 MR. FAST: Well, Bill, one of
3 the things I would say is operation's role. Although
4 they're in the plant, they take that for granted, but
5 they're not bringing that information to the plant staff in
6 the morning meetings, identifying their expectations. And
7 when I talk with shift managers about when was the last
8 time you were in containment, what did you see on your
9 tour, what is it that you think needs to get attention; I
10 get little blank stares.

11 And the reality is, their positions demand that they
12 be out in the plant looking and that they bring those
13 issues forward. And the forum we have in operating our
14 plant on daily meetings, creates the spot where a shift
15 manager can challenge the leadership team in the issues
16 that they see in the plant.

17 Another area that we would, we pointed out at the
18 last public meeting was operability justifications; and as
19 Lew has identified, we don't want to justify, we want to
20 evaluate and properly disposition issues.

21 We've challenged our operations staff to raise those
22 issues and to call on plant staff to bring the information
23 to the control room, so they can be properly
24 dispositioned. And our operations staff is being asked to
25 push back, ask those tough questions to ensure that the

1 issues are fully evaluated and fully resolved before we
2 identify the corrective action that's necessary. And
3 that's some of the examples of things.

4 We are seeing some improvement in those areas, but
5 there is lots of work yet to do.

6 MR. DEAN: In your pursuit of
7 this, have you established, are there some things you can
8 point to as being ones that would give you signals or signs
9 that they are having some success in that area?

10 MR. FAST: Bill, those are
11 some of the things that we're institutionalizing as part of
12 corrective action in the root cause. I'm not prepared to
13 talk at length about that, however the matrix of the
14 performance indicators will be clarified and tracked on a
15 crew basis.

16 MR. MYERS: One of the things
17 we said as managers, it's important hearing what operations
18 people said. Now you have me, you have shift supervisors,
19 and ops managers and Randy. That's a pretty strong message
20 by itself. And it may cause us pain for what the message
21 is, but that's where they sit in the morning meeting, and
22 they're at the head table where they belong.

23 MR. MENDIOLA: I don't have a
24 question per se, I just want to clarify a point I thought I
25 heard. Intrigued by your survey of the staff, and I

1 understand the results aren't necessarily collected and
2 haven't been evaluated. I guess I would see a little bit
3 of, will you be coming to us sometime in the future maybe
4 next meeting or so, with a full understanding of those
5 results and what steps you will take from your findings
6 from the surveys?

7 MR. MYERS: Absolutely.

8 MR. GROBE: I think it's

9 about time for a break, give our transcriber's fingers a
10 rest. But, before we do that, I want to just make a couple
11 of comments.

12 We've been waiting for awhile to receive the results
13 of your root cause analysis in the area of organizational
14 effectiveness. We received that last Thursday. And I
15 think that sometime this week, we're supposed to get a hard
16 copy document on the docket. We'll make that available on
17 our website.

18 I've commented in the past, and I'll reiterate this
19 comment. The fact that boric acid as a corrosive is not a
20 surprise to anyone. It's been known for many, many years
21 in the industry. The fact that metals fatigue and crack
22 eventually in service is well known. Those issues resulted
23 in degradation of the head. It wasn't the cracking with
24 the boric acid, it was the lack of safety focus of your
25 staff. And I think you've captured those thoughts fairly

1 well.

2 This is the root cause of what happened at
3 Davis-Besse. And, you have now articulated that
4 comprehensively and you're beginning to redevelop your
5 Management Performance Improvement Plan to address these
6 issues. As recently as August 3rd, I highlighted this
7 condition report. It indicates that the problem still
8 exists.

9 I know that you've initiated a number of activities
10 to begin to address this, but it's fairly clear that those
11 activities are not yet bearing fruit. And I look forward
12 to the Comprehensive Improvement Program laid out in your
13 Building Block in this area, and measuring, going in the
14 future through our inspections, as well as new performance
15 indicators, progress in this area.

16 I believe that this is going to be the pacing
17 issue. It's one of the most difficult issues to grapple
18 with. I think one of the keys is the assessment which
19 you're going to undertake with the first line supervisor,
20 and find out which have the right safety focus, which can
21 be moved to the right safety focus, and possibly which
22 can't. And, that's critical.

23 So, with those few comments, I just wanted to
24 briefly lay out how our inspection is going to proceed in
25 this area.

1 We've now received your root cause. We're going to
2 do a thorough review of that; both the NRC staff in Region
3 3, as well as headquarters and possibly some independent
4 contractors who are expert in organizational
5 effectiveness.

6 When we receive your Building Block, revision of
7 your Building Block, we'll do a thorough review of that to
8 make sure it matches the root causes and we believe
9 addresses the issues that are identified.

10 We will observe through inspection implementation as
11 well as perform independent inspection in this area. And I
12 want to emphasize this is now just beginning, and we look
13 forward to continuing dialogue in these meetings in the
14 future in this area.

15 Why don't we take a five minute break, and give our
16 transcriber's fingers a rest. And reconvene at 25 'til.
17 Thank you.

18 (Off the record.)

19 MR. GROBE: Lew, I peeked
20 ahead a bit and I definitely want to get through the next
21 two sections on Restart Progress and Nuclear Quality
22 Assessment. We'll take a benchmark of time at that point.

23 MR. MYERS: We would also
24 like to do containment also.

25 MR. GROBE: Okay. Are you

1 ready to start back?

2 MR. MYERS: Clark Price will
3 talk to you about Restart Progress and provide you some
4 overviews for our schedules and some of the performance
5 indicators that we look at.

6 MR. PRICE: Good afternoon.
7 As Lew said, my name is Clark Price. As the slide says,
8 I'm the Business Services Manager at Davis-Besse, but for
9 the restart effort, I'm Restart Action Plan Processor.
10 That was the center building block in the chart that Lew
11 addressed at the beginning of our presentation.

12 I have the responsibility for coordinating all the
13 activities in the Return to Service Plan, the building
14 block activities and also the overall restart effort.

15 They've brought me up here today to talk about our
16 excellent progress we're making, of course resumption of
17 safe power, safe operation of the plant. I'll be
18 presenting today a few of the key points we developed for
19 monitoring our progress.

20 Let me begin by saying, our focus here at
21 Davis-Besse is to ensure that our people, the plant and our
22 people are meeting a high standard for restart and
23 sustained safe operations. And further, I would like to
24 say our restart plans are just not focused on the next few
25 months, but for the long term safe operation of the plant.

1 Next slide.

2 Since the last public meeting in July, we've been
3 working very hard and made considerable progress. We've
4 developed governing procedure to control the Restart Action
5 Plan process. We developed Restart Action Plans and we
6 generated schedules for those plans and are completing the
7 integration for the schedules into the Integrated Restart
8 Schedule for the plant.

9 We're making excellent progress through the hard
10 work and dedication of all the employees at the plant. A
11 number of the milestones from the Restart Action Plan,
12 major milestones from the plans are included on this
13 slide. I'll briefly discuss each of those as following
14 presenters will discuss them in more detail.

15 The first item, we have completed System Walkdowns.
16 And this is a major milestone in our System Readiness and
17 Readiness Review Programs, as part of containment -- or
18 excuse me, the System Health Readiness Review Building
19 Block.

20 We've also are nearing completion, as Mel mentioned
21 earlier, in our containment inspection are near complete.
22 This is a major milestone also in our Containment Health
23 Building Block as we discover and complete all the
24 inspections due to the boric acid center condition
25 degradation occurred as a result of that problem.

1 We've completed cutting in the shield building, the
2 concrete cutting of the shield building that is a necessary
3 step in the replacement of the reactor vessel head. That
4 has been completed and that operation is currently
5 demobilized.

6 Our containment painting preparations are well
7 underway. Currently, we are prepping the dome of the
8 containment vessel for painting, and removing the existing
9 paint, preparing that for painting, as well as many other
10 areas of containment that are being prepped for painting.

11 We should complete this week an upgrade of our
12 Containment Polar Crane. This was a modification that we
13 performed in the Polar Crane to make it more reliable. And
14 this is a critical activity to support the many activities
15 that we have that are necessary with that crane, is
16 necessary for use between now and restart of the unit.

17 We have removed the coils from three of our
18 containment air coolers and those coils will be replaced in
19 September and October when the new coils come in.

20 As Lew stated, and just presented, we have completed
21 our Management Root Cause Reports. So, we have
22 accomplished many of our milestones in our Restart Action
23 Plans to-date.

24 At this time, I would like to turn over to Jim
25 Powers to talk over a few of the slides of the results of

1 the system walkdowns.

2 MR. POWERS: Thanks, Clark.

3 Jack, at our last meeting you requested an update of
4 what we were finding as part of our reviews. I wanted to
5 give a quick rundown on what we found from the Discovery
6 Phase of our System Health Walkdowns.

7 As you can see from the slide here, there was
8 approximately 80 separate walkdowns were performed over the
9 past several weeks. And, they were consisting of 31
10 systems that we have in the population of our System Health
11 Readiness Review, as well as the five systems that we have
12 for our Latent Issues Level Review, which is a deep slice
13 review. So, a total of 36 systems.

14 And these are material condition walkdowns, as we
15 refer to them, for discovery of problems out in the plant.
16 The Configuration Verification Walkdowns for selected
17 systems will occur later as we get deeper into the Latent
18 Issues Reviews, as we review modification and such, we will
19 get out and look at specifics on systems. Although, there
20 was an element of Configuration Review as part of this
21 walkdown with the drawings of the system.

22 Over 3500 man hours were expended in this effort.
23 We really focused our teams on getting out there and going
24 through the walkdowns. So, it was a focused effort over
25 approximately two weeks. So, the members of the review

1 teams that are doing the system reviews got out there, and
2 in addition, management oversight participation, as well as
3 operations and maintenance assigned to each one of the
4 teams.

5 Operations provided us specifically SRO involvement
6 on the teams. And generally, I was very pleased with the
7 response of the individuals on the teams. It was a good
8 opportunity for the plant staff to get together
9 multi-discipline advice, and work together, and walkdown
10 the plant and see what kind of standards they have been
11 living with and identify areas which standards should
12 improve.

13 I think there were a number of areas things should
14 improve, and it was positive feedback on the overall effort
15 and we're going to use this in the future, not only at
16 Davis-Besse, but other FENOC plants routine walkdowns.

17 Here we show a few pictures of walkdowns ongoing.
18 This is a walkdown of the Reactor Coolant System. You can
19 see the team, several of them are sitting on top of the
20 reactor coolant pump in the containment looking at their
21 drawings and documents as they check off the individual
22 components and attributes of the system that are going
23 down.

24 There is a very specific procedure that we use for
25 these walkdowns that tells the individuals exactly what to

1 look for and they're all trained for common basis through
2 these walkdowns.

3 MR. MYERS: Those are the
4 motors, right?

5 MR. POWERS: That's the motor.

6 MR. MYERS: You should say
7 that's a motor.

8 MR. POWERS: That is one of
9 four reactor coolant pump motors, that they're largely in
10 the containment that they're checking out.

11 Here they're checking out the containment air
12 coolers. We've talked about those in the meetings and the
13 health of our containment air coolers in containment.
14 Again, you can see they have documentation in containment,
15 keep it in bags to keep it clean.

16 They walk through and the individuals identifying
17 equipment, identification tags, so as we go through these;
18 and I participated in these myself. So, we go through, we
19 check the equipment ID, make sure it's clear which
20 component we're on, how it matches the drawing, what's the
21 condition of the component and note both positive and
22 negative attributes and take digital photographs, so we
23 have a record of what was done.

24 We take it back to the offices and document it all
25 in the Corrective Action Program any discrepancies we find

1 or questions we have for disposition.

2 Here's the walkdown going on outside the
3 containment. We have management participation actively
4 involved. You can see there is a team that gets into
5 details. Many times our management has been involved in
6 construction of nuclear plants, so they bring a wealth of
7 knowledge to the nuclear teams.

8 It's a very good chance to meet the people and
9 provide expectation on the level of standards that we
10 expect in these walkdowns and consequently in the daily
11 operation of the plant.

12 Here's some examples of things we found.

13 MR. MYERS: Who was
14 participating?

15 MR. POWERS: I think that was
16 Mr. Leidich participating, so we have our Executive Vice
17 President on that one. As I mentioned, many of us go out
18 in the management team to participate.

