PUBLIC MEETING
Between U. S. Nuclear Regulatory Commission O350 Panel
and FirstEnergy Nuclear Operating Company

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Meeting held on Tuesday, June 3, 2003, at 2:00 p.m. at the Camp Perry Clubhouse, Oak Harbor, Ohio, taken by me, Marie B. Fresch, Registered Merit Reporter, and Notary Public in and for the State of Ohio.

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PANEL MEMBERS PRESENT:

U. S. NUCLEAR REGULATORY COMMISSION

John "Jack" Grobe, Chairman, MC 0350 Panel
William Ruland,
Vice Chairman, MC 0350 Panel
Christine Lipa, Projects Branch Chief
Christopher Scott Thomas,
Senior Resident Inspector
U.S. NRC Office - Davis-Besse
Jon Hopkins, Project Manager Davis-Besse
Jack Rutkowski, NRC Resident Inspector

FIRST ENERGY NUCLEAR OPERATING COMPANY

Lew Myers, FENOC Chief Operating Officer
Michael J. Stevens,
Director - Nuclear Maintenance
Mike Ross, Restart Director
Mark Bezilla, Vice President Davis-Besse
James J. Powers, III
Director- Nuclear Engineering
Robert W. Schrauder
Director - Support Services
Steven Loehlein,
Manager - Quality Assessment
Clark Price, Owner - Restart Action Plan

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MS. LIPA: We're ready to begin then. Okay.

Good afternoon. Welcome to FirstEnergy and members of the public for accommodating this meeting today. This is a public meeting between the NRC's Davis-Besse Oversight Panel, and that's us over here, and FirstEnergy Nuclear Operating Company.

I'm Christine Lipa, and I'm the Branch Chief in Region III, and I'm responsible for the NRC's Inspection Program at Davis-Besse.

The next slide covers the purposes of this meeting, which are to allow FirstEnergy to present the status of activities in their Restart Plan; and then also we'll be discussing some NRC Oversight Panel activities, focusing on those activities since our last public meeting that was held in May.

We have the agenda here. These are the items we'll be covering today. And, before we get going too far, I would like to make some introductions.

On the far left is Jon Hopkins, and Jon is the NRR Project Manager for the Davis-Besse facility.

Next to John is Bill Ruland, and Bill is the Senior Manager in NRR in Rockville, Maryland and he's also the Vice Chairman of the Oversight Panel. And Bill's actual position is Director for Project Directorate Three in the

Division of Licensing Project Management.

On my left is Jack Grobe. Jack is a Senior Manager in the Region III Office in Lisle, Illinois, and he's the Chairman of the Davis-Besse Oversight Panel.

And then to my right is Scott Thomas, the Senior Resident Inspector here at Davis-Besse facility.

Also, we have Jack Rutkowski, the Resident Inspector, who's operating the slides for us today.

And Nancy Keller was greeting folks on the way in, in the foyer.

And Viktoria Mitlyng is our Public Affairs Officer. There is Viktoria.

And we also have Rolland Lickus, our State Affairs Officer. Great.

And then, Lew, if you would like to introduce the folks on your table.

MR. MYERS: Sure. To my left we have Steve Loehlein. Steve is the Manager of our Quality Assurance Group.

Mark Bezilla is next to me on my right. Mark is in charge of, he's the site VP at our site. Jim Powers in charge of Design Engineering.

Mike Ross, next to him, is our Restart Director at the present time.

Bob Schrauder next to him. Bob is Support Manager.

Mike Stevens.

Down at the end is -- Clark Price is down at the end. Okay. He's going to give the management performance indicators for us today.

MS. LIPA: Okay, great. Thank you.

Are there any public officials or representatives of public officials in the audience?

MR. KOEBEL: Carl Koebel, Ottawa County Commissioner.

MR. PAPCUN: John Papcun, Ottawa County Commissioner.

MR. WITT: Jere Witt, Ottawa County Administrator.

MS. LIPA: Okay. Thank you.

Okay. So, this meeting today is open to public observation. I don't know if I'm having trouble with my mike; does it sound like I am?

Okay, how does that sound? All right, excuse me.

Okay. So, as I was trying to say, this meeting is open to public observation. This is a business meeting between the Nuclear Regulatory Commission and FirstEnergy, but at the conclusion of the business portion of this meeting, but before the meeting is adjourned, we will have opportunity for public questions and comments.

In the foyer on your way in today, there were copies of our June edition of our monthly newsletter, and also copies of the slides for the NRC presentation and the Utility's presentation.

One of the good things about the newsletter, it provides good background information and current status information and also has contact reference information for our public affairs folks in the region, email address and phone numbers, if you want to contact them for more information.

We also on the Internet have a web page right on the NRC web page, a whole web page dedicated to Davis-Besse. And we also in the foyer had public meeting feedback forms that you can use to provide comments on today's meeting.

Today we're having this meeting transcribed by Marie Fresch. And that will maintain a record of today's meeting, and those transcripts are also available on our web page several weeks after each meeting.

MR. GROBE: Christine, before you go on, just quickly. One of the things that's a little different about the June newsletter is it includes a little bit of background information on our Resident Staff at the site. The reason we did that, Scott has been around a little while, but we've got two new Residents.

Jack Rutkowski is new and we introduced him last

month, but also joining us, we just selected an additional Resident Inspector for the Davis-Besse facility. Her name is Monica Salter-Williams, and she'll actually be moving out to the site in September.

She's finishing up some work in our Region I Office right now. And, when she gets here, we'll certainly introduce her to everybody, but there is a little bit of background information on the staff.

Normally, we only have two Resident Inspectors at each of the nuclear power plants in the United States. We've added a third Resident at Davis-Besse to provide additional oversight during the next couple of years.

MS. LIPA: Thank you, Jack.

Okay, so the next slide is a summary of the May 6 public meeting that was held here last month. And during that meeting we provided a status update on the NRC's ongoing inspections. And we also discussed some upcoming activities, and the public meetings, that we held a public meeting in May to discuss engineering issues. And later in today's presentation, we'll give an update on some recently completed and ongoing NRC activities.

Also last month, FirstEnergy provided an update on their efforts towards restart and they discussed some management changes and some other topics that are listed on the slide.

So, I would like to go on to the next one, which covers significant NRC activities since that May meeting. We did issue on May 29th, the Final Significance Determination, which is a red finding regarding the vessel head degradation. And we had issued a Preliminary Risk Significance in February. And then last week we finalized it with the final letter.

Also in May, we completed most of our program inspection, and closed several Restart Checklist items. We've now closed 11 of the 29 items on the Restart Checklist. And there were four Restart Checklist items closed through that programs inspection, and those are listed on the next two slides.

Go on to the next one.

Also, since the May 6 meeting, we did hold a public meeting in the Region III Office on May 7, and that was to discuss a number of engineering and design issues that Davis-Besse management is working to resolve.

Continuing NRC activities. These are some inspections that we have that are ongoing. The System Health Readiness Review Inspection includes safety function validation of systems and some topical issues, which are like high energy line break, environmental qualification, seismic issues. And this inspection is being conducted by several inspectors and is nearing completion.

The next one is inspection into the area of Safety Culture, Safety Conscious Work Environment. The focus there is to evaluate the Licensee's process and the tools for monitoring the improvement in Safety Culture and Safety Conscious Work Environment and the effectiveness of the Employee Concerns Program.

Another inspection is the Corrective Action Team Inspection. This is an inspection to review the effectiveness of the corrective action process at Davis-Besse to ensure that it's effectively implemented and appropriate corrective actions are being taken to prevent recurrence of problems.

And then the Resident Inspection, Jack talked about the Resident Inspectors. There are two full-time Resident Inspectors and they're permanently stationed and they inspect a broad spectrum of activities, such as Operations, Maintenance and Testing. And the Resident Inspector Reports come out every 6 to 7 weeks.

Some other upcoming NRC activities. We do plan to conduct an inspection of the lower reactor vessel head area, and this will be as the Utility is prepared to go into Mode 4. We'll be following that test. And the inspection will review the procedures and the related ASA codes, requirements relative to that leak test on the Reactor Coolant System and we'll also observe parts of the

test and verify proper implementation at those procedures.

We're also planning to conduct a public meeting to discuss the Licensee's assessment of their Safety Culture work. Once they have fully integrated their independent and internal assessments. And right now we're looking around July for that meeting.

One of the other activities the NRC plans to do is a backlog, an assessment of the backlog of issues. And this will really depend on as Davis-Besse approaches restart, what work items they've deferred to do after restart. And we'll be doing an inspection to take a look at those.

The NRC is also preparing to conduct a Restart Assessment Team Inspection, when Davis-Besse nears the point where it will seek NRC authorization for restart. That inspection will review the readiness of the plant and the plant staff to resume plant operations safely and in compliance with NRC requirements. The inspection findings will be considered by the NRC Oversight Panel in making its recommendation to the Regional Administrator on possible restart.

The next item. There have been several LER's that have been issued. Those are Licensee Event Reports. So, there are specific conditions that were identified by the Utility or by the NRC that need to be corrected. A part of our process, we also review the past significance and past

enforcement and the causes and make sure those issues are properly corrected.

Two other upcoming activities that I don't have on the slide; we are planning a meeting on June 19th, in Headquarters. And the purpose of that meeting will be to discuss the high pressure injection pump modification. We will have that video conferenced in Region III, and also bridge lines available for people who want to call in to listen to that meeting.

Also I want to mention that next month's meeting will be July 9th, and we're planning to have it at the Oak Harbor High School.

So, that summarizes the NRC activities since our last meeting. And the inspections that I discussed are part of our Restart Checklist Item, which is our listing of issues that need to be resolved prior to restart of the plant.

With that, I'll turn it over to FirstEnergy for your portion of the presentation.

MR. MYERS: Thank you, Christine.

One of the people that I didn't get a chance to introduce is Bob Saunders; he is with us today; the President of the FirstEnergy Nuclear Operating Company, in the audience with his wife, Carol.

We've had a pretty interesting month this month. Made some changes and some decisions that change the flow path of our schedule. We'll talk about that today.

Our desired outcome today is to update you on the plant performance, some of the tests we've run, where the plant is at now, some of the management human performance progress we've made since the last meeting, to provide you some information, concerns, and decisions on the high head safety injection pump.

We've made decisions on the, which as you remember, we're going down two flow paths; one is replacement, one is modification. There were some real advantages to the modification option. We made that decision, moving forward now. So, we're down to one path that we're focused on.

To provide you with an update on the quality oversight, Steve is next to me, and he'll do that today. He'll give their independent perspective on some of the issues we have, and provide you a status of several of the engineering issues and how they're moving along. And we think they're making good progress at the present time.

Then, finally, to status you on our overall schedule. We've made some changes there when we decided to take the flow path on the modification, high head safety injection pump, fits into the critical path, flow path.

So, we made some changes there. Additionally, then

provide some information on the performance indicators that we monitor to focus toward restart.

I introduced the members at our table today. Mark Bezilla will status you on the plant. I'll give you some information on the Management and Human Performance update. Specifically, our Electrical Distribution and Safety Injection Relays is Jim Powers. Bob Schrauder is with us. He'll talk to you about that High Pressure Safety Injection Pump and the Corrective Action Program. And Steve Loehlein, Independent Assessment.

The remaining issues, we really got a good list of all the issues and the status of those issues and Mike Ross has really been focused on that. He will provide you some of that information. And if time permits, we'll look at the Schedule Milestones and the Restart Performance Indicators. If it doesn't, we have those back on the board.

With that, I'll turn it over to Mark Bezilla, so he can talk about plant status.

MR. BEZILLA: Thank you, Lew.

I would like to brief you on where we are with regards to our Reactor Coolant System Pressure Testing and our efforts to complete work in Containment.

My desired outcomes; demonstrate our increased confidence in Reactor Coolant System and its support

systems and provide an update on containment activities.

Next slide.

We completed the 50 pound pressure test of the Reactor Coolant System on May 6. We inspected approximately 1100 components, connections, items, including the reactor vessel closure head; it's an O-ring area, the CRDM flanges and the reactor vessel bottom head.

No leakage was noted from the reactor vessel closure head, the O-ring area, the CRDM flanges, or the reactor vessel bottom head. We did identify 54 items that required additional attention. And, this could range from a repack, to a tighten packing to a clean and continue to observe.

We completed the 250 pound test on May 25th. Again, we inspected those 1100, approximately 1100 components, connections, et cetera. And this time we identified 26 items that required additional attention. There were six active leaks; three of those were packing leaks, and the other three were reactor coolant pump seal package temperature elements.

Two valves of note, are decay heat valve number 11 and number 12. These valves are the first two valves off of the Reactor Coolant System to the Decay Heat Removal System. They had very small accumulations of Boron at the body to bonnet gasket, and we're currently evaluating the best course of action for those valves and to address that

small accumulation of boric acid.

There were 8 recurrent indications of Boron and these will also be appropriately dispositioned prior to Mode 4. And those were clean, inspect, and take a look and we saw some recurrence there. So, that's where you get the recurrent items.

I believe that these two pressure tests, the 50 pound test and the 250 pound test, have set us up well for our first operating pressure, normal operating pressure and near normal operating temperature milestone.

MR. GROBE: Mark, do you know on DH 11 and 12, do you know what the cause of the body to bonnet leakage is on those valves?

MR. BEZILLA: Jack, we suspect that that's a gasket leakage. It may just be because the valve is cold at this point, and as we heat up, that may help seal that body to bonnet leak. I believe our approach will be to clean. These are the two valves in our decay heat tank -- decay heat tank, decay heat valve tank, and do the first normal operating pressure, normal operating temperature test, then reopen the tank and take a look and see what those valves look like. We may also do some torque checks and/or additional torquing of body to bonnet holes.

I have a picture with me, Jack, in case you hadn't

seen it or you were interested, but this is, it's tough to see from there. This is a blow-up and you can see, it's about a quarter teaspoon of boric acid is what, the volume we're talking about, quantity we're talking about. I'll share this with you on a break.

MR. GROBE: Okay, thank you.

MR. BEZILLA: A few more notable items or items of interest. We determined that in the decay heat removal circulation homing mode, that is where we have the decay heat circulating reactor coolant and with the cooling bypass. So, we were cooling the decay heat, if you will, the decay heat reactor coolant circulation, if you will.

We can only get up to, close to 140 degrees for exit thermal couple temperatures, and only to about 130 degrees bulk reactor coolant temperature. The only note there is we have no decay heat in the existing core. Okay.

