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5 DAVIS-BESSE NUCLEAR POWER STATION

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7 SAFETY CULTURE AND SAFETY CONSCIOUS

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9 WORK ENVIRONMENT

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13 Open Meeting

14 January 30, 2003

15 10:00 o'clock A.M.

16 801 Warrenville Road, Lisle, Illinois

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1 PRESENT FROM NRC REGION III:

- 2 MR. JACK GROBE
- MR. JIM DYER
- 3 MR. DAVID HILLS
- MR. DAVID PASSEHL
- 4 MS. CHRISTINE LIPA
- MR. GEOFF WRIGHT
- 5

6 PRESENT FROM NRC HEADQUARTERS (via videoconference):

- 7 MR. BILL DEAN
- MR. TONY MENDIOLA
- 8 MR. JON HOPKINS

9
PRESENT FROM FIRST ENERGY:

- 10 MR. ROBERT SAUNDERS
- 11 MR. LEW MYERS
- MR. BILL PEARCE
- 12 MR. RANDY FAST
- MS. CONNIE LINCOLN
- 13 MR. FRED GIESE
- DR. SONJA HABER
- 14 MR. DAN BRINDLEY
- MR. RANDY PATRICK
- 15 MS. KATHY FEHR
- MR. DAVE ESHELMAN
- 16 MR. TIM RIDLON
- MR. STEVE FRANTZ
- 17 MR. PAT NORDEN

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1 MS. LIPA: Welcome to FirstEnergy and to members
2 of the public. I'm Christine Lipa, and I am the ~~grounds~~
3 branch chief in NRC Region III, which is here, and I
4 have responsibilities for the NRC inspection program
5 at Davis-Besse, and I'm also a member of the
6 Davis-Besse oversight panel, and I'll go through the
7 rest of the introductions of the NRC table here.

8 To my left is Geoff Wright, and he's a
9 team leader and a lead inspector, for the management
10 human performance area. To my right is Jack Grobe.
11 He's a senior manager in the Region III office, and
12 he's also chairman of the oversight panel. To his
13 right is Jim Dyer, and he's the regional
14 administrator here in Region III. And to Jim's right
15 we have Dave Passehl. He's a project engineer for
16 Davis-Besse. And to Dave's right we have Dave Hills.
17 He's a branch chief in our ~~mechanical~~ ~~chemical~~ engineering
18 branch here in Region III.

19 We have some panel members
20 participating by videoconference. We have Bill Dean.
21 He's a deputy director of the division of engineering
22 in NRR, and he's located in Rockville, Maryland, and
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1 he's the vice chairman of the oversight panel. Also
2 we have Tony Mendiola, and he is a section chief
3 responsible for licensing actions. Also Jon Hopkins,
4 and he's the specific NRR project manager in
5 headquarters for the Davis-Besse facility.

6 Here in the region we have other
7 folks. We also have Victoria ~~Mittin~~ Mitling, public affairs,
8 and John ~~Strassma~~ Strasma, public affairs. And I also wanted
9 to acknowledge public officials. I know I saw Jerre
10 Witt. Any other public officials here in the room?
11 Or at headquarters?

12 Okay. What I had was a one-page
13 agenda and I'll just go through for everybody's
14 benefit. The plan is to go from ten 'til noon, break
15 at noon for about an hour for lunch, regroup at one
16 o'clock, and then finish up at three o'clock. And
17 all these times are in Central Time.

18 And the purpose of today's meeting is
19 to discuss FirstEnergy's plans and efforts on
20 improving and assessing the safety culture and safety
21 conscious work environment at Davis-Besse. For folks
22 that have been following the Davis-Besse vessel head
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1 issue, you may be aware of other meetings, such as an
2 August 15th public meeting that we held here in
3 Region III where we discussed the management and
4 human-performance-related root causes on the head
5 corrosion; and some specific root causes that
6 FirstEnergy identified were a less-than-adequate
7 nuclear safety focus, focus on production over
8 safety, minimal compliance with regulations,
9 inadequate implementation of several programs, and
10 diminished rigor in assessing issues for the
11 potential impact on safety.

12 So that meeting was then followed up
13 by a meeting on September 18th that we held at the
14 Davis-Besse facility, another public meeting, where
15 FirstEnergy described their management and human
16 performance improvement plan. And during that
17 meeting the licensee presented the results of a
18 survey that the utility had performed to assess the
19 safety conscious work environment. Since that
20 meeting a portion of each of our monthly public
21 oversight meetings that we hold near the Davis-Besse
22 facility, a portion of each of those meetings has
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1 focused on the initiatives that the licensee has
2 taken and is taking to improve nuclear safety
3 culture.

4 Today's meeting is an important step
5 in the panel's assessment of licensee performance and
6 the plans that they have to improve the safety
7 culture at Davis-Besse. We also have three special
8 inspections that will cover this area. Today's
9 meeting is open to the public, and the public will
10 have an opportunity before the end of the meeting to
11 ask questions of the NRC. This is considered a
12 Category I meeting, in accordance with the NRC's
13 policy in conducting public meetings. Before the
14 meeting is adjourned, there will be opportunities for
15 members of the public to ask questions of the NRC or
16 to make comments for the record.

17 We are also having this meeting
18 transcribed to maintain a record of the meeting. The
19 transcription will be available on our Web page
20 several weeks after today's meeting. So it will be
21 important during this meeting that all speakers use
22 the microphones and be sensitive to the fact that we
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1 have people videoconferencing with us from
2 headquarters. We also have a number of folks that
3 have called in on the bridge lines that are
4 participating that way.

5 In the foyer on the way in we had the
6 brief agenda for today's meeting, handouts that
7 Davis-Besse brought with them, and we also have
8 public meeting feedback forms; and those feedback
9 forms will help us to make these meetings better. So
10 any members of the public or participants in this
11 meeting feel free to fill out a feedback form and
12 provide your comments to us.

13 Next on the agenda I'll turn it over
14 to you, Lew, and let you introduce your staff and
15 begin your presentation.

16 MR. SAUNDERS: Thank you, Christine. Bob's in
17 charge today, trying to help Lew out a little bit.
18 But I'm Bob Saunders, president of FirstEnergy
19 Nuclear Operating Company, and I would like to
20 introduce the table here.

21 To my right, of course, is Lew Myers,
22 our chief operating officer and also serving in the
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1 capacity as vice president for Davis-Besse. Next to
2 him is Bill Pearce, our vice president of oversight.
3 And beside him is Randy Fast, our general manager at
4 the Davis-Besse plant. Next to Randy is Connie
5 Lincoln, a consultant in human relations working for
6 us. Next to her is our new member, I would say, Fred
7 Giese, who is our manager of human resources. And
8 next to him is Dr. Sonja Haber, who is consulting
9 with us on human performance issues and measurements.
10 And I believe next to Sonja is Pat ~~McCluskey~~ McCloskey, our
11 manager of licensing.

12 We also have some other folks in
13 attendance here, not at the table. I would like to
14 introduce them as well. Todd Schneider, our manager
15 of public relations. Where are you, Todd? Stand up,
16 please. As I call each of you, please stand up and
17 be recognized. Randy Patrick, an operational shift
18 manager; Dan Brindley, a mechanic; Pat Norden,
19 another mechanic; Tim Ridlon, of our engineering
20 organization; and Kathy Fehr and Kevin Spencer. And
21 you already acknowledged that Jerre Witt is here.
22 Jerre does not work for us, but Jerre is a member of
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1 our restart oversight panel. So we're certainly
2 pleased to see Jerre here today.

3 MS. LIPA: Bob, if I could interrupt for a
4 moment, if you could pull the microphone a little bit
5 closer. I want to make sure that the people on the
6 bridge lines can hear.

7 MR. SAUNDERS: That's as good as I can do. I
8 have just some opening comments. We do appreciate
9 this opportunity to share with you all of the things
10 that we have been busy with over the past many months
11 to improve our safety focus. And believe me, we have
12 been working hard on this, and we also believe that
13 we have made significant progress, so we are happy to
14 share that with you today.

15 The agenda, I'll start off with just a
16 few comments. Then I want to turn it over to Lew to
17 give us a retrospective view, and then Lew and Bill
18 together will walk us through on how we're going to
19 anchor all these changes and ensure we never go back
20 over this territory again. Fred Giese, our new
21 manager of human resources, is going to talk about
22 our Leadership in Action program. Then Dr. Sonja
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1 Haber is going to talk to us about the methodology
2 that we're going to apply in trying to measure this
3 beast, and then Lew and Bill will talk about how
4 we're going to monitor our improvement as we go
5 forward. And then, of course, I'd like to conclude.

6 What we'd like to accomplish today, we
7 want to underscore that we are totally committed to
8 nuclear safety. There is no other way to have a
9 nuclear program than to have one that has a total
10 commitment for nuclear safety. We want to update you
11 on the progress that we've made on our safety culture
12 and safety conscious work environment, and we think
13 that the progress is significant. And then, of
14 course, lastly, we want to hear back from you exactly
15 what your thoughts are.

16 So our commitment starts with our
17 board of directors, and the board passed a resolution
18 last year recognizing the company's responsibility
19 for public safety and health in the operations of its
20 nuclear facilities and that safe nuclear operations
21 are a first and a foremost importance. And Jim, I
22 want to give you that resolution. Todd, would you
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1 give that to Jim, please? And that's a signed copy
2 to attest to its originality. But I think that sends
3 a very strong message that this corporation is very
4 serious about the operation of its facilities. And
5 that's not something I went on bended knee and begged
6 the board to do. That was spontaneous from the
7 board. I think that makes it all the more
8 noteworthy.

9 And let me tell you, our board is
10 fully engaged and I report to the board, the full
11 board, every meeting; and the board meets monthly,
12 with the exception of one month, I think, in July
13 they don't meet. Otherwise, I report to the board
14 every month. And of course, the major topic is
15 Davis-Besse and the progress that we are making, but
16 then they also want to know how the other facilities
17 are operating as well.

18 We have a nuclear committee of the
19 board and I'm going to tell you, they are also fully
20 engaged. It's chaired by Mr. William Conway. I
21 don't know if you know Mr. Conway or not. He has
22 probably 40 years of nuclear experience, plant
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1 manager of INPO. He retired from Palo Verde,
2 ultimately. So he chairs the nuclear committee, and
3 he visits all of our ~~cites~~ sites on a regular basis, and
4 recently we have had the full nuclear committee at
5 Davis-Besse and just recently at Perry. So they are
6 well engaged. They're very credible individuals, and
7 they challenge us and challenge us well.

8 Next is our chairman and CEO's
9 commitment. Pete ~~Burke~~ Burg has been to Davis-Besse three
10 times last year since March, and you think this is a
11 man over a \$14 billion utility, and he has made the
12 time to get there three times and talk to all of the
13 people at the station. And the message that he
14 drives is safe nuclear operations require an
15 unrelenting, uncompromising commitment to safety, and
16 he has personally delivered that message. And I
17 think that speaks very highly of Pete's commitment.

18 And the other thing Pete says and says
19 quite well is that the highest levels of productivity
20 are meaningless -- meaningless -- if they're not
21 achieved with a strong focus on safety. Those are
22 Pete's words; and when he delivers them, he is
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1 sincere. And believe me, I just agree with him
2 totally.

3 Next is me, and I've always believed
4 that there's only one kind of nuclear program, and
5 that's one that strives for excellence. In the short
6 time I've been here, our vision has been excellence.
7 That's our nuclear vision. And excellence, the
8 gateway to it is safety. If you don't have safety,
9 you can't get through the gate. We know that.
10 That's why we are committed to safety.

11 Next is the FENOC organization. And
12 prior to March of 2002, I had three site vice
13 presidents and myself, and it was only I that
14 reported to the board of directors. The events
15 following March showed us that this organization just
16 was not acceptable. So since then we have made Lew
17 our chief operating officer and we have made Bill
18 Pearce our vice president of oversight and we have
19 added Gary ~~Lidick~~ Leidich to our ranks from the Institute of
20 Nuclear Power Operations as an executive over
21 engineering. This represents a substantial amount of
22 experience and successful, many successful years of
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1 nuclear operation. I think it's a very strong team,
2 and a team that's definitely committed to safe
3 operations.

4 Bill reports directly to me in his
5 oversight role, and he also reports directly to the
6 board of directors. And that's a nuance that we
7 believe you won't find, I guess, in many other
8 utilities, but it is with us; and he does so on a
9 regular basis, and we think that's very helpful, and
10 the board also likes it as well.

11 A couple other comments. Pete and I
12 have been to all three sites and we have met with all
13 employees. The message we delivered was safety first
14 and the corporation never wants to sacrifice for
15 production, never.

16 Lastly I'd like to comment on our key
17 performance indicators. Now, these are the
18 indicators that are used to determine what our
19 bonuses are going to be, and we have done a great
20 deal of restructuring of those in response to the
21 criticism we put on ourselves in our root cause
22 evaluation. And Todd, would you hand those to Jim,
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1 please? This is a draft of the percentages of the
2 bonuses, and you'll see that 50 percent of them are
3 to safety, and we think that's a significant change,
4 we're pretty daggone proud of it. That's been
5 reviewed and approved by the compensation committee
6 of the board, and I think once again just underscores
7 our total commitment to a safe operation of the
8 facilities.

9 And with that, I'd like to turn it
10 over to Lew.

11 MR. MYERS: Thank you, Bob.

12 MR. DYER: Bob, before you go any further now,
13 we're going to make copies of this. Is this any kind
14 of propriety information --

15 MR. SAUNDERS: No, sir. Happy to share it with
16 you and the public, whatever.

17 MR. DYER: Okay. We'll make it part of the
18 meeting minutes then.

19 MR. MYERS: It's also the same thing that our
20 employees get, right?

21 MR. SAUNDERS: Yes.

22 MR. MYERS: Thank you, Bob. First I'd like to
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1 take a few moments and talk about somewhat about the
2 background, just refresh us on the background of
3 FirstEnergy and FirstEnergy Nuclear Operating
4 Company. FirstEnergy was formed, FirstEnergy Company
5 itself, November 1997. And at that time it brought
6 together the ownership of several nuclear power
7 plants. In April of 1999, we commenced the
8 transition to take over the operations of the Beaver
9 Valley plant and completed that December 3rd of
10 1999. And somewhere in between we actually formed
11 the FENOC Nuclear Operating Company that's
12 responsible for operating our plants.

13 Root cause report for the reactor
14 pressure vessel heads that we had in our Davis-Besse
15 plant found that management had less than adequate
16 nuclear safety focus. Management team had less than
17 adequate nuclear safety focus. Now, it also found
18 some other things out. First, production focus,
19 combined with minimal actions to meet regulatory
20 requirements, resulted in acceptance of degraded
21 conditions. What does that mean? It means when you
22 talk to the team there, they're always talking about
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1 minimal regulatory requirements rather than industry
2 standards. And in the case of reactor vessel heads
3 and the boric acid programs, we went below that.
4 Davis-Besse, until that time, as well
5 as several other plants, was operated basically as a
6 stand-alone plant. It wasn't until Bob Saunders came
7 on staff as president of FENOC in 2000, that he
8 immediately improved the focus on common processes to
9 try to improve consistency at our plants. It was
10 Bob's first focus area. I know that well. Up until
11 that point, we were basically stand-alone units.
12 FirstEnergy formed, FENOC formed, Bob took over.
13 In February, with degraded head
14 conditions, we identified that Davis-Besse still did
15 not have the same visions, goals and processes as the
16 other two FENOC plants. Stand-alone once again,
17 isolationism. Conditions were identified throughout
18 this reactor head event, though, at a very low
19 level. We went back and looked at our condition
20 reporting system, and we found out that our
21 employees, they're readily identifying CRs. In fact,
22 we've been reviewed by the industry, by the NRC, and
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1 our self-assessments, and our threshold for
2 identification of issues by our employees is
3 relatively low, pretty good. What we found, on the
4 other hand, is the management team was not using the
5 same corrective action process as the rest of us for
6 classifying CRs, the methodology for classifying CRs
7 and then the review and -- the review and root cause
8 analysis were not getting done at the right threshold
9 because of that. So the corrective actions were not
10 proper.

11 From a quality assurance standpoint,
12 we also noted that the quality findings were mixed.
13 You know, quality is sort of reported up through the
14 plant, not independently. The operations group was
15 not in an active role in the plant from an improving
16 material conditions standpoint. They really weren't
17 taking the lead on material. You could see that, had
18 sort of been taken out of the loop somehow.

19 After that, we put into place after
20 the event, our building block plan that we submitted
21 to you in August -- I'm sorry, in June. That
22 building block plan was designed to return the plant
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1 to service, No. 1; and No. 2, ensure sustained
2 operations. That's what it says right in the front.
3 It wasn't designed to be a short-term checkoff and
4 walk away, return to plant service. It focused on
5 all the things we thought we had to focus on to
6 repair the reactor vessel head. First thing we did
7 is we decided to replace it.

8 System performance, we brought our
9 systems down, found tons of problems. We probably
10 have the best benchmark right now of any plant in the
11 country on the status of our systems. You walk
12 outside my office, I've got two bookcases of reports,
13 independent reports on every system -- not every
14 system. On risk significant systems.

15 From a containment health standpoint,
16 we knew that we had boric acid in the containment,
17 but when you walked around our plant inside the
18 containment, the containment was -- it was in good
19 condition when you walked around. It wasn't just
20 falling apart. We did find boric acid in a lot of
21 ventilation systems, but you didn't find boric acid
22 lying around our floors or on our equipment or
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1 anything like that, you know? So we were replacing
2 it, the containment coolers and a lot of the
3 ventilation systems. We took the opportunity to go
4 back and do some painting and do -- fix some
5 long-term problems that we had in the plant. For
6 example, the containment ~~dump~~ sump, that's -- spending a
7 lot of money there, but it has nothing to do with
8 boric acid. The containment ~~dump~~ sump has nothing to do
9 with boric acid. And cooler repairs, nothing to do
10 with boric acid. So the containment health plan was
11 designed to improve the material condition of the
12 containment, period.

13 We developed a restart test plan to
14 test our equipment. And our intention is to heat the
15 plant up shortly, come up, coolant hasn't been
16 operating a year or so; we're going to find some
17 problems, you know. We're going to find some
18 problems with some of the workmanship. But we're
19 going to test our equipment and prove the plant is in
20 good material condition. Then we're going to shut
21 back down and fix anything we need to fix, cool back
22 down, before we start back up.

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1 Our program performance, we sent you a
2 list of all the important programs and we've
3 permatized that process in our self-assessment
4 process now. It's not something that's going to go
5 away. So we will be not only looking at
6 self-assessment from a group standpoint, but from a
7 program and systems standpoint in the future.

8 And then after we did our management
9 root cause -- I mean, our technical root cause, in
10 early May we started -- we put an independent panel
11 together, brought in experts, and had open testimony
12 of that panel -- independent they were -- and put on
13 the table what I think was a very comprehensive root
14 cause that myself and Bob sponsored.

15 Once again, the restart building
16 blocks were not put in place to get the plant started
17 up and walk away.

18 I'd like to talk some about how we're
19 anchoring the changes that we're looking at in our
20 business. Not just at Davis-Besse, but at our other
21 plants also. One of the things that we really
22 focused on that's opened our eyes during this event,
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1 if you will, over the last several months our
2 executives have worked on improving safety focus at
3 our plants, not just Davis-Besse. We have revisited
4 our business ~~plant~~ plan, spent an entire day on that -- I
5 have it with me today -- to ensure that we're
6 providing the right message to our employees. We
7 have the FENOC policy on command and control to
8 ensure that you have managers in charge. That's not
9 a policy for Davis-Besse. It's a policy for all
10 three of our plants. That ensures the proper
11 operational message.

12 We developed a policy and a model on
13 safety culture. You know, if you walked around and
14 asked somebody not long ago what safety culture was,
15 when this event started, you would probably get three
16 different definitions. I'm going to share our
17 definition with you today. But we didn't start doing
18 that last week or last month. These are things we
19 have been working on for months. And the policy and
20 a model of safety conscious work environment that
21 we've taken all three of these documents and we've
22 approved them. We've now trained each and every
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1 person at all three of our plants and in our
2 corporate offices on these documents.
3 I would like to take a few moments to
4 share these definitions. These are FENOC
5 definitions, similar to what you see elsewhere in the
6 industry, but not quite the same. Safety culture,
7 that assembly of characteristics that you find in the
8 organization characteristics and attitudes in the
9 organization that Bob talked about, and in
10 individuals as a result, which establishes an
11 overriding priority towards nuclear safety. And that
12 this ensures that issues receive the attention
13 warranted by their significance, by their safety and
14 reliability significance.

15 And then safety conscious work
16 environment, Bill will share with you later on. But
17 I'll give you the definition. It's that part of the
18 safety culture addressing the employee's willingness
19 to raise issues and management's response to these
20 issues. That's pretty clear and concise. You know,
21 what I've seen in the past is people seem to throw
22 these things all together, and we've sort of
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1 separated out. Really safety conscious work
2 environment is a subset, you know. So that's what
3 we'll be talking about.

4 The next area that I'd like to talk
5 about is the model that we're using in FENOC. As you
6 see, our safety culture model that I shared with
7 you -- Bill's going to do the safety conscious work
8 environment -- consists of three basic safety culture
9 areas, if you will; commitment areas we call them.
10 Inside those commitment areas are competencies.
11 That's the word we're using. Commitment
12 competencies. You should notice that the model
13 consists of these three areas, and I'd like to talk
14 about the first one, policy.

15 The first area has to do with our
16 corporate organization. It ensures that oversight
17 and self-assessment is monitoring the performance of
18 our work on a day-to-day basis. It's not just
19 stand-alone or isolationism, minimum regulatory
20 requirement. That resources are applied. Resources
21 don't mean people. It means time; it means people;
22 it means the equipment to do the job right.

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1 Management values structures is in the
2 business planning process. It provides our vision,
3 our values, statement of policy is clear and
4 acknowledgment of safety as a core value. We've
5 revisited that. I think, you know, I'm really proud
6 of what we've done with our business plan now. I
7 think we've improved it greatly.

8 The second area is the plant
9 management committee area, if you will. How are the
10 plant managers focusing on the business that we want
11 to achieve? When we look at that, we're talking
12 about the following commitments: An emphasis on
13 safety is our priority system that ensures that
14 issues get addressed. Typically, the way we address
15 issues through our corrective action program or
16 employee concerns program. But issues are getting
17 addressed.

18 Some of the problems we found in the
19 root cause area. Acceptance of responsibility. What
20 does that mean? That means that we're taking actions
21 to fix plant problems; not to justify them away, but
22 to fix plant problems.

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1 Qualifications in training. We're not
2 talking about just technical training there. We're
3 talking about the supervisory training, training
4 their supervisor on our Leadership in Action
5 principles; management training, trains our managers
6 and creates the environment in the organization that
7 we want; and finally, leadership training so that we
8 as leaders are looking forward at our fleet and
9 making sure that our fleet has been managed and
10 operated properly.

11 High organizational commitment. What
12 we're talking about there is the people; people's
13 willingness to identify with the organization. You
14 know, you don't want a plant where everybody is
15 walking around saying, you know, "who do you work
16 for?" "Well, I work at the Davis-Besse plant" or "I
17 work over ~~the~~ there at one of the plants" -- but they're
18 proud to work at our plant. What's more important is
19 they're proud to be part of the organization. They
20 understand our vision and can talk about our vision.
21 They understand our vision and they've internalized
22 our values. At our other plants we found our values
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1 were well displayed. When I got to the Davis-Besse
2 plant, I couldn't find our values or our vision.
3 That's not the same today.

4 The third area then you get to the
5 individual himself --

6 MR. GROBE: Lew, before you go on to the third
7 area, just a quick question. To help me understand
8 the difference between high organizational
9 commitment, which I think I understand you to say is
10 the alignment of the people in clear responsibilities
11 and cohesiveness, could you help me understand that?

12 MR. MYERS: Well, one of the things you look at
13 there is things like teamwork between groups. Some
14 of the things we found is, you know -- and the
15 willingness to sit down and get stuff done. We found
16 situations at Davis-Besse where there were backlogs
17 because there wasn't clear alignment of
18 responsibilities and no one was making sure those
19 responsibilities got taken care of, so consequently,
20 backlogs with just closing out some of the
21 paperwork. So that's what we mean there.

22 MR. GROBE: I understand. Thank you.
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1 MR. MYERS: The third area deals with the
2 individual himself. Drive for excellence. Those are
3 nice words, but our employees know that we want them
4 to do the job right the first time. If they need to
5 stop, it's okay to stop. We're going to schedule the
6 benchmark the best we can, but if something is wrong,
7 we want you to stop. We seriously believe that the
8 best way to have good productivity, good reliability,
9 everything else, is to prevent errors. Just stop and
10 do it right the first time.

11 Rigorous work control process. That's
12 performing our activities in a quality manner.
13 That's not really just work control. That's our
14 engineering rigor is there. When we do 5059 reviews,
15 safety evaluations, changes in design basis
16 information, it's also our work control process.
17 It's also our corrective action process.

18 The next area is open communications.
19 What does that mean? We all sit around and talk?
20 No. What it really means is that it's a blame-free
21 environment, that we focus -- we hold people
22 accountable when they need to be held accountable,
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1 but we focus on the situation and we strive to make
2 people nuclear professionals. And that's defined as
3 understanding the safety issues and other issues with
4 the work activity that you're involved with and
5 understanding how to respond.

6 What do you expect to get? You
7 understand that at the prejob briefing, one of your
8 termination criterias, how do you terminate? Very
9 important.

10 Let me spend some time talking about
11 the first area, policy level commitment.

12 MR. GROBE: Lew, before you go onward, the
13 rigorous work controls and prudent action, does that
14 include necessary actions to comply with regulations
15 and follow procedures?

16 MR. MYERS: Absolutely.

17 MR. GROBE: So procedural adherence would be in
18 there?

19 MR. MYERS: Absolutely.

20 MR. DYER: Lew, just a question to reiterate.

21 But I see safety in the policy level commitment, I

22 see safety in the managers' commitment, and I don't
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1 see safety in the individual's commitment. Not
2 overtly. Is there any reason why, or can you
3 explain?

4 MR. MYERS: Well, you know, I think as the
5 individuals do their work every time, they need to
6 understand -- that's in the professionalism area --
7 the safety significance of what you're dealing with
8 and how to respond to that. And that's where that's
9 at. What are you getting ready to do? "I'm getting
10 ready to work on the reactor" or "I'm getting ready
11 to work on the RPS," with the safety significance
12 here. We do these things every day and we're doing
13 calibrations, we're doing tests, operating our
14 systems as a nuclear professional, understanding what
15 you're dealing with and the risk associated with that
16 and the termination criteria, prejob briefing.
17 That's what we're looking at.

18 The first commitment area I'd like to
19 share with you some of the things that we have
20 completed. Policy level commitment. Corporate.
21 This area involves the corporate policies, the
22 management values, the resources, self-assessment,
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1 quality oversight. Several of the actions that we
2 have taken were shared by Bob in this area would have
3 prevented, that would have prevented the root cause
4 of the Davis-Besse issue.

5 Let me tell you what -- the strong
6 actions we've taken to date. We've staffed and
7 implement a strong corporate organization to ensure
8 good quality and ownership of our programs. We used
9 to have programs shared at our plants from an
10 ownership standpoint, and what we found is things
11 that we thought were being -- programs that were
12 identical were not identical. So now we've elevated
13 those programs to a corporate group, owned by the
14 corporate group, and we will be assessing the
15 ownership and that they meet industry standards, not
16 just the minimum plant standard.

17 We've strengthened our self-assessment
18 program. We have a strong corporate group that I
19 will probably use to schedule self-assessment at all
20 of our plants, not only to focus on the way we used
21 to do self-assessments across the board, general
22 area, group self-assessments, but we've built in to
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1 focus on risk significance systems, and programs now
2 versus industry standards. So as we bring teams in
3 and schedule our self-assessments each and every
4 year, we will be focusing on the systems and the
5 program implementation.

6 These actions were supported by our
7 board through the board resolution. Once again, our
8 CEO is very involved. Not only has he been to the
9 plant several times, but he's been to the restart
10 oversight panel board, met with them. Very involved
11 with restart of our plant.

12 We have reviewed our business plan to
13 focus on safety, people and reliability and aligned
14 our values to ensure that the message is safety
15 first. If you look at our new model that's hanging
16 on our wall, we used to have always things in bullet
17 form. Now there's a pictorial form of that, so it's
18 very obvious that safety is our cornerstone.

19 The board and CEO have revisited our
20 incentive program tied to safety. You have a copy of
21 that.

22 MR. GROBE: Lew, before you go on, I was looking
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1 at this document that you had provided us, Bob. It's
2 got a number of acronyms on it, and we will probably
3 be attaching this to the minutes for this meeting.
4 Could I make sure -- would it be okay if I annotated
5 this?

6 MR. SAUNDERS: Sure.

7 MR. GROBE: Okay. The KPI is key performance
8 indicators?

9 MR. SAUNDERS: That's correct

10 MR. GROBE: And then EPS?

11 MR. SAUNDERS: Earnings per share.

12 MR. GROBE: SVA?

13 MR. SAUNDERS: Shareholder value added.

14 MR. GROBE: And MPR?

15 MR. SAUNDERS: That stands for monthly
16 performance indicators. And you're going to see that
17 modified, Jack. It's going to become the nuclear
18 performance indices, NPI. But that's where it comes
19 from is our monthly performance indicators.

20 MR. GROBE: Is MPR monthly performance report,
21 maybe?

22 MR. SAUNDERS: Yes.
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1 MR. GROBE: Okay, got it. Okay. I think that's
2 it. Thank you.

3 MR. SAUNDERS: You're welcome. I wanted to just
4 interject a comment that struck me as Lew was going
5 through. We do have our restart oversight panel that
6 has been meeting monthly, usually the day before the
7 chapter meetings. And Jack, you have been in
8 attendance for those; a couple of them, I know.

9 I want to point out that three of
10 those outside members have met once with the nuclear
11 committee, the board of directors, totally
12 independent from us, and are scheduled to meet with
13 them again this coming month. Once again, totally
14 independent from us. And the three that meet are Joe
15 Kallan, I think who most of you know, Chris ~~Balton~~ Baken,
16 the site VP from DC Cook, and then Jerre Witt, who is
17 with us here today. But I think that's a nice touch
18 that they can go directly to the board and report on
19 how they view this entire Davis-Besse thing.

20 Sorry Lew.

21 MR. MYERS: That's okay. We've broken the tie
22 between the site staff and the quality organization.

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1 Quality assessment now reports to a VP, he reports to
2 our board of directors. That alone would have been a
3 significant change. And we've strengthened our
4 employee concerns program from a program which is an
5 ombudsman sitting in a room waiting for somebody to
6 come visit him, to have an employee concerns program
7 where we're out looking for -- being proactive
8 looking for issues. We've got independent
9 investigators now to ensure confidentiality. And we
10 strengthened the people in that group and we're going
11 to put a permanent person there later on before
12 restart.

13 The next area is the management area.
14 What that has to do with, once again, is with the
15 management team of the plant. We've improved the --
16 we think we've greatly improved the management
17 technical competence at the plant. In fact, if you
18 go look -- put up the slide with the organization on
19 it. If you go to look, there's a total of 24
20 managers that are at our site. There's a total of 24
21 managers at our site. Nineteen of our managers now
22 have technical engineering degrees or other technical
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1 degrees. There's a couple managers, like the manager
2 of human resources, we probably don't think that he
3 needs to have a technical degree, or document
4 control. So 19 of our 24 managers are either degreed
5 engineers, have a degree in chemistry or things like
6 that.

