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BEFORE THE UNITED STATES
NUCLEAR REGULATORY COMMISSION

IN RE: THE MATTER)
)
 OF)
)
DAVIS-BESSE)

REPORT OF PROCEEDINGS
October 1, 2003
12:30 P.M.

REPORT OF PROCEEDINGS had and testimony

taken the hearing of the above-entitled matter,
held before Mr. Jack Grobe, at the Nuclear
Regulatory Commission, 801 Warrenville Road,
Lisle, Illinois.

- PRESENT ON BEHALF OF N.R.C.:
- MR. JACK GROBE, Hearing Officer;
- MR. JAMES CALDWELL;
- MR. SCOTT THOMAS;
- MS. CINDY PEDERSON;
- MS. CHRISTINE LIPA;
- MR. GEOFF GRANT;
- MR. GEOFF WRIGHT;

1 MR. MONTE PHILLIPS; and
2 MR. DAVID PASSEHL.
3 PRESENT ON BEHALF OF DAVIS-BESSE:
4 MR. LEW MYERS;
5 MR. GARY LEIDICH;
6 MR. DAVE GUDGER;
7 MR. JOE HAGAN;
8 MR. RANDY FAST;
9 MR. FRED VON AHN;
10 MR. MARK BEZILLA;
11 MR. ART LEWIS;
12 MR. RAY ZUICHOWICZ; and
13 MR. JACK RUETER.
14 PRESENT At HEADQUARTERS;
15 MR. JON HOPKINS;
16 MR. BILL RULAND;
17 MS. LISA JARRIEL;
18 MS. CLAIRE GOODMAN;
19 MR. JULIUS PERSENSKY;
20 MR. TONY MENDIOLA; and
21 MR. STEVE BLOOM.
22

1 MR. GROBE: Good afternoon. My name is
2 Jack Grobe. I'd like to welcome First Energy and
3 N.R.C. participants and members of the public at
4 the various locations to this meeting. I'm the
5 Senior Manager here in the Region III office of
6 the Nuclear Regulatory Commission, and also
7 Chairman of the N.R.C. Oversight Panel for the
8 Davis-Besse facility.

9 The N.R.C. is meeting today with
10 First Energy to understand the progress that they
11 have made in restoring a healthy safety culture
12 in the organization at Davis-Besse and discuss
13 First Energy's plans for continuing improvement
14 and monitoring of the organization's safety
15 focus.

16 The N.R.C. goal today is to obtain
17 information from First Energy. We will not be
18 providing an assessment or conclusion regarding
19 the information we hear today. I expect that
20 there will be many questions from members of the
21 N.R.C. staff regarding the information First
22 Energy presents. Questions should not be

1 construed as positions or conclusions by the
2 N.R.C. We have ongoing safety inspections. When
3 the inspection team finishes its activities, we
4 will discuss its conclusions during the public
5 meetings.

6 This meeting between the N.R.C.
7 and First Energy is open to public observation
8 here in the N.R.C. Region III office in Lisle,
9 Illinois, and through video conferencing in the
10 N.R.C. headquarters offices in Rockville,
11 Maryland. Also, members of the public can listen
12 to the meeting through a toll free audio
13 teleconference bridge.

14 After the N.R.C. discussions today
15 with First Energy are completed, there will be
16 opportunities for members of the public here and
17 at Rockville, Maryland, and on the telephone
18 conference bridge to ask questions of the N.R.C.
19 staff or make comments.

20 We are also having this meeting
21 transcribed today to maintain a record of the
22 meeting. The transcript will be available on the

1 N.R.C. web page several weeks after today's
2 meeting.

3 Copies of the First Energy
4 presentation slides are available in the back of
5 this conference room and in N.R.C. headquarters,
6 and also available on the N.R.C. web site at
7 www.nrc.gov, then select under key topics
8 Davis-Besse, select public meetings on the menu,
9 and then select October 1, 2003.

10 Also, in our conference rooms are
11 N.R.C. meeting feedback forms that you can fill
12 out and provide feedback on the format and
13 content or any other aspect of these meeting, so
14 that we can improve the quality of our public
15 meetings.

16 Our web site has a Davis-Besse
17 link that contains a wealth of other documents
18 regarding activities that are ongoing at
19 Davis-Besse, including the N.R.C. routine monthly
20 public newsletters.

21 At this time I'd like to introduce
22 the N.R.C. staff that are here in Chicago today,

1 and also ask headquarters N.R.C. staff to
2 introduce themselves, and then have First Energy
3 introduce their staff at the table.

4 On my immediate left is Christine
5 Lipa. Christine is Branch Chief responsible for
6 Davis-Besse oversight in Region III. Next to her
7 in Cindy Pederson, Director of Reactor Safety for
8 the reactors in Region III. On my immediate
9 right is Jim Caldwell, Jim is the Regional
10 Administrator in this regional office. On his
11 right is Geoff Grant, our Deputy Regional
12 Administrator, and then Geoff Wright, the team
13 leader of the Safety Culture Inspection Team.
14 Also at the table is Monte Phillips, who is a
15 Senior Project Engineer working on the
16 Davis-Besse project.

17 Could I ask the headquarters
18 N.R.C. staff to introduce themselves at this
19 time.

20 MR. HOPKINS: Yes. This is Jon Hopkins,
21 project manager for Davis-Besse at N.R.R.

22 MR. MENDIOLA: tony Mendiola with N.R.R.

1 for reactor projects.

2 MR. RULAND: Bill Ruland, Project Director.

3 MR. PERSENSKY: J. Persensky, I'm part of
4 the Inspection Team for Safety Culture in the
5 Office of Research here at N.R.C. headquarters.

6 MS. JARRIEL: Lisa Jarriel, I'm also part
7 of the inspection team on safety culture and I'm
8 the agency allegations advisor.

9 MS. GOODMAN: I'm Claire Goodman, and I'm
10 also on the Safety Culture Inspection Team, I'm
11 from the office of N.R.R.

12 MR. BLOOM: I'm Steve Bloom, I'm the
13 Project Manager assisting on Davis-Besse issues.

14 MR. HOPKINS: That's it for N.R.C. folks
15 here in Region III. We do have one member of the
16 media here also.

17 MR. GROBE: Thanks, Jon.

18 Gary, could you introduce your
19 people?

20 MR. LEIDICH: Thank you, Jack, good
21 afternoon.

22 On my far left is Mark Bazilla, Site

1 Vice-President; to my immediate left is Lew
2 Myers, Chief Operating Officer for First Energy
3 Nuclear Operating Company. To my immediate right
4 is Fred von Ahn, Vice-President of Oversight for
5 First Energy Nuclear Operating Company, and on
6 his right is Randy Fast, Director of
7 Organizational Effectiveness, who will talk more
8 about his assignment during our presentation.

9 To his right is a new employee,
10 Joe Hagan, Senior Vice-President. We are excited
11 to have Joe on board, he brings to us a wealth of
12 experience from Exelon Energy, and he wanted me
13 to say Pico, so I did. To his right is Dave
14 Gudger, Supervisor of Regulatory Affairs. I have
15 a couple of additional employees, and I will just
16 ask them to introduce themselves.

17 MR. ZUICHOWICZ: Ray Zuichowicz.

18 MR. RUETER: Jack Rueter, I work at
19 radiation protection.

20 MR. LEWIS: Art Lewis.

21 MR. LEIDICH: The reason for these
22 employees attending is just to provide

1 opportunities for you to ask any questions of
2 them. They have been integral to our change
3 process from a safety culture perspective, so we
4 welcome the opportunity to have that exchange.

5 We do, as you noted, Jack, have a
6 lot of material, but we will try to run through
7 it fairly briefly right up front.

8 MR. GROBE: Thanks, Gary. I have a couple
9 opening remarks that I'd like to make. Just one
10 reminder, since we have folks on a teleconference
11 bridge, as well as the video teleconferencing,
12 it's very important to use the microphones, so
13 make sure your little LED is bright green, and
14 make sure you speak into the microphone when you
15 speak. Thank you.

16 In February of 2002, the
17 Davis-Besse facility was shut down for refueling
18 and inspection of the reactor pressure vessel
19 head penetrations pursuant to N.R.C. bulletin
20 2001-01. In March, 2002, during repairs of
21 cracks, First Energy discovered this reactor head
22 penetration. First Energy identified significant

1 corrosion and degradation of the reactor head
2 adjacent to a cracked penetration.

3 Since that time First Energy has
4 been implementing actions to identify and address
5 the causes of the reactor head degradation. In
6 August of 2002, First Energy reported to the
7 N.R.C. in a public meeting that a significant
8 contributor to the head degrading was inadequate
9 nuclear safety focus at the Davis-Besse
10 organization. The focus at that time had been on
11 production and minimum actions to meet safety
12 requirements that resulted in an unacceptable
13 tolerance of degraded safety margins.

14 In the fall of 2002, First Energy
15 evaluated the safety conscious work environment
16 with a willingness of the organization to
17 identify and address safety concerns. The
18 results of the evaluation showed many challenges
19 in that area.

20 A follow-up evaluation was
21 conducted in the spring of 2003. N.R.C. staff
22 reviewed First Energy root cause assessments and

1 agreed that safety culture was a significant
2 contributor to the reactor head degradation.

3 However, N.R.C. staff also
4 concluded that First Energy had not fully
5 evaluated the ramifications of this cultural
6 problem throughout the organization. Following
7 this, First Energy expanded their evaluation,
8 looked at multiple elements of the organization,
9 including operations, engineering, quality
10 assurance, corporate support and independent
11 oversight.

12 Those broader assessments were
13 found to be sufficient in breadth and depth.
14 Also, in the spring of 2003, First Energy
15 contracted for an independent assessment of
16 organizational safety culture conducted under the
17 direction of Dr. Soney Abram. That assessment
18 found that many of the elements necessary for
19 effective safety focus at Davis-Besse were in
20 place. However, there was inconsistencies in the
21 stated goals and expectations within the
22 organization and a lack of effective

1 communication and alignment on safety priority
2 across the various departments and vertically
3 within the organization.

4 First Energy has been developing
5 and implementing improvement actions to address
6 safety culture at Davis-Besse. Progress in this
7 area has been a topic discussed at multiple
8 public meetings in the past. Our goal today is
9 to occasionally understand where First Energy is
10 in implementation of the organization's human
11 performance and safety culture improvement plans
12 and what actions First Energy is considering
13 going forward.

14 Again, I expect the N.R.C. staff
15 will have a number of questions to clarify the
16 information that you present today. Those
17 questions should not be construed as positions or
18 conclusions of the N.R.C. I also note that you
19 have some 90 slides in your presentation, I would
20 hope that the N.R.C. staff will hold questions
21 until the end of each topic area to allow you to
22 efficiently present your material.