We placed the makeup and purification system in service. That was our normal makeup letdown seal injection. We did find a few items there that will need remediation, but all in all that's just a perform well.

We exercised and operated the pressurizer heaters and pressurizer spray valve. We drew a bubble, so we heated the pressurizer up to 400 degrees using those tools, if you will, those items. And again, those performed very

well also.

And, we ran each reactor coolant pump. Those are the biggest motors we have in the plant. And we ran each one of them separately and then ran them in combination from anywhere from 30 minutes to a couple of hours. Again, that gave us confidence in that big piece of equipment, if you will, or those four big pieces of equipment.

So, in summary I'll say, we gained additional confidence in the performance of Reactor Coolant System and its support systems.

Any questions?

MR. GROBE: Yeah, I want to go back to DH 11 and 12. Have you gone back through the mechanical work packages to identify whether there is anything that sticks out on reassembling those valves?

MR. BEZILLA: I did not personally, Jack, but I had my guys take a look, and we didn't do anything with the body to bonnet. We did repack the valves this outage, but we did not do anything with the body to bonnet.

MR. GROBE: Okay. Thank you.

MR. HOPKINS: Mark, I have a question. You mentioned three temperature elements for the reactor coolant pumps. Were all of those elements on the two reactor coolant pumps that you did work on?

MR. MYERS: We replaced the seals on all four reactor coolant pumps.

MR. HOPKINS: I thought you did more work on two than all four.

MR. MYERS: We did. We changed the rotating assembly on two. The thermal couple with the leaks on it are on the seal packages. We replaced all four of those.

MR. HOPKINS: Okay.

MR. BEZILLA: Jon, I believe it was three of the pumps, if I'm correct. And as Lew said, we touched all four of the reactor coolant pump seals. What was interesting was, they were leaking prior to the pump runs; and then after the pump, reactor coolant pump runs, I couldn't find any leakage.

I went and checked those myself, and I looked at the four pumps and then after we had ran the pumps, and I couldn't see any leakage. So, I don't know if that was because we had staged a seal and there was less pressure available to those sensors. But in any case, we have to disposition those, and I believe there is going to be some rework on those elements.

MR. HOPKINS: Okay, thank you.

MR. THOMAS: One clarification. It may be of some benefit if you describe

the temperature relationships between pressurizer temperature, RCS temperature, during the 250 pound test.

MR. BEZILLA: During the 250 pound test, bulk temperature was from, if I remember correctly, was somewhere in the 140, or actually 140 to 160 range, and overall reactor coolant system pressure was around 250 to 260 pounds. But the pressurizer, because we wanted a steam bubble was up over 400, I believe 400 degrees, to give us the steam bubble to have the 250 pounds in the system. So, that piece of the system was hotter than the bulk cooling temperature in the rest of the system.

MR. THOMAS: And the initial conditions for the latest HPI test required you to heat up in excess of 140 degrees and you did that.

MR. BEZILLA: We did that. We heated up -- Scott's referring to the high pressure injection pump testing that we just completed. We heated up to about 180 degrees and we did that with the reactor coolant pumps.

Reactor coolant pumps are big motors, big pumps, and they cause rotational energy to be imparted into the coolant, and we can heat up the coolant using the reactor coolant pumps.

Okay, next slide.

Now, I would like to provide you a brief update on our containment activities. First, let me provide an update on our containment health activities. In regard to the discovery action plans; 14 of 24 of those are complete and remaining 10 are in our internal review process.

I talked to Tim Chambers just before coming over here and he believes that those will be finished either late this week or early next week. So, we should have all of those completed by next week.

In regard to our Implementation Action Plans, there is 16 of those. Four of those are complete. Six are in our internal review process. One is in draft form; that has to do with containment air cooler motor replacement. And five are awaiting field work to complete, so we can complete those packages. So, I'll say progress is being made in those Implementation Action Plans.

Now, let me talk a minute about the containment work. I think we've made good progress on containment work. We have a few items to complete to get us to the point where we can put the equipment hatch on, which is effectively, I'll say, containment closure.

And those items consist of reconciling 250 pound test deficiencies or issues that we noted. Containment air cooler flow balancing, and there is some final strut and support work that we've got to finish up on the service

water pipe associated with those CACs.

Completion of a few containment health items. The seal along the basement wall, and then demobilization of containment, removal of tool, toolboxes, scaffold, things of that nature, and then I'll say final cleaning of the containment in general. We've been cleaning, but need to get the stuff out and then do the final cleaning and check of containment.

Installation of containment equipment hatch is an important activity for us. It signifies that the plant is near ready for that first normal operating pressure, near normal operating temperature evolution.

And, additionally, once we finish in containment, our daily exposure number is going to drop. We'll have our people in, I'll say, lower radiation areas not in containment, so I think that will help us from a personal dose standpoint also.

I believe we can be ready for installation of containment equipment hatch and containment closure within the next few weeks and I think it's very doable.

Once we install the containment equipment hatch, our Containment Health Project Manager, Tim Chambers, is going to conduct a turnover, I'll say, of ownership of containment to Mike Roder, our Operations Manager, and his staff. And, Ops will again own the containment. I think

that's a good thing.

In conclusion, containment activities are proceeding, and we should have the containment in a condition to support closure by putting the equipment hatch on and having ownership turned over from that Containment Health Project Manager to my Operations Manager within the next few weeks.

Any questions?

MR. THOMAS: Just for clarification, for when you say containment closure, that's the turnover to Operations; it's not the final closeout of containment; correct?

MR. BEZILLA: That's correct, Scott. That's putting the hatch on, and I'll say having Operations take control and minimize the number of people in there, the activities are ongoing in containment.

Okay, if there is no more questions, I'll turn it over to Lew.

MR. MYERS: Thank you.

Let's take a couple moments and reflect back on some of the actions we've taken on Management/Human Performance Plan, and then look forward. Our desired outcomes, discussed those with the actions we've taken to-date, and then some of the, in the next couple months, we have really got a focused effort that we'll be applying on the

Management Human Performance Plan.

Then we talk about going forward. Going forward is the plan for the remainder of this year. Then we have a, as part of that, we develop a long term strategy, a long term plan, that we'll be signing off in the near future for the continuous improvement of the Management/Human Performance issues to assure that everything is sustained.

The Management/Human Performance Building Block consists of actions we have taken to ensure that our team is built to last, if you will; and are the result, as you recall, the Management Root Cause Report that we sent you, the Engineering, Operations and Company Nuclear Review Board Function Assessments, the Corporate Oversight Assessment, the Independent Safety Culture Assessment, and the Quality Oversight Assessments that we performed, and the actions out of those.

Actions that we have taken to-date consist of the FENOC corporate organization has been strengthened, and we think strengthened significantly with the addition of the Chief Operating Officer position, the Executive VP of Engineering, and the VP of Oversight, which reports directly to our President, and actually reports on the dotted line to our nuclear -- Nuclear Board.

Davis-Besse, the Davis-Besse team now we think has been strengthened significantly. There is probably more

actions that we'll take there in the near future. For example, we have Mark over here. I'm pleased to have him here as the Site Vice President. The senior team was strengthened last year, we took prompt actions there. We've also been working on the management team to ensure we have proven leadership there.

Additionally, the Independent Quality Organization now reports, once again through a VP position, to the President of FENOC, the Board.

We've included several barriers, that if you go look at those barriers, I believe that we put these barriers in place, and the term I like to use, we've anchored them into our processes. And, I think that several of these barriers that we have up here may have actually prevented the reactor head event from occurring.

For example, the Engineering Review Board and Corrective Action Review Boards are both key barriers that we have in place now, that we've anchored in place, that we think will strengthen our organization in the future.

Next slide, please.

Additionally, the Company Nuclear Safety Review Board is a high level board of executives that's independent, and they're designed to provide independent feedback to the FENOC President. We've strengthened that board, not only from a member standpoint, but from a

process standpoint. So, it is strictly focused now and focused very well on nuclear safety issues.

We've improved the rigor and the classification of our corrective actions. And I think we're doing, we'll demonstrate in a few moments that classifications now we think are very conservative.

And also the quality of our root causes, cause analysis that we use in the Corrective Action Program. Terms we use; apparent cause and root cause. Well, root cause is a very thorough analysis.

We've also strengthened our Management Observation Program, and we've discussed some of the things we're seeing out of that program now, and it's made me proud.

Next slide.

If you go look at our Employee Concerns Program, I believe in our 4-C's Meetings and our feedback we're getting, we're now getting good feedback from our employees on the confidentiality of the program and also the effectiveness.

They've actually went out of their way a couple times in meetings with me to compliment us on the effectiveness of how we're taking on issues.

We've increased the rigor in our calculations. The standardization of our problem-solving approach. Once again, I think the problem-solving approach, which we're

using daily, I think Scott sees us using that. It might have been one of those new programs that are in place now, that have a lot of rigor and a good team. Asking tough questions, we may have discovered the reactor vessel head issue more quickly.

So, with that program, problem-solving approach, we think is a good program, and similar to what we use at our other plants.

We've initiated the, several employee communications committees; for instance, the 4-C's we think is here to stay. Mark is going to take that over as we move forward. The Town Hall Meetings and All-Hands Meetings are typical things that we use at our other plants.

Section specific improvement initiatives also have taken place in Engineering and Health Physics. And we developed several performance indicators. And group performance indicators, we're working on now, if you walk around our plant, have various groups in Maintenance, HP and Chemistry. You see individual department performance indicators. And in some of the main areas, you see the overall performance indicators of the status of the plant.

We think getting down to those groups; our mechanics understand what their backlogs are, and the material condition of the plant is going to be very important to us and increasing standards going forward.

I would like to take a moment just to look back and think for a moment about the definition of the term that we came up with. And, you know, if you'd asked me a year ago to define Safety Culture, I don't think that, that I could have very well. As well as I can now.

And, I could have gave you a definition, but often we would describe Safety Conscious Work Environment for Safety Culture. I heard everyone do that.

So, if you look, we have definition now as "That assembly of characteristics and attitudes", so it's characteristics and attitudes that effect people's behavior, "in the organization and individuals which establishes an overriding priority towards nuclear safety activities and that these issues receive the attention warranted by their significance."

So, what that means is, every day as we do our work in our power plant, are the safety-related activities totally articulated and are they receiving the attention they want by both supervision and management.

If you look at the Safety Conscious Work Environment. We define that as "That part of the Safety Culture addressing employee willingness to raise issues and management's response to those issues."

You know, the key term back then you use there, no such thing as a bad question. It's important that we take

every concern seriously. And I think we're, ROP met yesterday, and we're getting pretty good feedback, and we've made substantial progress in that area. I think it's an area that you never arrive in, sort of like the tag-out process, that you're always keep trying.

If you go look forward on the next slide, we have a pretty -- reason I threw this slide up here, I'm not going to go over issue there. I'll talk about some of them, but we have a very intense plan laid out for the remainder of the year. We keep adding things to it.

If you go look, in May and June, we have some procedures we're changing, our work management procedures, so that each work activity is classified as high, low, medium risk from a safety standpoint.

This week, we're taking Thursday, Friday, and Saturday and the senior team, myself and Mark are going off and laying out our strategies for the remainder of the year.

And, as you see, we've got a lot of activities lined out for between now and start-up, and then for the remainder of this year. So, then we'll have plans in place for, that we'll develop through this for next year.

So, it's not only are we working on the plant, but these three day activities with managers and supervisors and all of our employees, are very time consuming, but it's

something we need to do, we're taking seriously.

Next slide.

Let me provide you with some of those ideas. Our work management process requires management involvement based on risk. You know, at our other two plants, we have a procedure in place, and we bring that over here. Where depending on the system you're working on, look at that system, and then we evaluate the, are you being intrusive, are you just looking, what are you doing to the system. And, if you're working on the plant protection system or something like that, may cause a reactor risk; you would rate that as high to moderate risk. We give that more management attention and more, based on the risk significance.

And so, we're going to anchor that process at our Davis-Besse plant. So, we'll have that approved in the near future.

From an alignment activity, facilitated site alignment; we leadership development, department/section activities, and All-Hands Meetings scheduled for the rest of this year.

The Senior Management Team, for example, like I said, Mark and myself, we'll spend the next three days developing our short term transition plan for plant startup. You know, we're getting ready at that point now,

that we're talking about Mode 4 in the near future, and when we go into Mode 4, that's a pretty significant transition. We'll be heating up the plant, putting steam in our steam lines, testing all of our equipment. So, we need to understand how we change our behaviors when we get to Mode 4.

MR. THOMAS: Can we go back to risk management just for a second?

MR. MYERS: Sure.

MR. THOMAS: How long do you think the worker level, individual, what is their understanding of protected trainings; what a yellow risk condition is? Do you think there is a good recognition of what that actually means, or?

MR. MYERS: Well, I know there is. I don't think it's internalized as well as it should be, but I've gone to some of the shop meetings. For instance, I was in the services meeting a few weeks ago. They talked about the color of the risk.

When you talk to the employees, they understand that it's there, but I'm not sure, I think it's an area we can improve the level of knowledge on the behaviors associated with that risk significance.

So, they recognize it, but not to the, they don't, I don't think they internalize it as much as I would like.

Does that make sense?

MR. THOMAS: And the efforts that you just spoke about, will improve that?

MR. MYERS: Yes. We're focused to improve that. One of the things we'll be doing, I'll talk about that too, we plan on after we get -- looking ahead in my presentation. But after we have, we're going to have SMT Meetings we talked about. Then we have three days with managers.

One of the things we need to focus on, we got feedback from Sonja Haber's report and also our independent assessments, is the employees' understanding what the remainder of the year looks like and what are those activities that we have after we start the plant up. And, and what's important? What are those values and indicators that are important to us on a group basis.

So, these stand-downs, these one-day meetings are designed to develop a vision map of the short term and the long term to make sure we have clear understanding of some of our standards across the site.

We plan on having all 800, 900 employees sit down for a whole day in groups of about 20-- 200 at a time, to go over the vision maps and standards and everything with the directors and managers. So, we think that will be a good opportunity for us to go over dialogue, improve that

standard.

MR. THOMAS: Okay.

MR. MYERS: I rambled a little more on that question than I should have, but the answer is yes, you know.

MR. THOMAS: Okay.

MR. MYERS: If you go ~~lock~~ look at, you know, at the meetings we'll be having; we'll be applying the Lessons Learned from the Root Cause Reports and our Assessments. We'll develop our Leadership Strategies for Safety Culture going forward and then the critical element, elements and issues on both the short term and the long term that we'll continue to focus on as we move forward.