7 The senior management team alone has
8 over 160 years of successful nuclear power
9 operations. There are 15 new managers to the
10 Davis-Besse organization. All but one are new in
11 their position. So if you look at that chart, all
12 but one are in new positions. Now, when we say new
13 in their position, let me be real clear. We're using
14 the 18-month criteria, which includes Randy, so you
15 know. Twenty managers have previously SRO licenses
16 or certifications. So out of the 24 -- we really
17 don't think the guy in charge of human resources
18 needs an SRO. So if you really look like it, it's
19 like 22, and most of them are SROs or SRO
20 certifications. Thirteen of the SRO certifications
21 or SROs are on PWR. We think we've greatly improved
22 the management technical competence of our staff.

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1 MR. DYER: Lew, question in that area. What was
2 it before?

3 MR. MYERS: I didn't bring those numbers with
4 me, but it was considerably less. The number of
5 SROs? We've probably doubled it. Not much
6 operational experience in some of the engineering
7 areas and stuff like that. Corrective action person
8 wasn't an SRO; is now, SRO cert.

9 MR. DYER: Okay, thank you.

10 MR. MYERS: We've strengthened our corrective
11 action program. If you look at our corrective action
12 program, employees who write a CR now get an e-mail
13 back on how we dispositioned that CR. They should
14 know that. Not just it goes to management, some
15 subcommittee team gets evaluated, put in a drawer.
16 Now the charter for the corrective action review
17 board has been changed, and we've strengthened that.
18 It's not a subcommittee any more for doing the CRs.
19 It's the plant manager. He is the manager of our
20 corrective action review board. So Randy chairs that
21 board. He's got the operations manager in there with
22 him and the design engineering manager. So

1 management is very involved with classification and
2 evaluation of the CRs generated.

3 We monitor the accuracy and
4 classification and the board ensures proper
5 classification. First thing is the supervisory. He
6 classifies them. But then we look to make sure that
7 they're properly classified. We have trained root
8 cause evaluators and we are monitoring the quality of
9 these reviews. So all of the root causes are being
10 monitored. And we've actually changed our process so
11 that if it's a root cause, the senior management --
12 if we're putting a team together to do a root cause,
13 the senior management team now reviews that root
14 cause as a team. They bring it in, present it to
15 us. Additionally, as chief operating officer, I
16 select root causes from all of our plants and present
17 them to the nuclear group council. So we can look at
18 similar things across our fleet.

19 We are scheduling management
20 observations on safety-related activities. It's not
21 a little card any more. We're trying to make sure
22 that managers are looking at the important issues, so
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1 if we're out working on a piece of equipment,
2 burned-out valves, ~~decayed~~ decay heat pump, something like
3 that, we schedule management observations.

4 We revised the competence in our
5 appraisal process. As you'll hear Fred talk about,
6 we now have two new competencies that we've added to
7 our Leadership in Action, and the appraisal process
8 we use every year is called Ownership For Excellence,
9 and we have -- the two new conferences are Nuclear
10 Professionalism and Nuclear Safety Conscious in the
11 Work Environment. So those are the two new
12 conferences we've added.

13 The Leadership in Action training on
14 these competencies is being given to our supervisors
15 and managers. We're complete with that. We've
16 assigned new owners and new expectations for
17 engineers for all of our programs. We have
18 established a strong management observation program.
19 We've improved the management observation program,
20 brought it over from the other two plants, so they
21 learn how to use the computerized field observation
22 program at Davis-Besse we had at our other two
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1 stations. And the person that can testify to that
2 the best is Randy. He loves the thing. And we've
3 established a high organizational commitment. We're
4 out benchmarking other plants. Randy will talk to
5 you about that.

6 And the design modifications have been
7 installed to send the right message to our employees.
8 Many longstanding equipment problems will be fixed
9 during this outage. For example, it is not our
10 intent to start back up with any maintenance rule
11 systems that are not in the monitor mode. We will
12 address our reactor and cooling pumps, and since
13 fixed the equipment. We've improved our problem
14 solving and decision-making procedure and new
15 operating procedure. That's being used consistently
16 at all of our sites. We've made a nuclear operating
17 procedure so it's consistent. We're implementing
18 that procedure at our sites. When we find a problem,
19 we expect to bring the best and brightest in, look at
20 our options, and figure out how to go forward and how
21 to write approval through the new improved process.
22 We used that for our test this past weekend, and we
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1 use it every day now.

2 The restart review meetings are being
3 implemented for changes in modes. And that's
4 something that at our other two plants we've always
5 done, and it's new for Davis-Besse. But basically,
6 we work real hard every day to get ready to change
7 modes and move the plant to a different condition.
8 Prior to doing that we sat down after we worked so
9 hard, and said why should we go forward? And now
10 with the restart we created like 180 actions that we
11 put in place. And then we brought in Lincoln
12 Consulting Group to help to us with activities to
13 increase leadership, teamwork and alignment.

14 MS. LINCOLN: Okay. I'll start now. Actually,
15 Christine, do you mind if I turn up the lights? I'm
16 a little blinder than Lew is, and I don't know if
17 everybody can see.

18 MR. GROBE: I resonate with that, Connie. But
19 before we go on, I have a couple of questions, Lew.

20 I was at a meeting recently where we
21 presented the results of a routine ~~resin~~ residnet inspection
22 and asked some questions regarding the status of the
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1 field observation program that you've implemented
2 where you get managers out in the field observing
3 work performance.

4 Could you give me a sense of your
5 characterization of the implementation of that
6 program and how engaged your managers are in the
7 field observations and the coaching of staff?

8 MR. MYERS: Yes. We have -- Randy, do you want
9 to take this one?

10 MR. FAST: I actually have a report, and we did
11 a breakdown in several different areas. I don't know
12 if I'll be answering specific questions. I don't
13 know what specific information you need, but if I
14 provide some of this, maybe we'll open some dialogue,
15 Jack.

16 One of the things we did, we wanted to
17 find out who at what level were writing condition
18 reports as part of our observation program, and we
19 looked at it at the director and vice president
20 level, six percent came from there. Manager or shift
21 manager, 25 percent of our condition reports were
22 written by that group. Superintendents 18 percent;
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1 supervisors, 33 percent; and they have the technician
2 level 18 percent. And we looked at the observations
3 that were done by title. Three percent of those
4 observations were done by director or vice president;
5 13 percent were done by the manager or shift manager;
6 superintendent at nine percent; but most importantly,
7 supervisors, where they really are out in the field
8 monitoring, 53 percent of the observations were done
9 by first-line supervisors. As well through our peer
10 program, technicians did 22 percent of those. We
11 actually have achieved 81 percent overall in 2002 as
12 we implemented this new program. 81 percent of the
13 scheduled observations were completed in accordance
14 with what we laid out.

15 Let me identify some of the areas of
16 observation that really were part of our management
17 and human performance. Safety focus, as we looked at
18 the observations of whether they were saffed
19 (phonetic), that's no action taken, or there was some
20 coaching that took place. Eighty-nine percent were
21 saffed; 11 percent required some coaching.

22 Improvements in standards and decision making was the
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1 same, 89 percent staffed, and 11 percent resulted in
2 some coaching. We looked at prejob briefs and we --
3 of the numbers of observations that we did, we had 24
4 percent of all of our field observations focused on
5 prejob briefs. That's our preparation for the work
6 that we perform.

7 Let me just identify in broad terms
8 some of the things that we identified as strengths,
9 and as well identify some of the areas we identified
10 as weaknesses. Procedure usage, teamwork, ownership,
11 questioning attitude, communications, self and peer
12 check, and the use of as low as reasonably achievable
13 process work observed as strengths and noted on these
14 observations. Weaknesses that were identified were
15 housekeeping, use of personal protective equipment,
16 tool control, ladder usage, lifting and rigging. And
17 we focused most -- a lot of work on our deep drain
18 work. We did 75, I think -- 74, 75 valves,
19 first-off valves from the reactor coolant system, and
20 we wanted to make sure that we looked at all of
21 those. And we, as part of that, we had scheduled

22 awareness, job preparation and tool availability as a
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1 common denominator amongst these deep drain
2 observations.

3 So I wanted to provide at least a
4 capsule of some of the things that we're doing in
5 that arena.

6 MR. GROBE: You obviously anticipated my
7 question and have overachieved.

8 MR. FAST: Let me tell you, Jack, I believe in
9 this program. I honestly think that it is a
10 fundamental key to improving our overall
11 effectiveness. And even if we have to drive our
12 managers into the field so that we can find out what
13 the workers are dealing with and how to address the
14 issues that they deal with, then that's the behavior
15 that we expect. And this program gives us very
16 definitive information about who's monitoring and
17 what are the actions that are being taken.

18 MR. GROBE: Okay, good. Thank you. I believe
19 -- I apologize for not remembering all of the names
20 of the folks that you introduced, Bob, but I think
21 there's a senior reactor operator in the gallery,
22 right?

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1 MR. SAUNDERS: Yes, there is.

2 MR. GROBE: Could we get that microphone to work
3 over there.

4 Could you introduce yourself first?

5 MR. PATRICK: I'm Randy Patrick. I'm an SRO on
6 operating crew No. 5.

7 MR. GROBE: Thank you. How long have you been
8 at Davis-Besse?

9 MR. PATRICK: I've been at Davis-Besse since
10 June of 1980.

11 MR. GROBE: June of 1980. How were you selected
12 to come here today?

13 MR. PATRICK: My manager asked me. He said a
14 group of people of Davis-Besse people are going up to
15 Chicago. He asked if I wanted to come along. That
16 was on Monday.

17 MR. GROBE: Do you have any idea why he asked
18 you?

19 MR. PATRICK: I assumed it was for waiting in
20 the wings in case a question came up.

21 MR. GROBE: One did, by the way.

22 MR. PATRICK: Possibly it's just to, questions
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1 asked, just tell the truth and tell what I feel about
2 what's been going on concerning safety conscious work
3 environment.

4 MR. MYERS: Let me answer that question. Randy
5 and I are the ones who decided to bring some people
6 with us. You know, the real thing that drove that is
7 one thing is we might want to ask some questions.
8 But the thing that drove it more than anything else
9 is our people should be here with us hearing what
10 we're telling the regulators and the world. And it's
11 unfair, so we decided to bring a few with us. And
12 they were sort of -- I didn't really know who was
13 coming until the day I left.

14 MR. GROBE: Very good. Have you noticed a
15 change in the operational focus at the plant?
16 Specifically, I'm interested in Lew had articulated
17 that one of the changes in the technical competencies
18 in his management team is that there's much more
19 operational training and experience.

20 What's your reaction to that? What
21 positives and negatives have you seen in the
22 management cognizance of operational performance?

1 MR. PATRICK: I've seen a big improvement. It
2 makes a difference with myself. I can go to
3 management and I can talk how a senior reactor
4 operator talks. I can explain things the way I'm
5 used to explaining things. I can say here's what's
6 happening in the plant, and he understands. I don't
7 have to go through and I don't have to say, "well,
8 here's how this works and that goes over here," and
9 it makes it a lot clearer communications between
10 myself and that manager. And they understand if I
11 have a concern. "Here's what my concern is. And
12 here's why it's my concern." They say, "Yeah, that's
13 right. I was an SRO too. I know what you're talking
14 about," and they have a better feel for what it is
15 that we have to do to correct it.

16 Does that answer your question?

17 MR. GROBE: Yeah, it does. Thank you very
18 much. I think we have a mechanic here too, right?

19 MR. SAUNDERS: Two mechanics.

20 MR. GROBE: Could you introduce yourself, sir?

21 MR. BRINDLEY: I'm Dan Brindley, master mechanic

22 at Davis-Besse. I specialize in safety valves,
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1 anything in the piping system.

2 MR. GROBE: Okay, great. How long have you been
3 at Davis-Besse?

4 MR. BRINDLEY: Twenty-six years May 2nd.

5 MR. GROBE: As a master mechanic involved in
6 valves, I suspect you were involved in the deep drain
7 work?

8 MR. BRINDLEY: Yes, sir.

9 MR. GROBE: Very good. Did you have the
10 opportunity to do any of the peer observations that
11 Randy was talking about a few minutes ago?

12 MR. BRINDLEY: I was one getting the evaluation
13 sometimes.

14 MR. GROBE: What's your reaction to that
15 program?

16 MR. BRINDLEY: I think it's beneficial. It
17 brings any weaknesses I have within my job and my --
18 how I present things to the tooling and rigging and
19 stuff like that. I think it's beneficial. It can't
20 do anything but help.

21 MR. GROBE: Okay, okay. How does it work? I'm
22 particularly curious about this peer observation
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1 program. How does that work?

2 MR. BRINDLEY: When I was down in the -- when I
3 was in containment, I noticed Mr. Fast was standing
4 behind me unexpectedly, and he was taking a few notes
5 here and there. And some of his friends that were
6 with him, they went around to the different jobs that
7 was going on. They witnessed, I think there was
8 about four to five jobs going at the bottom of the
9 deep rig at that particular time, and they came
10 through and checked us all out, made sure everything
11 was going smooth, and basically, if we needed
12 something to perform our duties better.

13 MR. GROBE: Okay. Very good. Thank you very
14 much.

15 MR. FAST: Jack, let me mention on the peer
16 program, as part of our overall safety program, we
17 have a program called SCORE, which is -- that's where
18 individuals -- and Dan, I don't know if you want to
19 talk, mention anything about our SCORE program. But
20 that's where just a very simple card that identifies
21 some key attributes of working in the field, and that
22 is really used principally by the work force in
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1 identification of good practice or problems that we
2 have. So that's a peer driven -- it's overseen by
3 our plant safety committee, and we do a monthly
4 rack-up of what was provided. We have an award
5 program for good suggestions that are developed by
6 the work force. So that's a subset, we'll say, of
7 our overall observation program.

8 MR. BRINDLEY: The SCORE program is a very good
9 program because somebody could just walk up and see
10 how this rig, for instance, or procedures, adherence
11 and stuff like that. That's what it's usually used
12 for. Other times you can come up and maybe I forgot
13 to put the FNB FME cover on it. They bring that up
14 also. The coat that I wore in here today, I earned
15 that as a SCORE card winner for the month. I brought
16 up the way the industrial safety manual in FENOC, for
17 instance, had us setting regulators was not the
18 proper way to do it, and I questioned it, I brought
19 it up to management; and consequently, the whole
20 manual had to be revised or rewritten. So in that
21 aspect, it worked great.

22 MR. GROBE: Okay. Very good. Thanks, Dan.
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1 Unless anybody else has questions.

2 MR. DYER: I have one for Mr. Myers. Lew, you
3 know, I'm still stuck back in the background on slide
4 seven when you talk about the root cause and the
5 production focus combined with taking minimum actions
6 to meet regulatory requirements, and then you
7 highlighted it in the case of the vessel head you
8 weren't meeting the regulatory requirements. And the
9 part that concerns me -- and it's an overall theme --
10 is that you've talked earlier about your complacency
11 had slipped in since the event in '85 and a lot of
12 the recovery activities that you've done, and you've
13 gotten to this point.

14 And I guess the concern I still have
15 is, you know, the combined with taking minimum
16 actions to meet regulatory requirements. And the
17 regulatory requirements would get you there, would
18 maintain safety. The concern I have is how are you
19 determining whether or not you were meeting
20 regulatory requirements? Was it set by whether or
21 not the NRC caught you and issued you violations, or
22 did you have some other threshold within the
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1 organization?

2 MR. MYERS: What you heard, what that means is
3 we would talk to our management team and they would
4 talk about the regulatory requirements, "we can meet
5 the regulatory requirements." In the case of the
6 boric acid program, that actually got to the point
7 where they justified not meeting the minimum
8 regulatory requirements. But most of the programs
9 we've looked at, they meet the regulatory
10 requirements. That would keep you safe. But for
11 example, we should be benchmarking it against the
12 best industry practices which, you know, I think it's
13 sometimes over and above that. You know, for
14 example, there's a group of motor-operated valves
15 that you need to test to meet the minimum regulatory
16 requirements. What you find out is that's a pretty
17 good way of testing valves, period. And AOV is the
18 same way, that improves the reliability. So you
19 know, there's a difference -- different mind-set in
20 just meeting regulatory requirements and improving
21 the value of the asset. And the other two value
22 assets you have are people and the plant.

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1 If you go talk to our people, what I
2 hear in the 4C meetings is we were willing, and they
3 saw themselves, if you look at over a cycle basis,
4 for instance, was the material condition of the plant
5 improving or degrading? Were the qualifications of
6 the people improving or degrading? And if you look
7 back from the 19 -- started about 1990, we saw a
8 degrading trend, and a degrading trend in the
9 managers that left and technical skills of the
10 managers that we replaced them with, the degrading
11 trend on some of the willingness to let material
12 condition of some equipment operate in degraded
13 conditions, as long as it didn't affect
14 productivity. That's -- for instance, the diesel air
15 system has been a long-standing issue. And what we
16 did is add some dryers on that air system and just
17 change the carbon steel to stainless steel. So we're
18 going to do that. But that's been around since early
19 '90s, and it's not been addressed yet. But at our
20 other two plants, we have dryers already.

21 MR. SAUNDERS: I think it's important to
22 acknowledge, Jim, that we did not meet regulatory
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1 requirements as concerning boric acid inspection
2 programs. And if we had, we probably wouldn't be
3 sitting here today.

4 MR. DYER: But our own lessons learned reviews
5 and that identified that that was an area that we
6 chose basically not to inspect to, particularly
7 concerned with the vessel head and that, and the
8 question I have is this is the case where if the NRC
9 -- if your motivation for your safety culture and
10 that is to avoid the pain of an NRC inspection or
11 violation in that, that's one level as opposed to,
12 you know, meeting the regulations in all areas or
13 above the regulations in all areas --

14 MR. SAUNDERS: Our motivation is to be well
15 above minimum requirements. And like I told you, our
16 vision is operational excellence. We want to be in
17 the top decile for performance, and we can only get
18 there by very strong safety focus.

19 MR. MYERS: You should be regaining margin. One
20 of the things that we assessed is every cycle, are we
21 gaining margin on our equipment, on our core?

22 Another time we're back, did some new analysis that
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1 gave us a ton of margin because of new technology
2 that we have today.

3 What you see is at Davis-Besse was an
4 isolationism. How much benchmarking were we doing in
5 justifying not meeting industry standards? Some of
6 the things -- cavity seals is a good example. We've
7 got cavity seals already. Why didn't we go get one
8 -- if you've ever put one in, you would go back from
9 the cavity seal, you know. Fortunately, I put a few
10 of these in, so now we have a permanent cavity seal.
11 That's going to be a lot better on us in the future.

12 MR. DYER: Thank you.

13 MR. GROBE: Okay, Connie. Thank you.

14 MS. LIPA: For the people that are on the phone,
15 if you could refer to the page that you're on so they
16 can get caught up.

17 MS. LINCOLN: We're on page 15. My name is
18 Connie Lincoln, and I'm with the Lincoln Consulting
19 Group. I have been with FirstEnergy, the nuclear
20 plants, since '97, and I was also involved with
21 efforts at Millstone. So that's sort of my
22 background.

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1 Today what I want to talk about is the
2 strategy and activities to increase leadership and
3 teamwork alignment at Davis-Besse. I can say that in
4 May, when Lew came over from our Beaver Valley plant,
5 we sat down and said, "what are the key leverage
6 areas that we need to focus in on at Davis-Besse to
7 make a difference in teamwork and alignment? And how
8 do we go about doing that?"

9 So in sitting down with Lew and
10 talking through that, we determined there are four
11 key leverage or focus areas that we needed to focus
12 in on. One is the senior management team. As you
13 saw in the slides before, the organization has a
14 whole new leadership team at the top.

15 Second area was the management team.
16 Again, it was a team that there were players going in
17 and out, being moved around. So we had to bring
18 cohesiveness to that layer in the organization, which
19 is the management team.

20 The third area of leverage was our
21 communications. And we have a very good organization
22 within Davis-Besse that takes care of the formal
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1 kinds of communications, but we also need to take a
2 look at what are some of the infrastructures and some
3 of the cross-functional kinds of communications that
4 were happening, and what can we put in place so to
5 sustain having those communications still be there.

6 And fourthly, or the fourth leverage
7 area, was looking at the production organization;
8 and I call that operations, engineering, work
9 management, and RP and chemistry. We need to do a
10 couple things for that to get those organizations
11 working cross-functionally as a team. But we also
12 needed to bring alignment in the organization
13 vertically as we had new players all along, and those
14 were some areas of concern that we needed to do some
15 work in. So that's in working with Lew how we came
16 up with our four leverage areas of what is our
17 strategy in working with teamwork and alignment at
18 Davis-Besse.

19 Let me start with the end in mind
20 here. We're on a journey. You saw that it's a new
21 team. So any time you have a new team, you go
22 through these stages where they're forming, they're
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1 storming, norming and performing. So where we are
2 today I would say is typical of what you would see
3 with a new management team.

4 But let me say something else. I've
5 worked with Lew at Beaver Valley, I've worked with
6 Lew at Perry. Christine can attest to this. So it's
7 not the consultant that comes in and makes the team.
8 It's the leadership team, it's the senior management
9 team, their commitment to teamwork and alignment that
10 is going to drive that. I mean, I can help along the
11 way. We help to set up some of those structures.
12 But it's got to be the commitment from the top team.
13 And I think you can see if you take a look at
14 Perry -- and Christine was there with us -- is that
15 Lew is a proven performer in driving that teamwork
16 and alignment at that organization. The senior
17 management team works well together. The management
18 team is the strongest in our system, and you can see
19 the way they run outages, how cross-functional
20 teamwork happens at the Perry plant is very, very
21 good in comparison to what I've seen in the industry,
22 as well as in other organizations. I think that's our
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1 finest plant. And the thing about Lew is when he
2 leaves, you leave those infrastructures so it is
3 sustained and it continues.

4 Same happened at Beaver Valley, is
5 that -- I mean, we're still working with the
6 management team there, but it's to a person at Beaver
7 Valley, if you go back out and talk with a mechanic,
8 anyone in that organization and you talk about is the
9 senior management team aligned at Beaver Valley,
10 consistently you would have the answer yes. And I
11 can attest to that because I was out in the trenches
12 talking with people, talking with managers, talking
13 to supervisors. So my point to that is I am
14 confident in this team's leadership ability to drive
15 teamwork and alignment at Davis-Besse. They're
16 committed. What they did is bring us in to help set
17 up some of those structures, help them along with
18 that, in their busyness of the days doing everything
19 else, to make sure that we are institutionalizing
20 some of the things in the system.

21 So with that in mind, let me just walk
22 through some of the actual activities that we have
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1 been involved with since May, some of those
2 structures that we've put in place to help ensure we
3 have continued teamwork and alignment at
4 Davis-Besse.

5 The senior management team, we meet
6 with them. Strategy sessions -- that's done
7 weekly -- and one of the results of that is you'll
8 see them walk around Davis-Besse; you'll see they
9 have their senior management team standards and their
10 expectations. They didn't expect the rest of the
11 organization to set what their standards are and
12 expectations until they did it first. So we spent
13 some long hard hours creating that as the senior
14 management team on what's important to us and what
15 can every employee expect to see out of us?

16 We spent some time on that and we do
17 meet weekly and there's been some times where they
18 haven't met, but we are much more strategic, take a
19 look at the big picture, sit back and not get
20 involved in the day-to-day operations, but look at
21 the big picture. Where are we trying to go, and how
22 do we need to get there? So that's what we spend our
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1 time on with the senior management team strategy
2 sessions.

3 Also we spend time developing them as
4 a team. Because again, although Lew and each of the
5 team members have worked with one another at
6 different plants, it's a new dynamic when you bring
7 them together in this situation. So we spent some
8 time in working with them around group dynamics and
9 getting their relationships built. Davis-Besse is
10 certainly an organization that will sit back -- and
11 many do -- and say "I'll believe it when I see it."
12 When I see the senior team working well together,
13 when I see the management team working well together,
14 I'll know you're serious about this. I think, and
15 experience will show, that that hadn't been happening
16 in the past.

17 We have manager team alignment
18 meetings. Those are held twice a week. Just
19 recently we've moved those to once a week, and that's
20 a time when the managers get together, they create
21 their own agenda, and they deal with what are the
22 tough issues cross-functionally that we need to make
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1 decisions about? It's not that the senior management
2 team is off making all the decisions. They empower
3 the management team to do that, and they take the
4 ball and they run with it. And I have to give Mike
5 Roder, who is our ops manager, a lot of credit for
6 driving this. Again, it's not the consultant who
7 comes in and makes those things happen. It's having
8 the right players in the right place who can drive
9 those efforts. So Mike Roder, as the ops manager,
10 has stepped up and is doing an excellent job in
11 driving this and working through the agenda items.

12 We do coaching with directors and
13 managers. If you ever talked to Lew, he will tell
14 you that I'm his conscience in the organization. You
15 know what kind of shoes that is to fill. But Lew is
16 very open to feedback and actively seeks mine. You
17 know, at the end of a meeting he'll pull me over,
18 "how did I do? How else can I say it differently?"
19 He talks to me beforehand in going to a meeting, "how
20 can I present this well so I'm understood," because
21 sometimes people are misunderstood when they're
22 sending a message. So we try to help Lew with that,
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1 as well as with the rest of the directors and
2 managers.

3 We have sitewide supervisors and above
4 alignment meetings. Those happen monthly. And each
5 month it's a little different focus. Sometimes it's
6 information sharing. Sometimes it's a dialogue.
7 Sometimes it's actual training where we've done
8 Leadership in Action training or Safety Conscious
9 Work Environment. But we do bring that whole team
10 together, and it's all supervisors and above that
11 attend those sessions.

12 We've conducted transition meetings
13 with all of our managers. As you saw, there are new
14 managers in every position. So one of the things we
15 do to try to quickly integrate them into the system
16 is we do something called a transition meeting, where
17 what we do as the consultant is we go in ahead of
18 time, we interview the incoming manager and then do
19 focus groups and interviews with a cross-section of
20 employees in that area, find out what are the key
21 issues, what are the challenges, what do you want to
22 know about this new manager, what are your hopes and
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1 fears? And then we hold a four-hour team session
2 with the manager and every one of his direct reports.
3 The first part of the meeting is sort of an up front
4 and personal kind of interview, where I conduct that
5 with the manager and ask every question you can think
6 of that you would want to know about a new manager
7 but are afraid to ask. So you can quickly get to
8 know who that manager is, what are their
9 expectations, how do they communicate, do they prefer
10 things in e-mail, how do they want you to dress,
11 what's the best way of talking with them, what's
12 their vision for the new department? And then we
13 also have the opportunity for the two-way dialogue
14 where the employees also share, here's my hopes for
15 you, here's what I'd like you to do, here's some of
16 our concerns that we want you to deal with right
17 upfront. So it sets the stage for two-way dialogue
18 with the manager and his direct reports right from
19 the very beginning. We do that usually within the
20 first six weeks of a new manager taking over a
21 position. We've consistently done that with new
22 managers taking over.

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1 We've created management team meetings
2 to drive restart work forward. It was a couple-day
3 meeting that we had with the managers and the
4 directors in creating our transformational and our
5 transactional organization to get the restart
6 moving. That happened in early fall. We realized
7 that we weren't organized in the way we needed to be
8 and that we needed to share resources, we needed to
9 be clear about our roles and responsibilities in
10 doing the work as well as getting all of the 350
11 items and other things done. And what we saw is the
12 organizations weren't necessarily talking with one
13 another. So we pulled together some sessions where
14 we had that dialogue, we created clear roles and
15 responsibilities, chains of communication, and so
16 that was something that was initiated, again, by the
17 managers and team management team.

18 Being involved in restart readiness
19 meetings. Jack, I know you've sat in on those, you
20 and Christine. Those aren't always easy meetings,
21 but I think you see how they have been really going
22 deep and looking at what are the issues confronting
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1 one another, bringing up the tough issues, asking the
2 tough questions, and that consistently happens in
3 those meetings. We have had RHR assessment. RHR is
4 the name of a consulting firm that -- I don't know if
5 you're aware of; I'm sure you were -- that were
6 brought in to do an assessment of all supervisors and
7 above on their competencies, are they the right
8 people in the right place? And if so, from that what
9 we do is we create developmental plans for each of
10 those people. Now, what we're here to do is to help
11 make sure we provide one-on-one coaching to help them
12 with their development plans, internalizing those,
13 looking for some consistencies around the site, and
14 then dealing with those as a management team within
15 the organization.

16 We're also involved with transitioning
17 from the common process to standardization across the
18 fleet. And that's happening in the total
19 organization. Lew talked about engineering and how
20 we've done our common processes in the past haven't
21 been as effective as we would hope they would be.

22 Say we have a common process and there are some
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1 differences between the sites, now going to be driven
2 from the corporate staff. And we're involved with
3 helping to create that changed management plan so
4 those activities are smoothly disseminated within the
5 organization. So that's really your round leverage
6 point one and two around the senior management team
7 and management team.

8 Next slide, which is page 16. Move to
9 our employee communication and alignment. Again, as
10 I said, we have a very good communication
11 organization within Davis-Besse who does a good job
12 of disseminating information in a big picture on
13 what's happening. But also we wanted to put some
14 other structures in place so employees at any time
15 would have the opportunity to ask questions, get
16 information on a real-time basis; not only from their
17 supervisor and their manager, but also the leadership
18 team onsite. So we have weekly town hall meetings;
19 those are run twice, once in the plant and once out
20 in the building, where it's about a 40-minute
21 presentation on here's what's new, here's what's
22 happened in the last week, here's what's upcoming in
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1 the coming weeks where we have that vision of where
2 we're going, and then also it's a what's on your
3 mind, what do you want to know, what questions do you
4 have, what rumors have you heard, ask anything you
5 want. Sometimes we'll just throw out some questions
6 because we've heard that those are rumors out on the
7 site, and let me tell you what I've heard. So it's
8 an opportunity for two-way dialogue within the
9 organization.

10 Lew has talked with you about these 4C
11 meetings, which are compliments, concerns, changes
12 and communications. That happens on a weekly basis.
13 That information is compiled, it's looked at; when
14 appropriate, changes are immediately made based on
15 recommendations from them. And that is something now
16 that is run through our communications department.
17 We have monthly all-site meetings, which are
18 sometimes they're mandatory, sometimes not. Again,
19 it's a picture of what's coming up, what's been
20 happening, to give people the vision of where we're
21 heading to and what's the important critical
22 activities that are coming up.

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1 We had the reactor head case study
2 training, which, as you know, we took a whole day,
3 stopped all work, and each department in their
4 vertical departments sat down for at least four hours
5 and went through how did we get to where we are?
6 What kind of standards and expectations do we as a
7 team need to put in place so this doesn't happen
8 again, and what do we as a team need to do to move
9 forward so we continue these dialogues and don't get
10 back here.