1 At this time, Gary, I'd like to
2 turn the meeting over to you and First Energy for
3 your presentation.

4 MR. LEIDICH: Thank you very much, Jack,
5 and once again good afternoon everyone. The
6 agenda is presented on Page 3. I won't dwell on
7 that, I will go right to desired outcomes on
8 Slide 4.

9 MR. GROBE: Gary, excuse me, Scott Thomas
10 just arrived, he is the senior resident inspector
11 at the Davis-Besse plant. He was delayed this
12 morning because of an operational problem last
13 night at the plant. He had to report to the
14 plant very early this morning, and then drove to
15 the region, so he was a few minutes late. I
16 apologize, but he's here now.

17 MR. LEIDICH: Thank you. And once again
18 the desired outcomes today are to demonstrate
19 that we are building an organization with
20 proactive safety culture that is really built to
21 last. We recognize that the actions underway and
22 the actions that we need to complete from a

1 corporate perspective, not only Davis-Besse, but
2 really fleet wide, need to be fully comprehensive
3 and very long lasting.

4 We also today would like to
5 provide an understanding, holistic understanding
6 if you will of the key elements of our safety
7 culture model process results, the actions we
8 have taken to date, our view of the effectiveness
9 of those actions and longer term plans and
10 outlooks.

11 Slide 5, as reiterated before, we
12 do indeed have a corporate commitment from the
13 top of the shop down through the organization,
14 including actual written commitments from the
15 CEO, and also a board resolution from the First
16 Energy board and a policy on safety culture and
17 commitment to that policy.

18 At that time last fall we did
19 develop the three portions of safety culture that
20 we will present today, corporate commitment, the
21 management commitment an individual commitments.

22 Just a comment on the concept of

1 "built to last." We recognize the importance of
2 improving performance really in all aspects of
3 Davis-Besse, but particularly safety culture.
4 And the real challenge that we have, that anyone
5 has in a process like this is to build an
6 enduring organization, that is really
7 fundamental, and consistently aligned at all
8 levels to the core values of the safe and
9 reliable operation of Davis-Besse.

10 So as you can see here on Slide 6,
11 what we have been all about and what we will
12 continue to be about is to continuously
13 indoctrinate the employee to these values,
14 nurturing and selecting senior management that
15 fit with these values. And, again, we are
16 delighted to bring Joe Hagan on, and as you are
17 aware, we are recruiting other individuals as
18 well.

19 Consistent alignment with these
20 core values and goal-setting, problem-solving,
21 decision-making, and preserving those values and
22 a strong resolve for safety focus.

1 From an organizational standpoint,
2 over the past year or so you can talk about
3 transition of our organization. On Slide 7 is
4 our previous organization. Really, we were three
5 individual facilities with one president and CNO.
6 On Slide 8, you heard these before, that kind of
7 an organizational structure can lead to some
8 pitfalls and some issues, and we believe some of
9 those contributed to the situation at
10 Davis-Besse.

11 Certainly, the idea of
12 isolationism and difference in management
13 processes across all three stations, corrective
14 actions program weakness at Davis-Besse, cultural
15 variations, resistance of the facility to
16 industry standards, and really the independence
17 of oversight are all areas that that previous
18 organization really facilitated happening, if you
19 will.

20 So we have taken that to heart,
21 and Slide 9 is a display of our current
22 organization. And as can you see, it's

1 substantially strengthened in a couple of
2 aspects. First of all, top of the shop, in terms
3 of executive leadership, but also in terms of a
4 corporate office. And as Joe Hagan fills the job
5 of senior vice-president and engineering support,
6 he will have the primary responsibility involved
7 in those standards across the fleet.

8 The advantages to today's
9 organization as we see it to is develop those
10 common processes based on industry best practice,
11 and our executive team, including Lew and myself,
12 my experience, we believe we have seen what those
13 practices look like, and we were in the process
14 of beginning to put those in place, particularly
15 at Davis-Besse, really fleet wide, that creates
16 for us a strong governance from a First Energy
17 perspective. And of course, as we have talked in
18 the past, we now have a completely independent
19 oversight officer who is responsible for
20 oversight and reports on the dotted line to the
21 board of director's nuclear committee.

22 Lew will have responsibility for

1 consistent implementation of those common
2 processes, those best practices across all three
3 of our stations, and of course he's had up close
4 and personal operating experience at really all
5 three of our plants, so that that will facilitate
6 him being able to do that, and as I mentioned,
7 Joe will have the responsibility for developing
8 those processes.

9 So our bottom line is that we have
10 an organization in place today to ensure a strong
11 safety focus and facilitate top fleet
12 performance. About halfway through the
13 presentation as I talk about the long-term plans
14 and where we go from here, we will cover a few of
15 those specifics about what we mean by that.

16 So in an introductory standpoint,
17 that completes my remarks. And I don't know if
18 you'd like to take any questions now, Jack, or we
19 can do this in pieces, or --

20 MR. GROBE: I think most of that
21 information had already been shared with us
22 publicly. I'm not sure there are any questions

1 at this point. Why don't we move on to Lew's
2 presentation.

3 MR. MYERS: Thank you, Jack, Gary. Today
4 I'd like to talk about six functional areas, if
5 you will. First, the definition of safety
6 culture and how safety culture and safety
7 conscious work environment are related. I'd like
8 to review the model of safety culture, then I'd
9 like to talk about the process that we are using
10 to evaluate our safety culture and make
11 improvements in our safety culture going forward,
12 and ensure that we have the organization built to
13 last in that area.

14 I will share with you the results
15 of the actions that we have taken based on our
16 assessment to date and effectiveness of those
17 actions, if you will.

18 Safety culture is an interesting
19 definition. I went back and read last night
20 where the definition came from, and that is
21 simply, "that assembly of characteristics and
22 attitudes in organizations and individuals which

1 establishes and overriding priority towards
2 nuclear safety activities and ensures that issues
3 receive the attention warranted by their
4 significance."

5 The definition of safety culture
6 has very important words and actions that are
7 important. The first is the assembly of
8 characteristics and attitudes. If I look that
9 up, that means defining features and quality, the
10 quality of the organization and features we
11 possess. Next, in both the organization and
12 individual people must have a common interest,
13 they must share a common interest. And that has
14 to do with our organization and our individuals.
15 Safety is a word that has to do with nonexposure
16 to risk, nonexposure to risk, understand the
17 safety issues and their exposure to risk and
18 attention to their significance is the
19 appropriate treatment based on importance.

20 Proper safety culture establishes
21 an environment in which people are encouraged to
22 identify problems and ensures that problems are

1 effectively corrected without fear of
2 retaliation. So safety conscious work
3 environment is a good part of a good safety
4 culture. You can't have one without the other.
5 We started out with our safety
6 culture model by looking at the International
7 Atomic Energy Agency Model INSAG-4, which is an
8 independent inter-government science and
9 technology based organization in the United
10 Nations family that serves as a global focal
11 point for nuclear cooperation.
12 They develop standards, and these
13 standards promote the achievement of maintaining
14 high levels of safety, as well as protection of
15 human health and environment against a high
16 radiation. The basic principles for nuclear
17 plant safety were developed, and the document
18 they prepared is INSAG-13 and then final safety
19 culture is document INSAG-4.
20 The present commonly used safety
21 culture objectives, concepts and principles that
22 can be used both by international assistance

1 members when evaluating and improving the safety
2 culture at the plant, INSAG-4 document was
3 brought by Dr. Sonja Haber, who has a strong
4 background in the international family in safety
5 culture.

6 Dr. Haber is the president of
7 Performance Safety and Health Services. Dr.
8 Haber had been involved with research in the area
9 of human performance and analysis for over 20
10 years. She conducted research in the evaluation
11 of behavioral data in various applications for
12 the past ten years.

13 Dr. Haber worked primarily in the
14 nuclear industry with an emphasis on the role of
15 organizational management influence on safety
16 performance. She's been extensively involved in
17 conducting field work for both nuclear regulatory
18 agencies, the U.S. Department of Energy and other
19 organizations overseas.

20 We brought her and her team in and
21 performed an independent assessment of our safety
22 culture last year -- at the beginning of this

1 year. The first thing that we did is we took the
2 INSAG report, which was approved in 1991, after
3 the Chernobel accident as an industry-accepted
4 model.

5 The INSAG report was intended to
6 promote practical actions to all levels to
7 enhance safety and provide a basis for judging
8 the safety culture. That is the basis of that
9 document. The safety culture mold was
10 established with a document as well as
11 methodology for evaluating safety culture. So if
12 you go in the document and read the specific
13 questions and objectives that can be used to
14 evaluate safety culture.

15 Based on our review of that
16 document, our starting point was that this was a
17 quality methodology. If you look at the
18 document, there is a model that is presented here
19 that talks about policy level commitment. That
20 has to do with the organization commitment, the
21 management level commitment at our plants and
22 finally how that affects the individuals and

1 their work every day to ensure that
2 safety-related activities receive the attention
3 warranted. We thought that that was a good
4 starting point.

5 On April 14, 2003, the Performance
6 Safety and Health completed their independent
7 review of our safety culture. They evaluated
8 Davis-Besse Nuclear Power Station, they looked at
9 particular behaviors and attitudes that were
10 evaluated to determine the extent to which the
11 organization had attained safety culture
12 objectives.

13 In their minds the methodology
14 consists of functional analysis, structured
15 interviews that were prepared, behavior anchored
16 rating scale, which is a model used to look at
17 behavior ratings, behavior checklists and finally
18 surveys.

19 A new term was introduced at many
20 of our meetings called "convergent validity" that
21 had to do with various methods of evaluating
22 safety culture and looking for common

1 indications. It's a fancy term, convergent
2 validity, that we have learned to accept at
3 Davis-Besse. We wanted to take the INSAG-4 model
4 and compare it to Dr. Haber's model. Both
5 address the behaviors and the attributes, but to
6 ensure that there was similarity between our
7 process and to ensure that there was convergent
8 validity in various methods, so if you look at
9 the chart that we have here, it's called a
10 relationship diagram, where we took all the
11 behavioral criteria that Dr. Haber has across the
12 top and looked to ensure that our criteria across
13 the left-hand side was in line with that of Dr.
14 Haber's, or are we missing anything. That's what
15 we are trying to do.

16 Based on that review, we went back
17 and looked at the atomic -- International Atomic
18 Energy Agency guideline for the behaviors and the
19 Dr. Haber report and we added four new criteria
20 to our model, if you will. Cross functional work
21 management and communications was a criteria
22 added at the bottom left. And environment of

1 engagement and commitment was another area added.
2 Assessment -- self assessment was a final area
3 that we added, and then independent oversight,
4 which we thought was really a stand-alone
5 criteria that wasn't really reviewed in the
6 INSAG-4 model.