We revisit our Safety Conscious Work Environment Program with each and every employee and talk about the changes we've made prior to taking the reactor critical, that's what we find here as Mode 2. And we'll do that at the All Site Meeting with our employees. So, we want to reiterate the importance of Safety Conscious Work Environment at that time.

Next slide.

Some other actions we'll have, is we'll continue on organizational development activities, both in Engineering and Maintenance. Maintenance is an area now that we're

very focused on.

We'll continue with our employee communication. We're going to reinstate, if you will, our Weekly Managers Meeting. About a year ago, we stopped having the weekly, the daily management meeting, because we had the 6:30 meeting. So, as we move forward and as we transition to more of an operational mode, as we move to Mode 4 and Mode 3, and focus on startup; we need to reestablish these managers meetings, have the organizational structure put in place and understand what that structure looks like.

I think it's fair to say that we were not completely pleased with the management meetings we had before. So, that structure is going to be very important.

We're going to initiate our monthly departmental and section meetings. We'll continue that as we move forward, and continue our monthly All Site Meetings for at least the short term to ensure that we maintain good alignment with our employees.

Then conduct a weekly Senior Management Team Strategy Meetings. So as we, as the Senior Management Team, I would like to say is, we always are looking for changes or improvements as we sort of guide the ship down the river, and course direction. So, the strategy meetings every week we're having now, we look for those course changes; and we'll continue those.

The next slide, if you will.

From a Safety Conscious Work Environment standpoint, we're going to continue to monitor our effectiveness. In the third quarter, we plan on doing a survey. And then we plan on continuing doing the surveys at least for the next two years, and maybe longer as we see the need.

So, that Safety Conscious Work Environment Survey also provided to you at previous meetings, we think it gives us a very good benchmark from where we're at; and if we keep that consistent, we can monitor how we're doing going forward.

From a quality standpoint, quality has a survey that they use also, and they performed their survey in the fourth quarter, and then annually for the next couple of years at least.

Then from a FENOC standpoint, we have our Safety Culture Assessments that we'll be performing as part of startup. I think y'all guys have sat in on a couple of those. We think, we're sort of the leaders right now in the industry from what I've seen in our procedure for monitoring safety culture. I think we've made some more improvements there. It's a cursory process.

But we'll perform those activities prior to Mode 4. We'll have a Safety Culture Assessment for readiness. We'll perform another assessment prior to Mode 2, then for

subsequent outages in the future, at least for the next year or two.

Then FENOC is working on a program going forward where we continually monitor our safety assessment. We're looking for, at group performance indicators that we'll use in our corporate standpoint, we'll look at Safety Culture as we move forward.

MR. RULAND: So, Lew, if I understand, you're not going to come in at this stage to, basically doing these surveys for the life of the plant; you're going to reevaluate it sometime later. Have you thought, maybe this is too far in advance, have you thought about the criteria you would use to decide whether you would continue those surveys or not?

MR. MYERS: What we really plan on doing, if you look, we talked about Mode 4, Mode 2, and then typically what I do is Restart Readiness Review Meetings that we continue to do after every major outage.

But, what we're doing at FENOC levels, we're looking for a group of performance indicators, and we're working that already where we use a FENOC level at all of our sites to continuously monitor the Safety Culture.

MR. RULAND: So, the plan would be to do that for the life of the plant?

MR. MYERS: The plan would be

to do that for the long term, yes. Life of the plant, you know, is a long term.

MR. RULAND: Thank you.

MR. MYERS: I don't know if I'll be alive that long.

MR. RULAND: Both of us at least would be retired.

MR. MYERS: Yes. So, the intention is to do it for the long term, yes.

And, that pretty well concludes everything that I have. Any questions?

Next couple of months are going to be very busy from a Management and Human Performance standpoint. Thank you.

MR. GROBE: Lew, you brought up some interesting topics. One of the questions identified by the Management/Human Performance Inspection Team during their review of your internal Safety Culture Assessment Tool, which you call Restart Readiness Review Procedure, was the way in which you build up to your colorization on that chart that you've shown us many times; where you could have some poor performance in critical areas that get averaged into some other performance in maybe some less critical areas.

Have you analyzed that concern or question that they raised and decided what action, if any, was necessary to

address that?

MR. MYERS: Actually, Jack, there was two questions. One y'all guys raised, and the other one they did.

Actually, the doctors that did the external assessment for us, they don't like grading Safety Culture; they just like general assertions. And y'all guys tend to like measurable devices.

We've gone back and looked at, we took, I think, with the survey we did, they call them characteristics or behaviors or something. We did a very, very good cross-functional check to make sure that we were covering everything that they were in that assessment.

Then we went back and had some questions about, are there some critical type areas, like if operations is red, would you go forward. That term, term be the indicator red in that area. And the answer to that, if you look at our procedure, there is some subjectivity there, and we clarified that procedure.

We think, the answer is yes, we think we've addressed it, but you know, there is always management subjectivity. And, you know, if we had operations red, we would definitely consider that at a higher rating when it came to overall rating than we would maybe, maybe some other department, you know, like the procedures group, or

something, you know. Even though both of them are poor.

So, I think we have addressed those questions. And we spent a, the Senior Team spent several hours going through and resolving those questions a few weeks ago. Okay?

MR. GROBE: So, there has been a revision to the procedure or just how you're going to apply it?

MR. MYERS: No, there's been a revision to the procedure, clarified words, clarified some sections, and then the overall objectives we probably tried to clarify that also.

So, there is a revision procedure. I think we signed it, do you remember, Jim, a couple weeks ago?

MR. POWERS: Last week.

MR. MYERS: Last week? That seems like an eternity, maybe not.

MR. GROBE: Can you get a copy of that revision to Scott and he'll forward that on to the Region?

MR. MYERS: I will be glad to do that.

MR. GROBE: Just to be clear, we were reviewing your procedure, it's not what we want, it's the structure that you set up to assess your

organization, and we provided those comments to you, in your procedure.

MR. MYERS: Right. We certainly like things that are measurable; we tend to be engineering type. And so, there is, there is things that are objective and things that are subjective. And when you get into these kinds of models, you do have some subjectivity to them.

MR. GROBE: Okay. The outcome of this, and the way that NRC approaches measuring the effectiveness of an organization, we do it based on performance. And then look, if there is performance problems identified, look for the root cause of those performance problems.

You're creating a structure here that's going to be approaching the front end of that organizationally to make your organization effective, and of course you're also looking at performance.

There is a couple of things that happened recently, which I think may provide a springboard for discussion items at our next meeting. One was a rather significant operational configuration management problem, where you were filling the circulating water system and there were several valves that weren't in the position that you expected them to be in and ended up flooding condenser pits

in the facility.

It's significant from the standpoint that Operations needs to know the condition of all their equipment at all times; and in this case, they didn't.

I would be interested in a broader perspective, if you have any thoughts on that issue today, that would be good, but I would also next meeting be interested in the broader perspective of Operations' performance, what you've seen, as more systems, Mark indicated possibly in the next few weeks containment would be turned over to Operations.

So, I would be interested in a perspective of Operations, what you've been learning, what you've been seeing, not only the front end of the organizational effectiveness, setting it up right, but the back end of performance.

MR. MYERS: Why don't we give you an operational review next meeting.

MR. GROBE: Okay. And I think it was two meeting ago you talked about problems you had seen in a Maintenance area, and you indicated again today that you had been working in that area. It might be a good time to, to look at Maintenance's performance and how you're grading that, how you're judging that, and what you've learned.

MR. MYERS: We've already

taken time. We reorganized some pretty strong actions that we ~~plat~~ put the organization side; had some stand-downs with employees. There is several jobs, I think just recently done, Mike will discuss that later, but we've actually done a fairly good job on.

But you're right, there is actions still to be taken there. We have an improvement plan. Maintenance was not something from a 350 standpoint or shutdown standpoint that we spent a lot of time speaking with Engineering, Operations and HP, and recently started focusing in the Maintenance area.

It's not unusual when you start improving performance in one group, you start seeing the other one showing up. So, we've taken that on now, so we know the plan.

MR. GROBE: I think there was an interesting issue that just came up a day or two ago, when you were disassembling the HPI pumps, the high pressure injection pumps, and found some bolts, screws that were broken. Had you identified were those overtorqued or what caused that?

MR. MYERS: To my knowledge, they were overtorqued.

MR. ROSS: That's right.

MR. GROBE: So, that may have

been a Maintenance problem.

MR. MYERS: Yes.

MR. GROBE: Okay.

MR. BEZILLA: Jack, on that issue, and I've got one of my experts down here. I believe we had overtorqued, it was skill of the craft. There was no specifics in the procedure, and we now have specific torque values for those bolts in the procedures. So, that should not recur. So that's what I believe was the cause of those broken bolts.

MR. GROBE: They are somewhat of a unique design bolt. Okay.

The other thing, I spent some time with Jim Powers this morning, and we were talking about Engineering. We haven't really touched broadly on Engineering quality in awhile. It might be good next meeting to go over Engineering in a broad context of all the things you've learned over the last several months and where you see Engineering.

MR. MYERS: We can do that. So, we have Operations, Maintenance and Engineering.

MR. GROBE: That pretty much covers it; doesn't it?

MR. MYERS: Pretty much covers it.

MR. GROBE: Okay.

MR. MYERS: With that, I'll turn it over to Jim Powers. He will discuss Engineering issues we have.

MR. POWERS: Okay, thank you, Lew.

Two issues I would like to cover this afternoon, concern our Electrical Distribution System and our Safety Features Actuation System Relays. We've touched on these in past meetings and I want to do an update on where we stand.

First of all on the electrical area, one of the issues we had been evaluating concerned our emergency diesel generators and their performance under a starting transient and loading the safety electrical busses. We had found during testing at the site that frequency and voltage dips during those transients did not meet statements that we had in our Updated Safety Analysis Report for the site, which is our licensing basis.

And, based on that discovery, we instituted a study to determine the significance of that, particularly on the performance, not only the diesel generators, but all the equipment that they supply on the emergency busses.

Going through a detailed evaluation, we prepared what we refer to as an operability evaluation that

documents the performance and evaluates it and provides to the Operations staff the basis for the, for operability of the emergency diesel generators.

We provided that on May 15, and they reviewed that in detail and accepted it. And that allowed them a basis to declare the diesels operable for all modes. It was a successful outcome determination.

Some of the things we've got prior to plant startup to do, is to -- yes, Christine, question?

MS. LIPA: Maybe you're going to get to it, but based on the operability evaluation for now, but your long term plan to restore it; is that what you're getting to?

MR. POWERS: Well, the long term plan is, to go down the bullets here, the first step is to update our USAR to reflect the actual performance of the engines. We have a draft USAR change in the process of review right now to do that.

Then, as you'll see in the last bullet on the page, evaluating the actions to improve the engine performance. And there is a couple of changes that could be possible to improve that performance, but based on the current overall performance of the engines and the equipment in the system, they perform acceptably and are operable.

MR. GROBE: You indicated

that your diesel generators are now operable for all modes. Are there any conditions on it? Have you resolved the room temperature questions?

MR. POWERS: Good question, Jack. The room temperature issue is one that we've made big strides in as well. We had a, a technical team looking at that issue. This is one where the, the engines, these are very large diesel generator engines in rooms. And the ventilation system has not been able to provide cooling to maintain during summer outdoor temperatures, maintain the room temperature to acceptable levels.

And we've evaluated the components in the room, the electrical components largely that are sensitive to high temperatures to determine that they were satisfactory up to outdoor ambient temperatures of 95 degrees and have submitted an operability evaluation for that particular issue to Operations as well.

So, we're continuing work in that area. Although, we've completed that assessment, which provided operability to 95 degree outdoor temperature, which positions us well for this coming summer. There are three modifications we're pursuing in the rooms, and we're continuing forward to add margin to the plant.

And that, that is insulating the exhaust manifold for the engines, providing ventilation to the electrical

cabinets that are in the room, and we're also providing large fans that we have retrieved from our Perry unit that were originally intended for the unit two over there and they were not utilized.

And we retrieved those, provided refurbishment of them, and are planning a modification to install them at Davis-Besse now. So, putting that equipment to good use to improve margin in those.

MR. THOMAS: So, the temperature issue is not going to require a USAR change; is that correct?

MR. POWERS: The temperature issue may require a USAR change as well, Scott, in terms of the temperature in the room. The current temperature I believe in the license basis is 120 degrees. And, currently is 134 degrees, is what we evaluated for the capability of the equipment in the room, so.

MR. THOMAS: Now, it's my understanding that the fans, once you installed the fans that you would regain that margin; is that correct?

MR. POWERS: That's correct, the fans will provide a significant increase in cooling.

MR. THOMAS: But still may not get you back down to 120?

MR. POWERS: I'm not sure on

the detail, that will get us all the way back to 120 or not. We don't have a complete analysis done on that yet, but if they don't, then we'll have to change our license basis to be consistent, Scott, with that.

MR. THOMAS: I understand. The latest on installing the fans; is that post restart, prerestart?

MR. MYERS: Post.

MR. THOMAS: Post restart issue?

MR. POWERS: Right. We're working to position ourselves to do it promptly, continuing with engineering and procurement and planning for that, but seems post restart.

MR. THOMAS: Cabinet modifications and the exhaust insulation are prerestart?

MR. POWERS: Yes, they are. Those design packages should be issued this week and work commencing shortly thereafter.

MR. THOMAS: All right. Thank you.

MR. GROBE: Jim, are there any other limitations on this operability evaluation, similar to this temperature limitation? It appears by this spring that we're never going to get to 95 degrees, but

it's always possible. Are there any other limitations?

MR. POWERS: None that comes to mind.

MR. GROBE: Okay, thank you.

Oh, one other question. You have "prepare and issue USAR change". What's the specific focus of that USAR change and will that require NRR approval?

MR. POWERS: We do not believe it's going to require a license amendment and NRR approval at this time, Jack, based on our review of the draft. The specifics are, the USAR said that on the starting of the diesel generators, the voltage would dip below 75 percent of nominal voltage for several cycles. In fact, we found from our testing analysis it would be longer than several cycles, so we're changing it to be specific to the results of our analysis.

MR. GROBE: Okay.

MR. POWERS: Then I'll go through our 5059 Process for changes to our license basis.

Okay, I'll move on to, with the Electrical Distribution System, our AC Distribution System. We've been doing a very comprehensive analysis, or reanalysis, using Electrical Transient Analysis Program, ETAP calculation. And our electrical engineering team has been preparing the model of all the electrical system running

through the plant.