19 Some of the debris we found in containment, we were
20 not pleased with what we found. This is typical of debris
21 we found in some of the less readily accessed areas of
22 containment and I'll comment just generally.

23 The condition of the plant as Lew mentioned is
24 pretty good, but particularly in the areas that were most
25 actively accessed; the main walkways and around areas, can

1 get behind components, inside panels that are not
2 frequently opened, indicates containment into areas did not
3 access, we found examples of debris. The basic
4 containment, we found nails and some screws, things like
5 this, and duct tape and tie wrap that's been cut.

6 So, housekeeping issues did not meet our
7 expectations, specifically in containment, we were
8 concerned about the functionality of our emergency sump
9 down there, which would need to strain any of this type
10 debris out, which would migrate over to the drain, if it's
11 required for excellent communication.

12 So, this is an example of the type of housekeeping.
13 We are going to be cleaning up these areas, and steps for
14 housekeeping.

15 In the control room is a panel, part of our Safety
16 Feature Actuation System, which is one of the safety
17 control systems at the plant, and this gives a good idea
18 about the level of detail the walkdown teams have gone to
19 looking in this case control room panel. This is a
20 microswitch.

21 And the concern by the electrical engineer who is
22 responsible for engineering for the system, the
23 terminations and the crimping details up in the upper left
24 flyer that you see with the blue plastic sheathing, that's
25 the crimping details determination for the, for that one

1 terminal. And there is a little bit of exposed wire there,
2 and that does not meet an electrical engineer or
3 electrician's expectations. The insulation should be
4 continuous on there, including that blue plastic sleeve.

5 And so, this is the type of issue that's written up
6 in Corrective Action Program for this position; is that
7 acceptable. Are the bending of the wires, is that
8 acceptable. The angle that the plugs come in and number of
9 plugs that are terminated on each terminal there; does that
10 meet the design requirements and expectations. So that's
11 the level of detail we'll get into.

12 Here's another example of a problem we have found
13 that needs a more general review done, and that's going to
14 be done as part of extended condition of Corrective Action
15 Program. This is a fastening device. We have a nut on a
16 bolt there. You can see that the bolt does not extend all
17 the way through the nut. And in the industry, it's what we
18 refer to as thread engagement. And we want to see at least
19 one thread sticking out of the nut area, so you know all
20 the threads are fully engaged and you have full structural
21 capability in that fastener.

22 This is one we found, does not meet that
23 requirement. And we will be looking more generally as to
24 the condition of our fasteners and thread engagement as a
25 result of this walkdown.

1 So, some of the generic issues; numerous small valve
2 leaks. We've seen that, particularly from the Containment
3 Health, some of our Boric Acid Walkdowns. We notice a
4 number of valves we need to repack.

5 We need to improve cleanliness and proper
6 housekeeping in less accessed areas. I mentioned the
7 thread engagement. Not only is it for fasteners,
8 structural fasteners, but packing followers, valves, studs,
9 on components. It's the same issue, that we need to turn
10 our attention to.

11 Also loose conduit and tubing. Walking down the
12 systems, we checked out all the instrumentation, as well as
13 the electrical conduit just to make sure it hadn't loosened
14 through the vibration during operation. Found some cases
15 where it needs to be tightened. And our maintenance people
16 will be doing that.

17 We found crushed tubing and bent sensing lines.
18 This is another issue with standards. These small tubes
19 tend to get damaged during day-to-day operation of the
20 plant and refueling outages. And it's really standards
21 issues, that we shouldn't tolerate that, and need to go
22 back and correct the situation rather than living with them
23 like that.

24 This is more significant findings we will be
25 following up on. I talked about the debris in containment.

1 There is also a lot of dust in the control room panel.
2 It's a 25-year old plant. And in the control room panel,
3 dust has accumulated over the years to the point where it
4 was observed; really doesn't meet the expectations of the
5 plant staff. We need to do a cleaning there.

6 There is an issue with thread engagement on
7 pressurizer manway that's part of the Reactor Coolant
8 System Walkdown. We found one of the studs there did not
9 have full thread engagement.

10 There was another potential for motor operated valve
11 lubrication degradation, which can occur over time due to
12 heat in the vicinity and frequency of preventative
13 maintenance lubrication. The effectiveness of
14 lubrication.

15 We talked about the Safety Features Actuation
16 System, and workmanship of the electrical terminations and
17 how they are holding up in the control room cabinets.
18 We're going to be evaluating that, support long term
19 functionality of the system or not. That's one of the
20 institutions that needs to be done.

21 Then we found some potential noncompliance, or EQ
22 requirements for motor operated valves. These were
23 electrical terminations, T-drains, in the Aux. Feedwater
24 System, which is high engine line break, design
25 considerations for the Aux. Feedwater Rooms. And there is

1 a contribution room to room, and we do have a high energy
2 break, high break, steam environment. And we need to make
3 sure that the adjacent rooms are appropriately treated and
4 keep, to keep that moisture out. It's an area we need
5 improvement. So, that's an extended condition for
6 improvement as well.

7 MR. GROBE: Jim, how did you
8 identify potential lubrication degradation in the leads?

9 MR. POWERS: I think it was in
10 that case from the walkdown. Taking a look at the leads
11 themselves, looking at the grease. I didn't participate on
12 that walkdown on that particular phase, Jack, but I think
13 they're looking for grease, which is grease hardening,
14 which can be inhibitive on the threads.

15 MR. GROBE: Did you go back to
16 look at your periodic valve testing to see if there was
17 degradation in the test results.

18 MR. POWERS: We haven't done
19 that yet. What we're doing is collecting all these issues
20 in the Corrective Action Program. As you'll see in the
21 coming slides, there is a large number of corrective
22 documents passing over two hundred, and they're still
23 finishing up the documentation. So, that will be ongoing,
24 Jack. We'll be able to get a report out on detailed
25 assessment.

1 MR. GROBE: Okay, thank you.

2 MS. LIPA: I have one
3 question on these. I know you have another slide with more
4 examples, but are you doing as-found reviews? I know you
5 plan to fix a lot of these things before you start, but are
6 you doing as-found reviews for reportability?

7 MR. POWERS: Yes, as-found
8 conditions will be documented in Corrective Action
9 documents. As necessary, operability determinations will
10 be done and reportability will be followed through with the
11 normal process for as-found conditions.

12 MS. LIPA: Okay, thank you.

13 MR. POWERS: We did find an
14 issue with Emergency Diesel Generator, Heating and
15 Ventilation Air Conditioning System Exhaust Hydramotor
16 Damper. Basically, that's the motor enforcement damper on
17 the air cooling system. There was a damper arm loose and
18 it was bound up. And did not look like it was going to
19 work properly for a long term. So, that was a very good
20 find by the walkdown team, with attention to detail needed
21 to be corrected.

22 We also found the exhaust silencers, which are
23 outside the building, muffler essentially large diesel
24 engines, tornado missile shields and where they're attached
25 to the concrete parapet started to crack and fall. Either

1 through water freeze and thaw cycles or thermal growth of
2 that shield. So, we're assessing that.

3 And as I mentioned, it's over 200 CRs initiated
4 to-date. These are snapshots, but we are finding some good
5 issues out there, and the attention to detail and standards
6 as these teams go out is really paying off. And, we're
7 continuing to write CRs to finish documenting up everything
8 that we found.

9 With that, I'll turn it back over to Clark for
10 further about measuring profits.

11 MR. PRICE: Thank you.

12 In the last public meeting, we presented some of the
13 performance indicators that we were developing to monitor
14 progress of our restart efforts and our improvement
15 efforts. Two weeks ago, we published our first set of
16 performance indicators and I would like to go through a few
17 of those now.

18 We've established indicators to track progress on
19 the Building Block Plans, progress on the NRC Inspection
20 Manual Chapter 350 Restart Checklist and also progress
21 towards meeting new standards for restart and sustained
22 operation excellence.

23 The following slides are some examples of those.
24 This first slide represents the restart actions that we've
25 identified today through a process that we have in the

1 Restart Action Plan. These are all the restart actions
2 identified for restart procedures, slightly over 800 right
3 now.

4 These actions at this point are primarily in the
5 form of condition reports; and through evaluation, these
6 condition reports would generate approximately four to five
7 on average corrective actions per condition reports. So
8 you can see our volume is going to go up significantly.

9 We're seeing a steep incline right now, and that is
10 expected because of our program reviews and system reviews,
11 system walkdowns that Jim just referred to are generating a
12 lot of condition reports through the process we have. A
13 lot of those condition reports are being evaluated to
14 criteria that we have in the Restart Action Plan, being
15 identified as required for restart.

16 I would say probably in the last two weeks, we are
17 seeing about 50 percent of the condition reports that were
18 initiating or getting classified as required for restart.

19 MR. GROBE: Clark, let me
20 make sure I understand this. The width of the line going
21 up, that's the number of corrective actions completed?

22 MR. PRICE: Actually, this is
23 an indicator of open restart actions, so everything there
24 is currently open. What we have right now are the
25 condition reports were making up the major portion of our

1 open actions. Over time, we would expect what will happen
2 is the dark line, which is the corrective actions, will
3 become the larger volume and the condition reports will
4 become smaller.

5 And at restart, the condition reports will be
6 essentially all turned into corrective actions and
7 completed.

8 MS. LIPA: I have a couple
9 questions on this. So, the corrective action is an outcome
10 following condition report?

11 MR. PRICE: Yes, corrective
12 actions through the evaluation and condition report, are
13 the corrective actions that come out of that, are the
14 Restart Station Review Board that we have evaluates both
15 the condition reports up front, and then the corrective
16 actions as they're developed, to determine whether they
17 meet restart criteria. And the ones out here met restart
18 criteria.

19 MS. LIPA: Okay. I was
20 looking at your plan earlier and there is a flow chart, and
21 at one point you decide whether it becomes a restart list
22 item or restart action item. These must be restart action
23 items.

24 MR. PRICE: These are all
25 restart action items.

1 MS. LIPA: Okay, thank you.

2 MR. PRICE: Any additional

3 questions on this slide?

4 Okay, if we move to the next report. This is a
5 progress report here. Performance measures more in the
6 form of progress report. This is one that we use to
7 monitor the progress of the reactor vessel head project.

8 And primarily what it is, you can see the bars
9 identify, the yellow bar is our schedule, target schedule,
10 and the blue bars are the current schedule. And you can
11 see that project, we're pretty much right on schedule.

12 No questions on that, I'll move on.

13 The next slide is our System Readiness Reviews.
14 This is the progress report that we have for the 31 systems
15 reviews that are going through the System Readiness Review
16 Process under the System Health Building Block.

17 The small inset box notes Progress Review Process;
18 and until the box on the right starts filling up, we don't
19 get any actual report completions here.

20 The schedule, as you can see right now, looks like
21 we're not making any progress; however, what that schedule
22 represents right there is the walkdown period that we've
23 just gone through. It has been completed and now the
24 reports will start coming out of that process over the next
25 few weeks; we'll be completing all those reviews.

1 MR. GROBE: Clark, just so I
2 understand. So, none of the system reviews have been
3 completed such that the report has developed and presented
4 to your Engineering Review Panel?

5 MR. PRICE: That is correct.
6 That have not been completed.

7 MR. GROBE: When will the
8 panel receive the first completed report?

9 MR. PRICE: As soon as
10 possible looks like about next week, should start seeing
11 reports being completed based on the schedule.

12 MR. GROBE: I see, okay. So,
13 it goes from 31 to 30.

14 MR. PRICE: Right. That would
15 identify the reports based on the schedule should be
16 available for review.

17 MR. GROBE: Just out of
18 curiosity, do you know which system that is?

19 MR. PRICE: No, I do not.

20 MR. POWERS: I think it might
21 be 125, Jack, that was pretty well on the head, moving
22 along. I think that was it. I'll get back to you on
23 detail with that.

24 MR. GROBE: Okay. We're going
25 to want to see the results of these early on, so we can get

1 a sense and give feedback on our view of the adequacy of
2 the review, as well as the adequacy of the oversight by the
3 panel.