7 Once again, for each one of those
8 criteria under the functional areas, then the
9 individual commitment area, the plant management
10 commitment area and the policy or corporate level
11 commitment area, the specific and manageable
12 criteria that we used to assess our safety
13 culture. The development of our safety culture
14 process has taken many months. We communicated
15 the importance of nuclear safety culture with all
16 of our employees, that is one of the first
17 actions we did is sit down and explain the model
18 before we explained it to the N.R.C. to the
19 employees, we created a safety culture model
20 based on industry experience to date, and that of
21 the International Atomic Energy Agency
22 Performance Safety and Health Associates

1 performed their independent review in February,
2 and then we conducted -- since then we have
3 conducted two self assessments and internal
4 surveys to evaluate the safety culture at the
5 Davis-Besse plant and develop the business
6 practice that we are using today in each of our
7 meetings prior to changing plant conditions to
8 ensure that safety culture is on a positive
9 trend.

10 After Performance Safety and
11 Health Association's safety culture assessment,
12 actions were taken to improve the policy level of
13 commitment, management level commitment,
14 individual commitment areas. Management policies
15 were improved, management meetings were improved
16 to focus on safety improvements that were made in
17 the management observation process.

18 For example, we did not have a
19 management observation process that was
20 computerized like we have now, and we gained a
21 lot out of that process. In individual
22 commitment areas, actual actions were taken to

1 share this report immediately -- the Dr. Sonja
2 Haber report with our employees to strengthen our
3 turnover process as a result of that review. So
4 we took prompt actions after that review.

5 The first assessment for Mode 5
6 indicated all three commitment areas were rated
7 as yellow, needing prompt management attention.
8 Areas for improvement were included.

9 If you look at this first Mode 5
10 assessment, all the -- we rated ourselves in all
11 the functional areas, individual commitment
12 areas, plant management commitment area, policy
13 or corporate level commitment area as yellow.

14 The yellow indicates that either
15 strong compensatory actions need to be taken, or
16 in the long-term, management improvements need to
17 be taken, but the basic safety culture would be
18 rated as acceptable.

19 Some of the things that drove that
20 evaluation was the FENOC business plan, which
21 needed many improvements at the time. The FENOC
22 business plan that we had at the time, the vision

1 was not clear, safety was not a clear focus in
2 that plan, and we went back and made many
3 upgrades since then to improve the vision
4 statement and the safety commitment and even the
5 functional areas in our business plant. Also,
6 personnel in the personnel resources and
7 engineering and security were a problem. Those
8 two issues were the main reason that the policy
9 level commitment area was rated as yellow.

10 Radiation protection, as you know,
11 in our plant was an issue. That was an issue
12 that we had to take on. That specific issue was
13 a major factor in rating the plant's management
14 commitment area yellow.

15 Organizational work control issues
16 were also a problem in our plant at the time. We
17 were having to rework some problems. Rework was
18 higher than desired, and it still is, and that
19 was a major influence to the yellow aspect of the
20 commitment area.

21 Then in the individual area, we
22 were having significant problems with rework at

1 the time, especially in the -- not only in our
2 own class, but some of the contractors we had
3 problems with jobs like our feedwater jobs and
4 also some jobs in our containment. And based on
5 that individual commitment area, we went ahead
6 and looked at the rework area also.

7 Our next assessment showed
8 significant improvement, and was prior to this
9 Mode 4. The policy level and individual
10 commitment areas were rated as white, which
11 indicates that the areas are acceptable, and yet
12 there is still some areas for improveMent. The
13 management commitment area was rated as yellow
14 because self assessments for the next year have
15 not been scheduled yet, and with all of the self
16 assessment we have done at the plant, all the
17 self assessments we continue to do, we still do
18 not meet the requirement of having next year's
19 self assessment plan in place and approved, so we
20 rated the plant management commitment area as
21 yellow based on that.

22 Employee development plans were

1 also not complete and was a major input and
2 management observations that we were performing,
3 and even though we had the numbers up, were not
4 giving us the results that we had hoped for, and
5 we didn't feel that they were as critical as
6 outside organizations that we were bringing in to
7 perform other management assessments of work at
8 our plant.

9 Those things wound up causing the
10 management commitment area to be yellow once
11 again. Once again, the overall safety culture at
12 our plant we rated as significant between the
13 Mode 5 evaluation and the Mode 4 evaluation.

14 MR. GROBE: Why don't you leave that Slide
15 21 up for a minute. I observed some of your
16 meetings that implement safety culture assessment
17 model, and our inspection team, safety culture
18 inspection team have also observed a number of
19 these activities, along with resident staff. I
20 think there is a number of questions that they
21 may have on the way in which you do this internal
22 safety culture assessment. Why don't we pause

1 for a minute and see if there are any questions.

2 MR. WRIGHT: Excuse me, this is Geoff
3 Wright. In looking at individual areas, Lew, in
4 the inspection, we also looked at how you put
5 this together against some of the international
6 documents, the pieces below this that feed in
7 here. Now, those are items, though, that you
8 generated on your own as to how to look into
9 these various areas; is that true?

10 MR. MYERS: Yes and no. We generate -- I
11 would say yes, but we looked at questions that
12 were in the INSAG-4 document, and that helped
13 generate some of the questions. And then we went
14 back and looked for specific measurable criteria
15 that can be used for each one of the objectives.
16 To measure that objective, if you look at our
17 process, I think it's like a 40-page document for
18 -- for example, in the commitment to safety area
19 there would be -- there will be a complete list
20 of questions and criteria that we used to measure
21 that area. That objective --

22 MR. HOPKINS: We are having some trouble

1 hearing you, Lew, if you try a different -- it's

2 like you're breaking up.

3 MR. MYERS: I can hook up --

4 MR. HOPKINS: It comes in and out. We're

5 not sure what it is.

6 MR. MYERS: Did that answer your question?

7 MR. WRIGHT: Yes. The only follow-up I had

8 was in, you know, we have looked at the process

9 for how you start answering the questions and

10 that all rolls up to what we see here?

11 MR. LEIDICH: That is correct.

12 MR. WRIGHT: I know some changes have been

13 made in the way that rolls up and where you find

14 yellows and reds, you are taking action or

15 putting out condition reports --

16 MR. MYERS: Right.

17 MR. WRIGHT: Could you tell me a little bit

18 about at what level? I know we start with the

19 individual questions will determine, you know, if

20 an organization is yellow or red in a specific

21 area. Is that a CR or the CRs only come once you

22 get up to what we are seeing here on Slide 21?

1 MR. MYERS: No, we would expect the
2 organization to write a CR, if they have issues
3 to address those issues, but it would not be high
4 level management CR. If one of these commitment
5 areas is red, then that would be a high level CR
6 that would require -- the way our process would
7 work, would require you bring that issue in to
8 the senior team and present the action plan to
9 make corrections. So it would be a more
10 broad-based CR that we are seeing multiple cases
11 of a particular problem, maybe it's staffing.
12 It's a good example when we had two areas in one
13 of our evaluations that we had staffing concerns
14 in security and engineering at the time, so as a
15 senior leadership team we look at that issue with
16 a CR, the action plans had to come to us for
17 approval, and we drove in to staffing that we
18 needed in place.

19 MR. WRIGHT: Okay. For just the
20 information like you said, you've got about a 40-
21 to 60-page -- about a 40-page document of
22 questions that have to be answered for -- so that

1 everyone understands, how are the answers to
2 those to pages answered? And you have what, 22
3 organizations --

4 MR. MYERS: Right.

5 MR. WRIGHT: -- that deal with this, and in
6 a metrics method, how does that roll up to here?

7 MR. MYERS: Let me talk a little bit about
8 our process then. Our process is -- once again,
9 it's got like a 40-page document of questions, I
10 have it here in front of me. Here is -- for each
11 management commitment area, there is a whole list
12 of criteria. We asked each department to go back
13 and assess themselves to that criteria, you know.
14 Now, once they have done that, we hold a meeting,
15 a management meeting with all the managers at the
16 plant, and have the managers present their
17 management criteria to the management team.

18 And then often changes, like for
19 instance if management comes in, which they did,
20 and they thought their rework was okay and we
21 were not satisfied with that rework, even though
22 before they got through, we wound up getting one

1 from maybe white to yellow.

2 And so it takes a consensus of the
3 management level to agree on a grading of a
4 specific criteria, so each group comes in and
5 presents each individual criteria to that
6 management team, we have agreement on top of
7 that, we bring some independent contractors in,
8 and we also have our quality assurance group do
9 their own self assessment of the safety culture
10 of our plant. So they sit in the back and
11 listen, and that way we get convergence, similar
12 to the Haber methodology, and additionally we
13 have some surveys that we use to ensure that we
14 have convergence, 4-C survey to see if we get the
15 same data out of the 4-C surveys that we are
16 getting out of the management review. So there
17 is about -- so we have a detailed review by
18 management, quality assurance contractors, and
19 then we have our surveys that we use. All of
20 that feeds into each and every criteria to ensure
21 that we would properly assess the criteria.

22 MR. WRIGHT: Okay. If at any point I'm

1 asking something you are going to cover later on,
2 let me know.

3 One of the items that we had
4 discussed and had looked at in going through
5 those 40 some odd pages, you know, with the 22
6 organizations is how do you protect against, in
7 your process, you know, a larger group, you know,
8 carrying the day for one assessment where you
9 have other organizations that aren't looking as
10 well, and you end up with an averaging that kind
11 of averages out the poorer performers up to a
12 middle ground?

13 MR. MYERS: That's an excellent question.
14 We go around the table, and suppose we are
15 looking at a situation -- this is staffing, you
16 know, and we are getting staffing, and maybe we
17 go around the table, and you have got -- human
18 resources may have three people in their
19 organization, operations is a very critical
20 course, but before we -- we will average -- we
21 will look at averages, but then people come to a
22 consensus as a management team that that average

1 adequately represents the grade.

2 If it doesn't, it's not unusual at
3 all for us to say that, because it was always
4 management subjectivity here that operations is a
5 big area, very important area, so we may actually
6 turn a white to a yellow, and we actually -- we
7 have done that before. So we tend to grade
8 harder than the actual grades.

9 MR. WRIGHT: Okay. Thank you.

10 MR. PHILLIPS: Let me ask a slightly
11 different question. I heard you say yellow and
12 reds get condition reports, correct?

13 MR. MYERS: Yes.

14 MR. PHILLIPS: Now, trending that to what's
15 going from green to white, would that also
16 generate a condition report?