As you can imagine, this is a very complex model. It takes the large transmission lines that you see outside the plant with offsite power in the plant through large transformers, progressively smaller transformers. The voltage is reduced and distributed to the various equipment at various voltage levels down to 120 volts AC, which is your common power for small items.

The analysis is intended to demonstrate under all conditions the electrical system can provide adequate voltage.

We've gotten our initial analysis results last week. And, this involved a number of different plant alignments and cases of equipment loadings, whether it's on or off and given plant mode as we've gone through that analysis. And, we're currently evaluating the results of that now, so some impacts on plant equipment.

What we're finding is that there is a certain mode, unusual lineup of plant transformers that can result in low voltage under a certain set of conditions, which is high summer temperatures with all the equipment running to its duty capability, off-site power coming in through one startup transformer. And, running under that condition and having an accident, with all the accident equipment loads sequencing on the bus quickly, the voltage appears that it

is low in that condition, relative to our acceptance criteria, based on our initial runs of the analysis.

What we're doing this week to look at that in detail, we've got an independent industry team here. We've got some individuals from the Institute of Nuclear Power Operations, as well as peer electrical analysts from other utility sites who have gone through similar analysis projects here to critique what we are doing, and look at it and give us any imput, critical input in terms of what we're doing, what we may be able to do better.

The bottom line on it, we're evaluating the conditions that we're seeing from that initial runs of the analysis with the, with those initial lineups to determine actions necessary going forward, and that could be adding some relays into some of the equipment in the plant to assure that it's not on the electrical system under this set of conditions, and improve voltage on the distribution system in that manner.

MS. LIPA: Jim, is there any chance that this could result in a tech spec change, or, because I know you have a definition of off-site, on and off-site circuits.

MR. POWERS: Right.

MS. LIPA: Is that under question here?

MR. POWERS: Thus far, we haven't been looking at a tech spec change, but we have been looking at the alignments that the tech spec could allow. That's part of the modeling and the different system alignments, that we could be in this type of alignment submitted by the tech specs, but thus far, we haven't considered a tech spec change.

We have considered administrative restrictions that we must have above and beyond the tech spec requirement, for example, two startup transformers must be in service in order to satisfy, satisfy the operability. But we're in the very early stages of evaluating this, and have the team actively doing that now.

MS. LIPA: Thank you.

MR. GROBE: Just so I understand, the only thing you've identified to-date is possibly that a tech spec could be nonconservative, in which case you would need Administrative Letter 98-01 to apply some administrative controls and assume a tech spec change order?

MR. POWERS: That's right. That's essentially where we are. We haven't gone to that level of detail, but that's the type of --

MR. GROBE: You're not there yet?

MR. POWERS: No.
MR. GROBE: Okay.
MR. MYERS: No, not at all.
MR. POWERS: Okay. Next topic I wanted to brief on is the Safety Features Actuation System Relays. These are relays in a system that were changed out very early in the refueling outage last year. They were part of the planned projects for the refueling.

We changed to a different type of relay. It was intended to be installed to replace the original relays that were supplied with the plant. Over time as we've been replacing those relays, we ran into a problem with obsolescence; that is, the supplier stopped manufacturing the replacements for us. So, we needed to come up with an alternative replacement.

The replacement that was developed, we found from our testing, is not really suitable for the application. So, we've taken those out. And, we're in the process of evaluating and returning the original relays to service, while we regroup and review and develop a replacement for them.

Some of the things we've done in this technical evaluation, we've looked at the predominant reasons for replacement of the relays and we found out there is -- replacements are usually due to coil problems. And, we

found out with perspective coils and replacements, they're random with respect to age.

We've tested the original relays. We've developed a bench test criteria looking at coil resistance and contact resistance and insulation performance of them, and gone through and screened out a small population that did not meet our acceptance criteria and we took those out of the population.

We believe that the remaining relays that, of this original group, will have improved reliability as a result. And we've developed an action plan to go through, based on our problem-solving decision-making process, to go through this testing and evaluation process. MPR Associates is our lead technical support team as we go through this evaluation.

Because we screened out a number of ~~outlayers~~ outliers that didn't meet our acceptance criteria, we obtained replacements from another utility for the ones we could not reinstall in our plant. And we have those on site now and we're going to run those through our bench test as well to be sure that those are demonstrating appropriate performance before we install them in our plant.

On the next slide, we see our Technical Evaluation is in process. Talked a little about the industry experts, MPR assisting us with this.

Our average replacement, we found from a historical review, has been about two percent per year for the past twenty years. We have had a low level of replacement activity ongoing.

We looked at temperature effects relative to aging. Does not appear to be an issue, but we're going to take several relays apart to confirm it, and look at their material condition to confirm that and to confirm their functionality for another fuel cycle. And we're also going to perform an independent review of this technical work that we've done.

We're going to prepare an Operability Evaluation to confirm operability in this case. The original relays that we had installed were operable. We had an obsolescence issue with them. We're reinstalling them. We'll document the technical basis for that for Operations to review. And expect to confirm that those relays were acceptable for operation through the next operating cycle.

And I should point out, one of the major other activities that's included in this effort is procurement of a new generation of relay that's specifically engineered for the application of panels, and that's ongoing now with the initial specification stages as well.

MR. THOMAS: What's been done to strengthen your procurement process, specifically in the

area of equivalency evaluations, to ensure you're getting the components that you need to go into your safety related equipment?

MR. POWERS: We have a Significant Root Cause Condition Report that was written on this issue, and that was assigned to our Procurement Engineering Group to investigate, evaluate this issue, and how those replacement relays at the beginning of the refuel outage were specified, and what problems led to the issue of their application.

So, they own that Condition Report. We have an individual that's investigating it, feeding back what he sees as potential causes. I have met with the Supervisor of Procurement Engineering personally, and with the CR Investigator, to go over some of the considerations when we seek to get replacement parts for the plant, the level of detail that we go into in scrutinizing the application of the parts, and the application that they're in.

So, we've had that dialogue, Scott, to assure that that's well understood, the issue here, its relationship to procurement process.

MR. GROBE: Just one more relay question. If the failure rate has been fairly consistent, two percent per year, does that indicate that there hasn't been -- it was my understanding that the

initiating action here was a perceived higher failure rate combined with a difficulty getting replacement parts, which caused you to replace these relays.

MR. POWERS: Right. What we're finding when we say perceived high failure rate. We find from historical records that there was a relatively steady low level failure rate. When you have a failure in IC, Maintenance needs to do a change-out. That activity was ongoing.

But, where it really became a critical issue is when the manufacturer stopped providing that style relay. It became an obsolescence issue that needed to have changed.

MR. MYERS: We're working with three other utilities.

MR. GROBE: Sorry?

MR. MYERS: We're working with three other utilities that also have this same relay in their systems. In fact, we went out and got them to give us their relays, so we would have enough for this cycle. I think it was like 256 relays.

But support knows this is a reliability issue. These relays, when they do fail, they fail in a safe state. They fail on trip mode. So, what you wind up with is a reliability issue.

MR. GROBE: So, these relays

won't be treated any differently under the maintenance rule then? They're in fine condition from a maintenance reliability perspective?

MR. MYERS: I think that's correct, yes.

MS. LIPA: Okay. Anybody else, questions for Jim?

This would be a good time for a 10 minute break. Your next session is about to start, right?

Okay, so 10 minutes.

(Off the record.)

MS. LIPA: Okay, Bob, you can go ahead.

MR. SCHRAUDER: Thank you.

I'm going to talk about two issues today; the high pressure injection pump modification we're pursuing, and also give you an update where we're at with the Corrective Action Program. I'll start with the high pressure injection pump.

Before I get started on that, I would like to recognize John O'Neill, who is in the audience. He is our Site Project Manager and coordinates all the activities involved with the high pressure injection pump. And, he's going a really good job for us on the site. I appreciate the support we have with him.

High pressure injection pump modification. The last time we got together, we talked about the potential for modifying the existing pumps in lieu of replacing with the pumps that we had purchased. Since that time, we have looked at this option in more detail, and have decided that this will be our primary success path.

We have confirmed for ourselves that this modification will work. With the modification installed, the pumps will perform all of their required activities. And we continue to work very closely with MPR Associates on this activity.

And the issue with the high pressure injection pumps is, we found even with the new screens that we put on our sump, that very fine debris that can get through the sump screen could impact the existing internal pump clearances and had the potential to cause the pump not to be able to perform appropriately.

Again, we had looked at replacing or modifying these pumps. Since our last meeting, we have not abandoned the replacement activity, but we put that on hold right now and are not proceeding with that option. We have very high confidence levels in the modification approach, as it's far less complex, touches fewer of the plant systems, and that type of piping modification and support modifications that would have been involved in the replacement option.

What we will do is modify our existing pumps with an internal strainer that will strain the water that goes to the hydrostatic bearing.

I'm going to talk a little about the project milestones, the strainer design and its testing, what we're doing to validate the pump performance for potential clearance opening as a result of pumping the debris water; and then talk a little bit about what it's going to take to implement this modification in the field. I would say that that field implementation represents the biggest challenge certainly from the perspective of the schedule.

So, on the next slide, I'll talk about the strainer design and the testing. The strainer will allow water to pass through and supply the hydrostatic bearing and the seal. It's what I call a self-flushing strainer. That would determine analytically that the transiental flow and the velocity of the water will maintain the screen clear of debris and allow water to get through, but will not allow the debris to get through there.

If you go to the next slide for a second, we'll talk about a little bit different design approach than we talked about last time. Right in here are the screens that we talk about. And right here is the take-off that feeds the hydrostatic bearing. This represents the volute in the fourth stage of the pump.

The last time we had talked, this screen, the port that goes over the bearing was located, is currently located right there. And the screen would have gone, can't see it real well, but this is a curved surface in here. And we have changed that location to the one that's shown in this configuration.

And we did that, because we found that by relocating those ports, the water that supplies the hydrostatic bearing has a higher flow velocity achieved to the screen itself over a wider range of the pump flows, which will assure that the screen stays clean, particularly at the, near the shut-off head of this pump or in the minimum recirculation mode, the velocity we would have gotten pretty low at the screen, and would have increased the probability of plugging the screen.

So, this new location also allows the pressure to be higher and to be more constant. That in turn maintains a more constant flow to the bearing, which will make the bearing stiffness more constant over a wider range of the pump operation. That's one design change that we had since the last meeting.

We have also discovered since the last meeting in this design, that the French actually have this type of pump, not the exact same model, but a similar pump in service in some of the French plants. And they have

actually done this modification; not the screen modification, but they've moved that port, we found, for very much the same reasons, which we kind of discovered after we come up with this design, that another group of engineers had actually found this also, that they get better performance out of the pump by just moving that port to the hydrostatic bearing to a different location there.

MPR Associates again is performing the design work for us. They're going to mockup and test this strainer design at Wyle Labs.

One of the things we discussed last time, we depicted a picture of what the mockup would look like. Since that time, we've obtained a pump, again similar to our pump design, not the same design, it's a single stage pump, but it has the same type of approach that this volute, that we can test more accurately, let's say, than we did the mockup. We'll actually be doing the strainer testing in a pump in the environment we need to have it with the debris in the water.

MR. GROBE: Bob.

MR. SCHRAUDER: Yes?

MR. GROBE: Just quickly, did you indicate that these pumps, this same design problem exists on pumps that are used in nuclear plants in France?

MR. SCHRAUDER: That is my

understanding right now. I checked yesterday to see if the French had these in their nuclear facilities, and was told that they do.

We are attempting to get the reports on this, modifications that they've made, from the French, and we're expecting to get those in the next couple of days, so we can look in detail at that.

MR. GROBE: I have the other interest; you indicated that they don't have these types of screens installed in the other pumps?

MR. SCHRAUDER: No, they don't. They found by simply moving the port, it was acceptable. We looked at that and decided that the added assurance of the screen provides us a level of protection that we want; and we're going to continue with the screen modification.

MR. GROBE: Okay, thanks.

MR. THOMAS: Bob, did you say you were doing both; you are going to move the -- is that the location?

MR. SCHRAUDER: Currently, right here is where the existing pumps take-off would be, okay.

MR. THOMAS: Okay. I see. Thank you.

MR. SCHRAUDER: They were over here. And it's a down, and then into the port. So, it

changes, it's not a direct take-off of that anymore.

Okay. The next subject I'll talk about is the validation pump performance, validation. We actually did perform the first test on this with the pump clearances as they actually exist in the pump. Our rotodynamics analysis has predicted satisfactory pump operations.

What we'll do, is we're going to do two periods of this. The first one is called the baseline test. It helped us confirm the model that we created and took some baseline readings on vibrations for the pump, found where the critical speed of the pump was. We were able to find that. We did find in this test that the vibration was very steady on the pump throughout its flow regime that we exercised it through.

The next test that we'll do is, we have opened up the clearances, and we'll performed what we call the 2X Test, where the clearance are twice what they are normally in the pump. And we'll run the test again, and validate it with that isolated opening of the clearances due to debris impacting on the clearance, that the pump would continue to perform in a satisfactory manner.

The 2X was chosen, it's a maximum estimate that we currently have of what the tolerances and clearances would open up to. We're going to do a mockup test also on similar material to our pump to identify how much clearance

you would actually get, but we expect that the 2X clearance or twice the clearance will easily encompass the maximum amount of degradation we would see for the commission time of this pump.

Then after the, after the modifications are made and the pumps are resembled, we'll of course have post modification testing on the pumps before returning them to service.

Field implementation. Again, the biggest challenge, particularly in Pump Room Number 2. Pump Room Number 1, which is the pump that we're using to perform the tests on, is relatively easy; as easy goes to disassemble a 6,000 pound pump; but it's a fairly straightforward, pull the internals out of the pump, plenty of clearance there, then we move the pump to a plug in the floor where it can be lifted out and transported to the facility that's going to do the modifications on it.

The number two pump, on the other hand, has a lot more interferences by way of other pumps, other motors in the area, and it presents the biggest challenge to us to getting this pump out and maneuvered out of the building into the facility to modify and then to reinstall it.

So, there is about a month's work of activity between disassembly and reassembly of that pump in the schedule. And we have not had this pump apart in this

manner to take it out like this before, so we really don't know exactly how long it's going to take us to get it in and out.

There is a fair amount of rigging that's involved in there, and verification that our rigging points will take the six thousand pound load. There are conduit clearance that have to be made, taken out and reput in when we get back. So, there is a lot of field implementation challenge in pump number two.