4 MR. PRICE: We did provide,
5 Jack, we did provide a schedule that has all the projects
6 laid out in detail and represent what shows up on the
7 performance indicators. So, we'll make sure you understand
8 that schedule you receive, that will identify the systems.

9 Any additional questions on this? Okay.

10 Okay, the last one that we have to measure progress,
11 that we got as a sample today is on our phase and program
12 reviews. And as you can see in this particular slide,
13 we're a little bit behind schedule on some of those
14 reviews.

15 We've gone through a learning process on a number of
16 these Phase 2 Program Reviews and, however what we feel,
17 even though we're a little behind schedule, we'll have much
18 better progress as a result of incorporating what we've
19 learned to date through that process.

20 We did have early on inspection visit by Ken
21 O'Brien. He provided a lot of insight on review of a
22 couple of programs. And we've taken those comments and
23 incorporated them into our plans.

24 If there is no additional questions on those, the
25 last two charts I have; this one is on Root Cause Quality.

1 These are more performance indicators, are looking at
2 performance improvements. And, as we rebaseline our
3 standards and improve on our programs, we have some
4 performance measures here that are trying to measure our
5 progress where we're at and where we want to be.

6 This particular performance indicator looks at Root
7 Cause Quality, our significant condition reports. We have
8 a Corrective Action Review Board, as we discussed earlier,
9 Randy is the Chairman of the that. And that committee,
10 that board has established new standards for approval of
11 Root Causes to assure that the quality is there, to assure
12 that the corrective actions will prevent repeat efforts.

13 And as you can see right now, the raising of the
14 bar, the standard, we have a long way to go yet to get the
15 root causes through the Corrective Action Review Board the
16 first time. This is measuring basically what is approved
17 the first time through and what requires rework, before
18 it's going to come back and get rereviewed and approved.

19 So, right now we're averaging around 40 percent and
20 our goal is to be at 90 percent approval rate. So, we have
21 a long way to go here.

22 Randy, any additional comments?

23 MR. FAST: I was going to
24 say, as part of the change in the standards, we review the
25 specific conditions adverse to quality, and if we don't see

1 them; one of the typical problems we see is, if we have a
2 good story, tells what happened, doesn't say why it
3 happened. And we want to see why things happen.

4 We also look to see was there a direct correlation
5 between the root causes and the corrective actions. There
6 should be a one-to-one correlation for every root cause for
7 corrective action.

8 As well, the teams that have done the root causes
9 have identified or provided supporting documentation. What
10 type of root cause was performed; we have tap root as an
11 example of more or some other process. That wasn't
12 identified nor was that documentation provided, so we're
13 asking that documentation be provided.

14 So, we've got lots of room for improvement, but
15 we're actually enforcing high standards to ensure that
16 significant conditions adverse to quality meet those
17 expectations. So, it's been a learning experience for all
18 of us. I believe it will help our program moving forward.

19 MR. PRICE: The last
20 performance indicator we have today is on the Engineering
21 Quality. We have an Engineering Assessment Board that's
22 chartered to review the products that come out of the
23 engineering organization in the areas of design, safety
24 evaluations and conditional report evaluations, for
25 example.

1 The Engineering Assessment Board has a process by
2 which they grade the products that come out of engineering
3 on a zero to four scale. And we have a goal to be at a
4 scale of 1. Zero being the best score, 4 being the worst
5 score.

6 And as you can see here, through the first four
7 weeks of really tracking this, we're not meeting the goal;
8 however, we have seen it oscillate a little bit. It
9 depends on the population of the products coming through
10 the board at any one time.

11 The Engineering Assessment Board is challenged with
12 again raising the standards and changing, rebaselining the
13 standards for the engineering organization.

14 Jim, do you have any comment?

15 MR. POWERS: I think they've
16 done a good job and found a number of issues through and
17 brought change of quality of products depending on the
18 individual preparing it. And what we're finding, for a
19 large part, is how the staff integrates together when it
20 produced for example a design, how they integrated to get
21 all the various aspects of that design cap purchased as
22 part of the review and what stage does that happen.

23 And, the design modification process that has been
24 in place at the plant rests on the interdiscipline review
25 at the end of the preparation of the design product; and

1 consequently, they prepare at the end and have missed an
2 element that really should be in it.

3 And we're changing that process. Actually, it's in
4 the process of being changed this month. We're going to
5 have a common process modification process with FENOC.
6 It's in place with the other two plants, at Perry and
7 Beaver Valley. And we're going to be adopting it at
8 Davis-Besse.

9 That calls for an interim interdiscipline review to
10 get those comments by the various specialists and experts
11 that reside at the plant or are available in the industry
12 to us, to get their input to a product before the end.

13 So, some of the comments that are asked by the
14 Engineering Assessment Board will find weaknesses in the
15 technical areas on specifics. And that's not a surprise to
16 us. I think it's good. It shows it's good probing going
17 on and good learning going on by the staff at the station.

18 MR. GROBE: Jim, could you
19 describe in a little more detail what an item is, like
20 calculation item?

21 MR. POWERS: Pardon me, Jack?

22 MR. GROBE: If the, it says
23 Engineering Items Reviewed. I'm trying to understand what
24 an item is.

25 MR. POWERS: An item could be

1 an operability determination or it could be a modification
2 package, it could be corrective action investigation
3 report. So, an item is an engineering product. It can be
4 a calculation also.

5 And we've got four subcommittees that are reviewing
6 the Building Blocks. We have one for Programs, one for
7 Systems Health, one for the Containment Health and then one
8 for Modifications Operability Determination Calculations,
9 and the balance of engineering products. So, we have
10 special subcommittees focused on those areas.

11 MR. GROBE: Do each of those
12 subcommittees include site staff as well as independent
13 experts from other parts of the industry?

14 MR. POWERS: What we've, thus
15 far we've got industry expertise. We have an individual
16 from site staff that's on the board. And we also when we
17 do review such programs, we bring in all the site staff
18 owner, but also his peer owners from the other two
19 stations. We can share experiences and drive a higher
20 standard within FENOC and use it as a beneficial tool to
21 us.

22 We plan to integrate more of the line staff in that
23 process as we go on with time, but we're not fully engaged
24 with all line staff as far as we want to go yet.

25 MR. GROBE: I found it

1 interesting that you chose that your engineering staff are
2 aspiring to be zeros.

3 MR. PRICE: Are there any
4 additional questions?

5 Christine, I know you have additional questions that
6 you mentioned earlier.

7 MS. LIPA: I spent a lot of
8 time reviewing the plant and this helps, combined with your
9 discussions.

10 MR. PRICE: If there is no
11 other questions, I would like to turn this over to Bill
12 Pearce, who will talk Nuclear Quality.

13 MR. PEARCE: Thank you,
14 Clark.

15 Good afternoon, I'm Bill Pearce. I'm the Vice
16 President of Oversight for FENOC.

17 Since this is the first time I've attended this
18 public meeting this afternoon, I thought I'd give you a
19 little background about myself. I've worked in this
20 industry for many years, primarily in the area of Plant
21 Operations. And I've been a Senior Line Management
22 position for a long time, many years, but this is the first
23 time I've ever been in Quality Assurance Organization.

24 And I guess to tell you what my expectation is, I
25 believe I can bring something to improve the Quality

1 Assurance Organization. I think I can help us get to more
2 of an operational focus. So, enough introduction about
3 myself.

4 First thing I want to go over is the root, we've
5 done a Root Cause Evaluation of Quality Assurance and its
6 performance; and we did this, because we acknowledge our
7 failure to identify the reactor head issue, just like the
8 line organization. So, we like the line organization did a
9 Root Cause Evaluation.

10 The evaluation was performed by a team, and the team
11 was made up, we brought in an outside team leader, because
12 it was well experienced in quality assurance. The team
13 also consisted of Perry and Beaver Valley folks from our
14 other two sites.

15 And we did an independent root cause of missed
16 opportunities; where could we have failed issues or brought
17 issues forward and gotten them resolved that would have
18 precluded this head issue that we have. Finally, as we did
19 this, we came up with some things that we wanted to get
20 corrected. We started looking at that.

21 Next, let's look at the preliminary results of
22 this. This root cause is not all fully completed yet, but
23 we're far enough along to be able to look at some of the
24 preliminary conclusions.

25 Here is the Root Cause. FENOC Nuclear Safety

1 Values; behaviors and expectations were inadequate to
2 enable oversight to effect needed positive change in
3 station operations.

4 Now, I know that's a complex statement. Let me
5 explain it in a different way to try to, for you to gain
6 some understanding. What it's really saying is there is no
7 differentiation between standards of the QA Organization
8 and standards of the rest of the site organization. This
9 was caused by a lack of independence.

10 The QA Organization reported into the management of
11 the plant, and then forward to where the standards of the
12 plant went, QA went with it. And this is what it's trying
13 to explain, there should have been an oversight group.

14 So, thus QA was not holding itself to a higher set
15 of standards; and really, this is one of the reasons I am
16 here now, is this gives me independence. I report directly
17 to the President of FENOC, and I don't report to the line
18 organization of the plant.

19 So, the Quality Assessment Group can look at the
20 plant and not be affected by the things that affect the
21 rest of the plant and have an opportunity to raise issues
22 or elevate issues outside the plant if it becomes necessary
23 to get those resolved. That's kind of what the Root Cause
24 was about.

25 There are also in the preliminary conclusions some

1 contributing causes. Ineffective training of the Quality
2 Assurance Group for a previous event we had that had, it
3 had boric acid involved in it. It was involved with the
4 Reactor Coolant System. It involved some unexpected
5 degradation.

6 And we did a root cause, training our folk on the
7 causes of that degradation and how it should be treated,
8 but obviously this was ineffective, because we saw some of
9 those same issues on the head. We were ineffective at
10 recognizing those and the importance of those issues in
11 getting the issue brought up and resolved.

12 The second one kind of, sounds kind of odd. The
13 process for providing oversight of the oversight function.
14 For every group, including us, we provide oversight to the
15 line organization, but there are organizations that provide
16 oversight of us, such as the company's Nuclear Review
17 Board; Joint Utility Management Assessment, which is all
18 the nuclear utilities participate and we go assess each
19 other.

20 It's a Quality Assurance Organization and gives a
21 report on how we stand; a self-assessment that we do of
22 ourselves; and then of course management oversight of
23 ourselves. What this is, what this is telling us is those
24 two failed too recognize that our performance was
25 inadequate to recognize this type of issue and get it

1 resolved.

2 The third one is an interesting one. For a period
3 of time the management of the audit/evaluation process was
4 not independent from the management of the corrective
5 action process.

6 What it really means is the person that was in
7 charge of the oversight function actually had other
8 responsibilities in the organization that would not let the
9 Quality Assessment Organization be independent of the line
10 organization, which kind of gets back to the first part
11 again of it. The fact that the standards in quality
12 assessment were the same as the rest of the site, so
13 therefore where we stand on the site, so went the quality
14 assessment.

15 With that said, that's enough about the conclusion
16 or the causes. I would like to talk a minute about what
17 are some actions that we're taking going forward.

18 First of all, we want to elevate standards. I
19 believe this is extremely important. We hold the Quality
20 Assurance Organization to a higher standard. And then we
21 can hold the Line Organization accountable to a higher
22 standard, but first we have to get our own standards raised
23 to where they need to be.

24 Increased intrusiveness. We've got to put a lot
25 more attention in making sure that the Quality Assessment

1 Group is out in the plant being intrusive, looking at
2 things that are happening in the plant, and being involved
3 in seeing what's going on.

4 In fact, I just got this today. I had name tags
5 made for all the Quality Assurance folks. I had a little
6 thing put on it, says, "I know, because I looked." I think
7 that that says a lot. And it's about standards, you know,
8 it's the standard of we don't accept just what we read in
9 reports. We go out and look and we know what's going on in
10 the plant.

11 We need to raise tough issues, make sure we bring
12 issues forward that are not comfortable to deal with, and
13 we get them on the table, so that we can make sure we get
14 the things resolved that need to be resolved.

15 We need a method to escalate unresolved issues to
16 higher management and we have that now. We're formalized,
17 but we're putting that in place, so that finally if we
18 can't resolve things between the line management at the
19 plant, myself, we can escalate it to the President of FENOC
20 and even to the Nuclear Board, if necessary, for
21 resolution.