11 We have our restart overview panel
12 sensing sessions. There's been a couple of those
13 that have happened where Jerre Witt and Buzz Carnes
14 -- Jerre and Buzz, where they requested a random
15 selection of employees from supervisors on down,
16 cross-sectional groups, where they would hold like
17 five or six sessions of employees, have an open
18 dialogue on tell me what's on your mind, what's going
19 on, what about our safety culture here, what about
20 safety conscious work environment, are you afraid to
21 go to your boss, and compiled that information, fed
22 it up to the senior management team and the
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1 management team and then actions were taken as part
2 of that. Another effort of communications and to
3 keep people informed and pulsing the organization
4 what's going on.

5 Other site-driven activities, we have
6 staff meetings. Those weren't necessarily happening
7 before with the manager and with the supervisors. We
8 have safety conscious work environment meetings and
9 training that's occurred. We have our daily focus,
10 which any employee can go on on-line and take a look
11 at what's happened in the last 24 hours, what's
12 critical path for the next 24 hours, and what are key
13 accomplishments that we've done on site? We have our
14 on-line newsletter which comes out monthly, as well
15 as we have the restart Web page that anyone can click
16 on and find real-time information.

17 So our intent in setting up some of
18 these structures -- and again, in each department
19 they do it differently. In engineering they have
20 some breakfast meetings, they have lunch meetings.
21 Those happen every other week with a random group of
22 people who want to come and ask questions and see
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1 face-to-face the director. So we've tried to set up
2 several different structures for the opportunity to
3 have dialogue and two-way communication within the
4 organization.

5 On to the next page, which is really
6 our fourth area of leverage, which was that
7 production team that I talked about, and paying
8 attention to these four organizations needing to
9 cross-functionally communicate and understand what's
10 going on in each area and problem solve together,
11 versus inner silence, as well as create vertical
12 alignment in each of those organizations because we
13 had new managers at the top of those, as well as a
14 new director who was responsible for those areas. So
15 we needed to bring about the alignment in the
16 organization. And we did that overarching with our
17 management and human performance root cause.

18 You'll find -- as an addendum in that,
19 you'll find organizational and leadership plans that
20 were specifically developed for each of those areas.
21 And how those were developed were with the director,
22 with the manager and a cross-section of employees in
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1 that vertical department who came together and said
2 what's going well, what's not going well, and what do
3 we need to do differently? And how we collected that
4 data is we did focus groups and interview in those
5 areas on what are the key issues, we fed it back to
6 this team, and then that team created specific action
7 plans for their department on what we need to do to
8 move forward. And those are being looked at, those
9 are being worked. We have consultants who are
10 assigned to each of those areas who are working with
11 the managers and directors.

12 And again, just some of the other
13 things on there, just talking about some of the other
14 interventions that are under those leadership plans
15 that we've done. We consistently sense and pulse
16 organizations. You won't find us at a desk at a
17 computer. You'll find us out in the site talking
18 with people all the time, what's up, what's going on,
19 what's happening. And oftentimes we are just
20 involved in the crisis of the moment or the stress of
21 the moment as you can imagine, when the organization
22 is going through the amount of change that we are and
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1 the stress and the work hours that people are on,
2 we're going to help deal with that in any way that we
3 can.

4 Okay. So I get done with all that and
5 what I say, and what I would expect you to say as
6 well, is "well, so what? That's nice. You've talked
7 about what you've done, put some things in place, but
8 what's some evidence that you can show us on this
9 soft issue of teamwork and alignment that we're
10 making some progress and that we're -- that what
11 you've done and what the senior leadership team has
12 put in place is making a difference?"

13 Let me go through a couple examples.
14 We have active involvement in plant work activities.
15 You've heard about our management observation, I've
16 told you about the meetings that we've had. The
17 managers and the directors are out in the plant with
18 their work team. Now, I can say -- and you'll find
19 this, what we've found consistently in our 4C
20 meetings and in the ROP meetings, "I never see my
21 manager." And that in some ways is true. They are
22 in a lot of meetings because they are trying to
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1 develop their cohesiveness this way, and we're
2 working really hard on that in getting them out in
3 the field, out with the work group. But that's an
4 area that we still need to be working on.

5 We have cross-functional problem
6 solving and decision-making teams that have had a
7 proven track record. You look at your RSRB. We have
8 two teams that meet daily. Tell me they don't work
9 with some tough issues on the table every day.
10 What's in restart, what's out, what's the best way to
11 approach this? And they have to look at it not only
12 from wearing their own hat as the design engineering
13 manager, but they have to look at it on what's best
14 for the site? So those are some proven activities
15 where you see clear teamwork and alignment, and it's
16 happening horizontally in the organization.

17 We have our restart readiness
18 meetings. Those were pretty painful, but I can tell
19 you it wasn't a bad pain. It was a good pain because
20 we got the tough issues on the table. Lew said
21 there's 180 actions. And people had to come and look
22 eyeball to eyeball and say why am I ready to
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1 restart? And it wasn't always comfortable to hear
2 that you're not ready or you need to do this or that,
3 but I can tell you -- and Jack sat in on those --
4 there was some healthy debate. And that debate was
5 expected in that team, and we certainly got it.

6 We've had mode restraint meetings,
7 and that was an effort that was led up by Mike Roder,
8 where we had that production team, the
9 cross-functional team who sat down and looked at all
10 the mode restraints and said what do we need to do to
11 get to mode six? So it was that cross-functional
12 team who initiated that moving first and looking at
13 that before we got to our restart readiness
14 meetings. Again, I just can't emphasize enough the
15 role that Mike Roder has stepped up in really leading
16 the management team at Davis-Besse.

17 They had to do -- and just when I put
18 contractor reduction, that's just another example of
19 one of the outcomes that the management team had to
20 wrestle with is how do we, to meet budget and look --
21 how do we reduce some of our contracts? We need to
22 move that work over to our employees who are there
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1 all the time. How do we go about doing that? And
2 again, they had to wear the hat of the manager on
3 site and the leader on site, versus their individual
4 area in taking a look at where do we need to reduce,
5 who may need to shuffle some players because we need
6 more help in the outer organization than we need
7 here. So it was tough meetings, but the team came
8 together and made those decisions.

9 I think RHR assessment reinforced the
10 caliber of our leadership. We've made any changes
11 that we needed to make, but the players who were in
12 their position are the players who will be in their
13 position. They're competent and proven and with
14 developmental plans and actions that will set forth
15 as moving forward, you'll see that those are the
16 right people in the right place who have the
17 capability of aligning and developing teamwork within
18 their organization and working cross-functionally.

19 Lastly, I just want to end with
20 employee testimonies. As I said, we're out in the
21 plant. We talk with people all the time. We are in
22 these meetings, so sometimes unsolicited, sometimes
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1 solicited, we say, "well, okay. So what's different
2 here at Davis-Besse? Give us some examples of what
3 you see different." You get your mixed reviews, but
4 I can tell you that people say that it's a different
5 leadership team. "We see the difference. It feels
6 different here. I don't have any hesitancy in
7 bringing up issues," and that you hear that from our
8 managers, if you talk with them, as we constantly do
9 about how are you functioning as a team? It's
10 different than it was before. You know, as I said,
11 we're on a journey. They're working well together
12 now. Same with supervisors and same with our front
13 line staff. Any questions?

14 MR. MYERS: I was listening to Connie talking.
15 This is not a question I've shared with her, but it
16 sort of came up. If you look at working -- you
17 worked with Bill ~~Ganda~~ Kanda at our -- and the senior
18 management of Perry plant, also at our Beaver Valley
19 station, was there a -- you had the opportunity and
20 worked some over here at Davis-Besse prior to the
21 event. Was the relation -- did you see a difference
22 in the way you were utilized at the --
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1 MS. LINCOLN: Yes. And there was clearly, I
2 would always say, there was clearly a difference in
3 the management team's ability to work together. As I
4 said earlier, I thought Perry was the strongest
5 management team. Then actually I would go to Beaver
6 Valley. That's because they had a strong aligned
7 senior management team there. The management team
8 was coming along, but they were willing to talk about
9 the tough issues dealing with those things.

10 Then we went to Davis-Besse. We did
11 an assessment of just November of last, and took a
12 look, and we had the managers. It was a culture
13 survey that we did with the managers and senior
14 management on how well are we functioning together?
15 And the concrete data is we came out, and they
16 weren't. And their desired organization on how they
17 wanted to work together compared to how they saw
18 themselves today was diametrically opposed with where
19 they were and where they wanted to be. So they
20 weren't a cohesive team.

21 MR. GROBE: I sometimes lose track of time. Was
22 that November of '02 or November of '01?
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1 MS. LINCOLN: November of '01.

2 MR. MYERS: Okay. Thank you, Connie. Any
3 questions?

4 MR. PASSEHL: Yes, I have a question. You
5 talked a little about your management observation
6 program, field and training observations. How do you
7 integrate that with your formal corrective action
8 program? If they identify an issue in the field do
9 you write a condition report, or is that something
10 separate?

11 MR. MYERS: We actually -- if you need a
12 condition report, and you're a manager in the field,
13 you write a condition report. So if you find a
14 condition, you write a condition report. You don't
15 write a -- so as part of the management observation,
16 if you find a condition, you write a CR. But a lot
17 of times we find things where, coaching, you know,
18 prejob briefs, things like that, where we saw they
19 weren't doing, we'd write a CR. But if coaching is
20 involved, we're not, you know. But it could result
21 in a CR.

22 MR. FAST: It's incorporated in the observation
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1 program, so you have to ask -- you have to actually
2 ask that question is this something that then
3 requires a condition report because it requires some
4 action or follow-up? So if it's a coaching in the
5 field for a behavior, it doesn't require a condition
6 report. However, if we found a process problem that
7 needs to be documented and then formally corrected,
8 we could use a correction report.

9 MR. PASSEHL: Thank you.

10 MS. LIPA: Just to follow up a little bit more
11 on Dave's question, would the results of your
12 management observation, do you trend those, and does
13 that trend then become entered into the corrective
14 action program?

15 MR. MYERS: We would enter into collective
16 significance. We might enter into corrective action
17 if we saw a negative trend. In other words, we would
18 do that, but look for those trends.

19 MS. LIPA: Have you done any of that?

20 MR. FAST: I don't believe so.

21 MR. GROBE: Bill, do your folks look at the

22 results of the observation program?

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1 MR. PEARCE: That is one of the things that we
2 are looking at overall. But the observation program
3 is, in my belief, is starting to take hold now, and
4 we'll be digging more into that. And truly as we
5 start moving towards core load and some of those
6 things, it's going to give us more of an opportunity
7 to oversee and try to make some tie between behavior,
8 look at why the behavior is like it is. We'll
9 probably look at the observation program and see if
10 it was trying to correct that.

11 MR. WRIGHT: One question here. Oftentimes -- I
12 think it leads a little bit to what you're saying.
13 Oftentimes when a manager is out in the field, if
14 you're with an individual and the manager identifies
15 an issue, sometimes you could end up with two
16 separate pieces. One is the physical condition that
17 the person identified; the second being why didn't
18 the individual I was with identify what I saw? Is
19 that captured in both places? Do you write or put
20 together two documents, one is "I need to fix the
21 piece of equipment that was deficient or the
22 condition that was -- as well as look into why didn't
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1 the individual identify that?"

2 MR. MYERS: Right.

3 MR. WRIGHT: Is that done that way, or how is
4 that handled?

5 MR. MYERS: As part of your management
6 observation, if you found a material condition
7 problem and you identified it you'd note it in the --
8 either write a CR or work request on top of that,
9 whichever document you needed to generate;

10 MR. PEARCE: But Geoff's question, you'd also
11 coach the individual. That's really what it's all
12 about is management out there interacting with
13 employees, setting standards, coaching behaviors.
14 What's significance -- supposed to be significant
15 about the trend program that we've had asked, I think
16 it's an important point, is then you go look for
17 trend and say across the organization do we see --
18 are we having to coach a lot of people that they're
19 not wearing their protective equipment, and those
20 types of issues, and then take some corrective action
21 across the board of that issue.

22 MR. WRIGHT: Thank you.
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1 MR. MYERS: We would mark that as a coach, why
2 didn't the employee do that?

3 MR. DYER: Lew, a question for Connie, a
4 clarification. You referred to the senior management
5 team, the managers, the supervisors and that. Just
6 referring back to the organization chart, on the
7 senior management team, what group of individuals is
8 that?

9 MS. LINCOLN: That's Lew, that's Randy, Bob ~~Shrouder~~
10 Shrauder, Mike Stevens, Jim Powers. Those are
11 directors and Lew.

12 MR. DYER: And the senior management review team
13 is? That's them?

14 MS. LINCOLN: That's the senior management team.

15 MR. DYER: Then the managers are below them?

16 MS. LINCOLN: Right. Those are the heads of the
17 departments.

18 MR. DYER: What involvement would, say, Bill
19 Pearce's organization, the quality oversight, and
20 Gary ~~Lidick's~~ Leidich's organization of nuclear engineering and
21 support, how do they integrate into these reviews?

22 MS. LINCOLN: Well, one is Jim Powers is a
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1 member of the senior management team, so he is the
2 person who is responsible for the engineering
3 organization. So he's directly involved. He is a
4 member of that senior management team. And actually,
5 Bill does attend the sessions with the senior
6 management team, and I can tell you, he brings great
7 value and a different perspective and asking
8 sometimes the tough questions of the conscience of
9 that team. So Bill has been involved to date with
10 the senior management team when we have sessions with
11 that team.

12 MR. SAUNDERS: He's independent. Bill reports
13 to me and to the board.

14 MS. LINCOLN: But we think he adds value so we
15 appreciate his input.

16 MR. MYERS: Okay. So we talked about a lot of
17 things. What you heard, I hope, is that a lot of
18 activities that we have been doing, some of them
19 first part of last year. So we've been taking a lot
20 of actions.

21 And the next area that I'd like to
22 talk about is the final building block that we're
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1 working on, the management committee areas, the
2 individuals themselves. You know, going into this,
3 I've heard a lot of discussion about us compared to
4 other stations and 350 station [other IMC0350 stations]. I feel,
5 from a management standpoint right now, you know, I'm not --
6 I think our strength will be and it will be measured
7 by the relationship between our employees and the
8 managers and the senior management team. I feel
9 pretty good; I'm a pretty seasoned manager. And
10 Connie was talking about our directors. Our
11 directors are all seasoned. They're all seasoned
12 managers, seasoned leaders. There's some basic
13 differences that I feel -- I'm not afraid to walk
14 into the shops and I'm not afraid to bring our
15 employees down or you down or anyone down. That's
16 not to say everything is perfect, but we feel good
17 about some of the communications with our employees.
18 That being said, let me go into the employee
19 commitment area.

20 The employee commitment area, first
21 thing that we've done there is we've evaluated our
22 supervisors. We don't have a supervisor in place we
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1 don't believe in. That's not to say that we don't
2 have supervisors that we have developmental plans
3 for, because we do. And the developmental plan is
4 something that we have for all of our supervisors all
5 the time. Some people want us to get SRO licenses,
6 some want us to get other things. We have one guy at
7 the Perry plant working to get his degree. So
8 anyway, so we work on those developmental plans for
9 our supervisors and our managers all the time.

10 We've completed the case study with
11 all of our employees. That's not, "well, we do a
12 case study." That's not what we did. We went over
13 this event in great details and spent half the
14 morning with each and every person assigned. And
15 then we went over the standards in the department,
16 and we also looked at how each and every group --
17 and we did it on a group level -- could have
18 contributed to this Davis-Besse head issue, how they
19 could have prevented it, what could you have done?
20 And at the end of the day, to make sure that we had a
21 clear understanding, we had a test for understanding
22 for each and every employee. So that's the basis
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1 there.

2 We provided the supervisors with
3 refresher training in Leadership in Action. Not only
4 just the supervisors; we've done it for managers and
5 senior managers also. We provided the supervisors
6 training on safety conscious work environment for all
7 of our managers. That's been done. We've
8 strengthened our individual ownership and commitment.

9 Our engineering rigor is not something
10 we started on yesterday. We had an engineering
11 review board in place at our other two plants for a
12 long time. And that's the purpose of that board, is
13 to make sure that the -- it's a quality check to make
14 sure that the quality of the second check, peer
15 check, as you call it, to make sure that the quality
16 of the engineering information that we're putting out
17 is good. We didn't have that at Davis-Besse. We've
18 had that since we created the building blocks.

19 Operability decision making, that's
20 training we've done with our operators and our
21 engineers to ensure that we knew how -- we were

22 teaching operability issues correctly. That's
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1 complete. We trained over 200 people in that area.

2 Operator license responsibility

3 training. That's complete, right, Randy?

4 MR. FAST: Yes -- or the last crew may be done

5 this week, actually.

6 MR. MYERS: I think it is this week. So that's

7 complete with all our operators. Shift manager

8 command and control responsibilities. We've now sat

9 down with all of our employees at all of our plants

10 and at corporate and made sure that everyone

11 understood shift manager's responsibilities.

12 The town hall meetings, the 4C

13 meetings. There were 500 people there. there is an

14 independent person that comes in and meets with the

15 team before I do so if they're afraid to bring an

16 issue up to me, they can bring it up and present

17 their issues as a group. It's not an individual's

18 issues. What's really surprising to me now and a

19 very big change from what I saw when I first got

20 there, is I would come in with this list of questions

21 and go through them. And it was amazing the types of

22 questions, first of all, how they've changed now.

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1 But what's more amazing is people stand up and say,
2 "well, that was my question." I did hear that. Just
3 about every question, you go monitor it in the room,
4 somebody will say, "oh, that was my question." I
5 consider that an important step.

6 Participation in monthly all-hands
7 meetings. We have tried that. We got a lot of
8 feedback, came out of the 4C and town hall meetings.
9 People were getting things out of the newspaper, so
10 what we try to do is when we have a meeting of this
11 type or a public meeting, we're trying to make sure
12 that we communicate it to the employees first. For
13 example, I think the day before we came here, our
14 employees were receiving some information about this
15 meeting.

16 We strengthened our questioning
17 attitude. If you go look at our restart readiness
18 review board meetings, that's something that's normal
19 at our other two sites, but wasn't normal at
20 Davis-Besse. It is now.

21 We have a standard format for prejob
22 briefings that's in place all through our sites now.

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1 And then we've made our decision-making nuclear
2 operating procedure a nuclear operating procedure for
3 the entire sites. And we're using that every day.
4 In my mind, that process, you know, I was here --
5 that process got started at Perry when I was here for
6 an enforcement conference, and it was a systematic
7 way to go through troubleshooting and decision making
8 at our plants when we run into issues. Get a plan,
9 type it up, so it's handed off well, we understand
10 it.

11 The other night we had one where we
12 were looking at an issue we had, and Randy led the
13 team. They came in, 4:30 in the morning they called
14 all of us, the entire senior management team, on the
15 phone, they went through the options. We chose the
16 option. One of options was to do nothing, but that
17 wasn't a good option. We said, "no, not going to do
18 that. It's going to take us two or three days, but
19 we're going to go fix this problem. And here's the
20 most likely candidates," and we went through that.
21 And when we walked away from that 4:30 in the morning
22 telephone call, we had a consistent message on how we
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1 were going to go forward. Decision making is
2 important.

3 Implement our operator leadership
4 plan. That's well on the way, and Randy can talk
5 about that later.

6 Requalification of all root cause
7 evaluators. We took every root cause evaluator and
8 we did qualifications. We've now trained over a
9 hundred people -- retrained. So we have a good core
10 of competent root cause people.

11 With that, I'd like to turn it over to
12 Bill Pearce to talk about our safety conscious work
13 environment.

14 MR. PEARCE: Thank you, Lew.

15 MR. GROBE: Bill, before you get started,
16 it's -- we're about a third of the way through the
17 slides and nearly 50 percent of the way through the
18 time we allotted for this meeting. That's not a
19 hard-and-fast time that we're going to end, but -- we
20 can certainly extend it if that's what's desired, but
21 we do need to take a lunch break. I was just looking
22 over your presentation. It looks to me like you're
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1 going to cover about eight or nine slides. Is that
2 something that you want to do --

3 MR. PEARCE: I think I can do it, Jack -- and in
4 fact, that's what I was going to tell you is I've
5 covered this in a couple public meetings. This is
6 just to refresh everyone today so that we can go over
7 some of the monitoring areas later on in the
8 presentation, so I'm going to keep it at a high
9 level.

10 MR. GROBE: Good. Okay.

11 MR. PEARCE: Thank you. What I want to describe
12 is the safety conscious work environment and how
13 we're dealing with those at Davis-Besse and how we're
14 looking at them, and we've put together this picture.
15 And what it depicts is four columns and -- that
16 support the safety conscious work environment. And
17 it's founded in the basic principles, and of course,
18 those principles are anchored in the Leadership in
19 Action. All supervisors get the training on the
20 basic principles before they can become supervisors.
21 So we know that we've got that in place and it will
22 stay in place.

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1 The four pillars, I'll describe them
2 just one at a time, and then we'll go through and
3 tell you the actions that we're taking.

4 The first pillar is management support
5 and worker confidence, and then the second pillar is
6 the corrective action program or the normal problem
7 resolution process. The third pillar is the
8 alternate problem resolution process or the employees
9 concern program. And the fourth pillar is the
10 methods to detect and prevent retaliation, or the
11 forward-looking issue about safety conscious work
12 environment, and we call it the safety conscious work
13 environment review team. It's a team we put together
14 to deal with that issue. Next slide, please.

15 And the management support and worker
16 confidence column, we've issued a FENOC policy -- we
17 talked earlier about that -- from Bob on safety
18 conscious work environment, what our expectations
19 are. All employees were taught at all three stations
20 on that policy, were trained in the policy. Lew just
21 talked about his -- this is the 4C meetings I'm
22 talking about here. The site vice president met with
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1 400 employees -- and he said it's over 500 now, but
2 I know that it's over 400 -- in groups of 15 or so,
3 to reinforce management support.

4 Now, what's important about this
5 concept is Lew's a busy guy. I guarantee you, he's a
6 busy guy. He works a tremendous amount of hours.
7 He's spending four or five hours a week meeting with
8 a group of 15 employees to get a message across to
9 them. And it's primarily aimed at this: Making sure
10 that the employees can see that Lew is a person, that
11 what he cares about, what he values -- and one of the
12 things he always goes over at that meeting is safety
13 conscious work environment and that he wants to have
14 issues brought forward if they can't be resolved,
15 bring them to him. Those are the messages that he
16 transmits in that meeting. It's a highly important
17 thing we're doing. He spends a lot of effort getting
18 it done, and it's about this column in the safety
19 conscious work environment.

20 We've trained all managers and
21 supervisors on safety conscious work environment. We
22 brought in some experts in that area to do case study
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1 training with our managers and supervisors. It was
2 good training. Everyone went through it. I attended
3 it, Lew attended it. We have all been through it.
4 We also started training all the operators -- not
5 just the supervisors, but all the operators on safety
6 conscious work environment. And we're in the middle
7 -- in the midst of doing that. I think we're in the
8 last session of that. And so that's where we are in
9 that first column.

10 The second column is the corrective
11 action process. I'm not going to talk about this a
12 lot either since we've talked about this at multiple
13 public meetings, where we are, the actions that we're
14 going to take, and a lot of that's done now. We're
15 in the implementation. We've done the study, we
16 figured out what we want to do, we're now
17 implementing, we're getting a new process in place.
18 We've got to do good change management as we
19 implement the new changes. Although they're not
20 huge, there are some new ones. As we'll implement
21 that, we have to do good change management to make
22 sure our employees well understand how to do use the
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1 process and it still fits their needs and takes a
2 little feedback. But I believe that the new process
3 will be good. It's going to serve our needs. It's
4 as good as any in the industry, from our research.

5 The third part is employee concern
6 program, the third column. The program became
7 effective in December of 2002, the new program.
8 There was a program in place before. We've
9 strengthened it. The new program went in place last
10 December. We benchmarked other plants, looked at
11 what they were doing. Millstone, Diablo Canyon, San
12 Onofre and the NMC; some of the NMC plants were
13 looked at to understand how they were doing it. And
14 our model is around that. It reports directly to me,
15 and -- which means it's outside the line management
16 at the plant, and so that was a way to strengthen it.

17 Protection of confidentiality. We've
18 got a process in place now to ensure that the
19 confidentiality is maintained when it's requested or
20 required. Sometimes employees have reasons to want
21 the process to be confidential, and so we've got that
22 in place. We brought in four independent
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1 investigators, and they're professional
2 investigators. And that's important to try to
3 strengthen the types of investigations, the
4 independence of the investigators. In the past we
5 used management folks to do that, but -- and it gave
6 our employees a feeling of doubt about whether things
7 were really being investigated to the depth and get
8 to the real issues and that type of thing. And I've
9 gotten quite a bit of feedback, mostly to the
10 positive -- by far, I would say to the positive, that
11 they appreciate the independence of the
12 investigators, they think good investigations are
13 being done.

14 And the fourth column is --

15 MR. GROBE: Before you go on to the fourth
16 pillar, the employee concerns program, I know that
17 you were beginning to monitor a number of different
18 performance indicators and benchmarking those
19 performance indicators. Where do you stand on that?
20 Do you have a set of performance indicators for the
21 ECP?

22 MR. PEARCE: Yes, I do, Jack, and this afternoon
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1 we'll talk about that. That's what we're going to
2 talk about.

3 MR. PASSEHL: Just another question. How do you
4 advertise your employee concerns program?

5 MR. PEARCE: Marketing is a big facet of it, and
6 one of the ways that we're doing it -- of course, we
7 trained everybody on safety conscious work
8 environment, and that was a marketing tool in that
9 regard for the employee concerns program. Also, the
10 employee concerns program manager goes out and
11 attends -- we have morning tailboard sessions and
12 working line organizations, and he picks a couple of
13 those a week and attends them and talks in the
14 meetings about our program, what it's about, you
15 know, takes feedback; and he actually records some of
16 that data, as well as his monitoring points.

17 MR. PASSEHL: And where is their office located
18 on site?

19 MR. PEARCE: It's located in the training
20 building.

21 MR. PASSEHL: Okay.

22 MR. PEARCE: And the fourth column is the
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1 methods to detect and prevent retaliation. And this
2 is a review team and it's a concept, was kind of what
3 we started with, but we got it in place. And we
4 charged this team to look forward at pending actions
5 dealing with people. And that's where we're getting
6 a lot of the -- if we get issues with harassment,
7 intimidation, retaliation or discrimination, we get
8 those kind of issues, that's generally how they come
9 about, is we're dealing with our folks over some type
10 of discipline issues or something like that. So
11 that's where we put this team to look at. Any time
12 anyone is going to do any level of discipline at the
13 plant or we're going to make some changes, we run
14 those changes through this team. And it's made up of
15 top level managers. The directors are on the team --
16 Randy is on the team; and also, the legal department
17 is on the team; HR people, Fred attends a lot of
18 them. And so we review. And the purpose that we're
19 reviewing for is to make sure there's no harassment,
20 intimidation, retaliation or discrimination. Are we
21 being fair? Are we doing the right thing? Why are
22 we doing this discipline? Might the person be
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1 involved in some type of protected activity that we
2 need to look at to make sure it's not going on. So
3 that's why we've got the people on the team that we
4 do.

5 I'll give you an example of the next
6 one. It's the example I've been using about the
7 contractor reduction effort. We had this team look
8 at that before we got -- we were going to reduce
9 contractors toward the end of last year. Before we
10 did that, we had the team look through the contracts
11 of our vendors. You know, the people -- we'll hire
12 some company to work for us, and they bring in people
13 and then we say okay, we need to cut so many people.
14 Well, we had this team go look at their contracts
15 with us to determine what methodology were they going
16 to use in the force reduction. Was it, for instance,
17 last in, first out? That's a type of reduction
18 policy that's nondiscriminatory. If you're the last
19 guy to be hired, you're the first one out. That's a
20 seniority-based system. And there's several methods
21 that are utilized. So the team looked at the methods
22 that the contractors were going to use to make sure
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1 that we weren't going to use any types or any systems
2 to reduce force that might be perceived as
3 discriminatory for some reason. They reviewed the
4 results. We did exit interviews -- and that was a
5 recommendation. We did exit interviews for each
6 employee that was reduced, and they were asked in
7 that did they have any concerns? And of course, the
8 team reviewed the results of that. So I think it's a
9 good thing.

10 We're trying to understand and get
11 better at looking forward, staying on the front side
12 of it, rather than having to react to when someone
13 has had something that they believe is some type of
14 discrimination or harassment happen to them. We're
15 trying to get in front of those issues. And I
16 believe that we've had some success already with the
17 team. Like I said, they look at every time we
18 discipline anyone, the manager takes it to the team
19 and goes over with the team what he intends to do and
20 why and what the issues are around it. So I think
21 it's a good thing and I think it's going to give us
22 some payback.

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1 And that's my presentation, unless you
2 have any questions.

3 MR. GROBE: I had a question. I believe it's
4 probably over a month ago I read the charter for the
5 safety conscious work environment review team, and
6 the charter was a bit broader than what you just
7 described. It also included kind of continual
8 assessment, benchmarking and advice regarding the
9 safety conscious work environment. Is that still
10 part of --

11 MR. PEARCE: That's still part of the ~~char~~ charter.

12 MR. GROBE: Okay. Other questions?

13 MS. LIPA: This will probably be a good time to
14 take our break then, unless it disrupts the flow. So
15 what we should do is be back at five minutes to one
16 so we can get started promptly at one o'clock.

17 MR. DEAN: Before you break, I have one
18 question.

19 MS. LIPA: Go ahead, Bill.

20 MR. DEAN: Bill, on your slide regarding
21 management support and worker confidence, you
22 indicated that you're in the process of training the
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1 operators, including training operators on safety
2 conscious work environment. I assume that was just
3 the operations staff. What about the rest of the
4 organization? Are there plans to get to the
5 maintenance and engineering organizations as well?
6 MR. PEARCE: We trained -- we have been training
7 everyone on safety conscious work environment. In
8 fact, a case study had a piece on it. But we wanted
9 to give the operation group the same level of
10 training that we gave the managers and supervisors,
11 with the case studies, and so we've given -- we've
12 chosen the operators to give a more higher level of
13 training than we did the general population of the
14 plant. But we have trained everyone in safety
15 conscious work environment. We've discussed it.
16 We've discussed it in a lot of forums, too. In fact,
17 you heard us talk about that several times during
18 this meeting today where, if you look at, you know,
19 they talk about training of something and then all of
20 a sudden you see safety conscious work environment.
21 And we've taken every opportunity that we could to
22 add it on to different things that we've done to keep
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1 reinforcing the concept that it's important to us,
2 it's important for us -- for them to know that we
3 value it, and we just continue to try to market it
4 and give information on it.

5 MR. MYERS: I went to a couple hours of training
6 the other day in one of our engineering areas on the
7 safety conscious work environment policy, on the
8 safety culture policy and the command and control
9 policy we put out. And the meeting that I attended
10 and sat through was in the engineering area. But
11 we've done that for all three plants and our
12 corporate office also. So that's been done
13 consistently; that training has been done
14 consistently with all of sites.

15 MR. DEAN: The only other question I had related
16 to the employee concerns program, and maybe it's a
17 little too early to tell since it's really a new
18 program that only became effective the end of the
19 year. Has there been any observations regarding
20 through put or the amount of activity that the
21 employee concerns program has generated as opposed to
22 the previous ombudsman approach?