We have a team resolving all those issues, laying out the travel path for the pump, and how it will come out and be maneuvered up and through the room; and they're progressing with that.

We've actually gone and, the next picture shows a mockup, a full-size mockup of the internals of that pump that we built, so we can actually take it through the travel path and know exactly all the way through the plant that it will clear all the areas that we need to clear it to get it out of the Plant and then back in again.

The next picture just shows what I was talking about, some of the congestion in the pump room itself. In the wall back here, relatively close, the pump will come out the back. It has to go out 32 inches this way and then tilt up and level this way and then brought forward and maneuvered around the corner. So, it is, you can kind of

sense the congestion within that room. So, it's a delicate piece of rigging and a lot of attention is being paid to that.

So, that's where we're at with the high pressure injection pump modification. In summary, implementation of this mod will resolve in our mind a debris issue. We'll demonstrate by combination of testing in laboratory and in the plant, that the pump will perform under all of its required conditions. And that the schedule for doing this modification supports being able to do the normal operating pressure and normal operating test in mid to late July.

I gave Christine a schedule of the activities down at the lab where they're going to do the mockup, so that the inspectors can come down and see that in progress, as well as we'll be down there observing that also.

Any questions on the pump?

MR. GROBE: Yeah, I apologize. We have a conference call I think we're trying to schedule for next week to do some preliminary discussions with the technical staff on this modification; then a meeting on the 19th.

MR. SCHRAUDER: Right.

MR. GROBE: You mentioned earlier today or yesterday that there might be some testing that will be going on before that 19th meeting?

MR. SCHRAUDER: Right, that's the schedule that I gave to Christine. It actually starts I believe on, around the 15th or 17th of June. I wanted to make sure that we had that schedule so you could get down.

MR. GROBE: We'll have to make sure we discuss that during conference call.

MS. LIPA: Right.

MR. GROBE: Okay, thanks.

MR. SCHRAUDER: Then, the next topic that I want to talk about is the Corrective Action Program. And kind of where we're at there, what we're seeing in the Corrective Action Program, what you're seeing, and some of the inspections that you're doing. And, Steve is going to talk a little bit too what the Quality Assurance Organization is doing.

This is an important topic for us. As we recall, the Corrective Action Program effectiveness was found to be a significant contributor to the events surrounding the reactor vessel head degradation; and its vitality and its viability are key for our future success, that we avoid any such problems in the future.

We strengthened both the procedure and the implementation of this program. I would not say it's perfect. We still have work to do in anchoring the program to the standards for all of the people involved in this

program.

We have seen some problems or shortcomings in some of the new implementation and the new procedure we put in. And I'll address some of those as we go forward.

In the meantime, we have I believe implemented some compensatory actions and oversight in the program to ensure ourselves that we're getting the adequacy out of the program we need to move forward.

At the same time that we're trying to anchor this program, due to, you know, the extensive reviews we're doing in the plant, design world, and across the site, really, we've generated over 12,000 Condition Reports last year and so far this year. So, we're trying to rebuild the program. At the same time we're moving a lot of Condition Reports, more than you would typically see in a given period for this amount of time to the process. So, that itself presents some challenges on oversight and assurance of quality of that program.

The first thing, I picked three topics that involve really the, the strength of the program. And the last one is one that's come up several times, is the rollover issue of Condition Reports, and I'll talk about that.

When you talk about the strength of a Corrective Action Program, you want to make sure that the Condition Reports that you're writing and evaluating, ~~A~~ and, that you

have the proper level of threshold that people will write a Condition Report. But once its written, you want to make sure it's appropriately categorized so it gets the appropriate amount of investigation into the condition and the corrective actions associated with it.

So, we look at categorization. We look at the quality of the Corrective Actions and the investigation that's going in; and then you also look at the timeliness of responding to the Condition Reports, once they're initiated. So, those are the three topics that I'll talk about, and then discuss a little bit the rollover process.

First one in categorization. Again, the new process became effective for us in March of this year. And it was issued as a FENOC Nuclear Operating Procedure. The major difference I would say, big change in that process is, it went from several different types of cause analysis. We have an apparent cause analysis, we had a basic cause analysis, and we had a significant root cause analysis.

The new process has eliminated the basic cause out of it. That is more consistent with industry standards.

Now, in addition to eliminating the basic cause, what we did, we upgraded the requirements for doing an apparent cause. So, the requirements there are stricter. There has to be a specified simple analysis method performed. And, we also required on apparent cause

analysis now, generic implications and extent of condition statements within the Condition Report Evaluation.

Some of the ones that in the previous system were called apparent causes would now be fixes. And some of them would remain just upgraded apparent causes. We did benchmark the process and believe that it is very consistent with some of the better corrective action programs within the industry.

Categorization is one of the things that we would measure, is how well the supervisor that does the initial review on the Condition Report when it's being initiated, how well they meet the categorization as specified in the procedure. And that is done by the Management Review Board, which is a collection of managers and senior managers at the site.

We have seen actually fairly good categorization. We've made what might be considered a number of changes, category changes, for instance; and we had a Condition Report written by an individual at the site that said, it seems like you are getting an awful lot of changes that the Management Review Board hasn't changed. They lumped together in that the significance level and the cause evaluation level. And we're looking at that.

What we found is, in the category changes, what we track very closely is where the Management Review Board has

felt they needed to upgrade from what the supervisor identified; no, this evaluation needs to be of a higher level than what you identified.

So, category upgrades, we would consider identification of a condition that's not a condition adverse to quality, where the Management Review Board says, well, yeah, for these reasons it is a condition adverse to quality. And then also a Condition Report that's identified as a condition adverse to quality, but the Management Review Board believes that it is a significant condition adverse to quality.

So, in the, not a condition adverse to quality upgraded by the Management Review Board to a condition adverse to quality, we've seen 125 upgrades since the March revision went in place. And since we put the revision in place, we've had about 2,500 Condition Reports initiated. So, 125 of them, we upgraded from what we call an NCAQ to a condition adverse to quality, and eight of them from a condition adverse to quality to a significant condition adverse to quality.

Where we've seen the biggest, what I'll call, delta between the management review and the supervisor's review is in the type of analysis that's required for the Condition Report. And the biggest one of that is, where the apparent cause versus the fix; where the old

process, they would all have been apparent causes, now some of them would be upgraded to apparent and some of them are saying, these are fixed and trend.

What we found is that the supervisors are more apt to put it into the apparent cause evaluation, then the procedure specifies it would be a fix and trend. We've had in the order of 250 of those, where the supervisor had said it's an apparent cause, and Management Review Board says, no, it's a fix and trend.

We've had some others. The next biggest one is 57, where the supervisor said, we've ~~taking~~ taken the action sufficient, we'll close this Condition Report. And Management Review Board said, no, you have a couple other actions, therefore, it's a fixed. So, that would be a category process change there.

Then, the rest of them are all, a lot fewer, and those are by far the two biggest hitters that we've seen in the recategorization.

So, we have not completed yet our review on the Condition Report that was written. We have looked closely at the datum and those are the kinds of things we found.

One of the other things I'll say we did find in that Condition Report was an expression by several people, I guess, this person was taking input from. What I'll -- the frustration over the feedback mechanism. That is, the

Management Review Board is changing these categories, and they're sending back information to us that says they've changed it, but you haven't given us enough details to why you changed it or what is the category, so we can learn from that process, rather than have you continue to feedback that we changed the category.

So, we're looking at better feedback mechanism to explain more completely why we changed the category or evaluation process.

What we have found is several of those that we sent back and said, no, we think it's this, they've come back to the Management Review Board and said, here's where I categorized it that way, this was my perspective of why it should be in this category. And in several of those cases, we have agreed with the initiator or the supervisor and said, yeah, we can see that, and it may well be more appropriate to be in that categorization. So, we've changed some of them back to the original identified one.

The next, the graph just shows what I've been discussing. This measures what, again what we watch very carefully is those Condition Report categories, significant or condition adverse to quality, that we've had to change and upgrade the performance of it.

We would like to get this into the 90 percent range, and we're doing reasonably well on meeting that goal right

now. It's, fewer than ten percent of the Condition Reports are upgraded as a result of management review.

MS. LIPA: Bob, how long have you been tracking this indicator, have you been tracking it for years?

MR. SCHRAUDER: No, we're tracking this -- well, I think they did track before, before the new process went into place also. The statistics that I've been looking at are since we've changed the process specifically, and that trend has also been improving on which ones we had to change also. And initially, it was like 29 percent the first month, and then 23 percent the next month, and 14 percent. This is all changes, not just the upgrades, but the evaluation process ones too.

So, we are seeing an improvement, as people become more acclimated to the new process. We're also looking at additional training, site-wide training, and we provided training to the Condition Reporting analysts, but we're looking at more training across the site on that process also.

Any questions on categorization?

The next thing I want to talk about is quality of the Condition Reports.

What we really, right now the measure that we have for quality is at the Corrective Action Review Board; and,

how often we have to reject an evaluation that comes to the Corrective Action Review Board.

One of the things I'll say is, this first slide shows the Corrective Action Review Board, by charter, by procedure right now, is not charted to look at apparent causes, but as an interim measure we've decided that they probably will look at the apparent cause analysis too, because of this change in the procedure, to make sure that people understand that.

That's where we've seen the biggest, I guess, delta between the procedure and what's actually coming to the Corrective Action Review Board. You can see right now we're running at about a 60 percent acceptance rate on those, and rejecting them for one reason or another.

We're looking at a hundred percent of them right now. Our intention is to look at all of them until we have confidence that they're being evaluated and dispositioned appropriately.

Recent changes we've made to help enhance the feedback is that the responsible manager of the section that's presenting the Condition Report to us, is present at the meetings, so that he can sense firsthand why, the kind of discussions we have and why we are rejecting some of these, and then we'll have communication back into the group. And when necessary, we see a specific area that's

struggling, we'll give one-on-one communication with that manager.

MR. GROBE: It took me awhile, but I think I understood the chart.

MR. SCHRAUDER: Yeah, well -- I'm sorry.

MR. GROBE: If I could, the height of the bar there is the indicator of the number of items processed, but you don't have a trend line indicating acceptance rate.

MR. SCHRAUDER: That's right. Actually, the legend is, yeah, the total height is the ones we've looked at, and the red are the numbers that we've rejected. It's going to have a trend line. It is a twelve month rolling average that will trend. We just now got the twelfth week for a couple days, so we haven't done it, twelve month rolling average on it right now.

MR. GROBE: Got it.

MR. SCHRAUDER: But the current rejection rate is right around 62 percent on here.

Scott, do you have something?

MR. THOMAS: Yeah, you said that items were rejected for one reason or another. Have you identified any specific reasons why some of these things have been rejected?

MR. SCHRAUDER: That's the next thing I'm going to get to.

MR. THOMAS: I'm sorry. I'll wait then.

MR. SCHRAUDER: Some of the reasons why we've rejected it. Some of the reasons are, the evaluations just have not been in the CARB's mind thorough enough, we would reject it.

If it doesn't meet the new format. The new process has a specific format that apparent cause needs to follow. If it's not in that format, we'll just reject it, have them get it into the format and bring it back to us.

The thing to keep in mind is, many of these apparent causes were actually, because we had this large number, they were generated prior to the change in the procedure. Some of them still have to go through the new procedure process.

If, for instance, they had been generated as a basic, or went through a process when we put the new process in place, some of the basics became apparents and some of them may have gone to root cause. So, they still have to meet the new format, even though they were generated early in the process, and some of them were not meeting that new format. So, that would be a reason for rejection.

The Corrective Action identified was either not specific enough, in our mind, or measurable enough or clearly written or was not timely enough in the Corrective Action Review Board's mind; or the experience review required or the generic implications and extent of conditions may not have been performed, that would be reason for rejection.

And a lot of them, I sit in on a lot of CARB's and a lot of them have been rejected because they simply did not specify the analysis method that they used. May have been apparent in reading it what type of analysis they went through, but they didn't specify, and the procedure requires that you specify the simple analysis that you're using.

Again the interim compensatory measure for this is the CARB itself. Again, we're continuing to review the apparent causes, all of them right now, until such time as we see, we'll start relaxing on that when we see particular sections meeting the standards.

Some of them are doing very well. For instance, we have noted that the Design Engineering Section, which does a very good job at meeting all of the requirements on the apparent causes. And apparent causes come in pretty well. And we've had only one rejection I believe out of design, and that was as a result of just not specifying an analysis

technique.

So, we haven't yet, but we will move toward design in the direction of doing a sampling of their reviews, rather than a hundred percent of their analysis.

And we are looking at, we'll develop additional training for the -- we've trained the analysts, if the sections use them effectively, the analyst can help them make sure their Condition Reports are in, in the proper format and the like.

We've seen the organizations that effectively use their analysts do a much better job at getting these things in, but we'll provide additional training there.

We did generate a Condition Report on this issue itself, that we had a high rejection rate from the CARB, so that Condition Report is in the process now.

Scott, do you have a question?

MR. THOMAS: Do you have specific training for the folks that do the cause analysis, or apparent cause?

MR. SCHRAUDER: We have a specific training module, as you know, for root cause analysis. We are developing the training module for the, specifically, the apparent cause analysis.

The techniques, you can either use a root cause technique, or simple analysis techniques can be things like

brain storming, interviewing, methods of collecting the data and assessing the data. So, we have not had the training module put together on that yet, but that's one of the things we've discovered in this that we probably need to do some additional training on some of these simple analysis methods; where you think it might be reasonably clear and in some cases it's not. So, that's under development.

MR. THOMAS: How many of your folks have actual root cause training? I'm not asking for a specific number, just --

MR. SCHRAUDER: Hundreds, I would say. I don't know the exact number, but we did a lot of training in root cause analysis techniques.

MR. THOMAS: Okay.

MR. SCHRAUDER: I can get the number for you.

MR. THOMAS: That's not important.

MR. SCHRAUDER: It's a large number of people, it's not just one or two.

When these Condition Reports come to the CARB, we have a check-off sheet that we go through. It's not just, you know, our collective wisdom that judges the acceptability of them. There is a check-off sheet that

asks specific questions. You know, does the information present any significant doubt as to the cause of the events? Is the evaluation package, does it lack clarity or conciseness or relevance?

And we answer these questions yes or no, and then make a judgment as to whether we ought to accept the Condition Report and making comments back to the evaluators, or whether it ought to be rejected and redone and resubmitted to the CARB. So, it's a formal kind of check-off process that we go through.