22 Now, that was about the Root Cause. The next thing
23 I want to do is examine where quality assurance is involved
24 in the recovery process. I want to talk about the next few
25 slides about that.

1 First of all, we are assessing key activities that
2 are going on. When you heard them talk of the line guys
3 talking about the boards that are meeting, we sit in
4 independent oversight of that and overview what's going on
5 in the boards and the right kind of things being talked
6 about. There are things that we know of that are not being
7 brought forward.

8 We do in-depth technical reviews, independent of the
9 engineering organization for engineering products. So,
10 we're looking at the engineering products coming out and
11 making sure that we believe that the products are of
12 quality that are being brought forward.

13 Field verification of actual conditions. This is
14 our participation in the field activities, the walkdowns.
15 We do parallel walkdowns, and also independent walkdowns.
16 Then independent parallel reviews.

17 The next thing I'm sure you're asking, what are we
18 finding. On the next page, I'm going to show you a big
19 overview of what we're finding.

20 These are numbers of condition reports. When we in
21 Quality Assurance find something, we write a condition
22 report about it to ensure it gets in our Corrective Action
23 Program and gets resolved. And you can see these are the
24 number of condition reports written by the Quality
25 Assurance Organization per month. And you can see, this is

1 a twelve-month period, or actually 13 months. You can see
2 how the numbers have increased as we've tried to become
3 more intrusive.

4 But let's, but now let me tell you about some things
5 that we've really found. In the area of increased
6 intrusiveness, the most recent assessment, we identified 77
7 issues. Now, all of these are not huge issues, but they
8 are nevertheless issues and are recorded in the Corrective
9 Action Program.

10 We're doing real time assessments. We're out
11 looking at operational performance or real time performance
12 in the plant and not just reviewing paper. I think this is
13 important, because we are reviewing to not just minimum
14 regulatory requirements, but we're trying to hold the site
15 to a set of standards that are above that.

16 I know that sounds kind of negative about the
17 regulatory requirements, but just meeting the regulatory
18 requirements doesn't get us to where we want to be as a
19 station. We've got to focus on real nuclear safety and
20 things that are not required in the regulation, like
21 people's behaviors, how they think, are they thinking about
22 the right things. The requirements are there. They've got
23 to be met, no question about that. But beyond that, there
24 are other things that we need to focus on as an
25 organization.

1 Next slide is, here's some examples of real time
2 issues we've identified. First one is operation's group
3 failure to request engineering rigor for operability
4 determinations. This is an example of prestandards that
5 we're pushing in the organization. I think you heard some
6 of the rest of them talk about it. We've been effective at
7 moving the standard within the organization, and getting a
8 change in the behaviors for improvement in that area.

9 Another one we found was failure of the Line
10 Organization to recognize containment painting as a design
11 change. That was something else that we've done in Quality
12 Assurance Organization.

13 Under the area of Ensuring Product Quality, vendor
14 errors with implementation of the feedwater flow
15 modification. Here's an example of finding something in
16 the engineering area, looking at their product.

17 The second one there is failure to comply with
18 quality program requirements during overhaul of the decay
19 heat pump, which is a safety related pump and the issue was
20 how we dealt and the oversight we provided in a vendor that
21 was not a quality vendor, and the issues around that.

22 The next one is under the area of Elevating
23 Standards. Posting and protection of protected train
24 equipment. For those of you don't know what that is, for
25 our safety equipment, almost always at nuclear power plant

1 there are two trains. So, if you take one out to work on
2 it, beyond it being an amount of time sometimes, it limits
3 how long both of them, or one of them can be out.

4 We also try to protect it, so that somebody doesn't
5 go in the area and work on the remaining train, so we end
6 up with no safety trains available. While that doesn't,
7 does not meet the regulatory minimum requirements on no
8 trains, we want to do something beyond that to make sure we
9 protect the remaining train.

10 So, we do that by installing barriers and signs and
11 making sure something inadvertently doesn't happen.
12 Raising the standard of how we protect that remaining train
13 is what this is about and what was being brought forward by
14 the Quality Assurance Organization.

15 Documentation standards for unit log keeping. This
16 is documentation of like, what constitutes operability when
17 an operability determination is being made. What are the
18 specific issues that the equipment is called operable based
19 upon, making sure that those type of details are in the log
20 and well documented, so oncoming shifts will know exactly
21 what those kind of issues are, so if they are affected by
22 what goes on in the future, the folks that are coming on
23 will know what the issue is.

24 Potential corrosion of the containment vessel.
25 Quality Assurance Organization brought up the microbe

1 induced corrosion issue for the containment vessel, and
2 documented that earlier in the containment inspection.
3 Untimely corrective actions for previously
4 identified Corrective Action Program weaknesses. You've
5 heard Lew talk about the Corrective Action Program and what
6 they found during the program review. This was actually
7 documented well before that. Quality Assurance
8 Organization had written condition reports demonstrating
9 some of the same weaknesses found in the condition, in the
10 Program Action Reviews.

11 Here's some examples I think of being tough, or
12 raising the standards. In our second quarter assessment,
13 which is the overall assessment of all the departments at
14 the site, we found that five of the eleven areas had
15 marginal performance. I think if you look back in time,
16 you would see that that's almost a step increase in how
17 we've been looking at things prior to that. And we found
18 two unacceptable performance issues in our last quarterly
19 assessment. So, I think that's an example of us raising
20 standards in the organization.

21 MR. GROBE: Bill, do you
22 recall what those were?

23 MR. PEARCE: Which ones?

24 MR. GROBE: The two
25 unacceptable performances?

1 MR. PEARCE: Yes, sir.

2 Within the engineering functional area, the plant
3 modification process was identified as unacceptable. It
4 did not meet all the required items for Appendix B an ANSI
5 Standard November 45.2.11 requirements. It says, Nuclear
6 Quality Assessment would have exercised a stop work
7 authority if the line organization had not implemented
8 acceptable interim compensatory measures.

9 Then it says, additionally, the area of radiation
10 protection, the implementation of Corrective Action Program
11 was rated as unacceptable. Those were the areas.

12 Well, my conclusion, I guess, is that the Quality
13 Assurance Organization is already improving our standards.
14 We are not yet where we need or want to be, but we have
15 identified our weaknesses and are formulating an
16 improvement plan to get us where we want to be.

17 I thank you for your attention. Are there any
18 questions that you have?

19 MR. DEAN: I have a couple of
20 questions. One is, earlier we talked about the efforts to
21 try and move Davis-Besse towards an operations focus
22 organization. We talked about benchmarking and some of the
23 results of that.

24 Have you done a similar effort relative to the QA
25 organization and how it was performing previously and what

1 your approach is now; how does that benchmark against other
2 high performing organizations?

3 MR. PEARCE: As we did the Root
4 Cause, we brought one outside person in. And then at the
5 end, we actually brought a person from, well, from Florida
6 Power and Light and one from Intergy in and went through
7 all the facts to narrow down the conclusion.

8 We intend to continue to do that. In fact, last
9 week, for instance, the Quality Assurance Manager was on
10 vacation last week, and to fill in for him while he was
11 gone, I brought the Quality Assurance Manager from Perry
12 over and he filled in for him. Just to give a different
13 set of eyes in the actual management position. It's a lot
14 easier to see things if you haven't been in the middle of
15 them for some period of time. That gives us some outside
16 view.

17 We intend going forward not only views of Perry and
18 Beaver Valley people a lot, and in fact I believe that
19 either last week or this week, we had eight folks from
20 Perry and Beaver Valley at Davis-Besse helping us go look
21 at these programs. And there is a lot of advantage to
22 that. Not only does it give them some help and go out and
23 look at what we're doing, they take those standards back
24 with them.

25 You know, I really believe that a lot of times the

1 cutting edge for standards in our industry is produced at
2 the plants coming out of trouble. I think we can get a lot
3 of learning for the other two sites by making sure that the
4 quality assurance folks from the other two plants get over
5 here and be involved, so that they get the learning that
6 we're getting out of this and take it back to the other two
7 sites.

8 And, we intend to bring in some folks at times from
9 other companies within in the industry.

10 MR. DEAN: How about the,
11 pertaining to the line, you talked about raising the QA
12 standards above what regulatory is required, organizations
13 like INPO, which is intended to promote excellence
14 throughout industry. Have you gone to them and sought any
15 assistance from them?

16 MR. PEARCE: In fact, on our
17 Restart Oversight Panel yesterday, we had two members of
18 INPO. One is a member and the other was a visitor, who I
19 guess now he's in charge of all -- what is he in charge of?
20 It's a help --

21 MR. MYERS: Assistance.

22 MR. PEARCE: But, he's in
23 charge of all the systems for INPO, and he was at our
24 Restart Oversight. And that's in fact why he is here, to
25 make sure if we need some assistance that we're getting the

1 help that we need from the rest of the industry and, you
2 know, I think that's an example of how we're getting help
3 by INPO, not only from the plant, but from the Quality
4 Assurance Organization.

5 MR. DEAN: Second question I
6 wanted to raise relative to reorganizing and restandarding
7 the QA Organization. For a period of time, went along, you
8 were part of the staff, essentially; you were in the
9 staff. And so, a certain line stayed true to form between
10 your QA staff and their relationships. What's being done
11 in bringing fresh blood or different talent or different
12 mind set into the organization?

13 MR. PEARCE: I think we're
14 doing a lot, like I said, we're trying to bring in people
15 from Perry and Beaver Valley and a lot of them, instead of
16 totally supplementing our needs here with contractors from
17 outside, what we decided to do is use those, those folks
18 from Beaver Valley and Perry to supplement, but that is
19 outside, an outside look. I mean, we have not ever spent a
20 lot of time together like that in looking at those
21 standards.

22 In addition, we have got, we have gotten some
23 engineering people that have come out to some of the more
24 recent trouble plants and seen what standards are in those
25 areas and they're in working supplementing our organization

1 now, looking at some of the engineering products, for
2 instance; and using that to help build the standards up.
3 And personally, myself, I'm a line person, my whole
4 life, and now in quality assurance, and I've got a
5 background in operations; and I can help us raise our focus
6 on operational performance and not just meeting program
7 requirements.

8 MR. DEAN: Has there been an
9 effort to go to other parts of the organization, say I'm
10 looking for somebody that's a top notch engineering or top
11 notch operations person to come over to QA and give me some
12 discussions?

13 MR. PEARCE: Surprisingly
14 enough, I didn't do this. This happened before I got
15 there. That's been done recently at this site. I think we
16 have, I think we have a real good set of folks. And, I
17 invite you to come down. I would be glad to let you meet
18 them, but I think you'll think so too.

19 And they are, we've got a good mixture of people who
20 have had responsible positions within the organization, a
21 lot of places in the organization and then some
22 professional QA folks. We have got a pretty good mixture,
23 I think, at Davis-Besse.

24 MR. MYERS: We have. And, I
25 was asking, do we have plans to do some permanent cross

1 pollenization from people of other sites to the Davis-Besse

2 Plant?

3 MR. PEARCE: Yes, we do.

4 MR. MYERS: And that's sort of
5 what you asked awhile ago. We intend to do some of that;
6 we have some ideas in mind.

7 MR. DEAN: We'll ask more
8 about that later.

9 MR. MYERS: Okay.

10 MR. MENDIOLA: I know you don't
11 like to be here.

12 MR. MYERS: Pretty much be a
13 good time to look at a new job (laughter) public meetings.

14 MR. MENDIOLA: Okay. Knowing
15 that Quality Assurance Programs are often incorporated,
16 corporately across all the plants associated with the
17 company. For example, yourself and First Energy; is there,
18 well, I guess, to summarize your presentation basically, I
19 would understand that the Quality Assurance Program is
20 implemented more appropriately across First Energy, but had
21 gaps at Davis-Besse.