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1 MR. PEARCE: Yes. I've got that data, and I'll
2 present that this afternoon as part of the monitoring
3 part of --

4 MR. DEAN: Thanks, Bill. That's all I've got.

5 MS. LIPA: Okay. Thank you. So we'll resume
6 again at 1:00.

7 (Whereupon, a recess
8 was had.)

9 MS. LIPA: We'll go ahead and begin the session.
10 We plan to go from one to three with FirstEnergy's
11 presentation and questions, and then done by three
12 with that part of it, and then we'll start the public
13 question-and-answer period. We'll take a short break
14 at three and then start the public participation a
15 little bit after three. So that's the plan. Go
16 ahead.

17 MR. FAST: Thank you, Christine. Good
18 afternoon. My name is Randy Fast, and I'm the
19 Davis-Besse plant manager.

20 What I'm here today to talk about is
21 anchoring the changes in safety culture for
22 operations, and I'm just going to mention a couple of
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1 things. One, I know we want to get through a lot of
2 information here so I'm just going to provide a
3 high-level view, but I wanted to identify that
4 there's direct linkage from a root cause that we did
5 at operations back to our overall root cause, and a
6 lot of the things that we're doing are a subset of
7 really what came out of our overall root cause. But
8 there is that direct linkage.

9 One of the things we want to establish
10 is very clearly site-wide commitment to safe plant
11 operation. Bob and Lew both talked about our overall
12 commitment for safe operation. We really believe
13 that operations, the best of the best overall are
14 operationally focused and led by a strong operations
15 team. As part of our operations leadership team and
16 our overall plan for improvement, we have a
17 continuous improvement culture that's really always
18 looking at the way we're doing business and the
19 things that we're doing to improve the way we do
20 business, and that is part of our operations
21 leadership plan. And I think it's a mantra that will
22 serve us well in operations and being complacent or
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1 never being satisfied. We're always moving forward.

2 Part of what you have to do is really
3 drive things through a training process, and we do
4 have two license classes that are in the pipeline.
5 We have several of our senior reactor operators in
6 rotation of assignment. Operations took a leadership
7 role in the development of the 9118 [Generic Letter 91-18]
8 training that we've provided to all of our senior reactor
9 operators, but as well as our engineering folks, so
10 that we understand clearly operability concerns for
11 our equipment.

12 We talked about operations having all
13 of our folks have safety conscious work environment
14 because they are out at the plant seven days a week,
15 24 hours a day all the time, and they're there in the
16 presence of the work force.

17 One of the things we talked about was
18 the nuclear operating procedure for decision making,
19 and we have been using that most recently. In fact,
20 I brought some examples, ones I can share with you
21 later. But those are, I think, improvements overall
22 in our operations focus.

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1 Leadership in Action, operations has
2 taken a key role in developing operations leadership.
3 And I'll give you some specific examples. The shift
4 manager, which is the senior licensed person at the
5 station, and as Lew had talked about, the
6 identification of his roles and responsibilities had
7 a lot of administrative burden, and we examined that
8 burden, reduced that burden, carved out an actual
9 office for the individual that provided a place where
10 the plant staff could go and talk through any issues.
11 But our expectations -- and I believe they're very
12 clear -- is that the shift manager be visible in the
13 work force and in the workplace, out reinforcing
14 standards, adding value. And I have some specific
15 examples where our shift managers have improved
16 processes by being out.

17 We had some discussion of the
18 observation program, the deep drain work. One of our
19 shift managers was monitoring a job, the unpacking of
20 a valve and being able to examine the physical
21 condition within the stuffing box. He saw that the
22 lighting was fairly poor, the guys were using
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1 flashlights. He said, "Hey, I think we can get some
2 fiber optic equipment that will actually be able to
3 do a lot better examination, as well as some
4 additional tooling," and we went -- he actually went
5 and bought the stuff. And within about 24 hours we
6 were able to implement a process improvement that
7 really helped mechanical maintenance. So I think our
8 staff are appreciating the contribution that our
9 operations leadership are providing.

10 We have instituted a benchmarking
11 program, and all of our crews have been out to
12 benchmark, most notably Progress Energy, Entergy, and
13 Exelon, in looking at the way that they have focused
14 operationally.

15 The next item I was going to talk
16 about were measures to prevent recurrence. And as we
17 talked about, we're anchoring or institutionlizing
18 our expectations and our safety culture supporting
19 policies, programs and procedures. One of the things
20 we have seen really a lot of improvement in the
21 quality of oversight and the intrusiveness of quality
22 coming and questioning the operation staff about what
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1 we're doing, how we're doing it, why we're doing it.

2 And we appreciate that, and I believe it's adding
3 value.

4 And then we'll continue to monitor
5 our safety culture. It's -- I feel pretty good about
6 where we are. I feel that Ops understands where they
7 are, and I think our overall plan will continue to
8 mature to establish the standards at the shift
9 manager level.

10 Lastly, our FirstEnergy chief
11 executive officer, Pete ~~Burke~~ Burg, has a personal
12 commitment that each shift manager meet with him
13 prior to restart one-on-one so that Pete can have
14 that open and honest dialogue to ensure that his
15 expectations are satisfied and that the role and the
16 responsibilities of the shift manager is clear. I
17 think that's a tremendous commitment by Pete, and I
18 know that it will be value added for our shift
19 managers.

20 That's really all I had to prepare.

21 If there's no questions, I'll turn it over next to

22 Fred Giese. He's our manager of FirstEnergy Nuclear
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1 Operating Company human resources.

2 MR. GIESE: Thank you, Randy. I'm speaking to
3 page 28 in your slides. As Randy said, I am the --
4 and Bob Saunders earlier said -- I am the manager of
5 human resources for FENOC, and I am new at the
6 position. Not only am I new at the position, it's a
7 newly created position, and it was created with a
8 desire to have somebody in place, a senior HR kind of
9 guy, who helped with the three HR sites -- three HR
10 departments in the various sites, to develop some
11 consistency across the fleet and also act as a
12 coordinator between the corporation and the FENOC
13 organization.

14 I am the owner of the leadership
15 development process, and we talked a lot about that
16 in lots of different ways. Underneath the umbrella
17 of that process is the Leadership in Action courses,
18 the Ownership For Excellence, which is a performance
19 review process.

20 Let's talk about some of the things
21 that we've done to -- some of the actions we've
22 taken, some of the improvements we've made. As a
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1 part of the Ownership for Excellence and the
2 Leadership in Action, we have added two new
3 competencies which Lew and others spoke to earlier
4 on, which is nuclear safety consciousness and nuclear
5 professionalism. We have anchored those competencies
6 in our performance review program or Ownership For
7 Excellence, and they are not only being defined as
8 part of the competencies that we look for all
9 employees, but they are being measured as part of the
10 performance review process. And that will be done
11 this year as a part of an element of the reviews for
12 the prior year.

13 Lew spoke to refresher training in
14 these two areas. Let's talk about the impact. These
15 were six-hour courses where we sat down with all the
16 folks that were trained and spent six hours talking
17 about these two characteristics, these two
18 competencies. So it was not a brief conversation
19 kind of thing. It was an intensive amount of time,
20 and very completely discussed. We also brought in
21 our HR industrial psychologist to help assess the
22 capabilities of our supervisors -- the supervisors,
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1 managers and above, including the senior FENOC
2 management team. All of us have gone through this
3 process. And Connie talked to some of that. And
4 both Lew and Connie said that -- and I absolutely
5 concur that we feel that we now have the right people
6 in the right places. And we are doing the things we
7 need to do to support those folks, where needed, with
8 individual development plans. And the individual
9 development plans will be in place for all of our
10 supervisors and above at Davis-Besse within the next
11 couple weeks. The target date is February 15th.

12 We have, as I said a couple moments
13 ago, we have anchored these competencies of nuclear
14 professionalism and nuclear safety culture in our
15 performance review program, and we've reinforced that
16 a number of ways, as we've talked about it today, and
17 what we're trying to do, and get people's attention
18 and what the focus of this business is, as Lew has
19 said, and Bill and others. I'm not going to spend a
20 lot more time.

21 What I'd like to do is introduce Sonja
22 Haber, who is an expert that we brought in to help us
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1 evaluate the safety culture at Davis-Besse. And if
2 you have no further -- if you don't have any
3 questions, I'll turn it over to Sonja.

4 MR. DYER: Fred, I have one question, and that
5 is how are you proposing to measure these two new
6 attributes?

7 MR. GIESE: It's going to be part of the
8 Ownership for Excellence, which is the review
9 process, the performance review process. And I'm
10 going to look for Randy and some others to give me a
11 little help here --

12 MR. DYER: They seem rather subjective, from my
13 perspective.

14 MR. FAST: There are some very specific
15 attributes that, as we developed these competencies,
16 we looked at what were the enablers for those? An
17 enabler for safety consciousness will be training.
18 There's an element there. We focused on getting our
19 folks qualified and trained for the work that they
20 do. So we have rating sheets. In fact, there are
21 two rating sheets for each competency, so probably
22 somewheres around 10 to 12 specific attributes, and
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1 in one of three categories: it does not meet
2 expectations, meets expectations, or exceeds
3 expectations. So there's, as you go through each one
4 of the attributes, an individual is rated on those.
5 I performed that assessment for the folks that work
6 for me and --

7 MR. DYER: So you set expectations for these?

8 MR. FAST: Absolutely.

9 MR. MYERS: Absolutely.

10 MR. DYER: Okay.

11 DR. HABER: Good afternoon. Thanks, Fred. I'm
12 Sonja Haber. As was mentioned, we were asked to come
13 in and do an independent evaluation of safety culture
14 at Davis-Besse.

15 What I'd like to do today is to
16 present to you a little bit of background on the
17 development of the methodology that we're using, the
18 premise and the characteristics of safety culture
19 that we're looking at, what we will review with
20 Davis-Besse, how we will review it and, of course,
21 what the outcomes of the methodology will be.

22 I'll tell you a little bit about the
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1 background. We don't have to review here the human
2 performance issues that have occurred across the
3 nuclear industry, not only in the United States, but
4 across the world. As a consequence of those back in
5 the late 1980s, the United States Nuclear Regulatory
6 Agency Commission actually implemented a very large research
7 project, at that time looking at the influence of
8 organization and management factors on safety
9 performance. And I was integrally involved with that
10 project for many years. And the project basically
11 attempted to develop a methodology to assess those
12 influences, look at methods that could measure them,
13 and then look at the resulting outcomes with respect
14 perhaps to a regulatory framework.

15 A lot of the work that was done during
16 that project is documented within the USNRC
17 documentation. In the mid-1990s, the USNRC basically
18 stopped the research, or it came to an end before it
19 really ever implemented it in a regulatory
20 framework. We had conducted some pilot work in U.S.
21 plants and some other organizations. At that time
22 the Canadian Nuclear Safety Commission, which is the
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1 equivalent of the USNRC for the licensees in Canada,
2 decided that they were interested in the methodology
3 and decided to pursue it. And we were asked to
4 review the methodology, see if it needed to be
5 modified or adapted for the Canadian facility and
6 then we actually conducted over the next few years
7 the methodology of benchmarking their licensees using
8 this particular application. And that ~~proj~~ project just
9 recently ended.

10 During this time of this development
11 from the start of the USNRC work through the Canadian
12 work, the methodology has had some modification, not
13 a great deal. As you'll see as I describe, a lot of
14 the methods are not that unusual. But we also had an
15 opportunity to be working in countries of the former
16 Soviet Union with Soviet-designed reactors, and we
17 had an opportunity through some of our visits there
18 to implement aspects of the methodology in those
19 plants as well.

20 And finally, we've been involved with
21 the International Atomic Energy Agency in some of
22 their recent work in safety culture. In particular,
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1 I've been involved in implementing and developing
2 guidelines for the assessment of safety culture, as
3 well as on some evaluations of safety culture at
4 different nuclear installations around the world.

5 So the method that I'm going to talk
6 about today really has been through an iterative
7 process. It's been through a lot of peer review.
8 It's been used in different countries, different
9 cultures, different types of facilities. And I think
10 it brings to the table a lot of what people agree on
11 as to what's important with safety culture.

12 The premise of the methodology is that
13 safety culture exists in an organizational context.
14 And what I mean by that is you can look at culture in
15 many different mediums or contexts; and here we're
16 looking at the organization. You can look at culture
17 in a societal context; you can look at it in an
18 individual context. We're looking at it with respect
19 to the organization of interest.

20 If you do that, it's helpful to think
21 about Edgar Schein's model of culture. And I bring
22 it up. It's one that the International Atomic Energy
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1 Agency is using as a frame of reference because it's
2 helpful in understanding what you can assess when you
3 talk about culture. Schein basically argues that
4 there are three components to culture, and I'll just
5 take a minute to explain them.

6 The first is the artifact level.
7 Artifacts are the observables of culture that we can
8 see. For example, a plant has a mission statement,
9 it has vision statement, it has a policy statement.
10 And basically, you walk through a plant, you may see
11 posters on the wall that talk about "safety first" or
12 "stop, think, act and review." Those are artifacts
13 of safety culture. You can observe them.

14 Claimed values are exactly what they
15 say. It's what the organization espouses as its
16 values, in this case with respect to safety culture.
17 So you will hear things that "safety is first" or
18 that "management says that safety is a priority."
19 Those are claimed values. I think everybody would
20 agree that these first two levels are fairly easy or
21 easier to observe and measure.

22 But it's the third level that Schein
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1 argues is probably really the most important, and
2 that is the basic assumption level. And what we're
3 talking here is about what are the beliefs and the
4 attitudes that people bring into a situation with
5 them? In particular, I give you the example if you
6 believe that people are inherently good, then you
7 will behave towards people in a certain way, as
8 opposed to if you believe they're inherently bad or
9 that you're highly suspicious of people. By bringing
10 that basic assumption into your work environment or
11 into your life, you will change, or your behavior is
12 a function of that belief. So if you believe that
13 everybody can contribute to safety, and that's an
14 assumption or basic assumption in the organization,
15 then people in the organization will believe that
16 they can make that contribution to safety in the
17 plant.

18 So those are the three levels. And
19 the third level, as you might imagine, because it
20 concerns beliefs and attitudes, is often the most
21 difficult to assess. But we will talk about how we
22 will address that.

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1 In addition, the IAEA talks about
2 stages of culture development, and I think that's
3 very important too. First is the compliance stage,
4 when an organization basically is trying to follow
5 the rules, regulations that have been put into place,
6 in this case, by the regulator. And they just try to
7 meet, as we talked about, perhaps minimum
8 requirements. Then you would like to think that as
9 the organization is trying to promote a safety
10 culture, it moves into a performance-based stage.
11 And there the organization starts to develop measures
12 and actually tracks and trends those measures for
13 safety culture. Finally, the ultimate goal, which I
14 think is where we would all like to see
15 organizations, not just nuclear organizations is in
16 the process stage, where you believe that safety is
17 really a continuously improving process, that you're
18 not happy with a stagnant or a status quo, that
19 you've never really achieved the ultimate safety.
20 You're always learning and willing to
21 work towards a better safety culture. So I think we
22 need to keep those in mind as we talk about the
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1 methodology.

2 On the next graph -- I'm on Page 32 --
3 basically, I just want to point out very quickly that
4 a lot of people confuse the management of safety with
5 safety culture. And they really are two different
6 things, and we would probably argue that the
7 management of safety is part of safety culture. But
8 the management of safety really focuses on the
9 processes and the outcomes of those processes. And
10 we're pretty good in the nuclear industry in trying
11 to assess those processes and look at the outcomes of
12 those. But when we're talking about safety culture,
13 we're talking about the culture or the driving force
14 that really influences those processes and outcomes.

15 Mr. Myers gave you a definition of
16 safety culture that they've worked with here at
17 Davis-Besse. I'm just going to reframe it a little
18 bit into words that will make perhaps more sense as I
19 describe the methodology that we're going to use and
20 the material that I just provided to you with the
21 IAEA.

22 Safety culture refers to the
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1 characteristics of the work environment, such as the
2 values, rules and common understandings. Let me take
3 a minute. You can replace those with the three
4 levels that Edgar Schein refers to as culture. We're
5 talking about basically the values are the claimed
6 values, the rules may be the artifacts, and the
7 common understandings would be the basic
8 assumptions. And it's those things that influence
9 employees' perceptions and attitudes about the
10 importance that the organization places on safety.

11 I want to take a moment and just draw
12 your attention to the word perception. Having
13 applied this methodology in many organizations, the
14 one comment that we always get by many individuals is
15 that this is really a lot about perceptions and
16 people's perceptions and attitudes and what they
17 think about the situation. That's correct. And if
18 you think about it as most psychologists will tell
19 you, perception is reality. If you really believe
20 something is true, then that's how you will behave,
21 even if in fact that is not the case.

22 What are the safety culture
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1 characteristics that we're going to look at? They're
2 aggregated here into two groups. One is called
3 generic and one is called specific. And let me just
4 spend a minute because I think it's very important to
5 understand the framework in which we're conducting
6 this evaluation. These generic characteristics have
7 been identified in the literature by Robert Zambra
8 (phonetic) -- I can give anybody the reference if
9 they'd like -- that helped to define what constitutes
10 a highly reliable organization. And that's an
11 organization that must minimize failure because of
12 the consequence if it occurs, to public health and
13 safety in particular, if you're familiar with their
14 work. And over the years, they have amassed a great
15 amount of data, not just in nuclear facilities,
16 although they have worked there as well, but in other
17 highly reliable organizations, and they have come to
18 the conclusion that there are three things that a
19 highly reliable organization has. And in fact, if
20 you're thinking about promoting a positive safety
21 culture, you can use the same type of framework.

22 The first is that the organization
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1 aggressively seeks to know what it doesn't know. And
2 what do I mean by that? You're always trying to be
3 one step ahead of the situation. How do you do
4 that? Well, you train people to respond to all types
5 of anomalies. You also spend resources on
6 redundancy, and you also try to be one step ahead in
7 terms of the programs and processes that you have.

8 The second is that you design -- the
9 organization designs a reward and incentive
10 environment to recognize the cost of failure, as well
11 as the benefit of reliability. But an environment in
12 which the respect for people is very high. What are
13 we saying here? What gets measured gets managed.
14 People will basically do what they think they are
15 rewarded to do, and so if safety is a high value and
16 rewarded in an organization, then people will behave
17 in that fashion. And you need to design a system
18 that realizes the benefit of short-term safety, as
19 well as long-term reliability.

20 And finally, in a highly reliable
21 organization, there's consistent communication about
22 the big picture. What is the mission? What is the
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1 vision? What are the values of the organization?
2 And not only communicating it and getting people to
3 understand it, but getting people to talk about it
4 with each other. Not just in formal meetings, but in
5 informal situations, in anecdote, perhaps in a lunch
6 room, over a coffee break, getting people to really
7 buy into the mission and vision of the organization.
8 And this can be done also by the organization
9 spending resources for effective communication
10 processes. And of course, the one that we've heard
11 about is that management will encourage a culture of
12 open communication for this to occur. So these are
13 what we call the generic characteristics, because now
14 I'm going to tell you about the specific
15 characteristics. And in fact, they can be aggregated
16 up to these generic ones.

17 These characteristics you'll see
18 shortly in a document that the IAEA is in the process
19 of finalizing with respect to how to assess safety
20 culture, and they have been aggregated up from many,
21 many bullets that contribute to each of these. These
22 are not the only things that you look
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1 at. Of course, they include many other facets. What
2 I'd like to do is I'll give you some idea of the
3 kinds of things under each of these, but we don't
4 have time to discuss each of them today.

5 The first is that safety is a clearly
6 recognized value in the organization. How can you
7 see this? You can see this through documentation
8 that describes the importance of safety. You need to
9 see it through the transmittal and understanding of
10 safety throughout the organization. You need to see
11 it through decision making that reflects safety as a
12 value. And you need to see it in the allocation of
13 resources. How is the time, money, and people placed
14 with respect to things that are important to safety?
15 All of these bullets that I mentioned are artifacts
16 and claimed values in Schein's model.

17 If we really want to understand that
18 safety is a clearly recognized value, we need to
19 think about what would be the basic assumption. And
20 the basic assumption for this particular
21 characteristic would be something like safety
22 conscious behavior, both formally and informally, is
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1 socially accepted and supported in the organization.
2 And what I mean by that is not just that management
3 says that safety conscious behavior should be
4 encouraged, but that people in the organization,
5 peers, cohorts, coworkers, actually support that in a
6 social framework. I think we all agree that that's
7 most important, because even if management supports
8 it, if your work group or your peers don't support
9 it, then you won't perform in that fashion. So that
10 would be a basic assumption, that people would come
11 into the organization and believe that safety
12 conscious behavior was accepted both socially and
13 technically in the organization.

14 The second is accountability for
15 safety is clear. Roles and responsibilities are
16 clearly defined and understood, most importantly;
17 that there is compliance with regulations and
18 procedures; that there is a delegation of
19 responsibility but with the appropriate authority.
20 Often we delegate responsibility for safety, we don't
21 provide the individuals with the authority to
22 actually implement it; and that there is a major
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1 commitment to safety at all levels of management in
2 the organization.

3 Again, those are artifacts and claimed
4 values. What might be the basic assumption here
5 might be that ownership of safety is recognized at
6 all levels in the organization. So that everybody
7 really believes they have ownership of safety and
8 that they can take hold of that and help resolve
9 safety in the organization.

10 The third point is that safety is
11 integrated into all activities in the organization.
12 And here you would look at things like good material
13 condition, good working conditions, the quality of
14 documentation, perhaps more important, the quality of
15 processes, from planning through implementation and
16 through feedback. You would see a set of performance
17 indicators that are tracked and trended, but most
18 importantly also evaluated and used. And you would
19 see the use of self-assessments in the organization.
20 Again, artifacts and claimed values. What might be
21 the basic assumption is that everybody in the

22 organization can contribute to safety, that there's
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1 no individual in the organization who can't make some
2 contribution to that.

3 The fourth bullet is that a safety
4 leadership process exists. Here you want to see the
5 visibility and involvement of management in
6 safety-related activity. You want to see individuals
7 that are motivated in their job to perform in a safe
8 fashion. You want to look at the ability of
9 management to resolve conflicts and make decisions
10 with respect to safety as a value. And you want to
11 recognize, perhaps very importantly, the informal
12 leaders of safety in your organization. I think we
13 all recognize that there are formal leaders and
14 former leadership processes for safety. But often
15 the informal leaders are very influential in the
16 organization.

17 Those again are artifacts and claimed
18 values. A basic assumption here might be that
19 everybody in the organization is working towards the
20 common goal of safety.

21 And finally, that safety culture is
22 learning driven in the organization. Here you would
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1 look for an open reporting culture without blame for
2 reporting unsafe acts or conditions; that you would
3 use internal and external assessments; that there
4 would be the use of organizational and operating
5 experience, both from within the organization and
6 outside; and that while there are processes to
7 identify problems, there's also the development and
8 implementation of a very comprehensive and integrated
9 corrective action program; and of course, that a
10 questioning attitude would exist at all levels in the
11 organization. Here again, claimed values and
12 artifacts. The basic assumption here is that safety
13 can always be improved and, therefore, demonstrating
14 the willingness to learn.

15 If we think about those
16 characteristics, what are the types of behaviors that
17 we might want to see when we are conducting the
18 review or using the methodology? I've identified
19 some of them here. I'm really not going to go
20 through all of them right now, but they really
21 revolve around a lot of the same words that we have
22 just been talking about through the characteristics,
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1 constructive values or working together, teamwork,
2 drive for perfection, working so hard not to avoid
3 mistakes, the questioning attitude, minimal avoidance
4 behavior. We want people not to be afraid to take
5 responsibility because they're afraid of reprisal.
6 You don't want them to avoid responsibility. You
7 want them to accept responsibility.

8 High organizational commitment, work
9 with cohesiveness, job satisfaction, open and
10 effective communication and, of course, a heavy
11 emphasis on safety.

12 The methodology that we will use and
13 have used in other organizations is to look at the
14 following organizational behaviors. And they're all
15 related to what we've been discussing. These are a
16 comprehensive list of behaviors that were identified
17 through the processes that I mentioned earlier in the
18 background portion of the presentation through peer
19 review workshops, through multiple groups, through
20 academia, through the industry, from the private
21 sector, from universities that work together to come
22 up with this list. And behind each of these
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1 behaviors, of course, are attributes and, more
2 importantly, the tools that we're going to use to
3 measure them.

4 What I've done here is put together a
5 graphic to show you the relationship really between
6 the generic safety culture characteristics that we
7 addressed, three that I mentioned first, the
8 aggressively seeking to know, designing a rewards
9 system and consistently communicating were some
10 examples of some of the specific things that you
11 might see, and they're identified in the left-hand
12 column. And in the right-hand column are the
13 behaviors which we utilize in the methodology to
14 actually assess and measure those types of behaviors
15 and characteristics. Perhaps if we have questions,
16 we could come back to that later.

17 So now that we understand a little bit
18 about the characteristics and the behaviors that
19 we're going to use to assess the status or the
20 existence of those characteristics, what about the
21 method? I think the strength of the methodology --
22 the methods are not new. You've seen them used in
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1 various applications before. The strength of the
2 methodology was really premised from the USNRC's work
3 and the Canadians and the safety commission. That
4 was that they must be capable of broad-based use
5 across different types of facilities, by different
6 types of people, that they should be as objective as
7 possible. There's an issue about whether or not you
8 wanted objective types of assessment. The methods
9 have quantitative as well as qualitative results.
10 They have withstood and can withstand high scrutiny
11 and uses. Many of them come out of the open
12 literature. They have been peer reviewed. They have
13 been used across many different industries and
14 organizations. And finally, the real strength is
15 that they provide what we call convergent validity.
16 What we mean by that is that when we go in to look
17 at, for example, the behavior of communication, we
18 will not just use one method to assess that. We will
19 use multiple methods to assess communication so that
20 when we come away with the data on behavior, we've
21 acquired it from different types of tools and using
22 different sources of information; and the results,
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1 therefore, will have validity to be presented as
2 representative of that behavior in the organization.
3 And I'll explain the method.

4 Basically, the structured interviews
5 and focus groups are identified that way because what
6 we have amassed over the years, we have a data base
7 in question about all of the behaviors that I showed
8 you before. And we utilize that organization so
9 that when we go in to ask questions about any of
10 these behaviors, we can ask the same or similar
11 questions to people at all levels of the
12 organization. So we might ask the plant manager
13 similar questions to the maintenance technician or
14 maintenance mechanic. And that way we can understand
15 any difference that might be with respect to those
16 type of issues, or similarities. And that helps to
17 understand, perhaps, where the barriers in the
18 organization might be. Or perhaps, in some cases,
19 maybe they're meant to be there for a reason.

20 So we call it a structured interview.
21 Of course, it's not totally structured in the sense
22 that other issues come up. But we do use a minimum
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1 set of questions from our data base to ensure that we
2 will get the same type of information at all levels
3 of the organization and across all functional groups
4 as well. And we do similar exercises with some focus
5 groups. At the end of the interview we ask the
6 interviewee to complete what the next item is, which
7 is called a behavioral anchored rating scale, or BARS
8 for short. And many of you may not be familiar with
9 this, but it's another way for an individual to
10 present their attitude or their perception or their
11 understanding with respect to one of the behaviors
12 we're looking at.

13 So if we stay with the example of
14 communication, if we've just conducted an interview
15 and asked somebody about communication in the
16 organization, at the end of the interview we would
17 hand them a rating scale that showed different
18 behavioral examples of how an organization might
19 communicate. And you might in fact have there an
20 organization that would communicate very well, and
21 you would describe all the behavioral attributes
22 associated with that, right down to an organization
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1 that didn't communicate very well, with some other
2 examples in between. We ask the interviewee to put
3 an X next to the behavioral example that best
4 describes their organization, in this case
5 Davis-Besse, with respect to that behavior --
6 communication -- at this point in time. If you think
7 about the method that we use for the structured
8 interview, now you can also compare the results on
9 these behavioral anchored rating scales at different
10 levels in the organization and across different
11 functional groups in the organization. So it gives
12 you another nice way also to validate perhaps the
13 information that you received in the interview
14 through the use of the rating scale.

15 The fourth bullet are behavioral
16 observations, and here we go out and look at certain
17 activities, whether they be planned or unplanned, a
18 lot of shift turnovers, planning meetings. But the
19 difference is that we have a checklist that we
20 complete as the observer after the observation. So
21 in addition to taking our notes, which provide
22 qualitative data, we have quantitative data as well
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1 that will help us during the meeting to look for
2 certain attributes of the behavior.

3 Staying with my example of
4 communication, if I'm sitting and observing a
5 managers meeting and I'm interested in the
6 communication process in that meeting, I'll take
7 notes. But then I'll also, after the meeting,
8 complete a checklist that identifies some of the
9 attributes and whether or not they occurred in that
10 particular activity that I observed. The checklists
11 come about after hundreds of hours of observations,
12 shadowing managers and supervisors around nuclear
13 facilities. So they are based upon data collected
14 within the environment in which they will be used.

15 And finally, there's the organization
16 and safety culture survey. This is a
17 paper-and-pencil questionnaire, and it consists of
18 several different aspects to the behaviors that we
19 have been talking about.

20 The first thing it looks at is
21 organizational culture. Not safety culture, but
22 organizational culture. And the reason we do that is
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1 that the questionnaire really wants to understand
2 what do people think is rewarded and valued in the
3 organization. So when people complete that portion
4 of the questionnaire, they do not complete it with
5 what they do or what they think they should do, but
6 rather what do they think is expected of them to
7 succeed in the organization. And that way you're
8 understanding what their perception is of the values
9 in the organization that are rewarded. That's one
10 part of the survey.

11 Additional parts of the survey look at
12 communication, as you might expect, different aspects
13 of communication: the accuracy, the desire for
14 communication, the trust in communication. We also
15 look at coordination of work, work with cohesiveness,
16 job satisfaction, attention to safety, environment
17 safety and health issues; and several scales,
18 therefore, comprise the survey. And if you notice,
19 they also tap into many of the behaviors that we've
20 talked about. And I'll discuss in a minute how we
21 intend to implement that at Davis-Besse. But those
22 are basically the methods that we use. And as I
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1 said, in presenting the results, we feel that we have
2 convergent validity, based on data from several of
3 the methods for any particular behavior.

4 This is just a prototype of how you
5 might implement the methodology. This is not
6 specific for Davis-Besse. But what it really shows
7 is that you go across the organization, as identified
8 by functional area, and you go down within any
9 functional area through the organization. And what
10 we've identified here are the five specific safety
11 culture characteristics that we will look at
12 throughout the organization, both laterally and
13 vertically.

14 As I mentioned, the functional
15 analysis is the documentation review and some
16 preliminary and informal walk-throughs, talk-throughs
17 and focus groups. I will discuss towards the end of
18 the presentation on a schedule, but I can say that we
19 are in the process of doing the functional analysis
20 at this point in time, and we have received a great
21 deal of documentation from Davis-Besse to conduct
22 this portion of the evaluation.

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1 The structured interviews and
2 behavioral anchored rating scales, people will be
3 interviewed from all organizational components and
4 levels in the organization. Positions will be
5 identified during the functional analysis, the
6 individuals are chosen by the site. What I mean by
7 that is at the conclusion of the functional analysis,
8 we will submit to Davis-Besse a list of positions in
9 the organization that we would like to interview, not
10 individuals. So where there are multiple people in
11 that position, the site will identify the individuals
12 to be interviewed by us. Obviously, where there's
13 only one individual in that position, that will be
14 the person, and I think they will be
15 self-identified. But we will allow the site to
16 identify the individuals to be interviewed.

