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

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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.

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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

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

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

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

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

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

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

for Davis-Besse in our headquarters office.

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

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

(Noise)

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

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

(Off the record/fixing microphones)

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

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

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

In addition in the audience is Vyka Mitlyng. Vyka

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

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

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

Lew, why don't you introduce your staff.

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

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

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

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

Tim Chambers is here.

Mark McCullough is with us; Containment Health.

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

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

Tony Seller, Restart.

And then Dave Eshelman is Management Performance.

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

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

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

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

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

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

MR. GROBE: Okay, thank you.

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

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

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

Christine.

MS. LIPA: Okay, thank you.

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

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

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

So, we'll go to the next slide.

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

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

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

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

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

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

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

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

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

Then we talked about the System Health Assurance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The next slide.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HOLMBERG: Okay, thank you Christine.

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

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

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

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

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

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

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

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

The first finding that was identified dealt with

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

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

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

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

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

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

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

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

MS. LIPA: Okay. Thanks Mel.

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

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

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

That's all I have for Agenda Item 3.

Jack, do you have comments?

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

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

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

MR. MYERS: Thank you.

Our Desired Outcomes today:

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

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

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

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

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

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

Next slide.

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

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

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

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

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

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

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

quite a couple hundred informally.

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

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

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

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

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

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

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

The next slide.

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

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

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

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

failed to detect plant problems as opportunities arose. And you heard that at the end of their investigation, that opportunities to identify these problems were missed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

common process at all of our plants.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and last but most important training activities.

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

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

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

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

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

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

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

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

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

That concludes our actions on Nuclear Safety Focus.

The next area --

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

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

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

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

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

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

MR. MYERS: Right.

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

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

MR. MYERS: Yes.

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

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

Bill, do you want to discuss that?

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

MR. PEARCE: Okay.

MR. MYERS: Go ahead.

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

MR. GROBE: Sure.

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

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

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

we're in, but generally the same survey.

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

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

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

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

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

MR. PEARCE: Well, in my heart

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

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

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

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

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

MR. PEARCE: Yes.

MR. MYERS: That's a good analysis.

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

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

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

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

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

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

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

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

MR. MYERS: Sure.

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

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

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

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

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

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

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

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

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

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

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

MR. GROBE: Okay.

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

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

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

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

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

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

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

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

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

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

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

Bill is monitoring that. I monitor that.

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

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

effected.

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

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

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

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

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

Require the use of formal cause determination

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

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

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

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

Technical rigor, the next area, if you will.

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

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

MR. MYERS: Yes.

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

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

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

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

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

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

MR. DEAN: Thank you.

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

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

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

MR. GROBE: Like I said, this

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

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

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

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

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

MR. MYERS: Good.

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

MR. MYERS: We would invite that.

The next area is Technical Rigor. What do we mean

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The next area is implement the Management

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

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

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

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

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

attack those trainings.

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

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

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

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

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

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

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

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

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

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

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

MR. GROBE: Okay.

MR. MYERS: When we did the

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

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

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

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

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

that challenge.

That's all I have. Thank you.

MR. GROBE: Okay. Questions from the panel members?

Bill?

MR. DEAN: Lew, relative to the statement here on the next to last slide where you talk about establishing policies, report safety and in particular operations involvement, is there a vision there that you have as an organization relative to how do you see operations fitting within the overall concept of how Davis-Besse is going to operate that may be different than how it's operated in the past?

MR. MYERS: Do that again for me, I lost you somewhere.

MR. DEAN: The involvement of the operations has in leading the organizations as opposed to perhaps how it might have been in the past.

MR. MYERS: You want to comment on that, Randy?

MR. FAST: When you benchmark the industry, the best of the best, they're operation driven. License holders of the plants are our operators. It's the eyes and the ears of the plant. The expectations are that they run true to form. They set the standard for

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

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

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

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

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

that message is seen specifically across the site?

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

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

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

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

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

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

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

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

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

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

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

MR. MYERS: Absolutely.

MR. GROBE: I think it's about time for a break, give our transcriber's fingers a rest. But, before we do that, I want to just make a couple of comments.