22 Is there a corporate oversight function here that
23 needs to be discussed or revealed or possibly brought anew?

24 MR. PEARCE: That was the Root
25 Cause; wasn't it?

1 MR. MENDIOLA: I'm talking about
2 outside of Davis-Besse. I'm talking about First Energy,
3 down toward the plant.

4 MR. PEARCE: Well, you did say
5 First Energy, what we said was FENOC. And the root cause
6 says, FENOC nuclear safety values, behaviors and
7 expectations, which I believe is exactly what you're
8 asking, right, about where the right values, and this is --

9 MR. MENDIOLA: No, I'm a little
10 more global, to tell you the truth. Obviously, you've
11 assured yourself that Beaver Valley and Perry Quality
12 Assurance Organizations are functioning at the level that
13 they need to, and you're using them to go bolster and
14 augment Davis-Besse.

15 And, my question is, what oversight previous to this
16 entire occurrence was out there to, say hey, look, these
17 two plants are operating at a high level and this one is
18 not?

19 MR. PEARCE: We have the
20 Nuclear Review Board, looks at that, and has some input
21 there. The Joint Utility Management Assessment called
22 JUMA, which is a utility group that goes, looks at the
23 assessment function; does that very thing. We did
24 self-assessments at all the sites. And I guess there was
25 no higher level of management viewed on quality assurance

1 by itself and how it might be different between the three
2 sites.

3 But, it was, it was something that we were missing.
4 That's why, I think maybe we intuitively knew that, even
5 before this root cause was done. That's for instance why
6 we, we put me in my job, and made a corporate function to
7 provide that oversight for all the plants.

8 Maybe I missed the question. Did I miss it?

9 MR. MYERS: I think one of the
10 things that we're seeing from the corporate standpoint is
11 this whole corporate organization, FENOC did not exist with
12 the oversight, and Gary Leidich; he was strictly involved
13 by himself. We have some additional items, our common
14 processes and those kind of qualities, to look at the
15 standards and oversights.

16 A couple of things that went through the mind as we
17 went through this, I know, that at our other sites, we used
18 INPO for instance very effectively. And we particularly
19 have a need both ways and really try to use the industry.

20 Also know that our Davis-Besse was an outliner, and
21 did not really enjoy dealing with the Institute of Nuclear
22 Power. They would openly tell me that.

23 I also know that, Bill brought up the issue recently
24 in his presentation about a tag and safety training. We
25 lived through a very significant experience at our Beaver

1 Valley Plant. As difficult as that was, you would think
2 that we would just really internalize that over at FENOC
3 and have new standards at tag and safety trainings at each
4 one of our plants. Well, guess what? It didn't happen.
5 But I'll tell you what, it's happening now. And Bill is
6 running through safety training; I am too.

7 After we went through the significant emotion of
8 being at the Beaver Valley Plant and as much as we
9 discussed, it didn't seem to take. That gets back to the
10 complacency issue, you know, everything we did is okay. We
11 don't make any changes. That's, that's a major change in
12 the way we're doing business.

13 I think our oversight, Corporate Oversight Group we
14 have now, puts us in good standard between Gary and myself,
15 and Bill, to make sure we drive that, learn from each
16 organization and drive those standards through each and
17 every site. So, we know that's what happened before.

18 So, that's the way I'll answer that question. Was
19 there something amiss? Yes, there was.

20 MR. MENDIOLA: You answered the
21 question. Clearly, I was after whether there had been some
22 institutionalizing the approach across the plants, since
23 you obviously have had two good performers and one needed
24 performance enhancement. So, I was just trying to
25 ascertain whether there had been a corporate level

1 understanding of this, and reaction.

2 MR. MYERS: Thank you.

3 MR. PEARCE: If there is no
4 more questions, our next speaker is Bob Schrauder, who
5 would discuss the Head Resolution Plan.

6 MR. GROBE: Lew, excuse me,
7 before we go on, I would like to go for about another 15
8 minutes, and then take another break. Perhaps take another
9 break, and then move into the public comment part. So, if
10 there is something -- you would just like to continue on,
11 that's fine, but if there is some specific portion you
12 would rather have.

13 MR. MYERS: I think the
14 Reactor Head Plan is the major, major accomplishment since
15 the last meeting. Let's do that and see if we can get
16 through the containment very promptly. I think both of
17 those things we should know about.

18 With that, Bob Schrauder.

19 MR. SCHRAUDER: Okay, thank
20 you, Bill and Lew.

21 As Lew indicated, we are pleased with the progress
22 that's being made on the new replacement head. And I have
23 the senior management oversight for that, but I feel it's
24 only right to put the credit where the credit is due.

25 The success of the project we've had so far relies

1 heavily to our partners back in Grand Stone. In particular
2 to our project managers on the site; Dave Baker, Steve Fox,
3 Rich Chesko, Mark Wymer, Theo Swim provided oversight to
4 this project.

5 It's really taken a step forward and met the
6 challenge. We are on schedule. The bottom line, we
7 continue towards moving towards completion of this project
8 to support a safe, reliable return this year.

9 Up at Midland, the activities up there, our head
10 arrived, I believe it was, two days after our last
11 meeting. It was a two-day trip for the head to come down
12 from Midland, Michigan. And that trip really provided some
13 interesting sightseeing, I think, for some people along the
14 route to see that reactor vessel head on a 180-foot long
15 truck coming down the highway, it was interesting to say
16 the least.

17 In fact, one of the radio stations I was listening
18 to had a "Follow the reactor head" play-by-play throughout
19 the day. Got a lot of attention on the way down.

20 But the bottom line, we got it on site, and it was a
21 major milestone for us. It was something that we could
22 visibly celebrate at the site, which we did. We took time
23 out, served lunch for the entire organization at the whole
24 site, so they could see, have an opportunity to see that
25 the head had arrived and kind of get that sense that we are

1 making progress toward returning this plant to safe and
2 reliable operation.

3 So, it was a big momentous occasion for us to get
4 that reactor vessel head on site.

5 With that, all of our activities at Midland are
6 complete. We have closed up that containment. We've
7 exited the site and I think we left it in better shape than
8 when we got there.

9 Framatone has completed for us a composite co-data
10 package, code reconciliation package and our design
11 reconciliation package. Those have been submitted to FENOC
12 for NRC approval.

13 And as your slide indicated earlier, we have
14 provided all of the information we believe is necessary to
15 the NRC, so they can complete their reviews as this new
16 reactor vessel head will meet all the necessary
17 requirements for its use.

18 Just real quickly, give you some pictures. That's
19 the head being loaded at Midland. The next one is the head
20 as it arrives at the Davis-Besse site.

21 And, particularly the Davis-Besse site, let's talk
22 about progress there. Our reactor vessel head in the
23 containment has been prepared for removal from the
24 containment. The service structure preparations have been
25 complete. All the modifications have been made to that.

1 The temporary openings that were made in the service
2 structure have been restored and all that's left to be done
3 on that, we're going to put a new coat of paint on it and
4 we'll be ready to service our new reactor head.

5 As Clark indicated earlier, our shield building
6 opening has been complete and that was a marvel in itself
7 to watch the hydrodemolition of that, using high pressure
8 water to wash the concrete off. And it was a technical
9 operation by way of what the vendor had shown us and what
10 was demonstrated; very reliable source of getting the
11 containment open.

12 And that's where we sit with that. We're about
13 ready to cut the actual containment pressure vessel. We
14 are resolving some final conflicts with the NRC on the
15 desire to get a couple more samples out of the existing
16 reactor vessel head. We believe that we achieved
17 resolution on that today. And formal approval, we're still
18 waiting on that. So, we're moving forward very quickly.

19 That's the reactor vessel head as currently inside
20 our containment ready to be taken out of its containment.
21 Here's the target area we had to open the containment. We
22 had to protect our startup transformer, which sits right
23 outside of that area. We did that very effectively. I
24 believe we had no impact on that startup transformer.

25 Next slide shows preparation for the opening. We

1 had to erect a large platform there. Had to put a vacuum
2 plate on the containment.

3 Next slide. To make sure we didn't get water inside
4 the annulus while we were putting 20,000 pounds of pressure
5 on the outside of the containment.

6 This is a really good shot of washing the concrete
7 right off of the rebar. Not damaging or impacting the
8 rebar at all. Exposed one layer of rebar at a time and cut
9 that rebar out, tag it, and it will go right back in place
10 where it came from once we have the reactor vessel head
11 swapped out of there.

12 Finally, that's what the hole in the containment
13 looks like. The vacuum plate is obviously still on there,
14 all the rebar is gone, all the concrete is gone. And that
15 took us about six or seven days, I believe, to complete
16 that activity. So, again, very pleased with the activity
17 we have here.

18 The last shot that I have is our preparations for
19 the actual setting of the steel pressure vessel and the
20 rewelding of it. This is a mockup we had of the training
21 of people in the cutting activities, welding activities,
22 as we prepare to restore the containment to its design
23 intent.

24 That's where the head replacement has come to.

25 MR. MYERS: Let's move on to

1 containment if it's okay. Randy.

2 MR. FAST: I understand, five
3 minutes or less.

4 Well, I'm pleased to meet with you today to update
5 us on progress we're making on containment health. And the
6 first item I want to talk about is containment air
7 coolers. We have three containment air coolers. We're
8 doing complete refurbishment of those.

9 By way of a personal note, I'm kind of a car nut.
10 This is like body off restoration. We've got all of the
11 cooling coils completely removed, drop out registers are
12 being removed and the complete plenum is being replaced.
13 So, this is a significant level of effort.

14 We'll be replacing two of the motors on the fans,
15 and one refurbished. This is going to be a complete
16 refurbishment.

17 Got a picture of some of the workers. This has
18 really been as well good teamwork, and exercising good
19 safety practices, really meeting the challenges. And
20 samples we have here of the photographs of the crew
21 actually removing each one of the containment air coolers,
22 have twelve cooling coils, a total of 36. There is one of
23 them that's getting removed there.

24 Another item that we talked about the last time we
25 met, were the Containment Under Vessel; the vessel

1 examinations that we need to do. And as we had a
2 significant degradation of the reactor pressure vessel
3 head, we additionally had performed under vessel
4 inspections using a crawlup, but there was some areas that
5 were inaccessible.

6 Subsequently, we've put in a modification that
7 allowed us to put the incore instruments up in the vessel.
8 We've drained down. We're at 8 inches in the vessel, with
9 the index fixture in place.

10 We've removed the seal plates.

11 We have removed the insulation of 15 restricted
12 uses. That's first time revolution. And subsequently,
13 we're able to use the refueling machine with a camera to
14 fully identify the areas on top of the hot leg and cold leg
15 nozzles as well as the core flood tank nozzles.

16 Those inspections have been videographed. I believe
17 Mel you've had an opportunity to look at some of those.
18 Bottom line is we don't see significant degradation. It
19 seems to support our conclusion that we've had some
20 washdown of the vessel. So, those are, I'll say it, a good
21 news story.

22 Additionally, as Mel had talked about, the
23 inspections; we did complete the training of our new group
24 of inspectors, very experienced inspectors, using a new
25 procedure for training.

1 We have deployed those individuals and right now are
2 60 percent or so complete with the reinspections, very
3 detailed inspections.

4 And some of the things we talked about last time, or
5 some things we see different than what we saw before. If
6 we go back, the original thrust was boric acid program,
7 really looking at degradation mechanisms. This is a
8 complete containment health program, and we've seen a
9 significant amount of detail in the inspections performed.

10 Most notably, if you look at what is the difference,
11 we excluded a group of valves, the root isolation valves on
12 instrumentation systems. The original inspections had that
13 transition point and were not picked up through the new
14 inspection programs. Those were identified and we do have
15 minor leaking. So, those are in the population of areas to
16 be corrected. But overall, aside from the fact we have
17 very good detail on the inspections, we did not find
18 anything significant that was missed on the first time.

19 Next slide please. This is the decay heat valve
20 pit. Although this does not really represent a technical
21 issue or technical specification requirement issue, this is
22 a low standards issue. Systematically coming out of a
23 refueling outage, we have sealed this decay heat valve pit
24 used in red RTV.

25 That's what you see on the floor here. That does

1 not meet our expectations. And we have a team of folks
2 that are looking at several options that will really
3 improve this.

4 Bottom line is, there is two valves, decaying heat
5 valves that need to be maintained in an operable condition
6 during a large break LOCA accident in a flooded condition
7 and we're looking at options that are going to permanently
8 seal that valve head to improve our standards.