One of the things that we're learning as we go forward in quality measurements of the Condition Reports is that some facilities actually have a specific grade that they'll assign to the Condition Report.

We have a new program owner for the, FENOC program owner for this program. And he's in the process of benchmarking and developing some FENOC-wide performance indicators, and quality is one of the ones we want some additional ability to measure some of the quality.

The next slide shows these root cause evaluations that come in. These are typically the more significant issues. What we have found, this is probably a measure of the degree of training that you're given in root cause analysis, but we found a much higher acceptance rate and a much higher quality in the root cause analysis. Our goal

there is a 90 percent acceptance rate. We are currently meeting, meeting that; and the root cause has continued to be pretty good for the most part.

Things that we would reject a root cause for are really the same kinds of things. We don't see as many format-type problems with root causes, because they pretty much have a cookbook that they can fit their analysis and their evaluation into.

But sometimes if the root cause, maybe in the minds of the CARB they present the process, doesn't look like they maybe got to the root cause by way of not appropriately considering some pieces of data. So, if we felt that they may have missed some ingredient factor, we would reject it.

Again, if the Corrective Action is not clear enough, or we didn't believe it would have the potential to fix the problem, we would reject it. And a significant condition adverse to quality is different than apparent, in that the corrective action is expected that it would, would not occur again.

An apparent cause, you look at the apparent reason, and you do your best attempt at getting it, but you expect some percentage of those may recur. A root cause analysis is different in that you expect that you will get to the root cause and you will not have that condition repeat

itself. So, Corrective Actions need to be more stringent, more clear, more specific, and very clearly expected to prevent the action from occurring.

We would also reject a root cause if we believe that the extent of condition was too shallow, didn't, you know, look too narrowly for your extent of condition. So, that would be a cause for rejection for a root cause analysis also.

So, that's kind of where we stand in our look at the quality of what's coming in.

The next issue is timeliness. And this is another issue that I'll say is exacerbated by the volume of Condition Reports that we're getting in.

What we found, frankly, was that we had a lot of Condition Reports. The procedure requires a specific period of time, a default time, if you will, that an Evaluation and Corrective Actions are expected to be implemented within. And sometimes you extend those, depending on the circumstances and when the, you know, schedule in an outage, for instance, to get it done. But there is nothing in the procedure that allows for a Condition Report to just go overdue. So, we had a large number of, based on our volume of ones that were just overdue, were not being extended, and not getting done.

In response to that, we put together a high level

management review team that meets daily on the status of evaluations and corrective actions looking at what's coming up in the next three days, what's currently overdue, what's the reason for it overdue.

We can extend due dates in that meeting, but we have found that to be very effective. And that the overdue rate now is, is substantially lower, and is meeting a goal of less than five percent. For the last several weeks, it's been down hovering near zero of overdue. So, people are appropriately extending or getting their evaluations in and their corrective actions done.

MR. THOMAS: So, this chart doesn't take into account a corrective action that's been extended four or five times?

MR. SCHRAUDER: Does not measure extensions. We believe that extensions are granted at the varying levels of the organization, and extensions are approved with management oversight of them.

So that, now, that was the thing I was going to mention at the end of this, is that timeliness is another issue. I'm used to seeing more performance indicators. It wouldn't be as meaningful for us right now, based on, you know, several of these have been extended outs of post restart. So, the average age is one thing that you would typically look like, the average age of your Condition

Reports, Corrective Actions that haven't been completed yet. The average age to close a Condition Report is another one that you track.

We're not, we don't have those in place right now, because they wouldn't, wouldn't tell us much. As we move forward, we'll put together more timeliness of things too.

Go ahead, Jack.

MR. GROBE: What, what percentage in rough terms do you find -- you're involved in this group that meets daily, right?

MR. SCHRAUDER: No, I'm not. Mark is the chair of that meeting.

MR. GROBE: What percentage do you find that get extended?

MR. SCHRAUDER: I'd have to look at that.

MR. GROBE: Not precisely.

MR. SCHRAUDER: A lot right now.

MR. BEZILLA: It's stacks about this thick, and I'll say, it's probably about like five percent or less of that.

What we did was, about a month ago, we told the folks to lay out their work, match to their resource, and give us their due dates, and then they had to meet their due dates or hold them accountable to that; and if they had

trouble meeting their due dates, they need to come in and tell us ahead of time that they're having trouble, and we'll either help them meet their due date or we'll give them some relief on their due date.

And since we've done that in the last few weeks, we've had a lot less overdue items. In fact, we had a couple ~~day~~ days in row with like no overdue items. That's been very positive, I think.

MR. SCHRAUDER: In that though, if you look at the database, let's say, a lot of them would have had an extension somewhere along the line. That's what I was referring to. A lot of them in this process have been extended through the outage period. A lot of them are tied to plant conditions, where you're going to get. So, if the schedule moves, the due date moves out.

The process actually allows us to move those types, you know, where they're outage related and they're schedule, schedule driven, that an extension is not required to go through the same process, to move it with the schedule, so long as that, at the outage end date they are completed.

And that's part of our Restart Readiness Review, is that all the Corrective Actions, Condition Reports that were required to be completed for the outage are completed.

MR. GROBE: I think I agree with you, that this timeliness information doesn't tell the whole story. It seems like three items. Sorry.

This item is good, which is open corrective actions which are overdue, but you have two other indicators, one is number of extensions granted and the other is average age.

MR. SCHRAUDER: Right.

MR. GROBE: Extensions or indicator at a different level of organization management level.

MR. SCHRAUDER: That's correct, and we typically do in the processes that I've been involved with over at our other facility, we do track a number of extensions. And we do, we have a number of extensions on the Condition Reports, but it's a measure right now in the process that we're kind of in, that's not as meaningful, that once we get through this, this outage --

MR. GROBE: I understand.

MR. SCHRAUDER: -- and get them going. So, we will be adding those into our portfolio of Condition Reports that we use to look at the health of this program.

The next one is the same type of graph, and it

deals with the evaluations. It's the evaluations that we've done by its due date, the same type of information. The first one was the corrective actions that come out of it. This one is actually hitting the situation, evaluate it to determine what you need to do to fix it.

The other timeliness measures that we look at, shown on the next one, is the supervisor review. It's expected that the supervisor, once an individual has initiated a Condition Report, it goes to supervisor review that categorizes it, makes sure it's appropriately categorized and clearly identifies the problem.

We expect that to be done within one day. And again, we expect that at least 90 percent of them to get done within one day or less. And we're hovering right around 90 percent right now on that. So, I think that's 89 the last time we printed that out.

Again, that can be a condition of volume also, but the supervisors are doing a pretty good job right now getting through the Condition Reports on the day that they're initiated.

Then, the next review we looked at, is once the supervisor reviews it and moves it along, it's important that the shift supervisor and the SRO review it.

Now, it's not to say, if it's a significant condition impacting plant equipment, it's initiated, it's

typically walked to the control room, and control room is notified of, you know, potential immediate impact on the systems. But the process is, it's expected that the SRO would review the Condition Report within one day also of the supervisor's concurrence with, or not concurrence, but forwarding of the review.

We expect that to be 95 percent of the time, the SRO would get their review done within one day. Right now, we're seeing that it's right around 86 percent completed within one day. An overwhelming percentage of them are done within two days, so between 86 and 100 percent, nearly all of those are done within two days.

MR. GROBE: I'm not sure I understand this. Maybe I don't understand your process.

What review are you talking about here for the SRO review?

MR. SCHRAUDER: Well, every Condition Report that impacts plant equipment, that has any asset number in it that's a piece of plant equipment, goes to the control room for their review. They look at it for operability. They look at it for reportability. They look at it to understand what, you know, where the plant is at.

That's why, I mean, a lot of these Condition Reports are walked up to the control room when they're written for those very reasons. That if it's an immediate impact on

the equipment, the control room needs to know that right away.

That's what the SRO's review. Every Condition Report that is addressed to a piece of plant equipment or a configuration of the plant is reviewed by the SRO.

MR. GROBE: Does the CR first have to go through a supervisory review?

MR. SCHRAUDER: Yes, it does. Well, by the CREST software, before it progresses to the SRO, it needs to be progressed through the supervisor review.

MR. GROBE: And the SRO review timeliness, that does not include the amount of time that the supervisor took it?

MR. SCHRAUDER: That's correct. This is within 24 hours of the time that they get it, they have to have it reviewed in CREST.

MS. LIPA: Is this actually tracked in hours or days?

MR. GROBE: Days.

MR. SCHRAUDER: Days.

MS. LIPA: One day or two days or three days?

MR. SCHRAUDER: 24 increment is what is expected to occur in.

MR. GROBE: Are these calendar days or business days?

MR. SCHRAUDER: Doesn't matter.

MS. LIPA: Calendar days?

MR. SCHRAUDER: Right, 24 hours.

MR. GROBE: So, my statistics are a bit rough, but if you're 89 percent of the time the supervisors are taking more than a day, and 86 percent of the SROs are taking more than a day, sounds like less than 75 percent of your CRs aren't getting an operability review in two days.

MR. SCHRAUDER: That could be, but again, I'd say, when it impacts operability, it's walked to the control room quickly.

MR. GROBE: Who is making that decision, an operator?

MR. SCHRAUDER: The initiator and reviewer are tasked with the responsibility of recognizing whether something can impact operability or not.

And those statistics, Jack, if you recall, that's the entire population of Condition Reports. I would say probably, and this is a guess, 50 percent or less of them involve plant equipment that needs to get to the control room.

MR. GROBE: All right.

MR. SCHRAUDER: So, it's not quite what you say. But you're right; I mean, with a delay by the supervisor and the delay by the control room, you could have issues there.

We think we're doing reasonably well in getting operability issues to the control room rapidly, even if it hasn't progressed through the software system.

MR. GROBE: Well, I can't tell that from these indicators. And, I think I need to look a little bit more into this.

MR. SCHRAUDER: I understand your, your insight on that.

MR. GROBE: Okay.

MR. SCHRAUDER: Any other questions on the timeliness review?

The next issue is a, is the rollover process. And the rollover has been identified both by our Performance Improvement Unit, some of the inspectors that have come in, I'll say confusing and a cumbersome process.

What a rollover is, it's a method of transferring the evaluation, whether the complete evaluation or partial evaluation of one issue identified in a Condition Report to be addressed in the another Condition Report that's looking at essentially the same thing.

We have found, and your inspectors have found, that

it is a difficult trail to follow sometimes. There have been cases where there have been multiple rolls; where it rolls from one Condition Report to another, and then that rolls up to another and you wind up doing about sometimes seven or eight of these all in one Condition Report.

Again, is exacerbated by the large number of these being processed. One area we have particularly seen this in is Containment Health, you know, where we had a lot of the walkdown type of CRs being documented and the like. So, that's why I say, it's generally been concentrated in a few specific areas.

We've actually found very few cases where we believe that the case, that the issue has not actually been effectively resolved. It's just a very cumbersome process at times to track them from, to which CR, to which CR did it go to and which one finally answered it. But we have typically found that if you persevere through that process, you will find the answer.

Now, Steve Loehlein is heading up a review team, because we got enough comments and saw enough concerns I'll say in this area that we wanted to really take a look at. So, I believe Steve is looking at all the restart or the 0350 Condition Reports that had rollovers or rollintos in them; given us some more insight on that. Out of his -- that's the independent assessment.

One of the other things I wanted to mention is that many of these rollovers occurred before we revised the procedure. And the new procedure has more clarity on the process for rolling over and what you're allowed to roll to another Condition Report; and more specifics on the process and documentation of a rollover.

So, to enhance that, we don't believe it's a bad idea necessarily to roll, roll over Condition Reports when the receiving one is evaluating virtually the same kind of circumstance. It has to be well documented and an easy trail. But it does appropriately align resources. I think if you just try to evaluate each one individually, you wind up using resources over and over again to look at the same thing. So, if properly administered, I'll say, and documented, it's not a bad process, but it needs to be rigorously applied.

We've seen problems with, the procedure right now requires that if you're rolling to another one, the receiving Condition Report has a corrective action in it that says, hey, I got this one, so that the reviewer knows that he's got to evaluate this other condition in it also. We've seen some problems in that area.

So, like I said, we have revised the procedure, tried to provide more clear guidance. Steve is going to give us some more insight into it and we'll further

strengthen the rollover criteria or, you know, if his evaluation and assessment so indicates, we will consider whether we want to continue the rollover process or not; and we'll strengthen that process if we keep it and feed it into the FENOC procedure.

Questions on the rollovers?

MS. LIPA: Thanks for that discussion, Bob. I know our Corrective Action Team Inspection will continue to look at corrective actions, and through that, I'm sure we'll look at some of these rollover.

MR. SCHRAUDER: Right.

MS. LIPA: Any other questions for Bob?

MR. SCHRAUDER: With that, I'll turn it over to Steve.

MR. GROBE: Steve, before you get started.

(Microphone adjustments.)

MR. GROBE: When you're thinking about this rollover situation, think about it also in the context of your performance indicators, and how you treat rollovers in the performance indicators. I don't think you want to discuss it here, because I'm not sure I've given you a chance to think about it.

MR. SCHRAUDER: It is addressed in the procedure, Jack. If you roll it, it maintains its current due date. You can't roll it and get an automatic extension on it. So, it has to meet the original CR's due date or it has to be appropriately extended for that.

MR. GROBE: Okay.

MR. MYERS: Jack, one of the things, you know, we have a lot of experience at other plants. There has been a large number of CRs here. We don't roll, you know, at Beaver Valley we don't roll but a couple a week. It's not like the rollover process causes a lot of grief because we're not rolling over that many. It might be different at Perry, but at Beaver Valley I don't remember rolling over. Do you?

MR. BEZILLA: That's correct. Just a handful a week at the most, is what I remember.

MR. GROBE: Okay.

MR. LOEHLEIN: Okay. Thanks, Bob.

I have two things to talk about today. One has been mentioned several times, and that is the status of the Independent Review of Condition Reports; and the other is an update on Quality Assessments of recent oversight activities.

In the Independent Review of Condition Reports, we

talked about this, or Bob mentioned the rollover issue, but we also decided, and Lew Myers and I talked about this; we heard enough reports about people having some difficulty tracking through all the volumes of Condition Reports and issues. And based on what Quality Assessment had been seeing in its oversight, we agreed that doing an independent review of the Condition Reports for the 350 Restart would be a good thing to do.