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

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

well.

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

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

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

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

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

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

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

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

(Off the record.)

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

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

MR. GROBE: Okay. Are you

ready to start back?

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

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

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

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

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

Next slide.

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

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

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

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

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

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

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

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

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

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

the system walkdowns.

MR. POWERS: Thanks, Clark.

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

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

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

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

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

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

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

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

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

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

MR. MYERS: Those are the motors, right?

MR. POWERS: That's the motor.

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

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

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

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

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

or questions we have for disposition.

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

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

Here's some examples of things we found.

MR. MYERS: Who was participating?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GROBE: Okay, thank you.
MS. LIPA: I have one question on these. I know you have another slide with more examples, but are you doing as-found reviews? I know you plan to fix a lot of these things before you start, but are you doing as-found reviews for reportability?
MR. POWERS: Yes, as-found conditions will be documented in Corrective Action documents. As necessary, operability determinations will be done and reportability will be followed through with the normal process for as-found conditions.
MS. LIPA: Okay, thank you.
MR. POWERS: We did find an issue with Emergency Diesel Generator, Heating and Ventilation Air Conditioning System Exhaust Hydramotor Damper. Basically, that's the motor enforcement damper on the air cooling system. There was a damper arm loose and it was bound up. And did not look like it was going to work properly for a long term. So, that was a very good find by the walkdown team, with attention to detail needed to be corrected.
We also found the exhaust silencers, which are outside the building, muffler essentially large diesel engines, tornado missle shields and where they're attached to the concrete parapet started to crack and fall. Either

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

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

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

MR. PRICE: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. PRICE: These are all restart action items.

MS. LIPA: Okay, thank you.

MR. PRICE: Any additional questions on this slide?

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

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

No questions on that, I'll move on.

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

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

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

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

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

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

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

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

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

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

MR. PRICE: No, I do not.

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

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

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

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

Any additional questions on this? Okay.

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

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

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

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

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

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

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

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

Randy, any additional comments?

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

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

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

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

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

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

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

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

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

Jim, do you have any comment?

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

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

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

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

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

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

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

MR. POWERS: Pardon me, Jack?

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

MR. POWERS: An item could be

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

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

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

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

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

MR. GROBE: I found it

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

MR. PRICE: Are there any additional questions?

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

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

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

MR. PEARCE: Thank you, Clark.

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

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

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

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

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

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

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

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

Here is the Root Cause. FENOC Nuclear Safety

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

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

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

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

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

There are also in the preliminary conclusions some

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

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

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

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

resolved.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

induced corrosion issue for the containment vessel, and documented that earlier in the containment inspection.

Untimely corrective actions for previously identified Corrective Action Program weaknesses. You've heard Lew talk about the Corrective Action Program and what they found during the program review. This was actually documented well before that. Quality Assurance Organization had written condition reports demonstrating some of the same weaknesses found in the condition, in the Program Action Reviews.

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

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

MR. PEARCE: Which ones?

MR. GROBE: The two unacceptable performances?

MR. PEARCE: Yes, sir.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. MYERS: Assistance.

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

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

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

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

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

now, looking at some of the engineering products, for instance; and using that to help build the standards up.

And personally, myself, I'm a line person, my whole life, and now in quality assurance, and I've got a background in operations; and I can help us raise our focus on operational performance and not just meeting program requirements.

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

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

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

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

pollenization from people of other sites to the Davis-Besse Plant?

MR. PEARCE: Yes, we do.

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

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

MR. MYERS: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

Maybe I missed the question. Did I miss it?

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

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

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

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

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

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

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

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

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

understanding of this, and reaction.

MR. MYERS: Thank you.

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

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

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

With that, Bob Schrauder.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Next slide shows preparation for the opening. We

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

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

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

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

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

That's where the head replacement has come to.

MR. MYERS: Let's move on to

containment if it's okay. Randy.

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

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

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

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

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

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

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

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

We've removed the seal plates.

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

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

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

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

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

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

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

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

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

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

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

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

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

our walkdowns this week.