9 Okay. The next Containment Pressure Vessel, we
10 talked about this at the last public meeting. We had a
11 couple of items that came up. One is the MIC. And we have
12 done an evaluation analysis, and do not have MIC. So,
13 that's a good thing as well.

14 Corrosion. We learned some things from some experts
15 in the caustic conditions that exist with seal adjacent to
16 concrete is an environment where the pH is 12.6 plus, very
17 caustic environment that will not allow corrosion to
18 exist. So, the areas that we were concerned about where
19 metal is coming in direct contact with concrete, it would
20 be very difficult to assess, based on the pH would not have
21 corrosion.

22 Additionally, we have expanded the scope to include
23 equipment qualifications, things like motor operating
24 valves and other equipment default issues and those
25 walkdowns are in progress as well. We expect to complete

1 our walkdowns this week.

2 The next picture is, this is an area, look at the
3 very bottom of the picture, is our Containment Emergency
4 Sump. And this is an industry focus. It's, the Nuclear
5 Regulatory Commission is working advising the industry
6 about standards. This is an area of focus for us and we
7 are clearly dedicated to improving margin there. So, we
8 have a team of folks that are looking at several options
9 but we believe that you can gain pretty significant margin
10 by improving the containment sump area.

11 Containment coatings. We've got about 40,000 square
12 feet of dome. The dome has coatings that are peeling. And
13 we're in the progress of, we've got a company, Canon Sline,
14 partnership with them, 60 or so painters.

15 Scaffolding is now suspended in the overhead. You
16 can see the pictures. It's really a remarkable
17 achievement, because our polar crane is not in service.
18 So, we suspended the platforms up into the top of the
19 containment and we have painters removing the top coat
20 using needle guns. That's a very time exhaustive process,
21 but it will yield good results in removing that top coat
22 and going back with carbon units, qualified for the life of
23 the plant.

24 Here's another example where the scaffold is
25 actually underneath what's called the bull ring, which is

1 the support mechanism for the polar ring.

2 Some additional pictures. We did decontaminate from
3 the 653 foot elevation. On the 603, all of the exterior
4 walls of containment, that's really a brightened
5 containment. Made it visually much more appealing. We got
6 some additional work to do there on the concrete walls and
7 things, in the B rooms.

8 I think that concludes our pictures. So, you see,
9 we have a significant amount of activity inside of
10 containment. At any one time, you'll see well over a
11 hundred workers engaged in containment activities. So, we
12 feel good about the progress we're making in improving the
13 conditions in our containment.

14 Any questions?

15 MR. MYERS: Did you get on
16 the scaffold, Randy?

17 MR. FAST: I didn't get on
18 that scaffold. I would like to.

19 Just a side note. I think there is an interesting
20 perspective with the Restart Oversight Panel. We have
21 twelve individuals that took a fairly comprehensive tour of
22 the containment yesterday. And so that our Restart
23 Oversight Panel would have a good appreciation for, what
24 are the conditions in the containment and what work do we
25 have going on.

1 So, I did get valuable feedback from those folks and
2 they have an appreciation for the work going on, but that's
3 an example of dedication that our Restart Oversight Panel
4 has in really understanding the problems that we face, as
5 well as adding value in our input to the Containment Health
6 Plan.

7 MR. MYERS: Okay.

8 MR. GROBE: Lew?

9 MR. MYERS: We're ready to
10 go.

11 MR. GROBE: Yes.

12 MR. MYERS: I listen to every
13 thing we say and take notes. I said the other day, that we
14 are, myself personally, technically embarrassed about the
15 reactor vessel head issue, and our complacency on the
16 missed opportunities. I'll say that again. We're just
17 technically embarrassed there. We were complacent.

18 Today, as was indicated, that often though, the
19 cutting edge for improvement for the plants is coming out
20 of trouble. This is 350 process. That's where we're at.

21 As John Kennedy once said, "Great crisis produce
22 great people and great deeds of courage." We have
23 confidence in our people. The plant is their livelihood
24 and they stress that at meetings. They are well educated,
25 technically sound, hard working and proud members of this

1 community.

2 We will continue to be committed to comprehensive
3 approach here, to ensure that the Davis-Besse Plant's
4 restart, and is ready for safe and reliable operations and
5 sustainable performance in the future.

6 That's all I have to say. Thank you.

7 MR. GROBE: Any other
8 questions from the panel? Okay. Okay, very good.

9 Before we adjourn the business portion of this
10 meeting, I want to invite Jon Johnson to give us his
11 observations on this.

12 MR. JOHNSON: I just want to
13 say a few things. I was glad to get the opportunity to get
14 out of Washington and visit the plant today. I wanted to
15 come out and see what our team, the NRC team, is doing
16 here. I guess they've had several meetings, but I guess
17 what I would like to say is they're just getting started.

18 I asked, do we have an inspection schedule? The
19 answer is no. We're planning a lot of inspections.

20 I asked if you have a schedule that they can believe
21 in? The answer is no. You have a schedule that you
22 produce, and you know, I get questions when are you going
23 to do things, when are inspection teams going to do things,
24 but we need to know when you're going to do things, because
25 we're going to need to borrow inspectors from other

1 facilities or other regions and get some help. So, we're
2 going to need to plan. So, I think one thing that would
3 be helpful is if you had a schedule that we could count
4 on.

5 The other thing I would like to say is that you've
6 got a lot of work to do. And I don't think you probably
7 need me to tell you that. You already know that. But I
8 did get a chance to talk to some of your employees today,
9 and I did get to tour the plant, so I'll tell Mr. Pearce
10 the reason I know you've got a lot of work is because I saw
11 it.

12 MR. PEARCE: Good, we're glad
13 you saw it.

14 MR. JOHNSON: You can give me
15 one of your a little cards.

16 So, what I think you've got to do is you've got to
17 get the trust back of your employees. I asked them, you
18 know, we talk about appraisals and you appraise managers
19 and appraise employees, but you know, how often do the
20 employees get to appraise the managers. Not that often.

21 And, I asked them, you know, what they thought of
22 the management team, the management team is going to get
23 them out of this problem here. And, guess what they said?

24 What do you think they said, Mr. Myers?

25 MR. MYERS: I think they

1 believe we will get them out of the problem.

2 MR. JOHNSON: They said, actions
3 speak louder than words.

4 MR. MYERS: I believe that.

5 MR. JOHNSON: That was a pretty
6 good saying. I think, like you said at the end, that you
7 have some skilled staff, very skilled staff, and I think
8 they have the will to do the work. And I think what we
9 need to do is provide them the access to be able to do
10 that.

11 You've got to provide them the expectations and the
12 values of -- your slide here, I guess Mr. Pearce said,
13 FENOC nuclear safety values and behaviors and expectations
14 were inadequate. So, I guess my question is what are your
15 values? I couldn't tell. I couldn't tell from visiting
16 the plant today.

17 MR. MYERS: No, our values are
18 safety, communication, teamwork, customer focus. You know,
19 that's the FENOC values.

20 MR. JOHNSON: I think probably
21 what would help maybe is if you just continue to
22 communicate that to the staff, and to everyone else.

23 I think one of the things we've been criticized for,
24 we're getting criticized for not being able to do this
25 oversight. We need somebody else other than the NRC.

1 I'm confident in our staff. We've got a lot of
2 dedicated and experienced people on this team here.
3 Christine has been a Senior Resident Inspector. We've got
4 all kinds of engineering and inspection and licensing
5 experience on our Oversight Panel as well as our
6 inspectors. So, I think the NRC is confident in our staff
7 to oversee this.

8 One of the things I had a question about your
9 oversight team; you mentioned Mr. Karns provided you some
10 recommendations to go benchmarking. You had indicated you
11 had gone to benchmark some other facilities to get some
12 ideas from them. I didn't hear where you went to. Could
13 you let me know where you went?

14 MR. MYERS: We've been to
15 Byron, we've been to Salem, Cook. Cook a lot. Those three
16 in particular.

17 MR. JOHNSON: Do you know if any
18 of the operators got a chance to visit these sites?

19 MR. MYERS: Yes.

20 MR. JOHNSON: That to me, I
21 think, will go a long way for you to provide opportunities
22 for the operators to get out and see other places too.

23 One thing I wanted to ask about was the use of
24 risk. I didn't hear anybody talk about your PRA, use of
25 your PRA or safety significance, or types of walkdowns

1 you're doing. Maybe Mr. Powers can discuss that.

2 MR. POWERS: Sure.

3 MR. JOHNSON: Are you focusing
4 on systems that are important to safety?

5 MR. POWERS: Absolutely. The
6 criteria for selection of population systems was
7 Maintenance Rule Risk Significant Systems. That population
8 was 31 Systems Health Readiness Review. The latent issues
9 review or some of the key systems we feel are on that risk
10 significant, for example, Aux. Feedwater System and
11 Emergency Diesel Generator, but the Reactor Coolant System
12 was involved in the head degradation issue and service
13 water and component cooling water, which are not only,
14 they're risk significant, but they're also areas where
15 there are problems, plus tend to manifest themselves there.
16 So, we can think that population of deep slice latent
17 issues were used and give us a good health check.

18 MR. MYERS: In other words, we
19 didn't take primary watch.

20 MR. JOHNSON: When I was in the
21 control room, I noticed there is a lot of green stickers
22 all over the panels. And I guess my question is, are you
23 going to have any green stickers when you restart the plant
24 in the control room?

25 MR. FAST: Our plant includes

1 completing all of the control room activities and all of
2 the deficiencies.

3 MR. JOHNSON: I guess that's
4 something in terms of operator workarounds or the problems
5 with instrumentation, things that don't work right and
6 automatic. Whatever the case is, I think that will go a
7 long way to demonstrating to the people that you have
8 operating the plant that you intend to focus on safety and
9 the plant equipment.

10 When they say actions speak louder than words, I
11 think those type of things will send a strong message.

12 MR. FAST: We absolutely
13 agree.

14 MR. MYERS: We have control
15 board instrumentation, we have operator workarounds and we
16 have temporary mods on our list.

17 MR. PRICE: Those are all
18 currently part of the restart matrix that we have, not ones
19 that I presented today, but those are in our report.

20 MR. JOHNSON: I appreciate the
21 opportunity to tour. And I guess the last thing I'll end
22 with is, I know I got asked by one of the news media here
23 if they could visit the plant. I know in this day and age
24 of security increases, I think the increased concern for
25 certain types of visitors in the plant is a little

1 strengthened in background checks, but I know that you
2 would provide opportunities for local officials or elected
3 officials to visit the plant, and I guess maybe I would
4 just like to hear what you have to say about that in terms
5 of bringing in some of the people that live in the area to
6 show them what you're doing.

7 MR. MYERS: We would be more
8 than happy to do that. You know, it's hard, at our other
9 plants, we've actually taken tour groups inside the
10 protected area before and done that here. Can't do that
11 now after September 11. On a case by case basis, you know,
12 we more than welcome the press or some outside people to
13 come in and look at our plant.

14 In fact, we've got on Restart Oversight Panel, we've
15 got Jere Witt is a commissioner, or business manager for
16 the county, so that would not be a problem.

17 MR. JOHNSON: I think that also
18 goes a long way to generate trust and confidence in the
19 local people that live around the area.

20 MR. FAST: Jere was on our
21 tour of containment.

22 MR. MYERS: Jere was on our
23 tour of containment. We had him in the containment.

24 MR. JOHNSON: Okay, thank you
25 very much.

1 MR. MYERS: Thank you for your
2 kind comments and coming today.

3 MR. GROBE: Thank you. Jon.

4 At this time I would like to adjourn the business
5 portion of the meeting and take a five minute break. We'll
6 reconfigure the stage a bit and take public comments and
7 questions.

8 So, thank you very much. Be back at 5:15.

9 (Off the record.)

10 MR. GROBE: Okay, thank you
11 very much. Appreciate those of you that had the staying
12 power to get through the meeting, and those are very
13 formative meetings for us. I hope you found them
14 informative also.

15 What I would like to do is ask if there is anyone
16 here, this is the first meeting that they've come to
17 regarding Davis-Besse. Just raise your hand. Do we have
18 any newcomers. Excellent. Oh, Jon. Very good, very
19 good.