17 MR. HILLS: Quick question along those lines.
18 If you're doing that, how are you ensuring you have
19 an unbiased sample that the site --

20 DR. HABER: I'm sorry. Unbiased sample of --

21 MR. HILLS: Unbiased sample of the people you're

22 actually going on and doing the behavioral anchored
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1 rating scales you're talking about.

2 DR. HABER: You're talking about because the
3 site is deciding who will --

4 MR. HILLS: Right. Who are the actual people
5 who are going to be doing --

6 DR. HABER: We have identified to the site that
7 we have the right to ask for any other individuals or
8 ask for additional individuals if we feel in fact
9 that's a problem.

10 MR. HILLS: Is there anything you're looking at,
11 any criteria to decide if that's a problem or not?

12 DR. HABER: I think that if you've done
13 interviews, I think at some point you understand when
14 people are giving you at least the same picture and
15 the same line in the same arena, I think we would
16 just ask for another interview with a different
17 person that we might name or we might find, after --
18 after we've been at a site for a while.

19 The interviews last about one hour.
20 Occasionally we may do a follow-up if an issue comes
21 up and we want to validate something. We might ask

22 for a follow-up interview with a person or, as I
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1 mentioned, some additional interviews with people who
2 have not been proposed on our initial list.

3 As I mentioned, at the end of the
4 interview, the BARS, the behavioral anchored rating
5 scales, will be administered, and we do no more than
6 four rating scales for any interviewee. We are not
7 trying to be overly intrusive. But by doing the type
8 of cross-section that we will across the organization
9 and through the organization, we'll get more than
10 enough behavioral anchored rating scales for the
11 behaviors that we're looking at.

12 MR. GROBE: Sonja, any given work category,
13 let's say the position of maintenance mechanic, how
14 many people in an organization with a thousand
15 employees would you interview? If there's, let's say
16 50, 30 maintenance --

17 DR. HABER: What we try to do is we usually try
18 to do about ten percent of the organization total. I
19 can tell you that right now in our starting to
20 identify the list, we may exceed that a little bit in
21 this case. It depends on the how the organization is
22 structured. And if it's highly compartmentalized,
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1 where you might have a lot of smaller sections, you
2 might want to get a better cross-section and exceed
3 that. But we probably try to do at least three to
4 five mechanics if they have 50 mechanics, to answer
5 your question. It would be ten percent stratified
6 across the organization.

7 MR. GROBE: And is that the type of category?
8 You said you identified types of positions.

9 DR. HABER: Yes, yes.

10 MR. GROBE: Lew, have you thought about how you
11 plan on selecting the people to participate?

12 MR. MYERS: No. Pretty randomly. I would want
13 to ask David a question, based on his question.

14 First of all, you know, what I've
15 wondered, first of all, why would you stack the
16 deck? Second of all, how would you stack the deck?
17 I mean, I wouldn't know how to go out and find a
18 bunch of people that -- I wouldn't know how to stack
19 the deck, you know, that could answer -- I don't even
20 know the questions. How could I stack the deck?

21 MR. HILLS: That's what I was kind of asking
22 you.

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1 MR. MYERS: Why would any manager want to do
2 that? I mean, what you really want to do is take a
3 good representative and send that -- we've sent that
4 message to our population. She can talk to anyone
5 she wants to. Because what you really want back is
6 what you think is something you could use as a tool.
7 There's no reason for any manager to ever want to
8 stack the deck.

9 The next thing is, you know, I'm not a
10 psychologist but I certainly wouldn't know how, you
11 know, and I don't think we're that smart. You're
12 giving us more credit than we deserve.

13 MR. HILLS: All right. Thank you.

14 MR. PASSEHL: I have a question on page 43, your
15 last bullet there. Can you explain a little bit more
16 clearly what you mean by no more than four rating
17 scales are completed by an interviewee?

18 DR. HABER: Sure. At the end of the functional
19 analysis, we will decide on some set of behaviors
20 that we're going to focus on from that list of about
21 20 that I showed you. That's not to say that we're
22 not looking at all of them, but we need to focus on

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1 some, and they're not independent, and so therefore,
2 by looking at one, we're also capturing others. At
3 the end of an interview, we have behavioral anchored
4 rating scales for each of those 20 behaviors. We
5 couldn't possibly ask each interviewee to fill out 20
6 ratings scales.

7 MR. PASSEHL: Okay.

8 DR. HABER: So we'll do a sampling to ensure
9 that we get data from each level and each component
10 in the organization.

11 MR. PASSEHL: Thank you.

12 MR. GROBE: Sonja, it would help me understand,
13 as we go through the methodology, the answer to this
14 question. Is this an analysis methodology that would
15 give you a point estimate at any given time that you
16 can compare against a scale?

17 DR. HABER: Yes.

18 MR. GROBE: Or is it a methodology that you use
19 to measure trends, and its greatest value is
20 trending?

21 DR. HABER: Well, I'm going to talk about that

22 in terms of the deliverables a little bit. But it
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1 does give you a snapshot right now. And as I will
2 mention, we have gone back into organizations using
3 this, the first one as a base line, and then having
4 gone in later to look at whether or not interventions
5 have been effective. But we also believe that we
6 will attempt to do some trending, maybe not in the
7 quantitative sense, but in the qualitative sense.

8 I'll talk about that in a minute.

9 On the behavioral observations, as I
10 mentioned, activities -- and this is just a subset of
11 what we might ask to look at -- scheduled meetings,
12 routine activities, unscheduled, work processes, when
13 applicable. We have in some organizations done
14 minicase studies. If it happens that something comes
15 up during our first couple days onsite, something we
16 might want to follow through during the period of
17 time that we're at the site, that might provide us a
18 very nice case study of a lot of the different
19 behaviors that we're looking at.

20 We will conduct many observations of,
21 for example, shift turnovers. We will not be
22 reporting that data on just one or two. We'll often
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1 do anywhere from 10 to 20, depending upon the time on
2 site and also trying to get different shift crews.
3 The organization and safety culture
4 survey; I'll make a couple of points about this. I
5 think it's a very important, very strong piece of
6 methodology. We administer it in large groups, and
7 we're working with the site at this time to actually
8 organize that. The surveys are conducted
9 anonymously. And what I mean by that is we don't ask
10 for any personal identification, any company ID
11 numbers. The only thing that we will have is what we
12 call a background sheet so that we can ask if people
13 are -- in what work group they belong so we can look
14 at differences between operations, between
15 maintenance, between engineering. We'll also ask
16 people to tell us what their job classification is so
17 that we can then look at differences perhaps between
18 managers and nonmanagers. We'll also ask people for
19 how long have they been employed at Davis-Besse.
20 Because as we all know there are a lot of changes
21 that occur in an organization, and you can often
22 capture subcultures, if you will, based on different
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1 times in the organization or when people came into
2 the organization. So we will have that category as
3 well.

4 So all of the results by the survey
5 will be analyzed by these demographic variables, not
6 on any individual level. In fact, we tell people --
7 and we do not present results if any group is smaller
8 than eight individuals so that we can retain the
9 confidentiality and anonymity of those results.

10 We are planning actually right now to
11 administer -- and I'll go over this again in the
12 schedule, but we're planning to administer the
13 surveys next week at the Davis-Besse site.

14 MR. GROBE: Sonja, your first bullet on page 45,
15 that your goal is to administer the survey to as
16 large a group as possible, what would be the
17 expectation? Would you expect a hundred percent
18 participation in the organization survey, 30 percent
19 participation?

20 DR. HABER: We typically see, when we have good
21 management support and good communication, we
22 typically see 85 to 90 percent of the population. We
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1 won't use anything less -- or close to 50 percent to
2 60 percent, because then it's not a representative
3 sample if you're sampling the entire population.

4 MR. GROBE: Could you give us a sense of the
5 magnitude of this survey? Is it ten questions, a
6 hundred questions --

7 DR. HABER: It's about 190 questions. It takes
8 30 to 45 minutes for people to complete. We usually
9 schedule about an hour because some people take
10 longer, some people take shorter. But it's pretty
11 self-explanatory, although we will provide, our
12 people will provide instructions to the group so that
13 in case there are any questions, we will be there to
14 answer them.

15 MR. GROBE: I'm certainly not a survey expert,
16 but I've taken a few. It seems to me that
17 characteristic or effective surveys ask similar
18 questions or get at similar topics in multiple
19 different directions with different types of
20 questions, and there's a validity process in the
21 survey. Is that characteristic of your survey?

22 DR. HABER: Yes. In fact, part of -- the
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1 organizational culture part is actually a copyrighted
2 tool that has a great deal of reliability and
3 validity. The other scales that I mentioned are in
4 the literature, and plus we do additional reliability
5 estimates. And we've also used this in different
6 countries and translated it with very high
7 reliability. So the scales are reliable and they're
8 valid, and the validity has also been demonstrated in
9 the literature as well as in our own work over the
10 period of time. We also have in the survey -- I
11 think it's important because this question does come
12 up. Good surveys are designed so that sabotage is
13 not possible or detectable, and so we do in fact have
14 questions that are in the survey that would detect
15 any type of pattern of answering.

16 MR. DYER: Sonja, could you explain, is this --
17 are the results of your surveys and that going to be
18 correlatable to some of the information, say for
19 instance, Bill Pearce brought forward in September
20 18th, there was a rather startling survey where he
21 talked about the safety culture and where it was at
22 various points, 1999, I think, to 2001, 2002, and
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1 that. So as far as trending correlation, anything
2 like that?

3 DR. HABER: We hope to be able to do some of
4 that in kind of a retrospective analysis of what the
5 site has done, rather than in terms of what we're
6 doing right now. Since I'm still going through the
7 functional analysis portion of this, I'm not familiar
8 yet with all of the data that's available to us from
9 the site's previous activities, but we will intend to
10 try to make those correlations as much as possible.
11 I'm not sure, you know. The survey is not the same
12 survey, so we just want to be careful on how we make
13 those comparisons.

14 MR. GROBE: Before you go on to the -- I looked
15 ahead. I'm sorry. This is a lot of work. Could you
16 give me a sense of how many people are involved in
17 this activity?

18 DR. HABER: Sure. We will have -- actually, we
19 have two people that will be coming to do the surveys
20 because they can be done by a single person, and we
21 hope to do two sessions currently so we can minimize
22 the time of intrusiveness on the site. Then we will

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1 have four people basically onsite for about two
2 weeks, and we will work in teams of two so that we
3 will do two-on-one interviews where possible, and if
4 not, then we'll do one-on-ones. In certain
5 positions, sometimes that's desirable. And the other
6 person may be doing an observation. So we intend to
7 complete this within doing the surveys next week and
8 then two weeks after that. We have done larger
9 organizations in that period of time, so it is doable
10 from our perspective.

11 MR. GROBE: And the functional analysis is
12 essentially prework?

13 DR. HABER: That's right. And we're doing that
14 now, and we don't have to be at the site to do that.

15 MR. GROBE: Thank you.

16 DR. HABER: Okay. Just to tell you a little bit
17 about where the method's been used so you understand
18 some of the issues of credibility and reliability, we
19 have fully implemented the method in 18 different
20 organizations. Included in that are at least 12
21 nuclear plants, and the others are other types of
22 nuclear facilities, and then partially implemented in
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1 17 organizations, additional organizations. What I
2 mean by partially is maybe we only did the survey in
3 those, or maybe we only did some interviews and BARS
4 in those. But in 18 of those we've actually done a
5 full implementation of all the method.

6 We've implemented it across the
7 industries that I've identified here, nuclear power,
8 chemical reprocessing, mining, fossil fuel, health
9 care and the research-type facilities.

10 As I alluded to you earlier, the
11 methodology has been used effectively in five
12 different countries, representing different cultures,
13 in some cases different languages, and has worked
14 rather effectively. And I think most important is
15 that it discriminates between organizations, and that
16 really is helpful. Not only does it allow you to
17 look inside the organization and look for differences
18 within the organization in terms of subcultures or
19 differences that you see that might be useful for
20 management in trying to make intervention, but also
21 you can look across organizations and do some type of
22 comparative analysis. And part of that is because
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1 it's a systematic and standardized type of
2 methodology, and the data you often collect is very
3 structured.

4 MR. DYER: Sonja, did I understand you to say of
5 the 18 fully implemented organizations, 12 are
6 nuclear?

7 DR. HABER: Yes. But two of them are U.S. and
8 others are not. And the U.S. Ones were done in
9 conjunction with the USNRC research.

10 Deliverables. Okay, what can we get
11 after we've done all of this? First thing is that
12 there will be -- we believe, because the nature of
13 this is important for discussion and I think verbal
14 presentation, there will be a debriefing session at
15 the site with management and with employees. It's
16 very important that after you ask employees, of
17 course, to take part in this, that you provide them
18 with the feedback. So we typically do two briefings,
19 one with management and then one with employees.

20 There will be a report provided, and
21 this is what the report will include. It will

22 include an overall conclusion on those generic safety
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1 culture characteristics, the aggressively seeking to
2 know, the consistently communicating and the design
3 of a rewards and incentive system. Probably more
4 useful will be the summary of the specific safety
5 culture characteristics, the five bullets that I
6 talked about, with a description of strengths and
7 areas for improvement. So we will go through each of
8 those, based on some of the sample bullets that I
9 gave you, and identify areas of strengths and areas
10 in need of improvement, based on all of the data
11 collected. This is not just on the survey data, not
12 just on the interview data, but it's an aggregation
13 of that data rolled up into the characteristics to
14 provide that convergent validity.

15 We will provide some conclusions on
16 whether the safety culture characteristics are absent
17 or present. We don't want to always focus on the
18 quantitative. I think we'll all agree that it's
19 important to know first if the safety culture
20 characteristics exist, and then perhaps where are the
21 strength and areas for improvement?

22 And finally, as you alluded to before,
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1 we're going to try to identify trending in these
2 safety culture characteristics, and that will depend
3 largely on what we can get as a retrospective
4 analysis from the functional analysis portion versus
5 the data that we will collect from the evaluation
6 itself. We would like to be able to say that these
7 characteristics are improving or degrading if we have
8 that data available to us. But obviously, we can
9 only collect information at this point in time using
10 our particular evaluation. If, of course, you did
11 this again in another 18 months or two years, then
12 you would be able to go back and look at the trends
13 even in a quantitative sense; and we have done that
14 in a couple of organizations where they've asked us
15 to come back and readminister the method to look at
16 whether or not their interventions were effective.

17 And finally, I think most important is
18 we talk about continuous improvement, is that after
19 the independent evaluation it's our intention to
20 transfer this technology to Davis-Besse or to
21 FirstEnergy so that we can work and perhaps train
22 their people to use these tools so that they can
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1 continuously monitor themselves on these types of
2 characteristics in the future. I think that, from
3 all of my experience, the best way really to ensure
4 continuously improving safety culture is to get
5 people to do self-assessments, to understand the need
6 for these types of characteristics and how they can
7 monitor them over time.

8 MR. WRIGHT: One question. I'm not sure where
9 it fits in this presentation, so I waited toward the
10 end. Where you're dealing with people's beliefs, how
11 does the system, you know, if I really believe what
12 I'm doing is right and we're doing things in the
13 correct manner and the like, how does -- and let's
14 say we're not, as in pre-2002 Davis-Besse, where
15 people thought they were doing things right, they
16 thought they had the right systems, they thought they
17 had the right ways of doing business. How does this
18 system get past that where they think they're right
19 but they're not?

20 DR. HABER: Well, I think that we would
21 acknowledge there's a body of literature and there's
22 a body of experience that identifies what should be
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1 going on with respect to the safety culture
2 characteristics that I mentioned. And what we have
3 to do through the methodology is to match those
4 beliefs and attitudes and perceptions with the
5 artifacts and the claimed values that are actually
6 going on in the site, and so that's why I find that
7 that three-level model is very useful because you can
8 have one or the other, but you really need to have
9 all three of those in synch with one another. I'm
10 not ready to say yet because I'm really not familiar
11 with all of the material, but I would suspect that
12 there are probably ways to uncover, perhaps, what
13 wasn't going right before by some of these types of
14 methods. But you know, that's nice to say, but I
15 can't go back in time and do that.

16 MS. LIPA: Question I have is on the survey, you
17 talked earlier about that there's ways to prevent
18 sabotage and check the validity of the answer. But
19 it seems like there could be some external influences
20 on people might be concerned about losing their job
21 if the plant doesn't start up. And how does your
22 survey guard against people wanting to present the
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1 rosy picture?

2 DR. HABER: That's a good question. That's what
3 we like about the multimethod approach, because then
4 it would also have to come up through all the
5 interviews, it would have to come up through the
6 BARS, it would have to come up through the
7 observation. And over the period of time that we're
8 there -- and I would argue that we'll probably be
9 there during a high tempo period -- it will be hard
10 for all of those things to all line up so that those
11 results were consistent in the fashion that you
12 described.

13 It's been my experience in
14 organizations that have gone through similar
15 situations or perhaps newly transitioned
16 organizations where people are uncertain about the
17 future, that by and large, people are pretty open and
18 honest, especially if they really believe that it
19 will be anonymous and confidential. And that's
20 really one of the main things that we have to
21 ensure.

22 MS. LIPA: So you think that because of the
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1 different approaches, that will help to prevent that
2 bias in the results?

3 DR. HABER: Yes. If we only did the survey,
4 then you're absolutely right. You might have that
5 bias, and you'd have no way to check it against
6 something else.

7 MS. LIPA: Thank you.

8 MR. HILLS: I had a quick question on the
9 results. How are you going to evaluate the results
10 of the interviews, the BARS, the safety culture
11 survey? Is there preestablished criteria on how
12 you're going to judge it? For instance, if a certain
13 percentage of the people answer a certain way, does
14 that predispose a certain conclusion, or do you kind
15 of decide that after you review the data and then
16 come to your conclusions based upon that?

17 DR. HABER: Probably a little bit of both at
18 this point in time. But we have a lot of -- first of
19 all, we have a lot of experience and a lot of data.
20 But with respect to that, we integrated up into the
21 behaviors and then the characteristics. And let me
22 just explain that when we go through the interview
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1 data, for example, we never take any individual
2 interview data. If we don't hear something
3 consistently, it will not be reported in the
4 results. We're not out to just provide anecdotal
5 information, so that if we're looking for
6 communication behavior, just as an example, we need
7 to hear the same story throughout the different
8 functional areas, within the functional areas to
9 report that as a result, or for us to integrate that
10 result into our conclusion.

11 For the quantitative data, you can see
12 profiling fairly easily to look for differences
13 within the organization. So from a survey, where you
14 may not have a criteria on a seven point scale of
15 whether you want to accept a five or a four, we're
16 more interested in the profile of that and if it's
17 consistent in the organization or with discrepancies
18 or flaws. So it's a combination of having the
19 quantitative data to compare it against each other,
20 as well as the aggregation. Did that address it?

21 MR. HILLS: Yes.

22 DR. HABER: The outcomes of the -- continue?
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1 The outcomes of the methodology, just so
2 we understand what the expectations are, is that we
3 will be able to provide a status of those generic
4 and specific safety culture characteristics. We will
5 be able to provide anonymously, that is not
6 identifying the organization, but some comparative
7 results to other nuclear and nonnuclear
8 organizations. I should point out that we have over
9 20,000 people in our data base that have taken the
10 same methodology.

11 And finally, I think what's very
12 important --

13 MR. GROBE: Did you say 25,000?

14 DR. HABER: 20,000. That's nuclear and
15 nonnuclear.

16 MR. GROBE: You've been busy.

17 DR. HABER: Over a period of time.

18 MR. MYERS: One other thing is the nuclear
19 plants that you have in the United States were
20 prederegulation, right?

21 DR. HABER: Yes.

22 MR. MYERS: So there's a base line there that --
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1 DR. HABER: A little bit out of context in terms
2 of time.

3 MR. MYERS: That's good --

4 DR. HABER: Safety culture should have been
5 there.

6 MR. MYERS: That's right. Shouldn't have
7 changed.

8 DR. HABER: I think the last point is also
9 important to mention, and that is that this is a
10 safety culture review, independent evaluation, but
11 it's really only one result which needs to be
12 integrated in ongoing activities and, hopefully, will
13 be viewed that way.

14 We talked a little bit about the
15 schedule. We got notification, started putting a
16 team together and some preparation early in January.
17 We really started collecting some documentation right
18 around the middle of January. As I mentioned, we
19 will start the survey administration next week. We
20 hope to actually get that completed between February
21 4th and February 6th. Of course, some of the shift
22 crews will be doing those on shift. We will be
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1 working with the shift managers to do that, and they
2 will have to be collected over some period of time to
3 get all the crews.

4 The observations will begin, to the
5 extent that we have time, next week, when we're at
6 the site, since we won't be doing survey
7 administration all day. And the interviews and BARS
8 will actually start on February 10th. That's when
9 we'll have the full complement of four people on the
10 site for approximately two weeks.

11 We also intend to identify a few
12 people from the corporate part of the organization
13 for interviews. We will begin analysis and
14 evaluation of the data once we leave the site, which
15 will be around the 21st of February, and then have a
16 briefing and final report sometime probably towards
17 the middle of March or end of March, in that time
18 frame. We haven't fixed that date yet.

19 In summary then, the safety culture
20 review methodology will provide an independent
21 evaluation of the current status of the safety

22 culture characteristics at Davis-Besse. We also
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1 believe that the methodology will assist in the
2 enhancement of safety culture by identifying ways in
3 which the organization can continuously improve its
4 safety culture through self-assessment and continuous
5 monitoring; and just by going through the methodology
6 and learning about it and asking those questions and
7 thinking about those characteristics, you're already
8 going through a learning experience.

9 And finally, the review will
10 facilitate the progression of development of safety
11 culture from the compliance to the performance based
12 to the continuous improvement stages of development.
13 Thank you.

14 MR. GROBE: Questions?

15 MR. DYER: Yeah, one question. This is not
16 necessarily for Sonja, but to Bill Pearce. On the
17 presentation you gave us back on September 18th, is
18 there any ongoing -- does this supercede that, or are
19 you still following up on the training and that which
20 were done on your safety conscious work environment
21 independent assessment?

22 MR. PEARCE: Yes. We intend to continue that.
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1 And when I show the monitor, I'll show you how that
2 -- and that's in addition to what the independent
3 survey will accomplish.

4 MR. GROBE: I've got several questions, but Bill
5 Dean, do you folks have questions at headquarters?

6 MR. DEAN: I have a question regarding how Dr.
7 Haber intends or if she will intend to use any of the
8 information that's been gathered in the past, some of
9 the surveys the licensee has done, or are you
10 basically starting with a clean slate in doing
11 basically a moment in time to assess the status of
12 the plant now?

13 DR. HABER: In terms of integrating the previous
14 activities with what we find?

15 MR. DEAN: Correct.

16 DR. HABER: And your question is how are we
17 going to do that?

18 MR. DEAN: Are you going to do that, or is your
19 methodology really intended to be just a moment in
20 time, taking a snapshot now where is the plant at, or
21 is there an attempt to try and link it with --

22 they've done some surveys and some things in the past
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1 that have indicated the status of the organization to
2 some degree.

3 DR. HABER: Your point is well taken. The
4 methodology strength is in taking a picture now and
5 assessing the status of where the site is now. But
6 as I mentioned, in the functional analysis we do
7 acquire a lot of information that we've asked for
8 about what the plant has done previous to this
9 evaluation. And to the extent that we can integrate
10 those in relevant areas, namely the safety culture
11 characteristics, we will try to do that by pointing
12 them out and perhaps, as I mentioned, even
13 identifying trending of those characteristics as they
14 relate to the safety culture characteristics that
15 we're talking about. I really can't -- sorry?

16 MR. DEAN: I'm sorry, Doctor. I really --
17 really what I was kind of trying to get at is some of
18 the surveys that they've done in the past had some
19 indications that could relate to safety culture. I
20 guess the point I was trying to get to is what you
21 were going to be able to do, at least to provide some
22 assessment of either improvement or lack of
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1 improvement in some of those areas.

2 DR. HABER: We're going to try to do that,
3 identify the trending bullet. We will try to use
4 that information and compare it to the data that we
5 collect at this point in time.

6 MR. DEAN: Okay. Thank you.

7 MR. GROBE: Any other questions?

8 MR. DEAN: Lisa had a question.

9 MS. LISA JARRIELE: This is Lisa. I'm the agency's
10 allegation advisor. I had a question about the
11 BARS. Can individuals request to be interviewed at
12 the site? Is that part of the process?

13 DR. HABER: We have done that. If somebody
14 would like to be interviewed, we'd be more than
15 happy, within some boundaries, of course, because we
16 have limited time at the site, but we have done that
17 in other organizations. If that's something the site
18 would like us to do, we would be happy to do that.

19 MS. LISA JARRIELE: And the second question I had involved
20 your survey. Has the plant or your organization done
21 anything to -- in preparation for educating the
22 employees about the survey and how it's being done

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1 and how they will be protected and what happens to it
2 afterwards? Has there been some sort of an education
3 to enhance their participation in it?

4 DR. HABER: My understanding is there has been a
5 memo that was sent out to management. I'll let the
6 site address that. But we will also provide
7 instruction at the beginning of each survey
8 administration that will state how we will use the
9 results and the confidentiality and anonymity of the
10 results. But I'll let the site address their
11 preparation.

12 MR. GIESE: Do you want me to address that, Lew,
13 or do you want to --

14 MR. MYERS: Either one. What I can tell you is
15 that we're -- our management team is in full
16 support. We've already sent out some memos, and it's
17 our intention to, you know, to make sure that our --
18 all of our employees, through our normal
19 communications process and all town hall meetings, 4C
20 meetings and all this, to understand what we're doing
21 here. So we would hope that we wouldn't find
22 surprises there. So we're telling them every way we
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1 know how.

2 MR. GIESE: It's been introduced in the employee
3 communication document that goes out from our
4 communications department. There have been in the
5 various meetings that have been held it's been talked
6 about. It's been in the media; although that's not
7 our only internal communication, it's certainly been
8 there. And there has been a letter sent to everyone
9 onsite that was in advance of the stand-down meeting
10 that was held a few days ago that spoke to the fact
11 that this survey or this assessment would be going
12 on, it would be independent, it is absolutely
13 private, the folks conducting the surveys, the
14 conversations are not from FirstEnergy or FENOC.
15 They're external to our company. And I think we have
16 dealt with that in a number of ways and we'll
17 continue to do that as we move along.

18 MS. LISA: Thank you.

19 MR. DEAN: That's it for here, Jack. Thanks.

20 MR. GROBE: I've got a number of questions. I
21 guess the first question is more focused on safety
22 culture. Last August, I guess, FirstEnergy concluded
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1 that that was a principal cause of what happened at
2 Davis-Besse, that they had lost their eye on the
3 ball, as it were, the safety ball, and that
4 manifested itself in a number of performance issues
5 throughout the organization which ultimately resulted
6 in the organization not responding to problems
7 properly and the degradation of the reactor pressure
8 vessel proceeding. But what is the process, or what
9 is the time frame, in your experience, that it takes
10 to make adjustments to safety culture? Is that
11 something that's like a switch, or is it something
12 that takes two decades, or is it someplace in
13 between?

14 DR. HABER: That's a good question, and it comes
15 up quite a bit. I think that you can -- we have seen
16 changes in some of the behaviors. They can occur
17 perhaps more readily than changes in the overall
18 culture. Culture, typically, in my experience, has
19 been a three-to-five-year process. And it can --
20 that can change, depending upon the situation. I've
21 been in organizations where new management comes in
22 and there's really a culture of uncertainty for a
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1 while. And that has to settle down before you know
2 what the culture of the organization is going to
3 become. So I think three to five years is usually
4 what's considered to be a reasonable time frame to
5 look for changes in values and attitudes.

6 MR. GROBE: Okay. Interesting. How often --
7 this is a very intrusive tool the way you've
8 described it. I've not seen one of these before.
9 But how often would it be beneficial to pulse the
10 culture of the organization with this type of
11 intrusive tool? And I know, Bill, you're going to
12 get into some ongoing measurement, and I haven't
13 looked ahead on those slides yet. But what kind of
14 period would be appropriate for this kind of a tool?

15 DR. HABER: Well, as I mentioned before, you
16 don't have to always use all of the methods at one
17 point in time. So to do a comprehensive methodology
18 such as we will be doing it at Davis-Besse, we
19 wouldn't recommend doing it in less than two years.
20 But in terms of looking at certain of the behaviors,
21 where you might be able to just, let's say you do a
22 communication intervention because you want to make
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1 your communication process more effective. You could
2 do structured interviews or mass communication, you
3 could do BARS, you might do parts of the survey; you
4 wouldn't have to do the whole thing. So you can
5 use -- as I mentioned, we have done partial
6 implementations, and that's what I'm referring to in
7 different organizations.

8 MR. GROBE: I have a number of questions that
9 focus in the area of independence and inspectability
10 or scrutability. Let me start with the second area
11 first.

12 The report, you described in general
13 terms what type of report you provide. There must be
14 a wealth of supporting data and analysis that backs
15 that up. Is that also available?

16 DR. HABER: That will be provided to the site.

17 MR. GROBE: Okay. What -- we're in the
18 inspection business and -- you noticed that, Lew?
19 But there may be a situation where inspection of some
20 of the aspects of this activity could be disruptive
21 to the activity. Could you go in a little bit to the
22 concept of what aspects of your activity might be
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1 inspectable in process, in lieu -- or as contrasted
2 with after the fact?

3 DR. HABER: Sure. I think that the one area
4 that I feel most uncomfortable with inspection would
5 be the interview. I think, for obvious reasons,
6 because we do tell people it's confidential and
7 anonymous. With respect to observing the
8 observations, I think that that's -- you know, at the
9 site the NRC does sit in on a lot of the meetings and
10 types of things that we would look at, so I don't see
11 that there would be any problem there. We're not
12 asking -- that's really not an intrusive type of
13 activity.

14 With respect to the survey
15 administration, you know, depending upon who's there,
16 you want to ensure anonymity and confidentiality.
17 That might be an issue, but basically all you're
18 doing is watch people fill out a paper-and-pencil
19 questionnaire. That's what's done. So with respect
20 to those methods, I think the interview presents
21 perhaps the biggest obstacle.

22 MR. GROBE: The survey tool itself, is that
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1 something we would have access to?

2 DR. HABER: I'm sure, yeah, we could provide
3 that.

4 MR. GROBE: Let's talk a little bit about
5 independence. We just touched on sampling, and a
6 question was asked earlier about whether or not
7 somebody could volunteer to be interviewed. And I
8 think you described earlier that you don't report an
9 outcome from the interviews unless it's something
10 that appears systemic. You don't report individual
11 anecdotal information. I guess I'm interested in
12 FirstEnergy's view on the sampling and whether
13 they're comfortable with the commitment that this may
14 be a random sampling maybe from Fred's organization.

15 MR. MYERS: Yes.

16 MR. GIESE: Absolutely. In fact, not to demean
17 this, we've just asked a clerical person to pick
18 names, and we've not given directions as to what
19 names, other than Sonja's organization has provided a
20 list of titles or areas, and it is that random. So
21 there is no particular direction given as to who.