17 MR. MYERS: Not necessarily, no. We also
18 have a chart -- I don't have it in my
19 presentation today -- but there is a chart where
20 we look at each functional area across here, and
21 we sort of put an X on each function, that way we
22 can look at it holistically and say, is this the

1 right grade based on what we are seeing, and it's
2 another way to look at it, so we do that a lot of
3 times.

4 MS. LIPA: I have a question on the chart.
5 The yellow block says all major areas are
6 acceptable with several indicators requiring
7 prompt management action. So is the definition
8 of yellow acceptable?

9 MR. MYERS: The definition of yellow would
10 be acceptable provided you had proper
11 compensatory measures in place, yes.

12 MS. LIPA: Thank you.

13 MR. HOPKINS: We have a question here at
14 headquarters.

15 MR. PERSENSKY: Lew, you mentioned that you
16 do your surveys, and how are those incorporated
17 into your findings for this roll-up?

18 MR. MYERS: There is -- it depends. Each
19 department there is ad-hoc surveys they do.
20 There is a specific list of questions that -- I
21 have those questions with me here somewhere, I
22 can come back to them later, from our 4-Cs

1 meetings. I routinely have a meeting once every
2 couple of weeks with about 30 employees, and then
3 at that meeting so far, I think we have been with
4 over 700 employees this year, and we do a
5 spot-check survey, no names, I leave the room and
6 they can fill surveys out as they want and we
7 collect results of that survey so that we can
8 look at trends and the overall results on a
9 yearly basis.

10 So that that is an ongoing
11 process, if you will, and that -- the whole time
12 we are in the meeting that survey is used to
13 ensure that it actually addresses some specific
14 questions that ensure we have alignment with the
15 assessments.

16 MR. PERSENSKY: I guess, if I understand,
17 each manager fills out their own form here for
18 their organization, but the surveys are across
19 the organization, so you wouldn't even know who
20 was answering, since they're anonymous, what
21 organization those people are in when they answer
22 the questions?

1 MR. MYERS: That is correct.

2 MR. PERSENSKY: How do you resolve the
3 difference between an individual manager dealing
4 with his own organization as part of it, and then
5 the site-wide survey that's done if it's not
6 related directly to any organization?

7 MR. BEZILLA: I was -- this is Mark
8 Bezilla. I was going through here, and there are
9 some surveys we use across the sites, and I will
10 say those are anonymous so we get a site
11 perspective, and as Lew said, individual managers
12 will run, I will say informal surveys amongst
13 their people on things like, hey, do you feel
14 that employee concerns are being responded to,
15 any issues that you may be aware of, those types
16 of things.

17 So some surveys are I will say
18 site wide, but there is -- each department has
19 the option to do informal or formal surveys also,
20 and some of the surveys that we run you can put
21 in which department you belong to, and then we
22 can slice and dice the survey information. It's

1 anonymous, but we can capture which departments
2 the folks are attached to, if you will.

3 MR. MYERS: Once again, quality assurance
4 and independent contractors, they do spot checks,
5 and then our quality assurance group, they do
6 their own assessment of safety culture across the
7 site, so once again you get convergence by doing
8 that. If maintenance comes in and says
9 everything is lovely and that's not what they
10 have seen, then they will bring that issue up.
11 So that's the way we get the convergence.

12 MR. PERSENSKY: I think that's a little bit
13 different than the way Dr. Haber defines it, but
14 that is how it is, a spot-check?

15 MR. MYERS: That's right. Our process is
16 not identical to Dr. Haber's at all. We cover
17 all the areas, then we have convergence. The
18 good thing that we think we walk away with that
19 you don't get when you bring independent
20 contractors in is the process that we go through
21 allows our managers to have ownership and also
22 allows the management team to go in alignment by

1 doing that. When we walk out of the room, it's
2 not like someone's hand being up, it's something
3 you own yourself and you come to alignment on, so
4 you are more than willing to go take actions. We
5 think that is a much better process.

6 MR. CALDWELL: Lew, have you looked through
7 these 40 some odd pages -- there is a number of
8 attributes associated with each of the areas, and
9 then associated with those attributes are the
10 criteria for red, yellow, white and green?

11 MR. MYERS: That is correct.

12 MR. CALDWELL: Have you looked at those to
13 see if they are individual showstoppers? In
14 other words, if you have -- your roll-up may be
15 green, but you have red in there say from
16 resources and operations and you're getting ready
17 to talk about restart, and that is a red, even
18 though your overall assessment is good, that
19 would be a showstopper if you are going through
20 and made sure -- in fact, some of the things you
21 may need to grade to say you are ready because of
22 the way it's set up.

1 MR. MYERS: I personally looked at every
2 criteria on the list, and I have also made
3 changes to some of those criteria. For example,
4 this is a recursive process, some time ago the
5 criteria would be, let's have a policy in place
6 on safety culture, you know, so we have got the
7 policy in place, so that is not a criteria
8 anymore, you know. Now it may be an effective
9 use of it, it starts out at a lower threshold now
10 than it did the first time we used it, so we are
11 constantly improving the process after each and
12 every meeting.

13 But to answer your question, I
14 have looked at every specific criteria. There
15 would be some areas that if we saw that it was a
16 problem, it would be a showstopper, and us as the
17 management team would grade that harder. That's
18 what we get paid to do, and we'd expect the
19 quality group to do the same thing.

20 MR. CALDWELL: That would be great.

21 MR. MYERS: It would be a showstopper --

22 MR. CALDWELL: Until you fixed it.

1 And then I was looking at this
2 Page 21, and there is -- if I'm reading it right,
3 there is two reds, one that goes to policy and
4 corporate level commitment area and that is the
5 one on self assessment, and that area grades out
6 as a white even though you have red self
7 assessment, that is an acceptable approach?

8 MR. MYERS: Let's talk about why we had
9 red, I'm glad you asked that question. The only
10 reason we have the red in place is that our
11 schedule for next year is not in place. We have
12 done self assessments this year, our self
13 assessments are up-to-date, but we grade
14 ourselves hard because we are not meeting the
15 letter of the law of our own process that says
16 our schedule should be out at this time. I would
17 not consider that a limited problem

18 MR. CALDWELL: Depends on the decision you
19 are trying to make, but --

20 MR. MYERS: Yeah.

21 MR. CALDWELL: -- if the decision is what
22 am I going to do today, then that may be the

1 case, but if a decision is, are we set to go
2 forward in the long-term, that would be a -- you
3 haven't got a schedule for the next --

4 MR. MYERS: This would cause us to have a
5 high level management action or take prompt
6 corrective action, and that is not next month or
7 next -- you know, next year, that is prompt
8 management corrective action. So that would be
9 coming into the senior leadership team that would
10 take action on it.

11 MR. CALDWELL: I understand that. I guess
12 what I'm looking at is when would that become a
13 showstopper, what would drive you to fix that? I
14 recognize you put that -- you'd have your CR, but
15 are you saying that it would have to be fixed in
16 a week, a month, a couple of days?

17 MR. MYERS: Yes.

18 MR. CALDWELL: Which?

19 MR. MYERS: It depends on what the issue
20 is. If the issue is we don't have enough SROs in
21 the control room, then that would be a
22 showstopper, no doubt about it. We all know that

1 that would be a showstopper.

2 MR. CALDWELL: Even if you didn't and you
3 met your regulatory requirement, but you didn't
4 feel you had enough in order to do the job?

5 MR. MYERS: That would be a showstopper,
6 yes, sir.

7 MR. LEIDICH: Lew and I have had
8 conversations in the Mode 5 and again in the Mode
9 3 phase where we are in here beyond just covered
10 windows, I mean what are the real issues that we
11 have got to get straightened out before restart,
12 there was a lot of discussion underneath the
13 colors too. That is important.

14 MR. MYERS: In grading something red or
15 yellow, we would expect to be able to look at
16 you, the N.R.C. or the general public and explain
17 why that is not a showstopper.

18 MR. CALDWELL: And I would expect that that
19 would need to be done, not only for us but when
20 this is all said and done, I assume these things
21 would probably be public and would need to be
22 explained so that it would be clear, that it's

1 not something that is going to affect the
2 performance.

3 MR. MYERS: We would expect that also, and
4 our actions we are going to take.

5 MR. GRANT: We have another question I
6 guess along those lines. This was done to
7 support Mode 4 and 3, is that -- am I reading
8 this right?

9 MR. MYERS: That is correct.

10 MR. GRANT: So the red zone here, we are
11 concerned not with showstoppers, I would assume
12 that you had to -- that was a roll-up, and then
13 you had to look at that specifically to ensure
14 that your safety culture supported plant
15 operations that you were going to go into?

16 MR. MYERS: That is correct

17 MR. GRANT: How does that measure up, and
18 maybe it's along the lines of what Jim was
19 talking about, definition of several emergency
20 areas do not meet the acceptable standards. I'm
21 trying to weigh that, you know, conclusion for a
22 major block that is supporting plant operations,

1 so that whole area was deemed to be -- you know,
2 several major areas don't meet acceptable
3 standards, yet overall safety culture is
4 sufficient to support the plant operations
5 anticipated?
6 MR. MYERS: Let's talk about cross
7 functional work management. Cross functional
8 work management we would consider a problem in
9 our plant right now. Efficiency to schedule is
10 about 60 percent. It was about 40, we are
11 working to get that up. That is primarily due to
12 parts. We understand that, we are not happy with
13 it, but we've got plans in place to improve the
14 schedule, and what's really important is the way
15 we do it is with a schedule, we are not doing
16 things out of sequence, creating unsafe events.
17 We found out we were doing things out of sequence
18 and not using -- adhering to the schedule, and
19 that was causing unsafe -- that was probably a
20 showstopper, okay, so we'd expect to explain
21 that. There is a cross functional work control
22 communications process working. It may not be

1 working as effectively as we'd like, but we

2 understand why.

3 MR. CALDWELL: Is that where we rework?

4 MR. MYERS: Rework would fit in that area,
5 yes.

6 MR. GRANT: Is this a mathematical --

7 MR. MYERS: We do it as a mathematical
8 process, and then we step back and do the overall
9 assessment in the entire management team, like
10 this with quality there, contractors there, then
11 N.R.C. will be there to even ask, does this make
12 sense? We have added it up and figured it up,
13 does this make sense, and if it's not unusual
14 once again for us to take a white and make it a
15 yellow, so we tend to grade harder based on what
16 we know, that makes sense, you know.