20 What I'm going to do in this segment is to give a
21 little background information, respective to Davis-Besse,
22 and Doug will. And then what I'm going to do is open it up
23 to first questions from representatives of local officials,
24 and then from local community here around the Davis-Besse
25 Facility, and if there is other members, concerned members

1 of the public, we'll entertain questions from them.

2 Our primary focus, we're interested in any questions
3 or comments regarding the meeting or regarding Davis-Besse
4 or any other topic in our area for you that you're
5 interested in talking about.

6 MR. SIMPKINS: Well, what you
7 see up here, was actually taken off the NRC Website. If
8 you would like to go to that, it's www.nrc.gov. They
9 actually have an isolated viewing area. We took a slide
10 from that and put it up here for those of you aren't
11 familiar with how major power plants work.

12 Starting off with inside of what we call the
13 containment structure, we have the place where there is
14 actually the nuclear reaction going on. The nuclear
15 reaction is just used to generate heat energy to make the
16 water inside the primary system hot. That water then
17 circulates in a continuous loop.

18 Once it goes into the steam generator, it doesn't
19 mix with the other water, but instead it transfers heat
20 energy like a radiator in a car transfers the heat out and
21 it turns to water inside the steam generator to steam,
22 which then comes out the top, goes through a series of
23 pipes, and then goes through a turbine.

24 The turbine spins at a high rate of speed, which
25 turns a generator. That generator then makes electricity.

1 The water continues down into a condenser, which is then
2 circulated back into the system generator.

3 Off to the side, which you can't see here, the water
4 from the cooling tower, which everybody assumes is the
5 containment vessel. The cooling tower is the 493 foot
6 structure on the site; comes into the condenser, condenses
7 the steam back into water and goes back out to the cooling
8 tower.

9 Next slide.

10 On top of the reactor itself; is the head unit.
11 It's like if you have a pressure cooker, you have a sealed
12 unit on top. The water inside the primary system is
13 pressurized to keep it from turning to steam. And it's
14 held, the pressure is held in by this head structure.

15 Coming down through the top of the head are the
16 control rod drive mechanisms. Those are used to regulate
17 how much energy is produced in nuclear reaction. Through
18 the head structure, the control rod drive mechanisms go
19 through a nozzle. And those nozzles are what the problem
20 started as.

21 Next slide.

22 These nozzles penetrate the reactor head, which is
23 about a 6-inch structure; and it's sealed at the bottom
24 with what's called a J-groove weld. This J-groove weld
25 creates stresses in the nozzle, and as a result of

1 allowing the water to penetrate up through and come through
2 the top of the reactor head area.

3 The water inside the primary system has boric acid
4 in it, which is very, very similar to Borax, like you buy
5 in a store. That's sodium borate, but they use pure boric
6 acid here.

7 Next slide.

8 This is actually a picture taken on top of the
9 reactor head. And the deposits that you see coming out of
10 these what we call mouse holes or weep holes here are
11 actually boric acid that leaked up past the control drive
12 nozzles and are now on the head. They're kind of reddish
13 color, because they actually contain iron oxide.

14 Next slide.

15 This is an artist's rendition of the damage to the
16 top of the head. As you can see, the nozzle area had water
17 leak past it and create a cavity because the boric acid
18 dissolved away the metal. The last remaining barrier was
19 indeed the approximately 8th inch seal liner on the bottom
20 side. That was not wasted away, because it was stainless
21 steel, rather than carbon steel like the rest of the head.

22 Okay.

23 MR. GROBE: Okay, thanks

24 Doug.

25 At this time, I would like any local public

1 officials or representatives of the office to approach the
2 microphone, if you have any questions or comments you want
3 to make. Okay.

4 Members of the community here in Oak Harbor; are
5 there any members of the community that have any question?

6 I didn't mention to put your name on the page, but
7 Howard has done that before.

8 MR. WHITCOMB: Good afternoon.
9 My name is Howard Whitcomb. I have a couple of questions.

10 First, is regarding, I believe it's Slide 37, on
11 page 19 of the First Energy handout. There was a lot of
12 discussion regarding the I think obvious indicators on that
13 particular chart.

14 The first questions that pops out in my mind are
15 based on the expansive discussion regarding changes that
16 have occurred in employee culture and that sort of thing at
17 the site. At least that's what has been reported.

18 I guess my first question is, of that number of
19 condition reports that were, I guess it's somewhere almost
20 800 to-date; how many of those are by supervisors and how
21 many of those are by employees in the field; how many are
22 by office maintenance, health physics, quality assurance
23 and engineering; how many are by contractors versus on-site
24 personnel?

25 I think that a breakdown of that type of figure

1 might indicate whether these problems are just now coming
2 out of the woodwork from little books that people have been
3 carrying around for some period of time. I think we're
4 being led to believe that there is a more open environment
5 for bringing conditions or adverse conditions to light.

6 It would seem to me that if there is a breakdown in
7 those number of condition reports, it might provide some
8 insight. Have you asked that or has anyone from your staff
9 asked that?

10 MR. GROBE: I don't have that
11 on my fingertips. That's data that's normally maintained
12 and I haven't reviewed it recently, but I'm certain First
13 Energy has that data. I believe that they would be glad to
14 share that with you.

15 Is that something that you folks do? Not today at
16 the meeting, but I'm sure you'll be glad to get that to you
17 Howard.

18 MR. WHITCOMB: All right. The
19 second issue is for you, or your staff, Jack. And, I
20 understand that there is a caveat that you just recently
21 received the Root Cause Analysis Report from the Licensee.
22 But I guess the first question that comes to mind, I think,
23 Mr. Johnson kind of touched on it briefly; regarding, I'll
24 pick on Mr. Pearce's root cause that he identified. I
25 guess slide 45, page 23. He identifies that "nuclear

1 safety values, behavior and expectations were inadequate
2 through oversight."

3 The question is this; does the NRC believe that
4 First Energy has gone far enough in their root cause
5 determination? In other words, it seems to me that part
6 of the exercise of root cause evaluations and analysis is
7 to keep asking the question why. We all did that at a very
8 tender age and we always ask our parents why. Okay. As we
9 get older we become wiser and we become more self-confident
10 and we think we have the answer, but we don't ask the
11 question why.

12 But just in what was stated on slide 45, it appears
13 to me that you could ask the question why. And I don't
14 think the answer comes out. So, I'm not so sure that
15 they've gone as far as they need to go. Is the NRC
16 satisfied that they have?

17 MR. GROBE: We had a several
18 hour meeting last Thursday, and at that time we received a
19 copy of the Root Cause Analysis. There is many different
20 ways to do these types of analysis. I think we chose one
21 that's more management of oversight risk. And it is a very
22 structured approach to asking that exact question, ask
23 why. And it goes through a structured approach of looking
24 at systems and structures within the organization that
25 assure effectiveness, from defining policies to

1 communications, procedures and all sorts of different
2 things.

3 We have not had an opportunity to review that report
4 in detail. That's part of our inspection area of
5 Management Human Performance, is going to be. The first
6 part is going to be a thorough review of that Root Cause
7 Report.

8 MR. WHITCOMB: The third
9 observation that I would like to make is that several
10 pieces of equipment this afternoon, in addition to the
11 reactor head degradation, such as, if I can remember,
12 diesel generator, one of the damper arm levers was bound up
13 or loose or something of that nature, and the other was the
14 missile shield on the muffler.

15 Those types of issues suggest that either people are
16 not, are actually not walking the systems down or paying
17 attention to the system, or understanding that those
18 conditions exist or ignoring them anyway.

19 In addition to that, we've heard several times this
20 afternoon that there have been some problems with
21 classifying the equipment in certain categories. In other
22 words, the Maintenance Rule 6055, I think is the number,
23 but I don't remember exactly, but the Maintenance Rule Laws
24 that came out in the requirements clearly required
25 Licensees to make those component determinations.

1 Does the NRC have plans to evaluate the
2 effectiveness and adequacy of the Maintenance Rule
3 implementation at Davis-Besse?

4 MR. GROBE: To comment, your
5 first observation I think is correct, that either the
6 equipment, for example, you highlighted the damper,
7 actually the arm that was loose, and missile shield or the
8 tornado shield rather on the vent for exhaust generator. I
9 believe you're correct that either those weren't looked at
10 correctly or they weren't looked at previously. And I'm
11 thinking the systems discussion First Energy presented
12 today, they're going to have a structured, clearly defined
13 expectation for system walkdowns, regular system walkdowns,
14 that would be part of their System Health Program. I
15 believe that already exists in oversights. For whatever
16 reason, did not exist here.

17 The second comment, I think if I understood your
18 comment correctly, you may have misunderstood, I believe
19 what First Energy was talking about was a failure to
20 properly classify condition reports. That in the, the
21 Davis-Besse Plant has multiple levels of significance
22 condition reports from, you know, the very lowest level, a
23 lightbulb needs changed to the most significant, which is
24 for a significant condition adverse to quality requiring
25 cause.

1 In the past, they did not look in depth sufficiently
2 at the issue to properly characterize within those
3 hierarchical levels of significance, and consequently they
4 may have undervalued the significance of the issue and
5 not properly corrected it.

6 So, it wasn't the classification of equipment, other
7 than the contents of maintenance workers classification of
8 condition reports within the significant scheme that they
9 have in Corrective Action Program.

10 And your specific question, we do not have as part
11 of the restart plan, an evaluation currently of the
12 Maintenance Rule. That's not on the agenda. Okay, of
13 course, it's part of our routine base inspection, but it's
14 not a unique characteristic of restart.

15 MR. WHITCOMB: So, as a result of
16 the report, the NRC is satisfied the equipment has been
17 properly classified.

18 MR. GROBE: I believe that's
19 correct.

20 MR. WHITCOMB: Thank you.

21 MR. GROBE: Okay, other
22 members of the public, that have a question or comment.

23 MR. KEEGAN: My name is Michael
24 Keegan. I'm from Monroe, Michigan, just north of here.

25 I believe that the NRC and the utility, First

1 Energy, are on a collusion course for disaster.

2 Just this week, I see posted by the NRC that they're
3 considering looking to a third party. If there is need to
4 penalize the utility, they would like for a third party
5 arbitrator to establish what the penalty would be.

6 I see this just yesterday. They announced that
7 they'll be holding a workshop with IMPO on essentially how
8 to further deregulate the regulatory responsibility that
9 the NRC has.

10 In April, I was one of 15 groups led by concerned
11 scientists, which filed for Freedom of Information and
12 requested that information. We have been stonewalled on
13 that information. We have not gotten the information yet.

14 Today I learn that the 206 petition which we have
15 filed asking for immediate independent review has been
16 denied.

17 I have sat through an excruciating four-hour
18 conference call, where Jim Dyer said never, never could
19 this happen again. Never. Never. Never. Never. Wolf.
20 Wolf. Wolf. Wolf. Like the boy who cried wolf.

21 Either you are the regulator or you are not the
22 regulator, and your behaviors surely demonstrate that you
23 are not the regulator and you are not going to stand up on
24 the public's behalf and regulate. That's my comment.

25 I am concerned about this reactor vessel. I am

1 concerned about the issue of imbrittlement industry-wide.
2 And I wonder what the level of imbrittlement at this
3 reactor is, the potential for pressurized thermoshock at
4 this reactor. This is clearly a damaged piece of goods. I
5 wonder if you could speak to that.

6 MR. GROBE: There is a unique
7 characteristic at Davis-Besse that makes it different than
8 any other of the operating power plants in the United
9 States with respect to pressurized nuclear shell.

10 MR. KEEGAN: Do you have NSI's
11 of that, the building, the RV factors, the whatever?

12 MR. GROBE: I am not sure we
13 are prepared to respond right now, but what we can do is
14 get you in touch with the right people that can give you
15 more information on pressurized thermoshock.

16 MR. KEEGAN: This has been,
17 we've been stonewalled at the Palisades Plant as well,
18 which has seen beryllium since 1981, and the NRC has
19 rewritten five times the level of imbrittlement that they
20 will tolerate. So, again, my faith in the NRC goes back
21 over 20 years, and I don't have any.

22 MR. GROBE: So does mine.

23 MR. KEEGAN: Okay. On the
24 excruciating call that I sat through, I learned there were
25 700 pieces of data and 120 interviews for a total of a

1 thousand hits of data, 126-page document, which served as
2 the basis for the Root Cause Analysis.