22 The question of somebody volunteering has not come
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1 up. Unless there is a problem from Sonja's
2 perspective, we certainly would not object to that.

3 MR. GROBE: I'd want to make sure that that was
4 in addition to the random sample.

5 DR. HABER: I would agree with that. I think
6 that would be an additional interview, not a
7 replacement interview.

8 MR. GROBE: Your reporting process, you're going
9 off to somewhere -- by the way, where is it that you
10 go off to do your analysis and develop a report?
11 Because we might want to visit you.

12 DR. HABER: We do it in our home offices.

13 MR. GROBE: Okay. What's the process that you
14 use to develop the report and deliver it? Is there a
15 draft report that's shared with the company?

16 DR. HABER: Typically, at the time that we come
17 back to give the verbal briefing, we present a draft
18 report. And we allow the organization to check for
19 accuracies in anything that we may have presented --
20 not to change perceptions or beliefs, but if we use
21 an example, we want to make sure we've represented it
22 accurately.

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1 MR. GROBE: Okay. There's -- this is obviously
2 going to be a very important activity to the company,
3 and it's very important that the results of this are
4 clearly independent and demonstrably independent. Is
5 there the possibility that that could be done in a
6 public meeting, or would the company insist on having
7 a draft report and debriefing first before any of
8 this information is shared with the NRC?

9 MR. MYERS: You know, Jack, as we go through
10 this, I think we're perfectly willing to come in and
11 assess what we're doing any time. But we're not
12 allowed to bring this to closure, you know. I'll
13 talk some about what our responsibilities are next
14 before, you know, we put it in a public meeting.
15 Because there's other things we're looking at also.
16 This is just one tool.

17 MR. GROBE: I understand that. It looks like a
18 a good one, though. And I'm not sure you answered my
19 question, and maybe we need to circle back on it
20 later.

21 MR. MYERS: Okay.

22 MR. GROBE: Do you have an example, Sonja, of
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1 what this report is going to look like? I'm not sure
2 you necessarily want to share a report from some
3 other organization, but it's difficult to appreciate
4 what you've done. You've done a good job describing
5 everything that you're going to do, but it's
6 difficult to understand how it all comes together.
7 If we can see it, maybe a format of the report --
8 DR. HABER: I can briefly describe to you what
9 it would look like. The problem, of course,
10 depending on the client and the purpose, whether
11 you're doing it for the Nuclear Regulatory Agency as
12 opposed to the organization itself. But typically,
13 what we have will be an executive summary. We will
14 have the 20- to 25-page content, text content, which
15 will describe, as I mentioned, the deliverables, the
16 characteristics, the areas of the strength and areas
17 of the weakness. And then behind that would be the
18 appendices of the report, which will contain the
19 summary of all the data from the different methods.
20 So it will an aggregation of the interview results;
21 it will be an aggregation of the BARS; it will be an
22 aggregation of the survey data. And actually, the
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1 survey data will be presented -- it's an excellent
2 management tool also, and so they will have a lot of
3 data that they can look at that may go beyond what
4 the results in the report will actually be in terms
5 of what's on it. But basically it will be a text
6 report along the lines of the safety culture
7 characteristics with an executive summary and the
8 accompanying appendices behind. Did that help?

9 MR. GROBE: Yes, I think so.

10 MR. MYERS: One of the things we committed to
11 also in there, we're going to share the results with
12 our people. That's pretty public right there. But I
13 would want to share it with them before I share it
14 with you.

15 MR. PEARCE: Have you had this kind of
16 interaction with other people when you do your base
17 line stuff? In other words, did the Canadian
18 regulators, were they involved in the overview of you
19 doing this base line information? And I'm asking
20 that of pure interest because I don't know the system
21 or the process, and I don't know if we --

22 DR. HABER: Remember that in that case the
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1 client was the regulator.

2 MR. PEARCE: I understand that.

3 DR. HABER: In terms of their involvement in the
4 methodology?

5 MR. PEARCE: Right.

6 DR. HABER: They were actually trying to train up
7 their staff in the methodology, and so some of them
8 would be along.

9 MR. GROBE: Are there publicly available
10 documents where other regulators have evaluated your
11 results? You indicated that you were working for the
12 Canadian nuclear regulators. Are there publicly
13 available documents where they assessed and reported
14 on the results of your activities there?

15 DR. HABER: I'm not sure. The assessment of the
16 assessment, if you will?

17 MR. GROBE: Right. Or the assessment itself,
18 just to confuse it really -- seriously, the detailed
19 plan assessments, as well as an evaluation of your
20 assessment process.

21 DR. HABER: Well, the assessments, I think,
22 would be available through their -- they have an
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1 equivalent Freedom of Information Act. But I'm not
2 sure exactly how they distribute that. I'm not aware
3 of all of those details. I can provide a contact if
4 you're interested in pursuing that.

5 MR. GROBE: Could you provide that to Geoff?
6 That would be great. How about any of the work
7 you've done in Europe, or is most of it --

8 DR. HABER: We did a couple of plants in Spain.
9 I'm not sure that they were -- I believe those
10 reports are for the site organization.

11 MR. GROBE: Okay. Any other questions?

12 MS. LIPA: Yeah. We talked earlier, Jack asked
13 about inspectability. And it occurs to me that one
14 potential opportunity would be this analysis and
15 evaluation beginning on February 21, as far as when
16 your team -- those are like your team's assessment of
17 all the data that you've collected. Is that an
18 opportunity, do you think, to have some inspection
19 work on our part?

20 DR. HABER: Actually, at that point we would
21 just be aggregating interview notes and submitting it
22 to a centralized person -- me -- and the BARS and the
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1 survey will be done. It's done through software,
2 computer software statistical analysis, pretty
3 straightforward. It's not anything unique in that
4 sense. So when we leave the site, we'll have
5 basically raw interview data notes, we will have
6 surveys sent out to be scanned. The BARS will have
7 to be done in terms of calculating means across the
8 groups, and that won't start until after we leave.
9 I'm not sure what they would be to look at at that
10 point. The team will probably not get together
11 again, or maybe once before we have the final draft.
12 It will be circulated to the team members, but a lot
13 of that process occurs individually with people doing
14 their own aggregation and then centralizing it into
15 one location.

16 MR. WRIGHT: Following up with that is the
17 observers observing the observers, in that process.
18 Would there be -- obviously, one of the checks is if
19 I'm watching one of your people observe what would be
20 some activity, I'm writing down or making my own
21 notes of what I observed. The check there would be
22 to have some cross-checks so I could have some access

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1 to the notes from your individual, say, "did you see
2 the same things I saw? Did you see more than I did
3 or did you see only ten percent of what I saw?"

4 Is that -- would it be possible to get
5 or have access to those types of notes?

6 MR. PEARCE: Let me say something there. For
7 QA, right, I have some of the same concerns -- our
8 folks have some of the same concerns about how are we
9 going to do oversight. But a bigger concern on my
10 part is that we don't skew the results. And if
11 before they have not had a comparison of the data
12 when they made their data base, as we go through
13 these separate functions, what effect is having
14 someone come in and compare what they're getting,
15 going to do to the -- on the result now minus the
16 result when the base line was taken? I have no idea
17 and I don't know the process, but that's the thoughts
18 that I had about the QA organization --

19 MR. WRIGHT: Let me step back one then. Let's
20 go back. If it's just a question of when you look at
21 the information, that's different than whether we can
22 look at it at all. I mean, if it's after the
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1 analysis has been done and it's put into the process
2 and you've got a report, you've made your
3 conclusion. Then is it possible to go in and take a
4 look at what the information is at that point and
5 say, "did we see the same things?" You've already
6 used the information. Could we do it at a later
7 time?

8 MR. MYERS: Absolutely.

9 MR. PEARCE: I agree with that.

10 MR. MYERS: And while you're there, if we're
11 doing something, you're always -- if you're there the
12 day I'm being debriefed, you can sit in, you know?

13 MR. WRIGHT: Okay.

14 MR. PEARCE: It's not that we're trying to --
15 you know --

16 MR. WRIGHT: I understood the point. If we come
17 in and start discussing what your people saw versus
18 what I saw, that can have a bad effect on the
19 results. I would say if we can get in at some time
20 to look --

21 MR. MYERS: We intend to be as open as we
22 possibly can. We also intend to be as open with our
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1 people as we can. That's the only way we can take
2 this and use improvements -- turn them into
3 improvements. Are you ready to move forward?

4 MR. GROBE: I think so. Bill, any other
5 questions in headquarters?

6 MR. DEAN: No. We're good here. Thank you.

7 MR. GROBE: If I could just make a comment, Lew,
8 before you move forward. The level and depth of
9 questions we went into here, I don't want that to be
10 interpreted as an overemphasis on this one tool as
11 part of your overall structure. It's just something
12 we haven't seen before, so we wanted to explore it a
13 little bit more thoroughly. And I am particularly
14 sensitive to the issue that you raised, Bill, that we
15 want to make sure that we don't disturb the process
16 in such a way that it would affect the veracity of
17 the outcome, and we will be particularly sensitive to
18 that.

19 So with that, why don't we go on.

20 MR. MYERS: Let me see if I can -- I'd like to
21 think that Dr. Haber -- I'm really excited about

22 this. This is not something I've ever done before,
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1 and I would tell you, this is -- we had our
2 methodology and what we're going to do is I'm going
3 to present to you now, before we brought Dr. Haber in
4 and as we finish this, we might go back and make some
5 changes in things we're doing. So it's a pretty
6 exciting process for me too just to look at it. It's
7 a different way of doing business.

8 So once again, you know, as I told you
9 in August of last year, Davis-Besse's safety culture
10 was mixed. There were several areas of good
11 performance. The plant material condition at
12 Davis-Besse is probably the best of any of our
13 plants, you know. And I've worked at all of them.
14 But the plant material conditions here are good.
15 There was good plant performance prior to then, with
16 few plant trips and the number of personnel areas was
17 quite low when compared to the industry. We were
18 good at addressing several industry issues. In fact,
19 in some cases we sort of were the leaders; for
20 example, when I go back and look at the thermo-lag
21 issues, we were really aggressive in getting the
22 thermo-lag out at Davis-Besse. And in general, from
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1 an industry standpoint and a regulatory standpoint,
2 the performance appeared to be good.

3 FENOC's assessment in 2002 has shown
4 weaknesses in the corrective action program,
5 technical rigor, and the management team having
6 minimum regulatory standards. However, if you go
7 back and you look at the entire event, our people's
8 willingness to write CRs at a very low threshold
9 appears to be constant and consistent.

10 MR. GROBE: I think that's an important point.
11 Every one of the head inspections that identified
12 boric acid on the head was documented in a CR. There
13 was a wealth of CRs --

14 MR. MYERS: Twenty-nine.

15 MR. GROBE: Obviously, the problems weren't
16 properly addressed. But okay.

17 MR. MYERS: FENOC's goal is to verify the
18 adequacy of our safety culture as it exists and take
19 actions to address any weaknesses.

20 It is our management team's
21 responsibility to ensure readiness of our facility.

22 And one of the things that I've been doing recently
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1 is trying to drive us back to a normal organization.
2 And you're not a normal organization when you're in a
3 stand-down. We put a strong management team
4 together, seasoned veteran. Its responsibility for
5 ensuring readiness to move to different modes, take
6 the plant to different positions cannot be
7 delegated. And that's one of the reasons that we
8 bring our contractors in to try to help us do our job
9 better. We have decided to assess our safety culture
10 as we move forward, and I want to explain to you how
11 we were approaching this.

12 First of all, we had planned on rating
13 our commitment areas in a color code type system,
14 similar to the way the industry typically monitors
15 plants. For example, green, we would say a
16 commitment -- that's this little blue box -- all
17 major areas are acceptable with a few minor indicator
18 deviations. So we would say that would be green.

19 MR. GROBE: When you say commitment areas, are
20 you talking about page 10, in the blue boxes there?

21 MR. MYERS: The little blue boxes on the side,
22 right. And then we will rate the overall area as a
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1 management team. So the blue boxes, and based on
2 what you see there, in the commitments, commitment
3 areas. For example, management, management
4 commitment.

5 MR. GROBE: I understand that. Are you going to
6 go into how you get to these colors?

7 MR. MYERS: Yes. Somewhat. White would be all
8 major areas are acceptable with a few indicators
9 requiring immediate management attention. Yellow
10 would be all major areas are acceptable with several
11 indicators requiring immediate management attention.
12 Red would be several major commitments -- that
13 individual blue box, a couple of those -- in a
14 particular area do not meet the standards and require
15 immediate management attention. It's a collective
16 judgment to that process.

17 Here's what we would expect to see.
18 Ratings are based on what we call a convergent
19 assessment. Performance indicators, management
20 observations, demonstrated performance during
21 critical plant evolutions, feedback from an
22 independent safety culture review, and our nuclear
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1 quality assurance assessments would be the areas that
2 we would use to rate our overall safety culture.
3 We've also added Dr. Haber in now to feed into that
4 process, if you will.

5 For readiness for restart as a
6 management team, the type of things we would look for
7 is improving safety culture is a long-term activity.
8 For restart we'd expect to see no red areas.
9 However, we would not expect to assess ourself with
10 all green areas. If we did that, I don't think that
11 I would expect to see that at some of our good
12 operating plants.

13 MR. GROBE: Lew, Sonja didn't expect to see it
14 for five years.

15 MR. WRIGHT: Lew, on that one area, are there
16 any areas that you would say would have to be green
17 before you could proceed?

18 MR. MYERS: No. Here's what we would expect to
19 see. FENOC expects to see some areas that may be
20 white or yellow. The key for restart would be
21 showing improved safety culture, remedial actions for

22 any whites or yellows are in place, and the
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1 management team's assessment that we are ready to
2 move forward at our restart readiness review
3 meetings. That's what we'd expect to see.

4 Now I'd like to talk a little bit
5 about the various areas. Under policy level
6 commitment, there's four commitment -- that area,
7 there's four commitments. Statement of safety
8 policy, management value of structure, resources,
9 oversight self-regulation -- those are commitments.

10 Now, in the first area we would expect
11 to see an establishment of a safety policy and
12 emphasis on regular basis of that policy by
13 management. We will continue to evaluate our message
14 to our employees as we go forward and how they're
15 receiving the message. We'll do that with ad hoc
16 surveys of our employee awareness of the safety
17 policy. We will -- oversight will evaluate the
18 safety conscious work environment and safety
19 performance as we move forward, and we will anchor
20 this in our performance appraisal process, which
21 will -- the first step was the RHR reviews we did for

22 everyone and the new competencies; and then we'll
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1 anchor that in February, when we do -- for the first
2 time with these new competencies, we'll do the
3 Ownership for Excellence evaluations for each one of
4 our people.

5 And then assess the adequacy of
6 resources during the restart reviews. So each and
7 every time that we go to a different plateau in our
8 restart readiness reviews, that we have the right
9 resources and why do our teams and groups think that
10 they're ready to go to the next plateau? So we'll do
11 that in readiness restart review meetings.

12 The next area --

13 MR. GROBE: If we could stop here just for a
14 minute and make sure I understand, because the same
15 questions would apply to the next areas. By the way,
16 they're already learning convergent assessment.
17 That's interesting.

18 MR. MYERS: We picked that up last meeting.

19 MR. GROBE: Who's going to do this convergent
20 assessment? Is that done by the senior management
21 review team or --

22 MR. MYERS: The management team and senior
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1 management review team.

2 MR. GROBE: What role does the restart oversight
3 panel have?

4 MR. MYERS: They have a part of that too. We
5 will present our conclusions to them and make sure
6 it's in line. So the restart -- you have your
7 restart readiness review meetings, and then we
8 present our conclusions to them. Now, the restart
9 oversight panel, from a management standpoint,
10 they're out independently assessing our plan also.
11 So we -- we wouldn't -- we would not go, change,
12 start up without their authorization.

13 MR. GROBE: Just taking this policy level,
14 you've got four areas, statement of policy,
15 management value structure, resources, and oversight
16 and self-regulation, and you were going to develop
17 like a window system, a green, white, yellow, red
18 window system for each of those four areas?

19 MR. MYERS: Right.

20 MR. GROBE: And that window system will have a
21 number of feeding indicators or data sets?

22 MR. MYERS: Right.

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1 MR. GROBE: Is this all described somewhere --

2 MR. MYERS: We're putting it in a business plan
3 now, so that's what we're trying to do now. Now,
4 some of this stuff in this management policy area,
5 they're subjective.

6 MR. GROBE: I understand.

7 MR. MYERS: But wait until I get to the back
8 part, and you'll see more.

9 Now, when you get to the manager level
10 commitment area, the commitments are emphasis on
11 safety, their responsibility, the acceptance of
12 responsibility, qualification and training, and high
13 organizational commitment. I covered those earlier.
14 What would we be looking for in those areas? Well,
15 implementation of the management observation program
16 is effective, you know? That would be a tool.

17 Frequency of plant tours and
18 questioning of observed conditions.

19 Nuclear safety emphasis to employees
20 on a regular basis; can we prove that we're
21 emphasizing safety every day of the week in the way
22 we do business.

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1 Completion of Leadership in Action

2 training and safety conscious work environment

3 training. This will be added to the continuing

4 training for the future.

5 Encouragement of employees'

6 questioning attitudes on safety. And we'll do that

7 with some questions we're asking at the 4C meeting.

8 Recognition of employees who improve

9 safety. Let me tell you what we're doing there. We

10 have an employee of the month program. We're

11 changing that program considerably to focus on the

12 corrective action program and look for CRs that are

13 written that improve safety. And then at the end of

14 the month we'll look for the one that we think

15 improved safety the most, and that's going to be our

16 employee of the month. So that sends a strong

17 message there, we think. So we're changing that

18 program.

19 Application of our decision-making

20 tool. Now, we find cases of management team were not

21 using this tool. We found some cases. We have to

22 push them into -- our expectation would be that we

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1 would write a CR on that, okay?

2 Program ownership. Modifications to
3 improve margins. Can we identify things like the
4 containment emergency sump, long-term equipment
5 problems so that we can assess that we're improving
6 the overall material condition and margins in our
7 plant. Degrading containment air coolers would be an
8 example. We fixed those things for the long-term.

9 And then operator recertification
10 program. That's one of the things we just -- Randy
11 just went and assessed. We completed our operator
12 recertification program with no failures this time.
13 So we would look for performance problems in that
14 area.

15 The next area is clear
16 responsibilities and cohesiveness in management. The
17 kind of things we look at there are personnel error
18 rates, demonstration of clear ownership of the
19 programs, ad hoc surveys to pulse the organization's
20 understanding that nuclear safety is the highest
21 priority, corrective action review board assessments
22 of the ownership of CRs, engineering assessment board
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1 evaluations of ownership -- how good are engineering
2 products; we're already looking at that -- program
3 ownerships for leak rate programs, boric acid
4 programs, and reactivity management programs going
5 forward. We may change those as we move into other
6 areas, but right now those are the areas we want to
7 focus on.

8 Now, the next area under management
9 commitment would be acceptance of responsibility.
10 And the kinds of things we look for there -- and
11 remember what that means is are people going to be
12 doing the things that they're supposed to be doing
13 from our standards standpoint, doing their management
14 observations appropriately, things like that. You
15 see our managers taking on their issues, getting
16 their backlogs down, following through with the
17 actions they're supposed to get done, stuff like
18 that. So what are we looking for there? We're
19 looking for performance appraisals and development
20 plans. Are they following through with the things
21 that we put down under development plans?

22 Ad hoc surveys of willingness to
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1 challenge employees, other managers, and supervisors
2 regarding safety considerations. Do we see that?
3 And does quality see that?

4 System assessments as a means to
5 increase safety margins, such as flus leak monitoring
6 system, the containment emergency sump, diesel air
7 starting system. We've got right now probably one of
8 the best base line of books with all the system
9 issues that we possibly could ever have. There's a
10 lot of information there, and it's outside my
11 office. How do we use that going forward, and
12 continue to assess our systems?

13 Nuclear quality assurance field
14 assessments. We're looking at those.

15 And then finally, the number of
16 management observations requiring coaching. Are we
17 having to coach, how many do we see, and in what
18 areas?

19 The next area under management is
20 qualification and training. Now, remember, that's
21 not just technical training. That's leadership

22 training, supervisory skills training, and the
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1 management skills training. So what are we looking
2 for there? We're looking for performance
3 benchmarking of organizational staffing. You know,
4 we do surveys compared to everyone else. We have the
5 right number of people to do the job.

6 We've completed restart required
7 training already, and we've completed root cause
8 training already. We've completed the operability
9 determination training. A lot of this stuff is done,
10 is what I'm showing you.

11 We've completed training on the legal
12 responsibilities of licensed operators, and we've
13 completed the safety conscious work environment
14 training for 300 people, and completed the stand-down
15 on January 27th for safety culture policy training,
16 and completed training on the decision-making
17 NOP-ER-3001. That was a major issue to get completed
18 prior to fuel-up. So that -- that's the
19 management-type things that we consider a success
20 there.

21 Completed training on case study,
22 completed training on standards and expectations, and
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1 then continuing training identified by the curriculum
2 review committee. So now that we're moving forward,
3 what's the continuing training? And what we will do
4 as we go to the next plateau, we'll be looking for
5 more things, so that list.

6 MS. LIPA: Lew, you have two examples there
7 under the completed training on the problem solving
8 and decision making, decay heat pump and cavity seal.
9 Are those good examples of where that kind of
10 benefits you?

11 MR. MYERS: Yes. Where we see that tool used.
12 There's some areas where we haven't seen it used, you
13 know.

14 MR. DYER: Lew, on the -- you also have one,
15 completed training in legal responsibilities of
16 licensed operators. Is that their duties and
17 responsibilities to --

18 MR. MYERS: Yes, it is. Yeah.

19 MR. FAST: And it really, Jim, coincides very
20 well with the discussion you've had with our
21 operations about those duties. So we talked about
22 very specific legal requirements for our licensed
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1 operators.

2 MR. DYER: Okay. I hoped that was what it was
3 as opposed to what the legalistic requirements are.
4 That's the wrong --

5 MR. MYERS: So if you went right now and said
6 assess us for fuel load, these are the things we
7 wanted to get done. Did we get them done? Okay.

8 MR. PASSEHL: One more question. Is your
9 operability determination training part of your
10 corrective action procedure, or is that --

11 MR. FAST: It is an outcome. So if there's a
12 condition report that's written with a condition that
13 needs to be evaluated, we use a 9118 process. It's
14 flagged by the senior reactor operator and it goes
15 through the process of operation -- operability
16 evaluation.

17 MR. PASSEHL: But this process is in your
18 procedure? If I looked at your procedure, I would
19 see what's covered in this training in there?

20 MR. MYERS: Yes. It's embedded in the
21 procedure. Now, it's impossible to train -- to write
22 every possible condition, so what we deal with in

1 that training and those kinds of conditions, and we
2 wanted to do that before we changed -- before we load
3 the fuel. Because we're going to a different
4 plateau, right? So that was something we could
5 assess ourselves, did we get that done?

6 MR. PASSEHL: Thank you.

7 MR. MYERS: The next area is high organizational
8 commitment; and the things we're looking at there are
9 implementation and training of the employees on
10 safety conscious work environment. That took a lot
11 of time, but we wanted to get that done prior to fuel
12 load.

13 Effective employee concerns program.
14 Is it effective enough to move forward? Restart
15 oversight panel assessment, licensed operator
16 pipeline. Do we have the licensed operators in place
17 that we need and for the future? Benchmarking
18 programs against the industry standards, operation
19 crew benchmarking, scheduled management observations
20 program -- are we getting those observations done?
21 And then goals for zero temporary modifications, zero

22 control room deficiencies and zero operator
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1 workarounds.

2 So those are the kinds of goals we're
3 setting. Are we meeting those goals? And we would
4 assess ourselves to this group of things to turn that
5 panel, you know, red, yellow, white, whatever, you
6 know?

7 Now, the next area is the individual.
8 And when we talk about the individual, now we're
9 getting into some things that are no longer as
10 subjective, and I use a different term than -- if you
11 look, it's called performance monitoring. In that
12 area we have drive for excellence, questioning
13 attitude, rigorous work control, open communications
14 and nuclear professionalism as the commitments.
15 Now -- and they would be the commitment area of
16 individual commitment.

17 Now, from a performance monitoring
18 standpoint, the things that we would look for for
19 drive for excellence is the number of systems
20 classified in the a(1) category, you know? When we
21 start up this time, for instance, we had four or five
22 systems that were in a(1). Our intention is to have
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1 those in the monitoring mode of a(1) prior to
2 start-up, so we call that a success if we can meet
3 that goal. So for each one of these things we have
4 goals.

5 Number of operator workarounds, number
6 of temporary modifications, number of control room
7 deficiencies, individual error rates, number of
8 long-standing equipment problems, percent of
9 self-identified condition reports. We have to write
10 condition reports, so how much of those were
11 self-identified? And then engineering assessment
12 review board index, and that's where we grade the
13 engineering product.

14 MR. GROBE: Lew, before you go on from that
15 page, what is your expectation with the
16 identification of conditions by the working level
17 staff as contrasted with supervision or management?
18 Do you have an expectation or monitor indicator that
19 looks at how many of your front line folks are
20 identifying condition reports as contrasted with
21 supervisory and management folks?

22 MR. MYERS: What we do at our other plants --
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1 two things. From a management standpoint, we look
2 at -- we have a performance indicator that where we
3 look across the board at the number of CRs written by
4 group. And that was really a telling story at Beaver
5 Valley. Now, that's from the management standpoint.
6 And so if you see, you know, that all your condition
7 reports have been written by your IC department and
8 none by the mechanical, that's a problem, you know.
9 So we do address those areas.

10 Now, in individual department
11 performance indicators, what you'll see is the number
12 of CRs written per person, you know. So if you've
13 got people that haven't written a CR in two years,
14 you probably have to ask them why. So -- and what
15 you're seeing, we're going to install in our plants
16 the same thing that you'll see at our Beaver Valley
17 plant. Each department has group performance
18 indicators that are in the department area like that,
19 and they're in a shadow box and lit up and pretty
20 much all of our people can tell you those kinds of
21 things at that threshold. So we will have those
22 installed in the next couple months, I think.

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1 MR. PEARCE: We're trying to procure the boxes,
2 and they're hard to get.

3 MR. MYERS: I think I finished drive for
4 excellence.

5 MR. PEARCE: You wouldn't believe how hard they
6 are to get.

7 MR. GROBE: I believe you. Is there some unique
8 reason that you isolated number of engineering
9 condition reports outstanding? Is that a resolution
10 of old issues, or is there something else going on
11 there? Second to the last dash on page 62.

12 MR. MYERS: Looking for old issues.

13 MR. GROBE: So that's essentially the workdown
14 of the backlog of old design issues.

15 MR. MYERS: Old design issues.

16 MR. GROBE: Okay. I understand. I have not
17 seen before the, quote, "number of longstanding
18 equipment problems" as an indicator. How do you
19 measure that?

20 MR. MYERS: What we do is we look at our
21 equipment problems that are three, four, five years

22 old, and we have a top ten list that goes in our
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1 business plan at Perry and Beaver Valley, and we look
2 at how well we're performing working those out.

3 MR. GROBE: Okay. I understand.

4 MR. MYERS: Questioning attitude. The things
5 that we can look at there -- and once again, there
6 are some things that you can actually go physically
7 measure now is quality of prejob briefings as
8 management observation. What's the quality of those
9 things we're seeing? How many times do we have to do
10 management intervention? So we can monitor that.

11 Number of condition reports, CRs, if
12 you will, per person per group, once again. Number
13 of programmatic CRs that are against our programs.
14 The number of procedure problems and the number and
15 type of operational events -- tagging errors,
16 mispositioning, and things like that.

17 Now, under rigorous work control, you
18 remember I indicated that was more than just the work
19 control process. So we would look there at the
20 employee event free clock error rate. We have a
21 systematic process -- procedure, if you will, for
22 resetting our event free clock common at all three of
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1 our plants. So do we see trends there.

2 Industrial safety index. We can
3 measure that.

4 Employee error rate. We can measure
5 that.

6 Program process error rate,
7 significant human performance errors resulting in
8 plant transients, and backlog of procedure change
9 requests. Once again, that's something other than
10 just a work control process.

11 Quality control hold point/rework.
12 When our quality people go out for their hold points,
13 how many times do they have to stop the job and do
14 something different because they find a problem, you
15 know? And we think that's a good indicator.

16 Number of work orders in the
17 backlog -- oh, yeah. Number of work orders scheduled
18 to be completed each week versus what gets
19 completed. That's a tool we use at our other two
20 plants also.

21 The number of late PMs. One of our
22 other plants used to have a number of late PMs.

1 Today they don't have but two or three at the most,
2 and so number of late PMs is a good indicator.

3 Backlog of corrective maintenance, and
4 once again, number of a(1) systems. Now, in the area
5 of open communications, this gets a little hard. The
6 -- you get back then into the willingness of people
7 to identify problems. So we look at the number of
8 condition reports per person per group, and that's
9 that indicator that we use at our other plants. We
10 look at does it seem reasonable? Is there one group
11 out of line? And last year at our Beaver Valley
12 plant we found several areas there we wanted to
13 improve. So we think that's a good indicator.

14 The number of concerns going to
15 employee concerns programs versus the NRC. So does
16 it look like our employee concerns program is working
17 well for us?

18 Once again, we'll do ad hoc surveys
19 pulsing the organization about communications.

20 And then finally, feedback from our
21 4Cs meeting, that we ask some questions there that we
22 ask everyone each meeting to provide an assessment of
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1 the meeting. So we intend to trend that stuff.

2 And then finally, the SCORE program we
3 talked about a while ago, the peer program. We'll
4 use that to monitor.

5 Then the last area is nuclear
6 professionalism. I defined that a while ago as
7 understand what you're dealing with when you're
8 working on something in the plant, whether it be a
9 safety evaluation or working on a physical job.

10 And the things we would look at there
11 is completion of Ownership For Excellence, you know.
12 When you get in these jobs, you've got, I think it's
13 a year to complete the Leadership in Action. So the
14 completion of the Ownership for Excellence items,
15 training attendance, rework, individual developmental
16 plans, results of engineering assessment board
17 assessments, the number of yellow windows in
18 training. If you go look at the tool we use at our
19 plants for -- that's been very, very successful, and
20 we got that from the industry more than anywhere else
21 and improved on it is that each one of the
22 subcommittees grades their training effectiveness,
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1 and then that feeds up to the training review board,
2 which I chair, and we look at that routinely.

3 The absence of low-level radiation
4 protection events in our plant, and then chemistry
5 performance index. That's something we can monitor
6 also. So if you go look right now at what we have in
7 place, you have the first couple of areas that are
8 somewhat -- what was the word I used? -- somewhat
9 subjective, I would say. And then the last area that
10 we can physically monitor how we do work and behave
11 in the plant on an individual basis and what are
12 those performance indicators that we have there that
13 we can go look at? So those are the key areas that
14 we're looking at right now as a management team.

15 MR. GROBE: How often do you expect to assess
16 these?

17 MR. MYERS: You know, some of these things will
18 be monthly and some of them will be probably
19 quarterly, you know. But right now we would expect
20 to assess these at each and every -- as we go
21 forward, because we're changing conditions, at each
22 and every readiness review board meeting when we
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1 change modes or whatever. We probably would not do a
2 restart readiness board before mode four to five, but
3 we'll do one prior to fuel load, mode four, and then
4 prior to breakout.