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

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

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

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

the support mechanism for the polar ring.

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

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

Any questions?

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

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

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

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

MR. MYERS: Okay.

MR. GROBE: Lew?

MR. MYERS: We're ready to go.

MR. GROBE: Yes.

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

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

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

community.

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

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

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

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

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

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

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

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

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

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

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

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

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

What do you think they said, Mr. Myers?

MR. MYERS: I think they

believe we will get them out of the problem.

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

MR. MYERS: I believe that.

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

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

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

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

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

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

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

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

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

MR. MYERS: Yes.

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

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

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

MR. POWERS: Sure.

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

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

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

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

MR. FAST: Our plant includes

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

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

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

MR. FAST: We absolutely agree.

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

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

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

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

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

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

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

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

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

MR. JOHNSON: Okay, thank you very much.

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

MR. GROBE: Thank you. Jon.

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

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

(Off the record.)

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

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

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

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

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

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

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

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

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

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

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

Next slide.

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

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

Next slide.

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

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

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

Next slide.

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

Next slide.

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

Okay.

MR. GROBE: Okay, thanks Doug.

At this time, I would like any local public

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

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

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

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

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

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

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

I think that a breakdown of that type of figure

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

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

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

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

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

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

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

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

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

communications, procedures and all sorts of different things.

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

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

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

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

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

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

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

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

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

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

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

MR. GROBE: I believe that's correct.

MR. WHITCOMB: Thank you.

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

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

I believe that the NRC and the utility, First

Energy, are on a collusion course for disaster.

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

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

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

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

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

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

I am concerned about this reactor vessel. I am

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

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

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

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

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

MR. GROBE: So does mine.

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

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

I would like to know how I can get this in hand. And I don't want to hear file a Freedom of Information request, because clearly you stonewall everyone who does. And, I need to do my own root cause analysis, because I frankly don't have any faith in the NRC and I have less faith in the utility to come clean with what's going on.

So, how did I get that in hand?

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

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

MR. GROBE: No.

MR. KEEGAN: I want to review that.

MR. GROBE: It's not required to be submitted. When we do our inspections of the root cause report, we'll certainly be evaluating some of that. It's volumes and volumes of information available on site, but it's not available to the NRC in our office, and it's

not a public document.

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

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

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

MR. GROBE: I appreciate your point of view.

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

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

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

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

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

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

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

Bill?

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

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

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

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

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

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

MR. GROBE: Good. Go ahead.

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

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

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

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

There is a generic approach to all of this work that

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

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

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

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

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

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

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

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

Thank you.

MR. GROBE: Good, thank you.

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

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

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

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

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

MR. WHITCOMB: And --

MR. HOLMBERG: It ended on July 25th.

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

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

MR. HOLMBERG: Yes.

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

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

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

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

MR. WHITCOMB: Thank you.

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

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

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

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

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

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

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

Did you have another question?

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

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

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

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

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

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

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

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

and their evaluation of the quality of work product.

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

MR. WHITCOMB: But I am correct in assuming that, my concern is the concern of the NRC as well, and you're expecting that they will have something in place before --

MR. GROBE: It's on our checklist, Howard.

MR. WHITCOMB: Okay, it's on your checklist. I didn't, I didn't see it on the checklist, Jack, but okay. Thank you.

MR. GROBE: Other members of the public that have questions or comments?

Okay. Very good. We're going to be back here at 7:00 this evening, and make an opportunity for feedback from folks that were here this afternoon, want to come back; or folks that were unable to be here this afternoon.

Thank you very much.

And please, take an opportunity to provide us feedback on our feedback forms. Postage paid. Just fill them out and send them back to us.

Thank you very much.

(Off the record.)

CERTIFICATE

I, Marie B. Fresch, Registered Merit Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified therein, do hereby certify that the foregoing is a true and correct transcript of the proceedings as taken by me and that I was present during all of said proceedings.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Norwalk, Ohio, on this 28th day of August, 2002.

Marie B. Fresch, RMR

NOTARY PUBLIC, STATE OF OHIO
My Commission Expires 10-9-03.