17 MR. GRANT: But a red would indicate that a
18 lot of things in that group --

19 MR. MYERS: Not necessarily.

20 MR. GRANT: -- need substantial fixing?

21 MR. MYERS: Yes, sir

22 MR. GRANT: Thank you.

1 MR. HOPKINS: I have a question from
2 headquarters.

3 MS. GOODMAN: This is Claire Goodman, I
4 have a roll-up question via example. The
5 criteria is adequacy of tools, material and
6 equipment, and in that criteria or that
7 attribute, would say a yellow mean that a number
8 of scheduled tasks are not being completed in a
9 timely manner due lack of tools, material or
10 equipment? Now, you did not rate yourself as a
11 yellow, you rated yourself as a white, which
12 meant that a CR did not get written yet, seven
13 areas around the table said they were a yellow.
14 So, in fact, you have seven groups who feel that
15 they have work that is not being completed
16 because of the lack of tools, but no CR gets
17 written because you are a white. I just wanted
18 to mention this is one example of a roll-up
19 problem.

20 MR. MYERS: Well, we would look at that,
21 our criteria for adequacy of tools is more than
22 30 percent. Our criteria here is that more than

1 30 percent of key scheduled tasks are not being
2 completed by the section in a timely manner due
3 to lack of tools, material and equipment. That
4 would be -- that is one criteria. If you want to
5 look at what we consider completely ineffective,
6 more than ten percent of the key scheduled tasks
7 are not being completed by the section in a
8 timely manner due to lack of material or tools.

9 So, you know -- and we would look
10 at the specific area. If it was maintenance not
11 getting the work done and the material condition
12 of the plant degrading, then that would -- we'd
13 turn that into red, but if it's a -- it can be
14 some other areas that are not as significant, for
15 example, our human resource area, you know, or
16 our -- I will give you one of them. One of them
17 was the computer services group, we did not pull
18 some of the fiberoptics we wanted to get done or
19 something and we grade that red, but it's not
20 significant to the restart of the plant, so when
21 we grade it all out, it may come out as a white,
22 and we would say that was appropriate.

1 If it was something in
2 maintenance, we'd probably grade it harder, make
3 it a yellow, you know, so you can't say
4 everything is equal, and we wouldn't do that.

5 MR. GRANT: I guess that is the core of
6 what I was asking as a model, you know, for
7 optics, you know, it just is curious that as you
8 are talking about safety culture there is this
9 model where you have whole areas that are
10 considered to be red, and yet the decision is
11 made to -- that it's okay to go forward with
12 whatever the evolution is, and from an optic
13 standpoint, I wondered what is it communicating
14 to staff that says safety culture is important,
15 but there is, you know, the model that we, you
16 know, put up in front of everybody has a red
17 area, and yet we are going to continue forward
18 with what we were intending to do.

19 MR. MYERS: We would communicate -- let me
20 give you another example. We did not have all of
21 the personnel evaluations completed on human
22 resources, that they were all supposed to be

1 done, we turn ourselves red. That would probably
2 not keep us from changing modes, but we would
3 take that on and go get them done, and we did,
4 okay?

5 MR. CALDWELL: You get our point.

6 MR. MYERS: I get your point.

7 MR. CALDWELL: That is -- roll-up is not
8 going to help without going through and
9 specifically talking about the things, just like
10 you did, the individual things. This is a good
11 process, and we just want to make sure that you
12 understand the sensitivity of -- just because
13 something gets, you know, a green and red, the
14 red noses out the rest, but the red is a
15 showstopper, doesn't matter how many greens you
16 have, those are the kinds of discussions we would
17 want to have at -- you know, at the point of
18 restart.

19 And when you have something like
20 cross functional work management communications
21 as a yellow, and then for your motor change, and
22 then you have a significant rework problem during

1 the mode changes, do you go -- do you relook at
2 that to make sure you understand because the feed
3 linkage you were trying to reset the timing for
4 got -- you set their linkage wrong, and later
5 when you tested it, you found the linkage reset,
6 I would assume that is a rework?

7 MR. MYERS: I'm glad you asked that. We
8 have already looked back on that. Actually, the
9 problem with the linkage has been there since
10 2000, and now that we have gone back and looked
11 at it exactly like you said, we looked at traces
12 on the governor, and the traces were there in
13 2000, now, with the change we went back,
14 installed a new governor valve, it's tighter
15 around, tighter clearance than the old one, and
16 that new governor valve combined with a linkage
17 had been perfectly aligned, the result is times
18 outside the band, so do we understand that that
19 was a rework problem for us. We wrote out a CR
20 and took a look at the extent of condition.

21 MR. CALDWELL: When did you put the new
22 governor valve in?

1 MR. MYERS: This cycle, but the linkage was
2 there and you could see the linkage has been
3 there I think since 2000.

4 MR. BEZILLA: I think that's right.

5 MR. MYERS: Now, the other thing we do is
6 once again we publish a list of each one of --
7 this is a list of every issue that we have and
8 that was graded, and you can optically look at it
9 and tell from both 5 and 4 what the areas of
10 concern were in each area. We'd expect to be
11 able to explain that to you.

12 MR. LEIDICH: Also in response to your
13 question, Jim, there is going to be -- every time
14 we do one of the assessments we sort of clean off
15 the desk and say, where are we today based on
16 what we see today? I think part of your question
17 is, you are just taking this and taking where you
18 are in incremental improvement and another
19 incremental improvement without any consideration
20 of where you have been for the past several weeks
21 or whatever, so each one of these is a fresh
22 look, and I think that's what -- you know, the

1 way I looked at it is dust it off and say where
2 in the heck are we right now with an
3 ever-increasing standard and ever-increasing bar.
4 Otherwise, if we look at this over the next
5 several exercises and we are all agreed, we don't
6 have a good tool, that's not where we are at,
7 that's the idea.

8 MR. WRIGHT: I think there is a comment
9 from the back.

10 MR. RUETER: I just had a comment on some
11 of the facts that if you go back to your
12 definition of safety culture, and I think what
13 Lew was trying to say is that we applied the
14 appropriate significance to each individual
15 window. If it's very significant, it will be a
16 showstopper. If it's not significant, i.e. lower
17 on the priority, or it's not going to affect
18 nuclear safety, then it's applied appropriately.
19 Thank you.

20 MR. GROBE: I appreciate your comments.

21 MR. MYERS: I wish I'd have said that.

22 MR. GROBE: The inspection team is

1 continuing its work in this area, and as I
2 mentioned, a number of us have observed these
3 activities. Our sense is that the model to
4 collect data will give you a wealth of
5 information regarding safety culture in the
6 plants. It's not clear to us yet how you
7 interpret that information, and if there is a
8 tremendous amount of management, how on Earth do
9 you come up with the ratings?

10 We are probably going to be
11 focusing more at a data level in the overall
12 ratings level because it's not quite clear to us
13 how you roll these things up and how you
14 ameliorate a red finding at an individual
15 question and come up with an overall rating of
16 white since many of those individual questions
17 are very important.

18 MR. MYERS: Right.

19 MR. GROBE: I'd like to ask one more
20 question, just to make sure I understand. If you
21 have a red or yellow finding at the individual
22 question level that is subordinate to any of

1 these boxes on this page, Page 21, there is no
2 requirement that you initiate a CR for that?

3 MR. MYERS: I didn't say that I would
4 expect the group to initiate their own individual
5 CR. If it's up here in one of these boxes you
6 see on the board, then that would get to the
7 Senior Leadership Team level.

8 MR. GROBE: Okay. I think --

9 MR. MYERS: It's more significant.

10 MR. GROBE: A procedure of this nature is
11 fairly unique right now, and -- in the industry,
12 and as I have said in the past, you have earned
13 the opportunity to develop something like this
14 because of the problems -- magnitude of the
15 problems you had. It does give you a tremendous
16 amount of information that we are probably going
17 to want to discuss in the future public meetings.
18 I believe the next time you are planning on
19 performing this type of assessment is just prior
20 to your next Mode 4; is that correct?

21 MR. MYERS: That is correct, and then we
22 would do a spot check at Mode 2.

1 MR. GROBE: Okay. We will probably want to
2 talk about that in detail at the meeting to
3 discuss the results of that next assessment,
4 detailed public meeting, just focus on that
5 assessment.

6 Were you planning on providing
7 your procedure on the docket so that it would be
8 available to us and facilitate that kind of
9 public dialogue?

10 MR. MYERS: I think -- I thought we had,
11 Jack.

12 MR. GROBE: It's been -- it's been through
13 six revisions, so if you had, it might not be the
14 right revision.

15 MR. MYERS: I will send it to you.

16 MR. GROBE: Okay.

17 MR. BEZILLA: 7 is in the works, Jack,
18 also.

19 MR. GROBE: Revision 7. So it would
20 facilitate dialogue during a future public
21 meeting if the procedure was available publicly,
22 and that way it wouldn't be just us discussing

1 the individual details and procedures, but others
2 could have the opportunity to understand also.

3 MR. MYERS: I thought I sent you all the
4 later ones. I remember signing a letter, I
5 thought I had. I will look -- I will send it to
6 you.

7 MR. GROBE: I might have it, so it might
8 not have come across my desk as a public
9 document. I will see if it is.

10 MR. MYERS: Okay.

11 MR. GROBE: Other questions about the
12 internal safety culture assessment tool before we
13 move on?

14 MR. LEIDICH: We are trying to keep
15 objective and subjective here. We don't think
16 it's possible to put an algorithm on a piece of
17 paper that says here is safety culture, we don't
18 think it's a set of opinions by a bunch of
19 managers, so we welcome the back-and-forth
20 dialogue on how to get this combination of
21 subjectivity and objectivity and get the right
22 formula here so we recognize that.

1 MR. GROBE: It's very difficult to measure
2 attitudes and behaviors, and engineers have a
3 tendency to want to put a number on everything,
4 and we did come up with a viewpoint. I'm not
5 sure what it would mean, I think the details are
6 where the goal is coming from.

7 MR. LEIDICH: Very good.

8 MR. GUDGER: For the record, we did submit
9 the last revision to the procedure.

10 MR. GROBE: Before the next meeting we will
11 make sure the current revision is on the docket.

12 MR. MYERS: Good.

13 The next area we want to skip to
14 very quickly, some of the areas that we have
15 actions that we have taken in each area to date.
16 Our nuclear committee, the board policy level is
17 our plant is visited at least four times, the
18 entire board of directors has visited the site to
19 show their support and met with our employees.

20 Our ECO, Pete Burke, has
21 personally met with all of the SROs to show his
22 support of their responsibility and the CEO, once

1 again, has visited the site to participate in the
2 all-hands meetings with our employees to stress
3 the importance of nuclear safety. He stayed in
4 the lab all day, not only did he stay at the
5 plant and do a meeting that day, he stayed
6 overnight, until just about 8:00 at night, so
7 that's what I would call a significant commitment
8 in the highest level of our company.