So, Mark Pavlik, who is an auditor in the QA section, is the team lead for us on this. We have team members from other departments on site and from other plants.

Now, who we really targeted most often is people on this team, is either people from the Quality Organization or these Condition Reports analysts that in the process are advisors to the managers, are the people that we're trying to put on this team on a rotational basis, so they will carry back with them to their organizations the Lessons Learned from how to improve on the work that's done on the Condition Report.

So, the scope does include all of these 350 Restart Condition Reports and Corrective Actions.

Next slide, please.

The objectives are simple in this review. It's to confirm that the initially identified condition has been

evaluated.

The other objective is to track and confirm the issues that were rolled to another Condition Report were not lost. In any cases that we find problems in that area, then we use the Corrective Action Program to document the problems that we would find.

Next slide, please.

Now, as of last Tuesday, I think that's what May 27 was. In the system, there are identified 1,783 0350 Restart Condition Reports. They have associated with them about 7,700 Corrective Actions. Not all of those are restart related; about half of them are. But we're looking at quite a few nonrestart corrective actions, as long as they were associated with the 350 Restart Condition Reports. And the population of Associated Rollovers was identified in our system as 510. As we go through the reviews, these numbers can move around a little bit.

Next slide, please.

As of last Tuesday, we had reviewed 5,057 of the Corrective Actions of those 7,700; and that includes the Rollover Corrective Actions. In 87 percent of those cases, we were able to track the, how the Corrective Action relates back to the initially identified condition.

Approximately 13 percent of those cases were still in review, because that trail is not clear to us yet. So,

we're having to do additional reviews. And this is, we believe this percentage represents the difficulty that people are experiencing. When I get to some of the causes or some of the problems we've identified so far, we're starting to hone in on why that is.

MR. GROBE: Steve, just a quick question. Are the 510 on the prior slide, the 510 rollovers, those are Rollover Corrective Actions, not CRs?

MR. LOEHLEIN: Well, actually, they can be either one. When a rollover occurs, it can either be a Corrective Action that's rolled over and then becomes a Corrective Action in the Condition Report that it's now in, which is the process that Bob Schrauder described. The receiving Condition Report gets a Corrective Action to identify it has received that issue.

So, it can be a CR, it can be a Condition Report that's rolled, or it can be a Corrective Action that's rolled. We treated everything from the Corrective Action standpoint from the back end of the process and count them all there. That way we have them all, whether they were a Corrective Action that was rolled or a Condition Report that was rolled.

MR. GROBE: Okay.

MR. LOEHLEIN: Of that 510, you'll notice here, as may have been suspected, the number

of percentage we're having difficulty tracking from front to back, is higher in those that involve rollover than the general population of the ones we've looked at.

On the next slide, what we've got so far is identified concerns, is overall, what's being seen as a general weakness in some cases, documenting the resolution and the identified concern.

There are cases, for example, where the closure statement says that appropriate actions were taken to correct the condition, as an example. You can't tell from a statement like that whether or not an appropriate action actually was taken. You can't confirm it. So, for anybody trying to review that on the back end, that's difficult.

In the cases that we're examining, we're finding that there is evidence that correct actions were taken, but they're not taken credit for in the process. That clearly is a lessons learned for people using this process, that to document accurately what actually settled the issue is the practice and the standard you want to have for the Condition Reports.

So, that's been identified on the Condition Report as a generic concern with a number of these.

Another identified concern has been, with cases where the evaluation did not address the full scope of the identified issue. Now, here, the most common type we found

here is in the Condition Reports involving valves. Most commonly, if there was a valve that was expected to require a repack of the stuffing ~~blocks~~ box. In a number of these cases, the condition -- initial Condition Report had additional recommended actions on it. It might be to verify fasteners or to replace them.

In the resolution of the Condition Report, the packing issue is either addressed as repacking or may provide a basis for why repacking wasn't necessary, but the issue about the fasteners doesn't appear in the explanation as to whether it was or was not addressed. So that, we have written up on a Condition Report as a generic issue to make sure that has not been missed.

And in these cases, we're finding when we spend the time to track down the people that did them, in most cases, we're finding there is an explanation, but once again, the documentation of the actions taken being sufficient is what, is what people are having difficulty with in reviewing the Condition Reports.

In these ones we've reviewed so far, we have two examples so far of incorrect actions. One example in which there had been an error made closing a Corrective Action to a work order number. That was an incorrect work order number. The work order number associated with, did exist, but it was not complete yet. So, that was a mistake. We

identified that on a Condition Report.

And, we had another one we found in which a procedure improvement had been recommended and was not picked up in a Corrective Action. Those are two specific examples we found so far.

MR. GROBE: Before you go on, the definition of acceptable. If this Condition Report involved a design engineering issue, does that acceptable include a review of the adequacy of the design work, or does the acceptable mean that you can track through and identify the specific actions that were taken and they appear to be relevant to the question?

MR. LOEHLEIN: I think if I understand your question, Jack, you're asking about whether we're looking at or this team was looking at, say, the adequacy of the cause evaluation associated with the Condition Report; is that what you're asking?

MR. GROBE: Right, or the acceptability of the corrective actions to address that cause evaluation.

MR. LOEHLEIN: Right. I would say, what you just described there is what we're going to be taking on and are doing right now in Quality Assessment as part of a focused assessment. I'll talk about that in a couple minutes here.

This is strictly a review here. I'm not doing it as an audit-type function. So, it is a bit more superficial in the sense that it's really looking, when you can track the end result from the initial condition; and so I would say that the level of intrusiveness is not there. It's really a review, and that's why we termed it that.

But what you're talking about is questions that we are looking at in the Quality Assessment area under a focused assessment. I'll talk about that in a minute.

MR. GROBE: Okay, thank you.

MR. LOEHLEIN: So, that's a good lead in to the next slide, which talks about some of the recent key activities that we've been observing in Quality Assessment.

First thing I would like to comment on is the, are the two tests that the other members have spoken about recently; the 50 pound per square inch and the 250 pound per square inch Reactor Coolant System Leakage Walkdowns. In both of these cases, Quality Assessment Assessors accompanied walkdown teams in Containment to directly observe how this was being conducted.

The 50 pound test in particular was, we thought, an excellent decision made by the organization, because it is not required by the process in place to demonstrate return to service, but it really was used by the line organization

to do a couple things that are going to pay off. That is, that set a baseline, and also everybody involved in these walkdowns had an opportunity, while the system was at a very low challenge, to locate the components and make sure they knew where they were. So, that was a very positive thing we in QA thought.

The next bullet I have up there is Emergency Preparedness. This is an area that's always important, the emergency preparedness be in good shape. And certainly with the plant focused the way it is right now, it's an opportunity for QA to evaluate whether the organization is properly focused on this important area as well.

We watched and observed the activities in the last few drills and exercise, and did note that the weaknesses that were identified in the April drills and so forth, in large part were corrected in the May exercise. So, we continue to observe the activities in there, but the weaknesses that did come up were being addressed by the organization.

In the area of Observations of Technical Issues Resolution, there we're seeing some good decision-making being made, especially in the area of the plant support center and in senior management involvement. We saw a real turnaround.

This is something I get to see firsthand, because I

watch a lot of management decision-making. And the priorities are being established and emphasis on the effective resolution of the technical issues. And this focusing within this plant support center of these issues seems to have had a real strong influence on getting the issues focused on for resolution and clarity of the plans and the challenges to success are discussed well there.

On the other side of the technical issues resolution thing, we have continued to look at the contractor oversight part of this. Right now, a lot of the action in terms of contractor oversight is now in the technical resolution area.

Some months back we talked about what QA was observing in Maintenance. And early on, the contractor oversight activity is really more in the engineering end. And we have identified some concerns on the owners acceptance process that's been used, and identified that on a Condition Report. We felt too heavy reliance on using contractors as part of the owners acceptance process, and that's been shared with Engineering.

We've identified some issues in the control of purchase orders revisions, and discussed that, we briefed that with the Engineering organization as well.

And we continue in the System Health Condition Reports area also. We're watching those real carefully,

because of the same issues that Bob Schrauder mentioned about the Corrective Action Program. This is an area, Jack, where we're watching real carefully that the Condition Reports have in them a cause analysis that clearly substantiates the basis for the conclusions in the cause analysis.

And this is an area where if the evaluator is too cryptic or too brief in his description of how the solution is properly resolved, it will make it unclear for posterity as to why it was the right solution. So, that is an area we continue to watch and we think there is still room for improvement there.

MR. HOPKINS: Let me ask a question here, Steve. The last bullet about oversight vendor activities.

MR. LOEHLEIN: Right.

MR. HOPKINS: Are you just referring to on-site vendor activities or also off-site vendor activities?

MR. LOEHLEIN: The reason I added that bullet and hadn't spoken to it yet is we are reabsorbing quality control function back into the quality assessment, quality assurance umbrella. So, I thought I would add a bullet here on the type of off-site vendor activities we recently been involved in; like going to,

going out to Oklahoma to take a look at the radiographs that were done on the cyclone separator for decay heat pumps is one example.

Recently, just this past week, have been involved at a vendor shop in Utah to take a look at the troubleshooting that's being done on the service water valves for the containment air coolers.

We also were recently involved down in Cincinnati with Makeup Valve 3 looking at the certification of the AOP parts associated with that.

And so, we're looking now that they're part of the Quality Assurance Organization as to how we can be more effective in some of the vendor oversight, some of the off-site vendor oversight activities, because throughout the industry there have been some issues and we've had some issues with vendor supplied equipment.

MR. HOPKINS: Okay.

MR. LOEHLEIN: So, we're getting more active there. But I put that there, because they're a recent addition to Quality Assurance.

MS. LIPA: Steve, before you go on, you mentioned emergency preparedness, and that's an important area to us too. I neglected to mention earlier, we have a baseline inspection next week that is looking at your evaluated emergency preparedness exercise. They will

be here the full week, but they'll be focusing on that exercise the one day.

MR. LOEHLEIN: Right. Thank you.

MR. GROBE: I apologize for going backwards.

MR. LOEHLEIN: That's okay.

MR. GROBE: But you've keyed me into a thought. At the end of every outage, you're required to do an American Society Mechanical Engineer Leakage Test on the Reactor Coolant System, a pressurized test to look for pressure leakage. Is that normally done hot?

MR. LOEHLEIN: I believe that's done in Mode 3.

MR. GROBE: I'm still pondering the DH 11 and 12 valves and why they were leaking. So, normally, those are tested hot. So, you may have not seen leakage if in fact it's a temperature driven issue. Okay. Thanks.

MR. MYERS: If it's very minor --

MR. GROBE: It's minor at 50 pounds, but 250 pounds...

MR. MYERS: Let me finish. If

it's minor and it stays dry, which you find more on that, and it stays that way on up, then those valves that were in it, was close.

MR. GROBE: Right. So, you may not have seen it.

MR. MYERS: That's correct.

MR. GROBE: All right.

MR. LOEHLEIN: Okay, next slide, please.

Under some of the current activities, an important one is this Focused Assessment, Jack, that we talked about, or I mentioned just a few minutes ago, a Focused Assessment on Corrective Action Program. That's because we know that the organization made some stiff changes to the process on March 1st.

The early data we had did not show improvement in a couple key areas on implementation; specifically in the, we didn't see improvements yet in the numbers on the quality of the cause analyses and some other important parts of the process.

And the CARB data that you saw, Corrective Action Review Board data, showing their rejection rate also, we have a lot of indicators that this was an area deserving of a Focused Assessment.

What we do in a case like this, it's more like the,

the older common, done commonly years ago, used to call an audit, a checklist type, where we have a number of things we'll be looking at. We'll be interviewing people that are involved in the process, that includes both managers and lower level interviews. We'll continue to review the Corrective Action Review Boards, what they're doing.

We're going to also do a lot of random selection of Condition Reports from various categories, and we'll sample rollovers as well, to see that they have actually been completed through the process and all the steps the way they should have been, and take a look at what that data tells us. And we'll also verify compliance with the program itself. So, that is something we're doing right now in this quarter.

We'll continue in the next few months over the next, during the summer, continuing to do drills in the emergency preparedness area, we'll continue to observe those.

Then I put the last bullet down. It's just sort of a general kind of things that we do all the time and incorporate into our daily oversight activities, as the oversight of Management Decision-Making, Safety Culture, Radiation Protection and there is a lot of activity right now on the regulation changes for our Security Program.

MR. HOPKINS: Just mentioning a Security Plan, I would think a lot of those changes would

be generic to the other FENOC plants also.

MR. LOEHLEIN: That's correct.

MR. HOPKINS: So, you're in contact then with the other FENOC QA Organizations?

MR. MYERS: Absolutely.

MR. LOEHLEIN: Well, I know that, we talk every day, but I can't, you know, security being safeguard, we don't talk openly about a lot of things, but yeah, we do communicate with our, we communicate daily with QA from the other two sites, and one of the topics that is appropriate is the security part of that.

MR. MYERS: We also have a lead person, our corporate office for security issues.

MR. HOPKINS: I was just concerned that, you know, that I figured a lot of the changes would be the same from plant to plant; and I wanted to make sure the QA Organizationss are --

MR. LOEHLEIN: That is true, and that kind of conversation goes on, Jon, every time there is a projected change in security level as well.

MR. HOPKINS: Okay.

MS. LIPA: Just to give a time check, we have about 15 minutes for the next two sections.

MR. MYERS: Okay.

MR. LOEHLEIN: Mike Ross is going to take over.

MR. ROSS: Thank you, Steve.

Good afternoon. Our Davis-Besse Plant Support Center is in full operation. The following items have been completed. We developed an issues list and it currently has about 84 items on it. These issues are being reviewed in detail against the standard checklist to identify restart issues and obtain our agreement that the resolution is a quality and lasting type fix.

An Action Item Database has been created with owners and due dates. And the issues identified as needing decisions or extra assistance are being brought to the management team in a timely manner.

As clarity is brought to new issues, fragnets and part needs are developed and owners assigned, they are transferred to the Outage Control Organization for field implementation.

To ensure quick resolution to supply issues, the Corporate Director Supply Chain has been stationed on site and is part of the support center.

Listing of modifications has been developed with field implementation dates and is being tracked and prepared for field execution.

The Condition Report Database has been reviewed to

identify those issues not yet through with the evaluation process that may be restart. This will assure no hidden restart issue resides in that Corrective Action Database.

We do believe we know the issues that need to be resolved.

Next slide.