3 I would like to know how I can get this in hand.

4 And I don't want to hear file a Freedom of Information
5 request, because clearly you stonewall everyone who does.

6 And, I need to do my own root cause analysis, because I
7 frankly don't have any faith in the NRC and I have less
8 faith in the utility to come clean with what's going on.

9 So, how did I get that in hand?

10 MR. GROBE: It sounds like you
11 had a fairly good telephone connection, you got a lot of
12 detail out of the meeting last Thursday. During that
13 meeting, Les indicated that they would be submitting it on
14 the docket this week. It would be posted to our Website.

15 MR. KEEGAN: That's the Root
16 Cause Analysis. Will all thousand bits of data on which to
17 base the Root Cause Analysis be available?

18 MR. GROBE: No.

19 MR. KEEGAN: I want to review
20 that.

21 MR. GROBE: It's not required
22 to be submitted. When we do our inspections of the root
23 cause report, we'll certainly be evaluating some of that.

24 It's volumes and volumes of information available on site,
25 but it's not available to the NRC in our office, and it's

1 not a public document.

2 MR. KEEGAN: But the NRC will
3 be reviewing it on site?

4 MR. GROBE: Yes, just like we
5 have on inspections.

6 MR. KEEGAN: I believe the
7 public needs to have access to that as well.

8 MR. GROBE: I appreciate your
9 point of view.

10 MR. KEEGAN: Well, I will push
11 my point of view, and I want to get that data. So, I will
12 pursue an evidence, be it legal, what have you to get
13 that.

14 MR. GROBE: Okay. Do you have
15 any other questions?

16 MR. KEEGAN: I had a thought,
17 but it escape me at this time, but we're watching you very
18 closely, and I'm sadly disappointed that you've turned down
19 our request.

20 MR. GROBE: I think you made a
21 number of statements in your preamble to your first
22 question. Several of them are not correct. Your petition
23 was not denied. What was issued this week was a proposed
24 resolution to the petition, and it was requesting your
25 feedback and comments on that proposed resolution.

1 So, this is part of the process of the intensive or
2 .206 review process, and we would look forward to comments
3 from any or all of the petitioners.

4 MR. KEEGAN: I stand corrected,
5 and I will look at that document from you again, and will
6 respond.

7 MR. GROBE: There is a number
8 of other issues you raised. First of all, ultimate dispute
9 resolution as a potential vehicle for addressing the
10 issues.

11 Bill?

12 MR. DEAN: Your issue that
13 you raised initially regarding a third party arbitrator
14 relative to Davis-Besse. I think we were referring to, is
15 that there has been plans for a meeting to discuss the
16 potential of the use of what is called alternate dispute
17 resolution.

18 The NRC has done some assessment of that and is
19 looking to gather feedback on the potential of using that
20 in certain situations. It's not something we're looking at
21 in terms of resolving issues with Davis-Besse. This is
22 just being looked at by the agency as a potential
23 methodology for looking at certain types of issues.

24 MR. GROBE: Just another
25 observation. I think-- I'm grateful that you are engaged

1 in this, because every process is better if it has full
2 engagement, broad spectrum of views and opinions, and I'm
3 glad you had the opportunity to listen into and participate
4 in the meeting last Thursday.

5 We have gone to I believe unprecedented lengths to
6 provide that access, and I hope you continue to take the
7 opportunity to participate in the meetings either
8 telephonically, or both telephonic connection, video
9 conferencing links to Washington, as well as come to these
10 meetings here. I am appreciative of your input.

11 MR. KEEGAN: Just came to me
12 what my thought was that escaped me.

13 MR. GROBE: Good. Go ahead.

14 MR. KEEGAN: On the phone call
15 of last week, I asked what's the NRC been doing to review
16 all these walkdowns that the utility had intended to do.
17 And, the response I got was that you would review the
18 paperwork.

19 MR. GROBE: No, that's just
20 not, absolutely not.

21 MR. KEEGAN: Well, that's the
22 response I got on the phone.

23 MR. GROBE: Maybe the
24 telephone connection wasn't as good as I thought.

25 There is a generic approach to all of this work that

1 we're going to do. And, Christine refers to many stars in
2 the approach, but the first thing we're going to do is
3 review the program or the plan that the Licensee has.
4 That's a paperwork review.

5 Mel is sitting in the audience. He was the first
6 inspector that had an opportunity to look at the plan,
7 licensee was furthest ahead on the Containment Health
8 Assurance Plan, and provided substantive feedback to
9 Licensee on aspects of that plan that could be improved.

10 The next step is to review the Licensee's
11 implementation of that plan. In the case of, for example,
12 Systems Review. That includes observing the Licensee's
13 staff in the field doing the work that they're doing,
14 evaluating how they're evaluating issues that they come
15 across.

16 The next step is for us to review how the Licensee
17 characterizes its position issue that they have, and
18 finally to perform inspections. And each of our
19 inspections in each of these areas has components, and
20 that's how we will build confidence in the adequacy of
21 licensing activities and we will be communicating the
22 results of those inspections on each of those meetings to
23 the public as well as through our inspection groups.

24 MR. KEEGAN: I recall from
25 previous meetings, you said that you inspected one to two

1 percent of the systems. Seems that we have a culture of
2 production over safety that permeates First Energy. And I
3 would encourage the NRC to review the entire plant, walk it
4 down.

5 MR. GROBE: When we were
6 referring to, I believe in that previous comment, had to do
7 with our routine baseline program. I guarantee you that
8 First Energy is taking lots of our attention.

9 MR. KEEGAN: As well deserved,
10 as well as the NRC deserves public scrutinization.

11 Thank you.

12 MR. GROBE: Good, thank you.

13 Other members of the public that have a question or
14 comment? You don't?

15 MR. WHITCOMB: I didn't see Mel
16 hiding over here, so I have a question specifically for
17 him.

18 You would, apparently you've done a recent
19 inspection, and you identified two violations. I guess my
20 question is, when did you begin your inspection and when
21 did you conclude it?

22 MR. HOLMBERG: Okay. I heard
23 the question on the way up. The question was, when did I
24 begin the inspection of the Licensee efforts to do their
25 Containment Standard Issue Reviews and when did it end.

1 The inspection began in June, and the total time
2 that we spent on inspection was three full weeks reviewing
3 Licensee activities, and we identified those two findings
4 characterized as violations.

5 MR. WHITCOMB: And --

6 MR. HOLMBERG: It ended on July
7 25th.

8 MR. WHITCOMB: So, three weeks
9 from June to July 25. Well, July 25th, most of July.

10 And you found two violations, one of them being a
11 lack of acceptance criteria in violation of Appendix E
12 Criterion 5, and there was inadequate training, apparently
13 of VT-2 inspectors; is that correct? Were those the
14 essence of the two violations?

15 MR. HOLMBERG: Yes.

16 MR. WHITCOMB: As a result of
17 your findings, how much of the work that had been done
18 during this outage has to be redone?

19 MR. HOLMBERG: They're
20 reperforming their effort in its entirety.

21 MR. WHITCOMB: Okay. Do you have
22 any idea how far along they are in the reperformance?

23 MR. HOLMBERG: Their current
24 schedule, I think, this is just, I will probably have to
25 confirm this, is late August.

1 MR. WHITCOMB: Thank you.

2 MR. GROBE: Let me provide a
3 little more context to that.

4 The Licensee initiated a different approach to
5 containment. First off, the initial evaluation was limited
6 to boric acid impact on equipment in containment. And the
7 training was focused on what's referred to as a VT-2
8 qualification. That's a qualification of the American
9 Society of Mechanical Engineering standards for doing
10 visual inspections of the metal, degradation of metal.

11 Mel did the inspection, found some difficulties with
12 qualification, some problems with qualifications of people,
13 as well as went out in the field and found further issues
14 on equipment that had been inspected by the Licensee staff,
15 that hadn't been disclosed through their inspections. So,
16 Licensee went back to square one.

17 The foundation of the inspection was done. I think
18 you indicated that there weren't any, I can't think of the
19 right characterization, substantive issues disclosed, but
20 additional issues that were beyond the scope of the
21 original inspection.

22 Licensee brought in a number of new people to the
23 site, trained them to a much, what's referred to as systems
24 approach to training, much more comprehensive training
25 standard. Both of those were acceptable to us, and is in

1 the course of reperforming those inspections, and we're
2 continuing to inspect.

3 Just one other thing. Are the three weeks of, that
4 Mel referred to, is what we call direct inspection effort.
5 It's set over a period of multiple weeks; and in addition
6 to that, there is quite a bit of time that he spends in the
7 office reviewing documents. And those three weeks were the
8 weeks that he was on site providing direct inspection of
9 the Licensee's activities.

10 Did you have another question?

11 MR. WHITCOMB: Well, something
12 you had mentioned to me, or mentioned to the public here.
13 You say they brought in people. Are these contract people
14 that are only here on a temporary basis; is that your
15 understanding; or are these new people, permanent people?

16 MR. HOLMBERG: The new people
17 that are performing the current effort are contractors,
18 primarily. They've also brought their own staff on this
19 new training program.

20 The contractors, I know their work histories,
21 extensive backgrounds specifically in examination
22 techniques, many years of experience doing related type of
23 work, such as inspections. And, I hope that answers your
24 question. They're primarily contractors that are doing the
25 inspections.

1 MR. WHITCOMB: Well, I guess I'm
2 more concerned after the contractors leave, than I am about
3 their current qualifications. I'm sure they brought in
4 experts to do these inspections. I guess once they leave,
5 what's left to do further inspections in the future?

6 MR. HOLMBERG: I'm not sure.
7 I'll turn it over to Jack. He's heard about future plans.

8 MR. GROBE: I think that's one
9 of the primary focuses of the meeting today, was to
10 understand in greater detail the initiatives Licensee is
11 taking to address the root cause, which they characterize
12 as a lack of safety focus, putting production over safety.

13 So, they lay out insights they have, their plans on
14 reestablishing that safety focus, standards of technical
15 rigor and discipline in the way work is conducted. And
16 then, how they're going to provide management oversight of
17 that activity with field observations.

18 And then they have not gotten to us, but they're
19 planning on developing some sort of matrix performance
20 indicator package in this area that will provide insights.
21 And they did provide some of the, two of the matrixes, I
22 believe. One was Corrective Action Review Board,
23 percentage of time they reject corrective action
24 documents. And the other was Engine Review -- or
25 Engineering Review Assurance Board, I think it was called,

1 and their evaluation of the quality of work product.

2 So, I think it's too soon to tell, but I anticipate
3 over the next several meetings, next several months that
4 you'll see it's coming into clearer focus. This is
5 particularly the area that we'll be focusing on in our
6 inspections.

7 MR. WHITCOMB: But I am correct
8 in assuming that, my concern is the concern of the NRC as
9 well, and you're expecting that they will have something in
10 place before --

11 MR. GROBE: It's on our
12 checklist, Howard.

13 MR. WHITCOMB: Okay, it's on your
14 checklist. I didn't, I didn't see it on the checklist,
15 Jack, but okay. Thank you.

16 MR. GROBE: Other members of
17 the public that have questions or comments?

18 Okay. Very good. We're going to be back here at
19 7:00 this evening, and make an opportunity for feedback
20 from folks that were here this afternoon, want to come
21 back; or folks that were unable to be here this afternoon.

22 Thank you very much.

23 And please, take an opportunity to provide us
24 feedback on our feedback forms. Postage paid. Just fill
25 them out and send them back to us.

1 Thank you very much.

2 (Off the record.)

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1 CERTIFICATE

2 I, Marie B. Fresch, Registered Merit Reporter and
3 Notary Public in and for the State of Ohio, duly
4 commissioned and qualified therein, do hereby certify that
5 the foregoing is a true and correct transcript of the
6 proceedings as taken by me and that I was present during
7 all of said proceedings.

8 IN WITNESS WHEREOF, I have hereunto set my hand and
9 affixed my seal of office at Norwalk, Ohio, on this
10 28th day of August, 2002.

11

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Marie B. Fresch, RMR

15

NOTARY PUBLIC, STATE OF OHIO
My Commission Expires 10-9-03.

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