9 For policy level area also, the
10 new FENOC executive team that we put together,
11 the president sitting beside me has wealth of
12 experience, not only from the company, I'm the
13 new company chief operating officer. As we wind
14 up getting Davis-Besse back on line, my job is to
15 ensure consistent implementation across our site.
16 One of the things that we found, we thought that
17 we had the same corrective action program at all
18 of our plants, and our other two plants, even
19 though the procedure was the same, we called an
20 operability review and operability determination
21 at our other two plants. When we got to
22 Davis-Besse we found out that they call them an

1 operability justification, completely different
2 word, and that is my job, to make sure that
3 doesn't happen.

4 So we think this new structure is
5 going to help that, and then Joe brings a wealth
6 of experience in his new role and having him here
7 will develop our processes and get a line on
8 those processes is going to be good, and then the
9 vice-president of oversight reporting to the
10 board of directors and to Gary, you know, one of
11 the things that we looked at, if you go back and
12 look at the previous quality assessment at
13 Davis-Besse, but I have looked in great detail, I
14 have trouble reading the assessment and coming
15 out with the conclusion that the management team
16 was coming out with. Once again, it was
17 isolationism, so we think this new organization
18 will prevent that from happening.

19 The Nuclear Review Board is
20 changing significantly some of the members, so
21 they changed the structure to stay out of the
22 management area and focus strictly on nuclear

1 safety. We think that will help in that area.
2 There is a new vision and strategic objectives
3 now that really focus on nuclear safety. And
4 finally, the First Energy Talent Management
5 Program is in place now and will help us ensure
6 that we have the right talent in our plants in
7 the years ahead of us. And we think that if you
8 look at the Davis-Besse plant, one of the things
9 that happened over time was at one time it was
10 the pool for managers and we had a good pipeline
11 of training programs for SROs and stuff like that
12 that went from an SRO program to a site
13 certification program to no program at all, and
14 we just -- from a management standpoint, we can't
15 let that happen.

16 In the management level commitment
17 area, we think we put a team in place at our
18 Davis-Besse plant. Let me just -- let me -- I
19 will talk about that more in just a second.
20 Additionally, we went down and committed to the
21 regulators that we would ensure that we have the
22 right supervisors at our plant, and the line

1 organizations, and we brought in an organization
2 I will talk about later, RHR, and that's how we
3 went a lot further than that, we not only
4 evaluated the supervisors, we evaluated managers
5 and evaluated the Senior Leadership Team and up
6 to the president of FENOC. So we felt that that
7 worked well for us, to give us a common
8 understanding of the attributes that we had in
9 our supervisors and managers at the plant.

10 I'd like to focus for just a
11 second on the next slide, if could I read it.
12 The senior team there is here now, if you go look
13 at the Senior Management Team, we have in place a
14 strong team in Davis-Besse with proven leadership
15 and safety focus. Most of the managers are
16 previous SROs, or at least have an SRO
17 certification. Several of our senior managers
18 have extended experience. For example, you know
19 I was the plant manager when I was in South
20 Texas. Mark Bezilla was in Salem and Perry and
21 has experience from a previous start-up in the
22 past, and then Randy Fast was at the South Texas

1 plant, and Mike Ross was there through the
2 start-up of 3 Mile Island.

3 So we think we have a team in here
4 that is a management team that will drive the
5 standards that we want to drive. If you look at
6 the overall team, senior leadership level to give
7 you some numbers, they have over 200 years of
8 nuclear experience in the six players, all have
9 SRO certifications, all have engineering degrees
10 or higher, and four of the six have extensive
11 shutdown -- extended shutdown experience.

12 In you go down the management
13 level, next slide, and the management level, we
14 made some extensive changes also. That team
15 right now has over 260 years of experience, all
16 technical, which I think is important. Our
17 manager of human resources doesn't have an
18 engineering degree, but all of our technical
19 positions have engineering degrees or technical
20 degrees, such as chemists, which is 11 of 13, and
21 then 10 of the 13 have SRO certification
22 experience. So we think we have a really strong

1 management team at our Davis-Besse plant, and
2 when the strong management team was there before,
3 the plant performed in an outstanding manner.

4 I will talk a little bit about RHR
5 International, which was contracted to review our
6 line of managers and supervisors, and they had
7 several of the first review --

8 MR. GROBE: I'm sorry, just a quick
9 question, I apologize for interrupting. The last
10 slide that you had up there, in some places
11 behind a name there is an A and some places an I.
12 Could you explain what those mean? Behind
13 Farrell there is an A. By the director of
14 maintenance there is an I.

15 MR. MYERS: Interim alignment.

16 MR. BEZILLA: Interim alignment. We made
17 some adjustments, initially Greg had reported to
18 Mike, but for this -- the last few months we had
19 Mike and Greg directly reporting to myself, so
20 it's an interim alignment is what that is
21 showing.

22 MR. GROBE: Thank you.

1 MR. MYERS: Since we have Mark, he is
2 going to be site V.P., we share the duties, and
3 we did some interim things to ensure that we had
4 a strong management team, so that's what that is.

5 RHR International was contracted
6 to review the behaviors to ensure that the
7 conferences are anchored and defined. They not
8 only did that once again for our supervisors, but
9 all our managers. They did an overall review of
10 each individual, based on RHR evaluations at
11 round table meetings with the Senior Leadership
12 Team. So they came to us and went through the
13 competencies of each and every one of our
14 managers and supervisors with us. We think that
15 gave us a good starting criteria for actions
16 going forward, and employee development for
17 supervisor and manager level.

18 We have also done -- we have also
19 added two new categories, nuclear safety and
20 nuclear professionalism to our evaluation
21 process. Nuclear professionalism demonstrates a
22 great respect -- some of the criteria that we

1 look for there is demonstrates a great respect
2 for understanding nuclear safety, takes personal
3 responsibility for human performance and
4 participates in influencing industrial
5 organization, applies industry improvement, so
6 those are the type of criteria we are looking at
7 in those particular areas, but those are new
8 competencies tied to the managers' evaluation.

9 One of the things that I believe
10 would have prevented the Davis-Besse event from
11 happening would have been anchored oversight into
12 continuing processes. Oversight just did not
13 serve us well, and I think Greg will tell you
14 that we have taken strong actions, and Corrective
15 Action Review Board and Engineering Assessment
16 Board is now in place. It was not in place at
17 Davis-Besse. We had that in place at our other
18 two sites, it's now an order in our process.

19 And then the Management Review
20 Board, we have strengthened that review board to
21 ensure that CRs are properly characterized, and
22 we didn't have an identification problem, we

1 thought our threshold was fairly good to begin
2 with, even though -- but if you go look at some
3 of the CRs, they were not properly characterized,
4 and we think that we fixed that problem.

5 Also anchoring the management work
6 practice area is the risk management process to
7 ensure management oversight, so each week we look
8 at risk management and risks associated with the
9 job. Going down to the next to last area, based
10 on risk, assign managers to specific jobs, you
11 have a management observation program, a bean
12 count, watch the same guy do the same job every
13 month, because we ain't got the observations
14 done. That did not serve us well. We now assign
15 managers to jobs based on risk, and we sort of
16 make sure that we are getting all of those
17 management observations done that we scheduled.
18 It's important that we give management a sense of
19 the right job, and those two processes are
20 helping that.

21 MR. THOMAS: Do you have any data to say
22 how effective that management oversight has been?

1 MR. MYERS: In fact, I have got a whole book
2 here with me.

3 MR. THOMAS: Condense it a little bit.

4 MR. MYERS: Why don't you let me get back
5 to it later.

6 MR. THOMAS: Okay.

7 MR. MYERS: And we will --

8 MR. VON AHN: I will be discussing that in
9 my discussion.

10 MR. CALDWELL: Just to clarify, your
11 definition of risk is most safety and risk to the
12 plant, or --

13 MR. MYERS: Risk to the plant or risk for
14 job to either tripping the plant, causing an
15 event, you know, so we look at systems, a list of
16 systems and tasks being performed on that system.

17 MR. LEIDICH: My process for all stations,
18 well, if there is a risk-significant activity
19 going on at one of the plants, even if it's off
20 shift, we handle whatever. There will be strong
21 management observation of the activities to make
22 sure it's done properly.

1 MR. THOMAS: So this is the additional
2 oversight that is given ensuring freely-performed
3 testing?

4 MR. MYERS: Yes.

5 MR. THOMAS: That type of thing?

6 MR. LEIDICH: Also routine surveillance, so
7 it's a matter of what's the risk that we feel is
8 necessary to provide the oversight.

9 MR. THOMAS: Okay.

10 MR. BEZILLA: Just two things: Scott, we
11 created a new procedure, it's an EB something,
12 something 800, and that is for Modes 1 and 2, and
13 that will identify for what management process
14 low risk, which would mean the supervisor.
15 Medium risk would be manager attention to that
16 activity for that day, and then a high risk would
17 be a manager and direct level overseeing that
18 activity.

19 It can also be an infrequently
20 performed test or evolution. This is true of the
21 work management process, and that is a new
22 procedure that we put in place at Davis-Besse, it

1 hasn't been in Mode 1 or 2, but exposed the work
2 operators for that, and we will focus on making
3 sure that they are ready to go on the chance we
4 get in the Mode 2 and Mode 1.

5 MR. THOMAS: So this will supplement your
6 IP frequently-performed test guidelines?

7 MR. BEZILLA: It's a lower level, gets more
8 management attention sooner on activities.

9 MR. MYERS: The answer to that is yes.

10 MR. BEZILLA: And just one more thing. It
11 is plant equipment risk, can also be like high --
12 potentially high radiological evolution. As an
13 example, when we did the reactor vessel head,
14 removing of the nozzles we had a review meeting,
15 determined that that should be an infrequently
16 performed test and evolution and treated that
17 with I will say additional respect that it was
18 due, based on the potential that we have
19 contamination and/or dose absorption by our
20 people. And I think we did that job for about
21 half the projected dose, because I think we had
22 the right management attention on that evolution,

1 so we could use it there to -- Jack just said any
2 vessel would have an RP supervisor briefing, and
3 they would have that at the jobsite also.

4 MR. CALDWELL: What about like -- what
5 about if you were at a situation with the plant
6 where changes in pressure could result in
7 initiations or activations, or were those
8 recognized as high-risk activities?

9 MR. BEZILLA: Those evolutions for this
10 normal operating pressure test, what we had is,
11 we had the normal crew complement -- actually,
12 double crew complement and had an
13 infrequently-performed test or evolution
14 oversight individual, which was our op
15 superintendent individual, and also had select
16 managers and directors, and a few SRO types that
17 will provide management coverage, observation and
18 coverage through the normal operating pressure
19 test, actually had that through the entire test
20 period here.