Our focus is on early identification of new issues and proper resolution of existing issues. This includes delivery of a quality resolution to the field organization.

Several issues are receiving extra focus. These are High Pressure Injection Pump Modification, that's already been discussed by Bob Schrauder. The Electrical Transient Analysis and the Safety Feature Actuation System Relays. Both have been addressed by Jim Powers.

Other issues that are receiving extra focus; the Air-Operated Valve Program. We have identified some emergent work in this area, with identification of three new work items. This is the addition of air reservoirs for service water valves 1428, 1429, and 1434. It appears this will revolve without significant impact.

The Plant Block Walls Seismic and Tornado Loading issues. As a minimum, we will need a procedure change to resolve one issue dealing with the tornado differential pressure, and additionally a modification to the boric acid

tank room door to address the seismic ability of a wall during a postulated line break in the area.

The Thermal Overload Bypass for Safety-Related Motors issues. It appears we will have some field work for that item and a full understanding of and resolution for its being developed.

Additionally, we identified two modifications. They are designated, that are designated for restart. The Containment Spray Pump Cyclone Separator addition. This is the addition of a separator to ensure postulated sump debris does not affect the containment spray pump seals. A Boron Precipitation modification has been identified. This is an enhanced method of ensuring the backup capability to provide Boron precipitation flow after a postulated accident.

It should be noted, both of these items add significant safety margin to our plant. These items do not impact our overall schedule.

In conclusion, we believe we have scrubbed through the present issues and have a good understanding of what needs to be done. We continue to believe all issues are in fact resolvable.

MR. HOPKINS: Let me ask, Mike, the Boron Precipitation Modification, is that considered a restart issue?

MR. ROSS: It's a Mode 2 issue.

MR. HOPKINS: Okay, thank you.

MR. GROBE: Just one quick question. I've heard these two issues discussed; the Cyclone Separator Containment Spray and Boron Precipitation. For quite awhile now they've been on the engineering issues list. What causes something to get added to the modification list?

MR. ROSS: We go through our checklist to verify that it has an issue. We bring it to senior management. We get a firm decision early. And we put it through the process and get it started. That's the value we bring to the organization.

MR. GROBE: Okay, and you indicated that you also reviewed other CRs, and I assume that covers everything that's on Jim's Engineering Issues list?

MR. POWERS: That's correct.

MR. GROBE: And identified other key issues that could be risk items.

MR. ROSS: That's correct. We probably started with Jim's Engineering Issues.

MR. GROBE: Okay, good.

MR. ROSS: If there is no

more questions, I would like to turn it over to Mike Stevens for Schedule Milestones.

MR. MYERS: Why don't we skip over that one. Let's go to the Performance Indicators. I think we're running out of time, correct?

MR. GROBE: Okay. I mean, Clark's gotten skipped on multiple other occasions.

MR. PRICE: Okay, thank you, Mike.

Good afternoon. Can you hear me?

I would like to conclude our presentation today with an overview of our progress on the O350 Restart Checklist that Christine presented at the beginning of the meeting. Then take a quick look at a couple of our charts to show our overall restart progress on our restart required actions.

The next three charts provide a summary of our status on the 0350 Panel's Restart Checklist Items. These charts are colored to show where we are in the discovery and implementation actions.

You'll see, and also if you have trouble reading, I apologize on your handout, I know black and white is very difficult to discern between the colors. There is a chart over on your righthand side on the wall that also lays this out.

You'll see on each chart that we are complete with our discovery plans for each of the Checklist Items. So, I'll mainly focus my discussions on progress on our implementation plans.

On Checklist Item 1A and 1B. They both address our technical and nontechnical root causes and other root causes we've done in the Management/Human Performance area. We completed all our 0350 Restart Actions under these two items.

Checklist Item Number 2, A and B, address the reactor vessel head replacement and our restoration of the containment vessel. 2A is colored in light blue. Basically, it's on hold waiting for our Mode 3 full pressure test. And 2B is essentially complete, waiting on plant conditions to allow completion of a few local leak rate tests that we have remaining.

In the 2C area, that deals with restoration of our containment systems, structures, and components. And as Mark Bezilla discussed at the beginning of our presentation, we're closing in on final containment closure and turnover of the building and systems to Operations.

Mark addressed some closure packages that we still have that are being worked on in the discovery area; and we'll have those done hopefully by the end of this week.

On Checklist Item 2C-1, that's in our Containment

Emergency Sump, which we've completed. We discussed that project several times, and in the meetings. And all work on that, and the inspection activity is complete. We have a couple follow-up items that we're working on as a result of the inspection, and should have those to the inspector this week.

Our corrective actions for Checklist Item 2D, which looks at systems containing boric acid outside of containment building are also nearing completion.

If there is no questions on that slide, I'll move to the next one.

The next slide lists ten of our safety significant programs that are on the O350 Checklist. As you can see, we have completed and identified, the identified corrective actions in each of the implementation plans for the first eight programs. Those are either inspection complete or continuing with ongoing NRC inspection activity.

The Radiation Protection Program actions are 97 percent complete, and which is the 3H line item. They will be totally complete the first of July, which will support an NRC inspection that will be starting on July 14.

Then, our final and most recent Checklist Item, which is 3I, which is underway, is the Corrective Action Plan to address Checklist Item that deals with completeness and accuracy of NRC records and submittals. And we are

currently working on that action plan, which essentially includes procedures for the validation of NRC correspondence.

Training for our site employees; we have our training program developed for that and now we need to deliver that to our employees.

And extent of condition review to determine what we may have submitted on any previous correspondence in the past that may not have been totally complete and accurate. That is just a starting and we're putting that plan together.

Next slide, please.

Okay. In Item 4A-B, those contain Corrective Actions that were identified through Management/Human Performance Improvement Plan. We continue to make good progress in this area, and as Lew discussed earlier we have more work do to, but we have that plan scheduled and should be getting through that in the next month or so.

Our Checklist Item 5 covers our Readiness For Restart in both Systems and Operations Readiness. We've completed 91 percent of the Condition Report Evaluations and Corrective Actions that have been identified through our System Health and our Design Calculation Resolution Plan.

We also continue to enhance our Restart Readiness

Review Practice that we discussed earlier to ensure that we have comprehensive review of our readiness to make mode changes and ultimately for plant restart.

Then we have Checklist Item 5D, which is the test program which is 72 percent complete, which Mark Bezilla also addressed earlier, where we have completed so far our 50 pound and 250 pound test of the Reactor Coolant System.

Checklist Item 6 covers the licensing issues associated with the new reactor vessel head, and is complete, including the inspection activity, and closed out.

Then Item Number 7 contains our Confirmatory Action Letter; our responses, which are all progressing, and also in that area we cover our final Integrated Restart Report that we are currently working on.

If there are no further questions on that, I'll move on to the next final two slides.

Okay, these final two slides show at a high level our overall progress on our actions we've identified as required for restart. Many of these actions go well beyond the requirements of the O350 Checklist. As a matter of fact, approximately 60, we have approximately 60 percent of our total restart required Condition Reports and Corrective Actions, are actually over and above the 0350 identified Checklist Items.

The first slide shows the work-off of our Condition Report Evaluations for the Condition Reports that we have classified as restart during our entire restart effort. As you can see, we're closing in on nearing completion of those evaluations. They leveled off a little bit, but they're leveled off at a manageable level.

We continue our daily review classification of Condition Reports for restart by the Restart Station Review Board, which we discussed in previous meetings. Some of the recent additions that show up in the, these evaluations or Condition Reports are the results that were discussed earlier from our 50 pound and 250 pound test, and our walkdowns of the Reactor Coolant System that Mark Bezilla discussed at the beginning of the presentation.

And approximately 100 of the Condition Report Evaluations identified here out of roughly the 300 remaining to go, are to support the first mode change to Modes 4 and 3. As Mark Bezilla discussed earlier, those are all scheduled out now with due dates that support the milestones.

The final slide shows our work-off in our Corrective Actions that have been classified as restart from our, from the previous Condition Reports that I just talked about. Again, all the Corrective Actions have scheduled due dates.

We currently have, as you can see here, around 800 that are open. Out of those, 397 of those open Corrective Actions are scheduled to complete to support our first Mode 4, and changes to Mode 4 and 3. And so, we're working well, and have that, have that all laid out.

In conclusion, I would like to say that we are making good progress, and we have confidence that we will complete both our 0350 and the non0350 Restart Actions in support of our Restart Milestones.

Are there any questions?

MS. LIPA: Thank you. No.

MR. PRICE: Okay. If you don't have any, I'll turn it back over to Lew for closing comments.

MR. MYERS: The past month has been pretty significant. We've had, we started out last meeting with several organizational changes. We think those organizational changes have been very effective for us.

We changed our direction, which had a significant impact on our schedule. We focused on modification. We've already test ran the pump. Pulled the impeller on the one A pump. We're planning to pull the Number 2 pump now.

We continue to look forward to the, lots of activities in the Management/Human Performance area,

especially in the Safety Culture area in the next couple of months.

We were very pleased with the performance of our operators in the 250 pound test; and the overall, with the performance of the plant, even though there is some work for us to do there.

The modification of the HPI Test, we believe will be successful. And we'll be through that in July, early July, allowing us to, to be ready for Mode 4, and Mode 4 and Mode 3 pressure tests in the middle of July. And shortly after that, we'll be, from a plant standpoint, be ready to, look at restart of the unit, which right now we talk about the first part of August, from our perspective.

We demonstrated consistently that we're able to work off the corrective actions at about 140 a week. And consistently now, if you look at our back logs and all, it looks like the middle of July is easily done for Mode 4.

Checklists; Item Number 5 indicates we're about 91 percent complete with activities for Restart.

Once again, you know, I think we demonstrated today, we made good progress. We ran all four Reactor Coolant Pumps for a couple of hours. We drew a vacuum -- put a bubble in our pressurizer. Didn't draw a vacuum. And went through a 250 pound test that performed well.

We got, we really bounded the work. Now, I think

Mike Ross's group is going, did an excellent job of bounding the work, and laying the work out on the diesel air dryers. He got that lined out, assuring the parts are here. We know what the work is.

So, we really feel very solid right now about our ability to reach the schedule of activities at the first part of August.

So, with that being said, we continue to make progress, and we look forward to our next meeting. Thank you.

MS. LIPA: Thank you, Lew.

Well, that ends the business portion of our meeting today then. What we're going to do is take a ten minute break, and we'll go to public comments and questions.

MR. GROBE: Lew, I need to excuse myself. I have a meeting tomorrow morning which requires me to fly out tonight. Bill will continue chairing the meetings tomorrow afternoon and this evening.

(Off the record.)

MS. LIPA: Okay, we're ready to begin with the public comment/questioning period. We would like to open up the microphone for anybody who has a question for us or a comment to address for the NRC folks here.

Jack Grobe did have to leave, but Bill Ruland, the

Vice Chair, and the rest of us are still here.

What we would like to do is start with local members of the public first, and then we would like each person to limit their time to five minutes. And, at the podium we have a sign-in sheet. And, if you want us to follow-up with you, feel free to put your phone number, that way if there is anything that we didn't fully address, we can contact you later.

So, is there anybody who would like to come up and ask a question or give us a comment today?

Are there any members of the public that are not local that would like to come up?

MS. RYDER: Hi. My name is Amy Ryder. I'm with Ohio Citizen Action. I just have a few questions.

One is that, I might have missed this earlier in the meeting, because I was late, but if the Reactor Pressure Test does not identify conclusively where the additional rust is coming from, what happens next?

MS. LIPA: You talking about on the lower part of the vessel?

MS. RYDER: Right.

MS. LIPA: Well, right now, the NRC is evaluating Licensee's plans on how they're going to test that and how they're going to determine it. So, we

should know more before that test. And then once we get the results of that test, we'll be able to figure out what the information means. But I really can't tell you yet how we're going to process that information.

MS. RYDER: Will the source of that rust have to be identified before restart is completed conclusively?

MS. LIPA: The source of the rust. Well, I think what we'll be doing is making sure we understand the Licensee evaluation of it and what it means and whether that makes sense and whether there is an indication of a leak. That's my understanding right now where we're headed with that.

MS. RYDER: So, there is a possibility that it could restart not knowing where that rust came from?

MS. LIPA: Well, I don't really want to say that right now, but I think as we get closer to that test and after that test, we will be able to answer more fully your questions on that.

Do you have any comments on that, Bill?

MR. RULAND: The key criterion is that the reactor itself has no unidentified leakage, not that the rust stains have or have not been identified.

MS. RYDER: Okay.

MR. RULAND: So, theoretically, there could be some possibility they would not identify the rust stains, or excuse me, the Licensee will identify the rust stains. But if we were satisfied that the Licensee did a sufficient test to make sure there was no unidentified leakage --

MS. RYDER: Leakage.

MR. RULAND: -- we wouldn't have any problem with that.

MS. RYDER: Okay.

MS. LIPA: No, actually it's pressure volume leakage.

MR. RULAND: Right.

MS. LIPA: Pressure volume leakage is the criteria.

MS. RYDER: Okay. My second question is, whether or not the OI Investigation Report will be issued before restart is permitted.

MS. LIPA: I can't address that. That's all I can say.

MR. RULAND: The OI Report will be issued when the OI Report is ready.

MS. RYDER: Will you allow the plant to restart if that OI Report is not completed; I guess maybe is the more accurate?

MR. RULAND: That's all I can say; the OI Report is issued when it's issued.

MS. RYDER: Right. I understand you don't have control over when that's issued, but will the panel want to know what the report says before you allow FirstEnergy to restart Davis-Besse?

MS. LIPA: I think that's a question we'll have to address at a later time too, Amy.

MS. RYDER: Okay. Thanks.

MS. LIPA: Does anybody else have any questions for us?

Okay. Well, just a few things, then I'll check one more time if there is anybody else.

We will be returning tonight at 7 p.m. to give a summary to anybody who wasn't here; and if anybody wants to come back and ask questions, that's fine.

And then next month, July 9th, our public meeting will be at the Oak Harbor High School. And we're going to go for the same times with an afternoon meeting and evening meeting.

Then, we're also holding a meeting on June 19th in headquarters, but we'll have bridge lines for folks that want to call in and listen to that meeting. And the June 19th meeting we'll focus on the high pressure injection pump.

Was there anyone else that came up with a question while I was talking?

Okay. Well, then thank you for coming. Good day.

(Off the record.)

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CERTIFICATE

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Norwalk, Ohio, on this 13th day of June, 2003.

Marie B. Fresch, RMR

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