5 MR. GROBE: When will the guidance for doing
6 this be completed?

7 MR. MYERS: Well, we have some of this already,
8 like we already have all the business -- we've got a
9 really good tool I'll show you. I think you may have
10 seen it for the restart readiness review board
11 meetings. Did you see that with all the --

12 MR. GROBE: Sure. I think so. The handout at
13 the meeting?

14 MR. MYERS: Right. That's all done. And that's
15 what we're using right now. Then we're building this
16 business case that we'll be using in the future, and
17 that will probably be done in the next month,
18 anyway.

19 MR. GROBE: Okay. Before we go into -- I
20 assume, Bill, you were going to talk about -- other
21 questions on this part?

22 MS. LIPA: Yeah. We talked about that packet
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1 that Jack saw at the restart readiness review board,
2 but it seems like a lot of these factors are going to
3 be like the number of yellow windows. Have you
4 already defined your criteria for what makes that,
5 the number of a(1) systems? Have you already defined
6 how you're going to get green and white?

7 MR. MYERS: No.

8 MR. WRIGHT: Lew, just one other detail. On one
9 of the items that I know you do track right now is
10 looking at the coding of condition reports, the
11 initial coding versus what the panel finally comes up
12 with. I may have missed it when you were going
13 through --

14 MR. PEARCE: It's in this.

15 MR. WRIGHT: Okay. Thank you.

16 MR. DEAN: Jack, I have a question here from
17 headquarters.

18 Lew, with respect to the -- within the
19 individual commitment areas, I notice there was some
20 duplication of some of the measures as you move from
21 blue box to blue box. Is that a sense that some of
22 these give you indications in several different
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1 areas, or does there need to be a little bit more of
2 an emphasis on what truly contributes to each one of
3 these boxes?

4 MR. MYERS: No. When we put these together, I
5 looked at that, and I really think that as you're
6 grading that particular commitment, individual
7 commitment, that this is applicable to that. So
8 there may be six things there, and any three of them
9 may turn the thing yellow, you know. So to delete it
10 would be deleting something that, even though it may
11 be repetitive, but you need it for that box, you
12 know? So no. To assess it there, I think is
13 appropriate.

14 MR. DEAN: I thought that Geoff asked a good
15 question earlier about, I would think that there
16 would be some boxes here, you talk about they all
17 don't have to be green. I think there's probably
18 some here that you would want to have green before
19 you even considered restart. You know, for example,
20 manager's commitment on emphasis on safety, I would
21 hope that you would think that would be a green box
22 before you started up.

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1 MR. MYERS: I would hope so. But you know, I
2 think it's too early to tell right now, you know.
3 One of the things we would do is we would go back
4 and, what I said is, for instance, we've got our
5 policies. Are we reinforcing those policies? And we
6 may grade ourselves, yeah we're doing a pretty fair
7 job, and make that white, you know. But we'd like to
8 do better. We can identify three meetings where we
9 really reinforce this standard that we think we can
10 do better so -- before we grade ourselves white. So
11 I wouldn't think that that would be the end of the
12 world.

13 MR. DEAN: I think the important thing is that,
14 you know, in the past -- and we may be quibbling over
15 some details here, but the important thing here is at
16 least this provides a basis for dialogue and
17 discussion where we can have some appropriate
18 assessment discussions about how are you doing in
19 certain areas related to safety culture, which we
20 were struggling with in the past. So at least this
21 provides some sort of framework for doing that, so I
22 think that's a real good benefit.

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1 MR. MYERS: Yeah, I do too.

2 MR. GROBE: Other questions from headquarters,
3 Bill?

4 MR. DEAN: No, Jack.

5 MR. GROBE: Okay. Anything else here?

6 Okay, Bill.

7 MR. PEARCE: What I'm going to show you again is
8 the four pillars and very similar process. In fact,
9 it's supposed to fit in with the way Lew is
10 monitoring the safety culture issue.

11 So the first one is look at the
12 management support, worker confidence area. And
13 here's something you've been asking about is the
14 results of a standards survey is going to be one of
15 the things in it. And I put on here post core reload
16 because that seems to me to be the right point to do
17 this -- redo this same survey that we did previously,
18 and because -- and the reason I picked that point is
19 I'd like us to actually physically do something with
20 the people and something towards normal operation and
21 get -- just see how we do in performance and then do
22 the survey and see how they're feeling about things,

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1 because a survey is a lot of perception about how
2 they're doing and how they're feeling about their own
3 performance. So that's the point I think is the
4 right point. And that, of course, is not going to be
5 very long, hopefully, and we'll have another survey
6 done. If things were to change in the schedule, I
7 may change when that occurs too.

8 The next one is the NRC concerns or
9 allegations versus the employee concerns program, the
10 performance of those two. And I do in fact have a
11 graph here. Jack, I can give it to you and Jim and
12 let you look at it if you want to. And it's -- but I
13 guess -- you can see from those results that what the
14 graph shows is the number of employee concerns
15 program contacts are going up at a steep rate since
16 we've implemented the new program, and the
17 allegations are building -- the NRC allegations are
18 at a much slower rate. So it shows improvement when
19 comparing one to the other. We're looking at that
20 because that's going to be one of the things we use
21 to monitor this area.

22 MR. DYER: What's the Y axis on this graph, the
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1 number zero to 90? Is that allegations per month?

2 MR. PEARCE: No. That's cumulative since -- if

3 you look at the bottom, it says since 1 January

4 2001 --

5 MR. GROBE: Two. 2002.

6 MR. PEARCE: You're right.

7 MR. DYER: So this says there were no NRC

8 allegations from, according to you, from December

9 through January?

10 MR. PEARCE: None that we've been told of. And

11 then the next thing that we're going to use is

12 quality assurance interviews. And in fact, we

13 started the set of interviews this week, first set to

14 look at safety culture and safety conscious work

15 environment. And we intend that our process is going

16 to have us do ten percent of the employees where we

17 sit down face-to-face with the QA folks with the

18 employees and we go through a set of questions and we

19 write down the results of the questions, and then we

20 do some cumulative assessment of what that's telling

21 us. So that's the quality assurance assessment that

22 we're doing, and that's ongoing presently. And we

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1 will redo that a couple of times to get some feel for
2 this area. You're going to see that come up in
3 several of these pillars, but there's -- I forgot the
4 number of questions. There's 12 questions. So some
5 of the questions are relevant to different pieces of
6 different things.

7 All right. The next pillar is the
8 corrective action process, and here's going to be the
9 things we're looking at there, is the status of the
10 implementation of the corrective action program
11 improvements. We expect those to complete this
12 month.

13 The root cause evaluation quality,
14 that's an output of the corrective action review
15 board that Randy chairs, where they look at all the
16 root causes and how many did they reject versus how
17 many did they accept? So that will be a measure.

18 Condition report category accuracy.
19 Geoff, this is a question you asked earlier, is how
20 are we going to use that? And this is where we think
21 it applies here. We look at what the supervisor
22 classifies it versus what the management team
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1 classifies it. That's what we're looking at.

2 Basic cause evaluation quality, this
3 is more of a sampling. We'll go through about the
4 performance improvement group, then go through and
5 look at those basic causes and look at evaluation
6 quality on those. And Randy, you all are looking at
7 those also.

8 MR. FAST: Right.

9 MR. PEARCE: Condition report
10 self-identification rate, another one we talked about
11 earlier; that's the ratio of how many are identified
12 by the line organization versus the oversight or NRC
13 or who else. And results of the survey, again, post
14 core reload, it's the standard survey that we
15 previously performed.

16 And then of course, the quality
17 assurance interview results. There's a couple
18 questions around the CAP program in that interview.

19 The third pillar is the alternate --

20 MR. DYER: Bill, before you leave that one, your
21 review, I understand your basic cause evaluation
22 quality, that will be done by your organization?

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1 MR. PEARCE: No. It's going to be done by the
2 performance improvement with the CARB, actually that
3 data form, and they put that together. But it's a
4 corrective action review board. It's got Randy as
5 the chairman. It has the design engineering manager,
6 Ops manager, maintenance manager, systems engineering
7 manager, chemistry and --

8 MR. DYER: So do I understand that all of these
9 oversight activities are really done by line
10 organizations, and you're just monitoring them?

11 MR. PEARCE: Yes. We sit in on the meetings.
12 We come to independent assessment, what the line
13 organization is doing. Is that what you're asking?

14 MR. DYER: Yes.

15 MR. PEARCE: And we do come to some
16 conclusions.

17 MR. DYER: But no independent technical review
18 on your part?

19 MR. PEARCE: In some areas we do choose to do
20 some independent technical review, and we've got
21 those reports to show that. In fact, when we are

22 doing system health, we picked a couple systems

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1 ourselves, independently went out and paralleled with
2 the line organization and did some work, and then let
3 the line organization do its, and then compared the
4 results at the end to understand if we thought they
5 collected everything and got -- at the right level,
6 and came to our own conclusion with it. And that's
7 how we intend to go ahead with the rest of these
8 processes too.

9 MR. DYER: Where would that fit in this
10 monitoring? Is that one of the --

11 MR. PEARCE: Well, this interview results, at
12 the bottom, but we will issue a -- you know, how
13 we're doing in the area of safety culture and safety
14 conscious work environment. We'll come to an
15 independent assessment of that. And this interview
16 process that we're doing now is one piece of that.
17 Is that what you're asking?

18 MR. DYER: No. I was -- the question, I guess,
19 is -- and I'll use an example -- is are you going to
20 independently sample condition reports away from the
21 CARB and everything else and have your QA,
22 independent QA, corporate QA staff review them soup
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1 to nuts in an area that they have some technical
2 expertise in and then make an independent assessment
3 as to whether or not the line organization is
4 functioning properly?

5 MR. PEARCE: Yes, that's correct, Jim.

6 MR. DYER: How does that fit in --

7 MR. PEARCE: It's not shown --

8 MR. DYER: It's not going to be in here?

9 MR. PEARCE: No. It won't be in here, but we
10 will be giving that feedback.

11 MR. MYERS: We'll use that one way or the other,
12 independent quality assessment we would use that.

13 MR. DYER: Okay.

14 MR. PEARCE: And that's the methodology we've
15 used through this entire process thus far, and you
16 have inspected that in the areas that we've already
17 done. Okay?

18 MR. MYERS: What's sort of interesting, getting
19 back to safety culture again, is back -- if you go
20 back and read some of the quality assessment reports,
21 for example, on the corrective action program a year

22 or two ago, they're just really well-written
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1 reports. When you read them, then you look at the
2 overall conclusion they come to, there's a complete
3 disconnect. They're really well written. So the
4 independence that he has now with these reports
5 coming to the right conclusions, I think, will help
6 drive us along pretty well.

7 MR. PEARCE: Okay. And the third pillar is the
8 employee concerns program, and of course, we use the
9 use of employee concerns program by employees; that's
10 a number of concerns they're collecting. This is one
11 that we're working on. And in fact, we've got some
12 data. I didn't bring it with me, but satisfaction of
13 employees that have used it, employee concerns
14 program, where we go back in our -- we've got a
15 little process where we go back after a period of
16 time and go back to the person who had the concern
17 and get some feedback on the satisfaction that they
18 have with the program after they utilized it as an
19 indicator.

20 And then of, course, again, the number
21 of issues directed to NRC versus the number in
22 employee concerns program. I just showed you that.

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1 And the last one is the safety
2 conscious work environment review team, and here's
3 what we reviewed. We looked at the number of times
4 that we actually use the team to review issues and
5 get some type of trend or number out of that. Then
6 we're going to get the effectiveness of the safety
7 conscious work environment review team in avoiding
8 valid discrimination claims. So we'll -- we look at
9 that as a negative indicator because they're supposed
10 to be looking forward, and it should be causing those
11 things not to happen, or at least be on some kind of
12 decreasing trend.

13 And then all valid harassment,
14 intimidation, retaliation, discrimination reports.
15 So if we get something in the ECP or into the NRC and
16 we find that we've had a valid HIRD issue, then that
17 ought to be an indicator against this team looking
18 forward about why didn't we get that into the program
19 and do something ahead of time before we got there?
20 And I think that will be alarming for us, and we
21 should see those decreasing.

22 And the number of actions reviewed
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1 versus the number of actions rejected. This is a
2 little different indicator in that what happens at
3 this team level is that the manager or supervisor
4 that's got some issue or decides they're going to
5 discipline someone in the organization, they bring in
6 their recommendation, you know -- give background and
7 then the recommendation of what they think ought to
8 happen. If the team has to intervene to change the
9 level of what is going to go on because of some
10 issues, then we want to collect that to give feedback
11 to the managers and see if we've got our managers
12 properly attuned to be able to understand the level
13 and the types of things that they -- how they should
14 deal with issues.

15 And so that's the safety conscious
16 environment review team indicators.

17 MR. GROBE: Questions?

18 MR. PEARCE: Okay. I think Mr. Saunders is
19 going to give us closing remarks.

20 MR. SAUNDERS: Put the next slide up, please.

21 This is the atmosphere that we are developing, and

22 I'm not going to read you those attributes. You can

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1 read them yourself.

2 What I'd like to do is go back to
3 mid-2002, and recall that we commissioned a root
4 cause, what I refer to as the management root cause,
5 and it was published, I believe, in August of last
6 year. I thought it was thorough, comprehensive, hard
7 hitting, and I thought it was very clear and open
8 about our shortcomings and who was responsible for
9 them. And I think we did a very fine job of that.

10 Actually, I'm very proud of that piece of work.
11 What it really determined is that
12 management had a less-than-adequate nuclear safety
13 focus. That's what it determined. Production
14 focus. I think we presented you some material here
15 today that shows you that we clearly understand it
16 has to be a balanced approach, that if you do not
17 have a safety focus, you don't even get to play in
18 the game. We clearly understand that, so we do not
19 have production focus over safety.

20 Davis-Besse was operated as a
21 stand-alone plant. Well, I think if you look at the
22 new management structure that we've put in place,
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1 chief operating officer, another executive over the
2 top of engineering, and our establishment of a
3 corporate organization, it is not going to ever be a
4 stand-alone plant again.

5 Conditions were identified as relative
6 low threshold. I think that's very, very important.
7 As Lew said, 29 condition reports were written on the
8 reactor vessel head. The problem was recognition of
9 the importance of those reports and then proper
10 execution of what work should have been done in
11 response to them. I think our new corrective action
12 program, our new management team in place, will never
13 let that happen again.

14 Quality assurance findings were of
15 mixed quality. They were. We've got some fine
16 people in that organization, and I think under Bill's
17 stewardship, they have come a long way in a very
18 short period of time. They have become a quality
19 group. And a little simple example, we have a 0730
20 operation call every morning, and Bill, of course, is
21 on that call, and we talk about the daily activities
22 of the plants. And then Bill has an 11:30 call for
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1 quality assurance, and he better hear all the same
2 stuff out of his group or there's going to be
3 something to pay. Just a little insight as to how
4 that group is performing now.

5 Ops didn't have an active role in
6 really making improvements in the plant. We have
7 placed operations in a leadership role now. We have
8 good leadership there, and we emphasize that every
9 day. So we feel that we've got that well on its
10 way. I just thought it was important to go back over
11 that root cause and let you know that we think we
12 have effectively addressed problems that we have
13 identified. So FirstEnergy is definitely committed
14 to nuclear safety, and that's from the board room to
15 the control room. Thank you.

16 MR. GROBE: Okay. Questions? Bill, do you guys
17 have any questions from headquarters?

18 MR. DEAN: I have one question and maybe a
19 comment or two. My question is that you've
20 established a framework now, a monitoring system. I
21 guess what will be the first time that we will have

22 the opportunity to see how you've graded yourselves

1 in those areas so that can form a basis for dialogue
2 in our public meetings?

3 MR. MYERS: I think we're doing that. We have
4 been having -- we start readiness review meetings
5 now, we've had four days of those, and we're getting
6 ready to have another one Monday morning of this week
7 to determine why we should load fuel, you know? Why
8 are we okay and why should we go load fuel? And what
9 we're doing in those meetings is grading these
10 things. And you know, we won't go load fuel until
11 we're ready. And some of the things that's fallen
12 out of that is, like I said, we had 180 items, which
13 some of it was training and some of it was some
14 policies we wanted to get in place, and other things
15 were procedure changes. But a lot of it was
16 equipment. For instance, we're really pushing hard
17 to go ahead and complete the second decay heat pump
18 prior to fuel load, you know? So we're trying to get
19 that done.

20 So if you go look at that, I think
21 that's the meetings I would invite you to come and
22 sit in. And then the way I've thought about this,
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1 anyway, you have these restart readiness review
2 meetings, and they get you to the point now you're
3 ready to go in sustained monitoring, and that's when
4 we would start putting out like the monthly reports
5 or whatever on the sustained performance, you know?

6 So that's the way I've seen this, anyway.
7 MR. DEAN: I guess the issue I'm trying to get
8 at, Lew, is that we and you have identified the
9 safety culture as an issue that needs to have some
10 definitive progress before consideration of restart.

11 MR. MYERS: Right.

12 MR. DEAN: Thus far, discussions publicly have
13 been of an anecdotal nature, talking about insights
14 you get from the 4Cs meeting, talking about how
15 you've dealt with various equipment issues and doing
16 things to improve margin and so on and so forth. But
17 there really isn't anything out there that provides a
18 face on the whole effort to look at safety culture at
19 Davis-Besse. And what you've established now is a
20 monitoring framework that can do that, which is
21 green, white, yellow red windows. So what I'm
22 getting at is I think that would serve as a very good
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1 public display that then could form a basis for our
2 dialogue at 0350 panel meetings where we can talk
3 about okay, we've assessed this area as yellow, and
4 here's why. Here's what we've kind of got to do
5 about it. I think that that would help the public,
6 as well as us, better understand how it is that you
7 look at yourself from a safety culture assessment and
8 what it is that you're doing about it.

9 MR. MYERS: For instance, we'll be ready to talk
10 about how we assess ourselves and some basis for that
11 at the next 350 meeting, public meeting, because by
12 then, we will -- I hope we'll be loading fuel. We
13 won't load fuel until we assess ourselves ready to
14 load fuel, you know, and so -- then the next one will
15 be mode four. We won't go to mode four until we
16 assess ourselves ready to go to mode four, you know?
17 So each one of those we'll be able to talk about how
18 we assessed at those meetings.

19 MR. DEAN: Okay. My only comment is -- thanks,
20 Lew. My only comment is that I greatly appreciate
21 the fact that we now have this framework that we can
22 more effectively monitor and discuss what's going on
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1 in the safety culture world, and I think the
2 inclusion of the independent assessment that Dr.
3 Haber is doing will provide certainly some good
4 validation of your efforts and your state of affairs
5 in that regard. So I think what we've heard today,
6 generally, has been pretty positive, from my
7 perspective.

8 MR. MYERS: I'm really excited about, you know,
9 I believe we'll get the -- we'll make this transition
10 and then somewhere along the line we'll get this
11 report back. And it's going to be interesting to see
12 if that report matches up with our assessment. That
13 may cause us to change it somewhat, okay? So we're
14 looking forward to that. We think it's a healthy
15 thing too.

16 MR. DEAN: That's all from here, Jack. Thank
17 you.

18 MR. GROBE: Thank you. Just a couple of
19 observations. I think this meeting has been
20 extremely informative. It's pulled together a lot of
21 issues, a lot of activities that have been ongoing
22 for months. The NRC has been inspecting many of
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1 those activities in process, from detailed things
2 like attending 4Cs meetings and the safety conscious
3 work environment review teams, SCWERT meetings, and
4 various training activities have been ongoing. So we
5 have been engaged in this, but we have not been able
6 to articulate clearly how it all pulls together, and
7 this has been quite helpful.

8 The morning session -- I just want to
9 ask one question just as confirmation. You described
10 a variety of corrective actions that you have ongoing
11 for the safety culture area. Are all of those
12 captured in your management performance building
13 block?

14 MR. MYERS: You know, I don't want to answer the
15 question wrong, but I think the question is probably
16 yes.

17 MR. ESHELMAN: We've been developing these
18 activities since these -- since we first got into
19 this. And as we have been developing, part of my
20 role is making sure that they're in the corrective
21 action program. That's what we're using as a
22 tracking mechanism, so each of those activities will
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1 end up in the corrective action program which then
2 will get into my plan. And in revision one, which
3 we're working on after Sonja's assessment, will
4 reflect those.

5 MR. MYERS: The problem is I'm always coming up
6 with something else to do that I forget to tell him
7 about.

8 MR. GROBE: So shortly the management human
9 performance improvement plan will be capturing all of
10 these activities?

11 MR. MYERS: Should, yes.

12 MR. GROBE: It's not often that the NRC moves
13 into this area of assessing safety culture. It has
14 occurred in the past. The commission has established
15 a policy on safety conscious work environment, and
16 that's been published since the late '90s -- I think
17 it was '96. Clearly, there has been some visible
18 areas where we've monitored safety conscious work
19 environment and engaged in that area. One is most
20 known, for example, but also, Bill, you might recall
21 the Commonwealth Edison oversight panel in the early
22 to mid '90s, where we gained some insight into these
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1 areas also.

2 I can't remember recently a more
3 comprehensive articulation of an assessment of safety
4 culture. I guess I want to highlight that there are
5 no standards, NRC standards on how to do this. What
6 is important to us is that you have a set of
7 indicators that appears suitable that can be tied to
8 a logical process of monitoring the various
9 activities and areas that you're trying to monitor,
10 and that we understand the results of those
11 indicators and how you're utilizing them. And I
12 think we're headed in the right direction in that
13 regard.

14 Some of our inspections in this area,
15 the material that you presented most recently, the
16 kind of inspection activities we are going to
17 accomplish, I think we've done those before, and
18 they're pretty straightforward. The inspection that
19 you might consider for Dr. Haber's work is not clear
20 to me at all -- you'll probably be discussing --

21 MR. MYERS: Nor us.

22 MR. GROBE: I think that's all the comments I
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1 wanted to make.

2 Jim, do you have any comments before
3 we move into the public session?

4 MR. DYER: No. Thank you, Jack. And I wanted
5 to really echo what Bill Dean and Jack Grobe offered
6 up. It's been a very helpful meeting in trying to
7 get our arms around and understand the issues. And I
8 was thinking more in the background area in getting
9 ready for this meeting and the challenge -- the 0350
10 panel reports to me, and the challenge when we set
11 this up, I know that I spoke to Lew and at least in a
12 meeting one time when we set the panel up, was to
13 understand the root cause and look at the corrective
14 actions and level of involvement that the NRC would
15 be involved with was really the diagnostic or as
16 thorough a look and review of the root causes that we
17 performed as a regulatory agency. And it will either
18 be done by you all with our oversight; or if you
19 didn't do it, then we would have to find a way to do
20 it independently.

21 And I think this was one of the key
22 outstanding areas that, when you looked at all the
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1 root causes and some of the problems that you
2 identified, that I think, as Jack said, we were
3 struggling with understanding how were we going to
4 deal with this issue? And looking back as, also as
5 Jack said, the safety conscious work environment
6 policy statement is really our only guidance in this
7 area, and that talks to two aspects, safety conscious
8 work environment as has been discussed: the
9 discrimination and also the corrective actions aspect
10 of it.

11 And I just want to read the operable
12 paragraph as I went through this background document,
13 was the problem, effective processes, the expectation
14 for effective processes for problem identification
15 and resolution, and it talks, "thus, the commission
16 expects that each licensee will establish a safety
17 conscious environment where employees are encouraged
18 to raise concerns and where such concerns are
19 promptly reviewed, given proper priority, based on
20 their potential safety significance, and
21 appropriately resolved with timely feedback to
22 employees."

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1 And I think, as Bob Saunders just
2 said, in the case of the cavity formation and the
3 boric acid corrosion on the head, that wasn't the
4 case. And that's the key root cause on the 29
5 condition reports written throughout the history of
6 Davis-Besse. And clearly, it isn't a discrimination
7 issue, as it was looked at, at least not that we know
8 of now; but certainly, it was a corrective action
9 violation. It crossed over expectations, it was a
10 corrective actions violation, and the challenge, the
11 0350 panel does, has to look at, is the diagnostic
12 level of understanding and assuring that the
13 corrective actions are effective.

14 And the other thing that -- and again,
15 the 0350 panel still has to figure out how we're
16 going to complete that. But the presentation today
17 serves as a good foundation for them to work on.

18 The other challenge that I'm
19 particularly interested in is right now you're in a
20 restart mode. You've off-managed your organization
21 and have a lot of additional oversight. We're in a
22 manual chapter 0350 oversight role. Both of those
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1 are what I would call anaerobic states on both sides
2 of the organization, areas that we're not going to
3 maintain. And what we have to look to is to the --
4 what is going to be left when -- if and when we exit
5 these oversights, and what is the continuing emphasis
6 that's going to be placed on this area, as well as
7 all the root causes and that of the problem.

8 And I think you discussed at length
9 the enhanced corporate oversight and the
10 organizational increase in assets that you provided
11 to the FENOC organization, and I'm particularly
12 interested in the independent assessment, that it is
13 truly independent. That's why my probing questions
14 on the corrective actions. It can't be just a
15 monitoring of line organization data. It's got to
16 challenge the organization, not be a reporting-out
17 organization.

18 You know, I think Dr. Haber's
19 presentation, as I was looking back at the three
20 components, artifacts, claimed values, and basic
21 assumptions, and I'd echo my experience with
22 Davis-Besse before is that the written reports and
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1 the claimed values and trending and everything you'd
2 see around the plant were pretty good. There were
3 some innovative risk tracking initiatives and awards
4 given and that, but the basic assumptions weren't
5 there. And that's the challenging one, and that's
6 the one that the corporate organization and the line
7 organization has to make sure they get to, not only
8 in the process of improving their standards to an
9 acceptable level, but establish the programs that
10 will be ongoing and continuing to make sure that
11 there's no backsliding. And that's what I'm going to
12 look to, the 0350 panel, to provide to me, you know,
13 as part of our restart deliberations. So that's it.

14 MR. GROBE: Thanks, Jim. It's 20 minutes to
15 four, central time. Let's take a five-minute break,
16 and then we'll reconvene for questions and comments
17 from members of the public, both here in Chicago and
18 in Washington area and also on the phone.

19 (Whereupon, a recess was had.)

20 MR. GROBE: Thank you. At this time we'd like
21 to move into the second part of the meeting, where
22 members of the public can ask questions of the NRC
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1 staff or make comments, if they so choose. This is
2 kind of a complicated situation because we have at
3 least three venues. We have folks that are here in
4 the Region III office in the Chicago, Illinois area;
5 it's possible we have some folks in headquarters, I'm
6 not sure, in the Washington, D.C. area; and we also
7 have, I think, somewhere on the order of 70 people on
8 the phone.

9 What I'd like to do is first open it
10 up to the folks here in the Region III office, then
11 move to headquarters, and then to the MCI operator
12 and allow her to moderate questions from the folks
13 that are on the phone, and then repeat that just in
14 case somebody came up with an additional question as
15 others were speaking.

16 So why don't we start here in Region
17 III with any members of the public that are here.
18 Please approach the microphone that's on my left-hand
19 side of the room, and state your name and ask your
20 question or provide your comment.

21 MR. WITT: I'm Jerre Witt, county administrator
22 for Iowa County, and also a member of the restart
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1 overview panel. I just have a brief comment. It's
2 been a long meeting. It's been, I think as Jim Dyer
3 said, it's been a productive meeting in terms of
4 learning what's going on here.

5 The only comment I would like to add,
6 because we covered a lot of ground here today, is
7 that I've seen, through many observations, and I
8 think I counted up the other day just to see how many
9 times I've been to meetings on this issue with
10 Davis-Besse in the last year here, and it's somewhere
11 over 60 meetings, and some of them all day long.

12 The most important meetings I was
13 involved with was with the employees of Davis-Besse,
14 and I think the first meetings were back in August or
15 September and a successive meeting in December, and
16 then in discussions I've been involved with over time
17 with the employees. And I guess what I'd like to
18 comment on is the fact of what I have observed with
19 the employees and with the attitude change and the
20 safety culture that I believe is there with the
21 employees at this time. And I've seen many, many
22 displays of changes in that culture, and I've also
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1 observed issues brought forward by the employees.
2 And I think that's important here because when it
3 really comes down to where the rubber hits the road,
4 it's really there with the employees. I think the
5 management team has certainly ingrained that culture,
6 and I think it's happening.

7 And the other one comment I would like
8 to make is I know you've talked today about how
9 certain individuals were picked for this trip as
10 employees. And having observed the comments of some
11 of these individuals in the meetings, I can assure
12 you that they weren't picked because they were coming
13 here to say the right things, because they challenged
14 us in the meetings and I know they've challenged Lew
15 and the management staff; and that's a good and
16 healthy thing, and I'm glad that these individuals
17 are here today to observe what goes on and to make
18 their truthful from-the-heart comments. Thank you.

19 MR. GROBE: Thank you, Jerre. Other individuals
20 here in the Region III office who are interested in
21 asking questions or making a comment?

22 MR. WHITCOMB: Good afternoon. My name is
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1 Howard Whitcomb, and I'm a resident of Ottawa County,
2 northwest Ohio.

3 I had a number of prepared comments,
4 but I would like to focus on a couple of impressions
5 or perceptions -- that word was used this
6 afternoon -- that I've seen this afternoon. First of
7 all, I think FirstEnergy is about ready to embark or
8 is embarking upon, perhaps, one of the most critical
9 tests in its history, and that is the survey of its
10 employees in determining whether or not there's a
11 safety culture. What is disturbing is there is no
12 test acceptance criteria. Right now we're going off,
13 marching off and doing these surveys, but yet, we're
14 not sure what constitutes an acceptable level of
15 safety culture by which we can measure the results of
16 the survey. That is -- presents a particular
17 challenge, but yet that is the big picture that we
18 cannot let pass by.

19 Second of all, I had been approached
20 by several folks, FirstEnergy employees, and they
21 would like me to relay the following. Consider that
22 the current working environment at Davis-Besse
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1 Nuclear plant remains hostile. Within the last two
2 weeks at least two employees who raised concerns to
3 their immediate supervisors or who stopped work for
4 safety reasons received letters of reprimand, verbal
5 threats of harm by coworkers, and/or experienced
6 damage to their personal property while onsite. That
7 is slashed tires. While both the NRC and FirstEnergy
8 managements are aware of these incidents, neither
9 organization has raised or discussed them this
10 morning. Rather, FirstEnergy leadership emphasizes
11 the development of unproven programmatic changes that
12 they are trying to put in place. Any measurable
13 indication of improvement with respect to the
14 creation of the safety conscious working environment
15 has yet to ~~begin~~ begin. Thank you.

16 MR. GROBE: Howard, a couple of observations.
17 We went through what is very clearly a complex
18 analysis that Dr. Haber is going to be leading. I
19 believe she articulated that there are some measures
20 by which she will be judging safety culture and
21 making judgments on whether individual aspects of
22 safety culture, using her tools, are present or need
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1 improvement. I expect that in future public meetings
2 we'll be getting into more detail on that assessment
3 approach and the measurement technique that she's
4 using.

5 In addition, Lew and Bill presented
6 their ongoing assessment approach. We have not yet
7 seen that in writing, other than these slides, and
8 we'll be looking at that in more detail also. I
9 appreciate your comments in that regard.