21 Now, has that prevented us from
22 having any mistakes? No, we have had some

1 opportunities on the way up, we had one last
2 night that we talked earlier about Scott being
3 there, and we haven't prevented those. But this
4 dress rehearsal that we have done I will say the
5 normal operating pressure test has fettered out
6 the things that we were looking for, whether it
7 was plant issues, people issues or process
8 issues.

9 But the intent of the management
10 oversight is to minimize or lose the potential
11 errors or mistakes or events.

12 MR. CALDWELL: And it hasn't demonstrated
13 itself to be very effective?

14 MR. MYERS: That is not necessarily true.
15 There has been several issues that we have
16 actually caught, you know, and we briefed you on
17 that yesterday, but there have been several
18 issues that we have caught during that process.

19 MR. BEZILLA: Typically we don't talk much
20 about the successes, we only talk about the
21 failures or opportunities.

22 MR. CALDWELL: Right. Because you're at a

1 situation where failures are intolerable, so
2 that's what it comes down to, and both these
3 situations if there was oversight, they obviously
4 weren't looking at the history of implementation
5 that would have given them the opportunity to get
6 ready to either hit a trip set point or getting
7 ready to cause a corroded tank valve to open, and
8 that was my point.

9 If there was a lot of oversight
10 there, it wasn't helping at the time. First of
11 all, I expect the operators to have caught that,
12 not to have let that occur. And then you had
13 additional ROs and SROs and oversight for both
14 those evolutions, and that was ineffective in
15 preventing those things from occurring.

16 MR. MYERS: We would agree with that.

17 MR. LEIDICH: We recognize that we have got
18 work to do, both in terms of operator
19 performance, management oversight, and we have
20 learned that loud and clear over the last year or
21 so, so we are --

22 MR. MYERS: There is some improvements we

1 can make.

2 MR. LEIDICH: -- absolutely in the highest
3 level of attention.

4 MR. MYERS: One of the things we have used,
5 and I shared with Christine earlier, is a
6 document, you know, and it's a really quality
7 document, and it looks at several extended issues
8 of how to ensure operators are ready. The whole
9 -- one of the many purposes of the seven-day
10 evolution was to find some of the issues that we
11 have. We don't like finding those issues, but we
12 won't have those issues again. I guarantee you
13 that we will not have another problem with the
14 accumulator --

15 MR. CALDWELL: I'm not worried about the
16 accumulator flood tank necessarily as I am making
17 sure that the rigor is there such that you are
18 not going to have any other occurrences, and if
19 you have one, the only way in which you had an
20 opportunity to learn from and to provide feedback
21 to the operator, that that was unacceptable, and
22 you had one coming back down, which would

1 indicate that they didn't get the message, so it
2 doesn't give us confidence, I guess, in those
3 evolutions and the oversight.

4 MR. GROBE: You know, your individual
5 commitment area back on Slide 21 had drive for
6 excellence, questioning attitude, rigorous work
7 control and prudent approach, open communications
8 and nuclear professionalism. You were correct in
9 the sense that this evolution was performed in a
10 way in which there was minimal risk, nuclear
11 safety risk.

12 MR. MYERS: Right.

13 MR. GROBE: If fuel is essentially cool,
14 there is very little risk of any sort of safety
15 consequences. Nonetheless, I would not have
16 expected the types of operating problems that
17 were observed, especially given the fairly high
18 set of marks on your safety focus and individual
19 commitment.

20 And this goes right back to the
21 questioning attitude, rigorous work control,
22 prudent approach and nuclear professionalism.

1 And I asked the question before the meeting
2 started, how many plants are you aware of that
3 have two safety feature actuations a year, and
4 let alone a week, and it's troubling, and it also
5 -- I think Jim asked the question earlier on your
6 assessment process and what it tells you and what
7 it's telling you right then is based on what you
8 are seeing in the evolution.

9 MR. MYERS: One of the things we do is,
10 evolution is going to be a large part of our
11 assessment process to go forward, and that is, we
12 thought we were briefed on that yesterday, and
13 based on all the drills we ran and the assessment
14 done, we learned from that, and, you know, we
15 figured out that -- we will share now -- is that
16 our procedures in some cases are not as specific
17 as they should be, and they are not utilized the
18 way that we are used to seeing them utilized on
19 the other plants, so we will effect actions,
20 okay?

21 MR. GRANT: Just to reflect on something
22 that Mark said, and I'm sure you probably didn't

1 say it the way you intended, but you used the
2 word the evolutions over the past week, you know,
3 ferreted out, and I don't think you meant to say
4 that you are using the plant or the evolutions to
5 discover problems, you were actively trying to
6 find those sorts of issues before you did the
7 plant evolutions, you are not using those
8 evolutions to ferret out problems that might be
9 there. You've got to take advantage of the
10 situation if it occurs, but you're not using the
11 plant or these evolutions to discover problems,
12 right?

13 MR. MYERS: That would be correct.

14 MR. GRANT: Okay.

15 MR. MYERS: The last thing I want to talk
16 about, the slide, was what I consider a success,
17 and this is the seven-day evolution that we have
18 done, and that is the use of our problem-solving,
19 decision-making process. In my mind, and I
20 really do believe this, it's a rigorous approach
21 to taking on issues with the right team involved
22 and putting the right, best and brightest you

1 have in place. And an understanding of the
2 issues is a key to ensure that issues like the
3 reactor vessel head doesn't happen, and one
4 problem is isolationism. I really believe good
5 problem-solving would prevent us being here
6 today, and I also believe it would help us solve
7 a lot of issues that we found in this seven-day
8 test.

9 And from a breaker standpoint to
10 other issues that we found, each time I was
11 extremely pleased with the success. what I will
12 tell you about is the fact that I did not have --
13 Mark did not have to take our organization and
14 tell them to stop, put a problem-solving team,
15 sit them down, write it all up, make it visible
16 and go forward from here, you know. In my mind,
17 that was a success, and I think that one process
18 change alone would have prevented us being here
19 today.

20 MR. THOMAS: Do you believe that they also
21 effected prompt corrective actions? I would
22 agree with you that when an organization is

1 confronted with a problem, they assemble a team
2 that starts evaluating. Would you say that, one,
3 they determine that the cause corrective actions
4 were prompt?

5 MR. MYERS: What I would say is they don't
6 come out of the gate as quickly as I'd like to
7 see them come out, you know, and I think we got
8 great evaluations, not as promptly as I would
9 like to see.

10 MR. VON AHN: I will speak to that in my
11 discussions, because Q.A. would have liked to
12 have seen a little less of a learning curve on
13 this, and I will talk to that issue of the
14 problem-solving discussion.

15 MR. MYERS: And the individual level
16 commitment area we know we have done a lot to
17 strengthen our organization and get alignment.
18 We have done the case study training, run 4-Cs,
19 town hall meetings, refocused on the site on-line
20 articles. Right now when I go do surveys, one of
21 the questions I ask is about communications.

22 About 86 percent of the people in

1 the plant would rate our communications fair or
2 good and -- which is a big improvement from what
3 we had a year or so ago, so we have worked out
4 and communicated with our people.

5 And then finally the management
6 observation program allows our managers to
7 interface with the employees better and ensure
8 that we have the right standards. I still don't
9 believe, once again, we are getting the bang for
10 the bucks that we should here, but it's a big
11 improvement over what we had before. There is
12 still some room for improvement.

13 In the supervisors area, we have
14 completed leadership training. The employee
15 standards training, safety conscious work
16 environment training, that is training for every
17 employee on the site, problem-solving,
18 decision-making, and then finally we have a new
19 document that is coming out called a New Employee
20 Orientation Manual. I just looked at that last
21 week and Randy's the -- I think the sponsor for
22 that. So we think that is going to be a fine

1 document. Also we'd welcome your opportunity to
2 comment on that.

3 Let me move on to the definition
4 of safety conscious work environment.

5 MR. GROBE: I think this is a -- kind of a
6 whole new topic, and I'm sure we are going to
7 have some questions and dialogue. We have been
8 going for about an hour and a half, why don't we
9 take a brief break and give our transcriber a
10 minute to rest her fingers, so let's reconvene at
11 ten minutes after 2:00.

12 (Whereupon, a recess was
13 had, after which the
14 meeting was resumed as
15 follows:)

16 MR. GROBE: Go ahead.

17 MR. MYERS: Thank you. The next area is
18 part of the safety culture and safety conscious
19 work environment. That is an environment in
20 which employees are encouraged to identify
21 problems, are confident the problems will be
22 effectively evaluated and corrected and are

1 protected from any form of retaliation as a
2 result of raising safety issues or raising
3 issues.

4 You know, we think that we've made
5 great progress in this area, and that our program
6 is proactive rather than reactive. The program
7 we have in place now, just some statistics for
8 you guys on the 700 people in the past year that
9 we have surveyed in the 4-Cs meeting, 100 percent
10 of the people say that they would use the
11 Corrective Action Process, which is the first
12 part of the safety conscious work environment
13 process to identify a problem, 86 percent of our
14 people indicated safety conscious work
15 environment is -- confidence is a good increase.
16 93 percent of the people would bring a concern to
17 the safety conscious work environment if they
18 have one that cannot be resolved. 98 percent
19 said they would bring the current concern here to
20 their supervisors or the managers. So we think
21 that is really a strong message there, the
22 supervisors or managers. 97 percent said they

1 would use the N.R.C. if they needed to, so we are
2 one percent higher. 94 percent indicated that
3 concerns that they have made in the past were
4 treated fairly, 94 percent, so that is a good
5 number.

6 And then once again I gave -- this
7 87 percent right now would indicate that our
8 communications for employees are fair to good,
9 which we are pleased with. Also, we worked hard
10 to focus on communication in our program. Now,
11 one of the things we had before in the ombudsman
12 program was a strictly wait and see. If somebody
13 had a concern, the program was not proactive.
14 The method uses telephone, faxes, drop boxes,
15 company e-mail, face-to-face communication and
16 exit interviews to go out and specifically look
17 for employee concerns.

18 MS. PEDERSON: The statistics you
19 mentioned, do those include contract force?

20 MR. MYERS: No, they don't, they include
21 our work force.

22 MS. PEDERSON: Some of the other things

1 that you talked about, exit interview and things

2 like that, does that cover --

3 MR. MYERS: That could cover contractor

4 employees, yes.

5 MR. CALDWELL: So percentages that you

6 used, what percentage of the staff is that, all

7 the staff, or --

8 MR. MYERS: We have had 4-C meetings, there

9 have been 700 people that we conducted surveys

10 with.