10 On the second issue that you raised,
11 I'm very interested in additional details on the
12 specific examples, of course privately, that you
13 raised. We are unaware of the examples that you
14 raised. You stated that both NRC and FirstEnergy is
15 aware of that. That's not true. We are not aware of
16 that, but we would appreciate any specific
17 information that you would have on specific concerns
18 of a lack of a safety conscious work environment at
19 Davis-Besse.

20 MR. WHITCOMB: I believe two folks from Region
21 Ill have already spoken to one of the individuals. I
22 don't know what the results of that investigation are
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1 at this point.

2 MR. GROBE: Well, we should do this privately.

3 Actually, Brent, could you raise your hand? Brent

4 Clayton is the person I'd like you to talk with, if

5 you don't mind. Thank you.

6 Okay. Any other members of the public

7 here in Region III that desire to make a comment or

8 ask a question?

9 MR. DYER: I'd just like to comment on one of

10 Howard's questions, and let me ask FirstEnergy too.

11 The issue of acceptance criteria, again, I view this

12 as -- we heard the framework and that. What is the

13 -- I mean, you have benchmarking and comparisons and

14 that. Is it your intent to have your evaluation

15 criteria as you go in, or is this going to be a

16 consulting report made by --

17 MR. MYERS: I don't know if I know the answer to

18 that. Right now our process will have us ~~assess~~ assess the

19 areas that I told you about. We will not -- if we

20 assess those areas as red, we would not do something

21 before we change modes or restart it ourselves. Then

22 we would look to our oversight panel, the restart

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1 oversight panel, to provide us input. And if we had
2 multiple areas that were all yellow, we would be very
3 concerned about that too. So our intention is to
4 assess ourselves. Some things are objective -- are
5 subjective prior to each basic change in plant
6 conditions, and we won't move forward until we're
7 comfortable that we should move forward.

8 MR. DYER: What I was referring to is some of
9 them are subjective, but some of them are objective.
10 You had ratios and you talk about numbers and things
11 like that; and I guess, in my mind, when Howard asked
12 that question, the question I had is do you develop
13 your acceptance criteria before or after you see the
14 results?

15 MR. MYERS: No, no. Before. We've got goals on
16 all those things.

17 MR. DYER: Okay. Because I didn't ask that --

18 MR. MYERS: You know, for corrective maintenance
19 backlog, we have a goal right now, I think -- we came
20 down, we were going around 250 corrective maintenance
21 backlog ~~area~~ items. That's rough, you know, but we intend
22 to be in that same range when we restart, you know,
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1 from a corrective standpoint. So you know, not only
2 have we done all the things that we're doing, we've
3 maintained material condition at the plant. We have
4 goals in those areas; rework goals, stuff like that.
5 We have all that.

6 MR. DYER: Okay. So then you understand you're
7 going to establish acceptance criteria before you get
8 the results and you come up with your color scheme on
9 your thresholds?

10 MR. MYERS: Right.

11 MR. DYER: Okay.

12 MR. GROBE: Okay. Thanks, Jim.

13 Any other questions or comments from
14 members of the public that are here in Region III?

15 Bill Dean in headquarters, do you have
16 any folks there that have questions or comments?

17 MR. DEAN: There are no members of the public in
18 our meeting.

19 MR. GROBE: Okay, great. I'd like now to turn
20 it over to the MCI operator and let her moderate any
21 questions from folks that are on the phone.

22 MCI OPERATOR: Thank you, sir. For any
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1 participants on the audio portion, if you would like
2 to ask a question, you may press Star 1, and you will
3 be announced prior to asking your question. If you
4 withdraw your question, you may press Star 2. Once
5 again, to ask a question, please press Star 1.

6 We do have a question from Paul
7 Ridzon.

8 MR. RIDZON: Good afternoon. This is Paul
9 Ridzon at McDonald Investments. I think this topic
10 was touched on by some questions from headquarters,
11 but it did not come through the phone lines very
12 clearly. It appears as though FENOC has established
13 some pretty comprehensive metrics. I'm wondering if
14 that was basically the desired outcome of the meeting
15 today or whether you wanted to see some
16 quantification of those metrics or any actual
17 discussion of trends in those metrics and whether
18 that, getting those items, the quantifications or
19 trends, is going to be paramount to actually have
20 that information before you allow a restart?

21 MR. GROBE: Paul, could you spell your last
22 name?

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1 MR. RIDZON: R-I-D-Z-O-N.

2 MR. GROBE: R-I-D-Z-O-N. Thank you. First, the
3 purpose of this meeting was not to specifically
4 discuss performance indicators as much as it was to
5 gain a comprehensive insight as to the activities,
6 corrective actions that FirstEnergy has undertaken,
7 as well as understand how they're going to be
8 measuring safety culture and safety conscious work
9 environment going forward. We did not receive today,
10 I don't believe, any specific quantified performance
11 indicators, so I don't have a response to that part
12 of your question.

13 The second part of your question
14 concerned restart. And maybe it would be helpful
15 just to explain a little bit of the restart process.
16 There's an oversight panel that is comprised of the
17 people here in the region, NRC employees here in the
18 regional office, in our headquarters offices and at
19 the Davis-Besse facility, who are monitoring and
20 assessing licensee performance.

21 At some point in time I anticipate
22 FirstEnergy will believe that they're prepared to
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1 restart the plant, at which time they will meet with
2 the NRC in conformance and describe their basis or
3 their belief that they're ready to restart the
4 plant. The oversight panel will have been and
5 continues to monitor FirstEnergy performance, and
6 would provide its insights to Jim Dyer. The plant
7 would not be -- the NRC would not approve restart of
8 the plant until the oversight panel made a
9 recommendation to Jim and he were to accept that
10 recommendation; and he would do so in consultation
11 with the offices of nuclear reactor regulation and
12 headquarters and the executive director of operations
13 in headquarters. So it's a process that moves
14 forward.

15 One of the elements of the process --
16 it's guided, the process is guided by what we call a
17 restart checklist, and one of the elements on the
18 checklist is management and human performance.
19 Within that aspect of the checklist is the topic that
20 we were talking about today, and that is the safety
21 conscious work environment at the facility and the
22 safety culture. And Geoff Wright here with us today
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1 led the first phase of inspection into that area, and
2 we have additional inspections planned. We've also
3 been regularly attending a variety of the corrective
4 actions the FirstEnergy employees described in the
5 first part of today's meeting. So we have a number
6 of inspection insights to date that the panel has at
7 its disposal for considering performance at
8 FirstEnergy, and we will have a number of additional
9 inspections before the panel would make a judgment on
10 that specific aspect of the restart checklist, and
11 that is the management and human performance aspect.

12 So I think I've answered your
13 question. Do you have any other issues or questions
14 with the information I've provided?

15 MR. RIDZON: No. Just a follow-up, though.
16 You've got to close each meeting with a "we continue
17 to see slow and continual progress." I mean, is that
18 how you close this meeting?

19 MR. GROBE: Well, this was a different kind of
20 meeting. I think what you're talking about is my
21 normal meetings out in Oak Harbor area where we meet
22 with the company monthly to receive performance
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1 assessment. We didn't really receive a broad
2 dissertation on progress that the licensee has made
3 today, so I don't think, based on what we've heard
4 today, I would make such a statement. But
5 specifically in this one area, I think the
6 information that they've shared with us today has
7 been -- has met my expectations for what we wanted to
8 accomplish today, and that is that we have a
9 comprehensive description of the corrective actions
10 that they're taking, as well as our first thorough
11 discussion on how the company plans on measuring
12 safety culture going forward. So we've seen progress
13 in these areas, as far as articulating comprehensive
14 and corrective actions and articulating in a cogent
15 manner how they're going to be measuring safety
16 culture. So that is progress, but I don't want you
17 to infer that that's an assessment of overall plant
18 performance.

19 MR. RIDZON: Thank you very much, Jack.

20 MCI OPERATOR: The next question comes from
21 Billie Garde.

22 MS. GARDE: Hello?
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1 MR. GROBE: Yes. Can you state your name and
2 spell it, please.

3 MS. GARDE: This is Billie Garde, G-A-R-D-E.

4 MR. GROBE: Go ahead, Billie.

5 MS. GARDE: I have a couple of questions. First
6 of all, I've reviewed the procedure on -- or the
7 policy for maintaining safety conscious work
8 environment issued by Mr. Saunders on November 21st,
9 2002, and the kind of companion statement by Lew
10 Myers.

11 First of all, what we've heard today
12 is certainly far beyond what was set forth in the
13 November policy, and I assume there will be a
14 revision of this policy issued that captures the
15 commitments that were laid out today. I'm not sure
16 of that, but I'm assuming that.

17 But one of the things that was not
18 addressed today and I'm concerned that the NRC look
19 into this, is the expression in both the policy
20 statement and Mr. Myers' statement that workers can
21 raise concerns or they prefer to raise them up the
22 chain of command, and if not the chain of command, to
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1 the NRC. That is maintained kind of throughout all
2 of the documents, including a kind of disturbing
3 statement in the policies, that 3.5.4, that says
4 failure of a FENOC employee to comply with this
5 policy may result in disciplinary action up to and
6 including termination. As you know, the law provides
7 the right of employees to contact anyone, if
8 necessary, to resolve concerns, and I'm sure if the
9 only choice a worker had last year regarding the
10 corrosion would have been to go to the newspaper,
11 that that would have been preferable to not at all.
12 And so I'm concerned that that aspect of their policy
13 be addressed directly by the agency.

14 MR. GROBE: Billie, I appreciate your comments.
15 I think I heard two specific things that we need to
16 move forward on, or at least I can comment on.

17 The first one had to do with whether
18 or not the policy that FirstEnergy has issued needs
19 revision following today's presentation, and I ask
20 Lew to respond to that.

21 MR. MYERS: What I think she's reading is the
22 policy on safety conscious work environment. There's
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1 also another policy on safety culture that -- so
2 there's two policies. And under safety conscious
3 work environment, the intent there was, you know, our
4 corrective action program is our main frame of
5 finding and fixing problems, and that's the way we do
6 probably 90 percent of our problems. If an employee
7 is not happy with that, then there's other avenues up
8 through the management train, to me or to our
9 employee concerns program or quality programs; and if
10 they're not happy with that, they're perfectly
11 acceptable to go to the NRC, you know. And they can
12 use any of those at any time. You know, assuming
13 you're using one of those, you know, we certainly
14 would not think that anyone would be disciplined, you
15 know, in any way, but you know, in our mind, we think
16 if you've got a safety concern, then use one of those
17 -- using one of those avenues is definitely one of
18 our requirements. So that's the way we think our
19 policy is written.

20 Now, I'll go back and review it based
21 on your comments, but you know, I read -- I've never
22 read it quite the way you're reading it. It's
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1 interesting. So we'll go back and take a look at
2 it. Thank you for your comment, though.
3 MR. GROBE: And Billie, I hope that any employee
4 at any of our nuclear plants would first raise a
5 concern to the company, and if they don't have
6 confidence in the company or the employee concerns
7 program, that they would come to us. I would be
8 disappointed if their first choice was to go to the
9 media, simply because the media has no capability or
10 responsibility or authority to ensure the safety of
11 the nuclear plant. So I would hope that an employee
12 would come forward to those folks that can fix the
13 problem and have that responsibility first. But I
14 understand your question, that it would not seem to
15 be appropriate to eliminate all that use of bringing
16 issues forward as a performance matter. So I
17 appreciate your comment. Did you have any follow-up
18 questions?

19 MS. GARDE: I do. I don't want to get into
20 debate, but I really do recommend that you review the
21 law that's available to protect employees for raising
22 concerns and recognizes that the employee has the
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1 right to go wherever they believe they need to go to
2 have a concern addressed, because they can't possibly
3 second-guess the circumstances that they find
4 themselves in to raise that issue.

5 The second -- actually it's an
6 observation on the presentation today, is there was a
7 number of references to the employee concerns
8 program, and I, just as a member of the interested
9 public here, haven't seen anything that is available
10 for public review about the current ECP program. I
11 know that it has been under development, there's been
12 a lot of things to it. There was reference today of
13 using some independent people. But the last thing I
14 ever saw, other than what I heard today, was that the
15 ombudsman program at the site was -- had very little
16 procedures, had very little structure to it, no
17 formal policy on confidentiality, and wasn't tracked
18 and trended in a way that most ECP programs are. The
19 representations today are there have been those
20 changes made, and I would hope that the NRC would
21 review that or ask for a presentation specifically on
22 the strength of their employee concerns program and
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1 how it operates in a way that the public, certainly
2 informed public could review to make some kind of
3 determination on the strength of that program.

4 If the plan, as I assume it is, is to
5 restart the plant before -- or at least to hope the
6 NRC will approve restart of the plant before cultural
7 changes have really been able to take hold and a lot
8 of these changes are identified and worked out, the
9 quality and the rigor of an employee concerns program
10 as an alternative is critical. So I don't think it's
11 kind of just one of the building blocks that we can
12 get summary information on. I think it's critical
13 for public confidence to have a lot better
14 understanding of how that program works.

15 My final comment really is a
16 combination of response to the doctor's
17 identification of how she's going to deal with
18 anecdotal issues that come up within the context of
19 the interviews, and I guess from my perspective as a
20 member of the Millstone review team, which did very
21 similar work to what she is describing, although
22 it's -- certainly we had a lot more than four people
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1 over two weeks in terms of identifying issues.
2 Setting that aside and assuming she can do a job
3 consistent with her methodology that she's set out, I
4 would be very concerned that anecdotal issues that
5 she captures in employee structured interviews or
6 surveys are captured in some manner to evaluate
7 because I will tell you that the depth and breadth of
8 what changed Millstone was responding to the specific
9 anecdotal examples that were inconsistent with many
10 of the kind of broad-based inclusions and objectives
11 that management had. It is at that level. That is
12 on the individual behavior level between managers and
13 supervisors that you really test whether you've got a
14 safety culture that's working in accordance with the
15 goals and desires and visions that you've set out,
16 and rejection of anecdotal evidence because they're
17 one-time events and not -- I'm not saying they have
18 to be included in a way different than other
19 methodology, but they certainly can't be lost.

20 Those are my comments. There's a lot
21 of material presented today. Unfortunately, I was
22 not available to follow with the written material as
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1 well as you on the phone to be able to study that.
2 And other questions or comments I have I will put in
3 writing.

4 MR. GROBE: Thanks, Billie. Let me, Bill, do
5 you want to comment on the status of the
6 formalization of the procedure for safety conscious
7 work environment?

8 MR. PEARCE: Yes, I'll be glad to. We do have
9 the process all written up. It is, as she describes,
10 a formal process. It will formally protect
11 confidentiality as the process, and that's all in
12 there. I've already reviewed it. We're on the very
13 last stages of getting the formal written process in
14 place. I expect it's going to be out within the next
15 week or so. And in fact, at the next public meeting
16 we can report on the status of that, Jack.

17 MR. GROBE: Thank you. That would be great.
18 I'd -- Billie keyed a question in my mind. I guess
19 I'm a member of the public. I can ask questions.

20 MR. MYERS: Can I answer?

21 MR. GROBE: Sure.

22 MR. MYERS: I think I have the policy in front
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1 of me here, and the way it reads is "FENOC is
2 committed to maintaining a workplace with zero
3 tolerance for harassment, intimidation, retaliation,
4 or discrimination against individuals who raise
5 safety concerns. It's our first mission to not cause
6 or participate in any form of harassment,
7 intimidation, retaliation or discrimination of any
8 individual working at FENOC site. Failure of a FENOC
9 employee to comply with this policy may result in
10 disciplinary action up to and including
11 termination." That's if you intimidate or harass
12 someone, you know.

13 MR. GROBE: I appreciate your observation, Lew.
14 I think the specific question that Billie raised had
15 to do with if an individual lacks confidence in you
16 folks, your employee concerns program, and somehow
17 lacks confidence in the NRC, it could be construed as
18 going to the media or the public or a lawyer as being
19 a violation of your policy, which would be actionable
20 and --

21 MR. MYERS: That's not what that's written for.

22 MR. GROBE: Right. I understand. But if it's
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1 clear in your mind, that's fine. If it's ambiguous
2 in some respects and warrants revision, that's fine
3 too. I think the request was to take a look at it.

4 MR. PEARCE: We'll certainly go back and review
5 it in that regard.

6 MR. GROBE: Thank you. And the second half of
7 the question had to do with specific information that
8 is received during the course of interviews. If
9 there's a specific bit of information received in the
10 interviews that would indicate a violation of
11 requirements or a problem at the station, is the
12 review that Dr. Haber is doing going to be plugged in
13 somehow with your corrective action program?

14 MR. PEARCE: What we intend there -- what I
15 intend; I'm speaking for QA now, not the line
16 organization -- what I intend to do was to go review
17 some of that material after she was done to look for
18 that kind of thing. And because, I mean, there's a
19 certain set of expertise that's required in some
20 areas to understand some of the technical issue. But
21 that's what my intention was.

22 Now, she raises a good point. Are we
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1 going to collect all the anecdotal information? I
2 don't know. We'll have to think about that and look
3 at it, and I'll have some conversation with Dr. Haber
4 afterwards and see if I can figure out how to do
5 that.

6 MR. GROBE: I think it's important to not lose
7 the information that's collected, and particularly
8 important that if some of the information provided in
9 response to a question indicates a problem at the
10 plant, that that get into the corrective action
11 program. So I don't know how those interfaces work,
12 but I think those are important connections to make.

13 MR. PEARCE: Right. But it's going to take
14 someone outside in our organization to understand
15 what to put in and what not to.

16 MR. GROBE: I didn't say it was simple. I just
17 said it was important.

18 MR. PEARCE: That's why I said we will review it
19 afterwards and see what there is there.

20 MR. GROBE: Okay. Billie, did we answer all
21 your questions?

22 MS. GARDE: You answered my questions. I'm
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1 concerned about this anecdotal thing, capturing the
2 information that, you know, if she's asking
3 employees -- just two examples, are you aware of
4 issues that should have been raised that aren't --
5 and I don't know if that's one of her questions --
6 and the answer to that question is yes, I think that
7 has to be captured in a timely and effective manner
8 and run to ground through some process.

9 I, of course, would not want her to
10 have the credibility and integrity of independence
11 over process compromised, but that really is the meat
12 of her work or the possibility of her work outside of
13 drawing kind of broad organizational conclusions. I
14 mean, you could reject five specific examples and not
15 include them, and they would blow a hole in the whole
16 organizational conclusion if you don't capture them
17 correctly and run them to ground correctly. So I'm
18 going to be looking at, you know, when this whole
19 thing comes to fruition, not just the broad
20 organizational conclusions, what did people say about
21 what their day-to-day work was? Or even, I guess
22 since I don't know her questions, I don't even know

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1 if the questions are going to provide an opportunity
2 beyond, you know, multiple choice or single-word
3 answers to give examples.

4 But her discussion of rejection of
5 anecdotal issues concerns me because it just raises a
6 whole host of other questions which I've highlightd
7 on, and I'm sure you can pull the strings further,
8 but you see what my concern is --

9 MR. GROBE: I appreciate your thoughts,
10 Billie. I think they're very well taken. And during
11 the course of our inspection of this activity, we'll
12 make sure that we touch on those issues. Thank you
13 very much.

14 MCI OPERATOR: Our next question comes from Paul
15 Blanche.

16 MR. BLANCHE: Hi. This is Paul Blanche. Can
17 you hear me?

18 MR. GROBE: Yes.

19 MR. BLANCHE: I know many of you people know
20 me. I've spent 25 years at Millstone through the
21 rise and fall and so on and so forth.

22 The first comment -- I have three or
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1 four comments I'd like to make reinforcing what
2 Billie said about the procedure for reporting safety
3 concerns. In an ideal world we'd like to have all
4 employees feel comfortable bringing their concerns
5 through management. That's what we strived for and
6 eventually achieved at Millstone. And if they are
7 not comfortable going to management, we encourage
8 them to go to other avenues, such as the employee
9 concerns program, ombudsman program, Little Harbor --
10 which Billie worked for -- media, politicians,
11 courts, lawyers, public interest groups, so on and so
12 forth.

13 Let me just read from the root cause
14 analysis report which was produced by Valerie
15 Barnes -- and by the way, I think it was an excellent
16 report. And I'll just quote here. It states, "The
17 operations standards and expectations documents will
18 address (audio cut out) in operations by including
19 expectations for operational personnel to raise any
20 operational concerns. It also contains the
21 requirement for operations person (audio cut out)
22 leadership and resolving concerns by continuing to
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1 escalate them through their management chain, up to
2 and including the president of FENOC until resolution
3 is obtained. Davis-Besse and FENOC senior management
4 expect operations personnel to inform the NRC of
5 their concerns if management does not address the
6 concerns to their satisfaction."

7 I agree with Billie 100 percent. That
8 sends the wrong message, and in fact may even create
9 its own chilling effect. I communicated that to Mr.
10 Randy Huey with my thoughts on that already. That's
11 a comment, and it just reinforces what Billie said.

12 Comment on the operations root cause
13 analysis done by Valerie Barnes, I thought was
14 excellent. It was candid and very well done. But
15 reading that and knowing Millstone, I think you have
16 symptoms of the safety conscious work environment
17 that indicate to me it could be worse than Millstone
18 was ever. For example, Davis-Besse has already in
19 the year 2002 received 14 concerns related to
20 discrimination, and over 40 concerns. These numbers
21 are higher than Millstone from 1997 on. That's the
22 only data I have from the NRC. Further, there are
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1 still 23 open concerns with Davis-Besse.

2 Next comment is it appears as though
3 Dr. Haber is measuring the safety culture. While
4 that's an important measurement, I think what we're
5 really concerned about is measuring the quality of
6 the safety conscious work environment. I'm not sure
7 how that is going to be done within Dr. Haber's work.

8 The other problem I have is -- was
9 mentioned before. There is no benchmarking of the
10 survey. I realize that Dr. Haber has done a lot of
11 work in foreign utilities, but foreign utilities
12 certainly have their own cultures. I don't know of
13 any benchmarking that can be done versus other
14 utilities such as Millstone and other utilities who
15 have had similar problems. My only question is --
16 well, I'll make a statement first. At Millstone we
17 have a vice president, Mike Brothers, that was
18 appointed the point person to lead the safety
19 conscious work environment. He did a great job.
20 Does Davis-Besse have a designated overall officer
21 for the safety conscious work environment? And from
22 now on I'll just listen to the responses, if there
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1 are any. Thank you.

2 MR. GROBE: Wow. I think the question is pretty
3 easy to answer. The safety conscious work
4 environment function reports to the vice president of
5 oversight, Bill Pearce. So I think that's the answer
6 to your question.

7 I hope encouraging employees to bring
8 their concerns to plant management and to the NRC
9 doesn't send the wrong message, but I completely
10 recognize the observations that you and Billie have
11 made from the perspective of coming from Millstone
12 and other locations when there was a challenging
13 environment, that it's not appropriate to send the
14 message that if they go elsewhere, it would be a
15 failure to follow company expectations and would be
16 actionable as a personnel matter. So that's
17 something that I think FirstEnergy has already taken
18 on board and agreed to go back and look at.

19 I appreciate your comments, Paul, and
20 we'll continue to look at this. And I do receive
21 input from you on a fairly regular basis through

22 e-mail, so I appreciate that too. Thank you.

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1 Other questions or comments?

2 MCI OPERATOR: We do have a question from Daniel
3 Horner.

4 MR. HORNER: Hi. I apologize if this question
5 was covered already. I was off the phone for some
6 brief periods during the course of the meeting. But
7 Lew Myers sort of sketched out what the criteria are
8 for when FENOC feels that it will be ready to go
9 ahead with restart, but I don't have a clear idea of
10 what NRC feels are the criteria in terms of safety
11 conscious work environment for going ahead with
12 restart. What sort of changes -- presumably
13 submission of reports themselves are not sufficient.
14 At least, that's what I gather. But how far along
15 does the process have to be, and how are you going to
16 measure that in order to reach a point where you can
17 say yes, we've gotten to that point now and it's all
18 right to go ahead to restart, at least in terms of
19 this one category?

20 MR. GROBE: Dan, thanks for the question.

21 That's Dan Horner, H-O-R-N-E-R. It's a good
22 question.

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1 The commission's policy very clearly
2 articulates that each licensee is expected to have a
3 safety -- an organizational focus that allows issues
4 to be brought up and categorized and dealt with
5 according to their safety significance. So the first
6 answer to your question is when FirstEnergy
7 demonstrates that that exists, that will be a
8 benchmark. Beyond that, we will be performing
9 inspections of their implementation of the corrective
10 actions program, the safety conscious work
11 environment program, and this assessment in the
12 management human performance area, and we'll be
13 reporting on those inspection results publicly and
14 publishing them, and that will go into the assessment
15 that the panel will make to determine whether or not
16 the plant is ready to restart.

17 MR. HORNER: But do you have -- I mean, there
18 was a question as of FENOC, if they have test
19 acceptance criteria. Do you have criteria in mind
20 now that they have to get up to such and such a level
21 before you say go ahead?

22 MR. GROBE: I'm not aware of any specific
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1 criteria in any of these areas. You speak of such
2 and such a level. I'm not aware of any criteria of
3 that nature. What we will do is, once FirstEnergy
4 documents their process for measuring safety culture
5 going forward, we'll evaluate that and follow their
6 monitoring of it and evaluate their assessment in
7 that area and make our own independent assessment and
8 then make a judgment. There isn't an objective
9 number, you know, when you get to four, it's okay.
10 It doesn't work that way. There is subjectivity
11 involved in this.

12 MR. HORNER: But the problem really -- isn't
13 there sort of an inherent Catch-22, that you can't
14 really know if they're adhering to this until you see
15 how they're doing with a plant under normal
16 operations? But in order to do that, you have to
17 allow them to restart. How do you get around that?

18 MR. GROBE: The panel has to make a judgment
19 that it believes that the activities have been
20 adequately completed to address the issues in the
21 restart checklist and that there's sufficient
22 confidence going forward that the plant can be safely
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1 restarted and operated. Part of that assessment is
2 going to include a readiness for restart inspection
3 that will address both the operations and other
4 supporting organizations' readiness to operate the
5 plant safely, and that inspection will include
6 round-the-clock observation of operators in the
7 control room, activities in the plant at a time when
8 a significant amount of the equipment has been
9 returned to service and the operating environment is
10 challenging, probably more challenging than a normal
11 operating plant would be. So it will be a good
12 indicator of the operator's readiness to operate the
13 plant. And those inspections will occur within a few
14 weeks prior to the panel considering the question of
15 whether the plant is ready to restart.

16 MR. HORNER: Several weeks -- that probably
17 takes a few weeks, you said?

18 MR. GROBE: The inspection is likely to span a
19 couple of weeks, and it will occur at a time when the
20 plant has returned a significant amount of equipment
21 to service. So that would be sometime around the

22 second time the plant goes to Mode 4, operating Mode
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1 4. That's not in the near future.

2 MR. HORNER: Thank you very much.

3 MCI OPERATOR: Our next question comes from Joe
4 Carson.

5 MR. CARSON: Yes, sir. I'm Joe Carson. I work
6 as a nuclear safety engineer for the Department of
7 Energy. Can you hear me?

8 MR. GROBE: Yes.

9 MR. CARSON: Okay. I'm a licensed professional
10 engineer, and I have been in -- I'm a whistle blower
11 also in the Department of Energy. And I haven't
12 heard today -- I've been listening, I think, to
13 almost everything -- I haven't heard anything about
14 the relevancy of engineering ethics and/or
15 professional engineering licensure to the Davis-Besse
16 situation. And I guess my question is if it's not
17 relevant, then I question why there should be PE
18 licensure; and if it is relevant, why it's not being
19 identified as such.

20 MR. GROBE: It's a -- I appreciate the
21 question. It's a very interesting question, and
22 we've had some interaction with the State of Ohio on
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1 this question. I don't believe there is anything at
2 a nuclear plant that is dealing with nuclear safety
3 that requires a professional engineering
4 certification.

5 As you're well aware, professional
6 engineering certifications are required for various
7 engineering activities, but the NRC regulates the
8 engineering quality at a nuclear power plant for
9 those activities that affect nuclear safety. I don't
10 want you to infer that ethical conduct is any less
11 important because there is not a requirement for
12 licensure by the state as a professional engineer,
13 and we have very clear requirements on the
14 responsibilities each individual, as well as the
15 company, has to follow regulations. And those are
16 issues that we would follow up on if they became
17 apparent. So it's -- a professional engineer license
18 is not required to express engineering judgments to
19 approve engineering documents affecting --

20 MR. CARSON: I understand it's not required and
21 it's not required because the State of Ohio has

22 what's called an industrial exemption. It's really
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1 not because of the NRC. It's because of the
2 industrial exemption. But FirstEnergy could, on its
3 own, say, "independent of the industrial exemption,
4 we want our engineers to be licensed." If they were
5 were licensed, they would be just as subject to the
6 jurisdiction of the Ohio state board as any other
7 engineer who needed to be licensed. So that's my --
8 if FirstEnergy seems to be saying, "we're doing
9 everything we can with respect to safety," this seems
10 to be something -- engineering licensure is all about
11 public health and safety and creating an independent
12 legal accountability for it and obligation for it.
13 Could this also be a -- not required, I agree, but
14 just an appropriate means to be evaluated? There's
15 nothing that stops it. Let me put it that way.

16 MR. GROBE: I appreciate your comments, and
17 FirstEnergy has heard them. We believe that the NRC
18 has appropriate regulations and oversight of the
19 behavior of people at nuclear power plants, but I
20 appreciate your comments. Thank you very much.

21 MCI OPERATOR: At this time we show no further
22 questions.

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1 MR. GROBE: Okay. Are there any other questions
2 here in Region III?

3 MS. LIPA: I'd like to make one comment. This
4 was a person who comes to a lot of our public
5 meetings who was not able to be here, so she sent
6 some comments in, and her name is Donna Lueke. And
7 her comments were in the areas of making public
8 safety a part of every corporate document at
9 FirstEnergy and then also taking safety culture
10 lessons learned from Davis-Besse and applying those
11 to other nuclear power plants. And we will be making
12 her comments part of the minutes from this meeting.

13 MR. GROBE: Thank you, Christine. Could you also
14 provide a copy of that to FirstEnergy so if there's
15 something specific about Davis-Besse, they don't have
16 to wait for several weeks to get the transcripts?

17 MS. LIPA: Yes, I will.

18 MR. GROBE: Thank you.

19 Operator, are there any additional
20 questions or comments at this time?

21 MCI OPERATOR: We show no further questions.

22 MR. GROBE: Okay. Thank you very much.
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1 With that, we'll adjourn the meeting.

2 Thank you very much.

3 (Which were all the proceedings

4 held in the above-entitled

5 cause on this date.)

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1 STATE OF ILLINOIS)
) SS:
2 COUNTY OF DU PAGE)

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6 I, MARY N. LEAHY, C.S.R., Notary

7 Public

8 duly qualified and commissioned for the State of

9 Illinois, County of DuPage, do hereby certify that I

10 reported in shorthand the proceedings had and

11 testimony taken at the hearing of the above-entitled

12 cause, and that the foregoing transcript is a true,

13 correct and complete excerpt report of the entire

14 testimony so taken at the time and place hereinabove

15 set forth.

16

17

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