11 If you look at our model, safety

12 conscious work environment, the four pillars,

13 management support, we have really anchored our

14 management support and policy LP-2003, we

15 specifically have a policy in place now that

16 encourages strong management support for our

17 safety conscious work environment program,

18 problem-solving and our company process we think

19 has been strengthened in that we now give

20 feedback to each and every employee, and how

21 would he solve the problem, what we do with the

22 problem is we issue an e-mail, we make sure we

1 get feedback.

2 The effective alternate resolution
3 process. We have used this process several times
4 during the past year. It's a new process. If
5 you have a concern that you can't resolve, it's a
6 way to bring a third party in and look at that
7 concern and try to resolve it. We think that
8 program is a -- the feedback we are getting is
9 that program treats people fairly and with
10 respect. And then we have -- we wanted to make
11 sure that people didn't feel like they had
12 confidence in our program, and one of the things
13 we have done to prevent retaliation is evaluators
14 are independent, before we would send issues to
15 the departments for review, and we weren't
16 getting marks on the confidentiality we would
17 like, so now we have an independent evaluator and
18 we think that really helped our program.

19 From the first pillar, the
20 management support, worker confidence, once again
21 I mentioned the policy that we have trained all
22 of the managers and supervisors in safety

1 conscious work environment and trained our
2 operator on safety conscious work environment,
3 the CAP program if you will.

4 MR. WRIGHT: Before you go on to the CAP
5 program, you indicate here that you have trained
6 all the managers, supervisors and operators on
7 safety conscious work environment.

8 How about the rest of the staff?

9 MR. MYERS: We have not done formal
10 training, we have rolled out the corrective
11 safety conscious work environment program to the
12 staff. Can we get to there is a training report
13 for that? No. But our marks indicate that we
14 have gone out of our way to make sure the staff
15 understands our safety conscious work program.

16 MR. WRIGHT: Is that something you think
17 just a roll-out that way as opposed to some
18 specific training with some periodic training to
19 keep them apprised and understanding of where it
20 is, and that is going to be as effective as doing
21 a more formal program?

22 MR. FAST: That is captured both in the

1 employee orientation manual and as part of a
2 general employee training annually, so it's
3 reinforced each and every time an individual
4 requalifies to gain access to the plant, and as
5 well as new employees get that through
6 orientation.

7 MS. JARRIEL: This is Lisa Jarriel at
8 headquarters, I have a question on that line you
9 used to investigate the safety conscious work
10 environment action plan, a specific task, to do
11 formal safety conscious work environment training
12 for all employees. Can I ask why you decided not
13 to do that formal training?

14 MS. FAST: Lisa, it was my understanding
15 we were doing that, but I don't know that I can
16 verify that, so let me take the action to verify
17 that fact, because we were rolling that out, and
18 I don't know that we are actually capturing that
19 in our training process. It fits, so it will
20 allow me to take the action to close that gap and
21 figure out did we actually do it or not, and then
22 we will evaluate if we didn't that we should,

1 because it certainly is part of our ongoing
2 program.

3 MR. MYERS: We rolled it out over and over
4 again with our employees. Our employee margins
5 indicate that they understand our process and our
6 programs really well, but part of the systematic
7 approach to training, the answer to that is no,
8 and we will reiterate that in the new employee
9 training.

10 MR. BEZILLA: Let me help here a little
11 bit. When we actually rolled it out, I was at
12 Beaver Valley, and they were requesting us to
13 roll out -- it was a safety culture policy, as
14 well as had a safety conscious work environment
15 letter Lew had written, and we captured -- we
16 talked to all the managers, talked to the
17 supervisors, and rolled that out to our
18 employees, and we captured that all in records,
19 so I -- at least at Beaver Valley I thought that
20 was FENOC-wide based on your request.

21 MR. MYERS: We did that and we did it
22 FENOC-wide. We also, at an all-hands meeting,

1 went over the process we had with the ombudsman,
2 we came in -- not employee concerns, personnel
3 came in to present an all-hands meeting, stuff
4 like that, but I went to the systematic approach
5 to training, and said can I show you what we
6 have, we will do that as part of the general
7 employee training, training our employees to
8 understand the process that we -- I would say we
9 have trained them on the process. We have
10 communicated very well with them getting good
11 marks.

12 MR. GROBE: Is the training you provide in
13 your general employee training the equivalent
14 level to what you were providing to the
15 supervisors and managers?

16 MS. FAST: Let me answer that. What we
17 provided, what is on the slide was done by Morgan
18 Lewis, by an attorney, that actually provided
19 some of the details on the regulatory
20 requirements, and the laws that really back the
21 process. So that was the formal part that I
22 believe Lew is talking about.

1 That was done in a very formal
2 setting, it was about four hours of training. In
3 fact, in preparation, just talking to Art Lewis,
4 that was pretty a detailed kind of training.
5 When you get it from an attorney, there is a lot
6 of focus on the actual legality associated with
7 it, and the need for strict compliance we will
8 say. The part that Lew is talking about with all
9 of our employees was more of the conversation in
10 talking with our managers, not so much in the
11 legalistics approach, in a regulatory approach,
12 but in an environment approach what we expect of
13 our employees and what those employees should
14 expect of us as the leaders of the station. So I
15 believe that's where the little bit of difference
16 is between what we actually rolled out to
17 supervisors, managers and our operations folks,
18 because of their leadership role, and then what
19 we actually provided to our individual
20 contributors.

21 MR. GROBE: Thanks, Randy. Just a
22 follow-up to that. Have you done anything to

1 measure the level of knowledge or understanding
2 appreciation on the part of your supervisors and
3 managers of the details of that training, and is
4 there any plan on periodic retraining in this
5 area?

6 MR. FAST: Well, the answer to the first
7 question, Jack, we did have a test, so there were
8 case studies, and an actual examination that was
9 performed to ensure that the individuals
10 understood. We have not retrained at this point,
11 and I would say as well we are not in the retrain
12 period. We will have to have an evaluation that
13 is part of the ongoing annual training, but is it
14 the same detail? The answer is no, and we will
15 have to evaluate whether we could do that going
16 forward.

17 MR. GROBE: Okay. Thank you.

18 MR. MYERS: The corrective action process
19 is a key foundation. We know this is an area
20 that we made improvements in and we need to
21 continue to make improvements. We made process
22 changes, we think the -- we trained our employees

1 on process changes. We have had an independent
2 validation process now, and we think we have
3 strengthened the root cause process.

4 The next pillar is effective
5 Alternate Problem Resolution process. The
6 program became effective 12/30 of 2002. We
7 benchmarked our program against several other
8 utilities, Millstone, Diablo Canyon and others.
9 That program was reported directly to Fred von
10 Ahn, the vice-president of oversight. We protect
11 confidentiality, and once again we have an
12 independent -- we think the program right now --
13 my real belief is that would give us very high
14 marks by anyone outside the agency. That program
15 works extremely well for us.

16 MR. CALDWELL: I just got a brief on this
17 yesterday, and I understand a couple of the key
18 players in that program are no longer in the
19 program, it's down to half, or --

20 MR. WRIGHT: It's our understanding that
21 some of the investigators, the same group that
22 was there originally is not there any longer, at

1 least some of the players.

2 MR. MYERS: A lot of those people were
3 contractors, we bring them in as we need them,
4 but, you know, we have got permanent personnel
5 there in charge of safety conscious work
6 environment, so we have announced our key
7 manager, and as we need independent evaluators as
8 case loads require, we bring them in.

9 MR. WRIGHT: One of the things we noticed,
10 as Jim said, when we tied the information that at
11 one point I think you had four investigators,
12 three contractors and an internal person?

13 MR. MYERS: Right.

14 MR. WRIGHT: It's our understanding that
15 you have one contractor and the internal person,
16 and when we combined that as -- looked at some of
17 the statistics where the timeliness of the
18 reviews has gone from about 33 days to 120 some
19 odd days over the course of about a month, kind
20 of raised our eyebrows a tad as far as the
21 timeliness and getting back to people,
22 particularly when we see reduced staff there.

1 MR. VON AHN: We will look at that. As Lew
2 said, because the level of activity has gone
3 down, we did reduce the contract level. We do
4 have, as you said, the one independent
5 contractor, as well as the in-house individual.
6 The timeliness I will look at further, but there
7 were some significant issues we were looking at
8 in timeliness of the investigation is depending
9 on the significance of the issues, but that is a
10 good comment that I will continue to look at, and
11 if need be I will bring additional resources to
12 bear.

13 MR. BEZILLA: Let me help, Fred. On the
14 quarterly assessment that the team puts out,
15 there were two annual timeliness issues, Jack.
16 What they said here to me, they gave me this
17 update on a quarterly basis. They said that the
18 indicators were declined. However, there were
19 several complex issues that had to do with
20 corrective actions process items and warranted a
21 greater amount of time to evaluate, and that was
22 the cause of the timeliness resolution of the

1 employee concerns issues. There were a couple of
2 sticky wickets, if you will, and that's what
3 caused the timeliness to drop.

4 MR. MYERS: It was -- it wasn't a backlog
5 issue.

6 MS. PEDERSON: Can you give us an ECP?

7 MR. VON AHN: There is a slide later on in
8 the presentation, later on in the presentation.

9 MR. CALDWELL: We are not trying to get
10 into resources you need, we just looked at the
11 two indicators, reducing resources, increasing in
12 time and wanted to ask the question to understand
13 if they were related

14 MR. VON AHN: No problem.

15 MR. MYERS: And the last pillar is
16 Environment Review Team. We charge the team, the
17 team we use oversaw our contractors reduction
18 effort, we think we managed that well, and the
19 team actively looked for issues that may give any
20 kind of perception of discrimination. We think
21 that team is doing well also.

22 MS. LIPA: Do you have examples of where

1 that's had value, that team, or are you going to
2 get into that later?

3 MR. VON AHN: We get a quarterly report
4 from the safety conscious work environment team
5 leader. The first quarterly report indicated 15
6 percent rejection rate due to safety conscious
7 work environment issues that could have come up.
8 The second report, which was July 30th, indicated
9 a 13 percent rejection rate, so we do see a
10 positive trend here as well so that that team is
11 ensuring that safety conscious work environment
12 issues are upheld.

13 MS. PEDERSON: Can you give us some insight
14 as to why the rejection rate is, what are they
15 identifying that causes them concern?

16 MR. VON AHN: There is a checklist that the
17 Review Team is going through, and if there is any
18 hint of any kind of retaliatory action or
19 anything like that, the Safety Conscious Work
20 Environment Team would reject that, so the check
21 would say this person has initiated a possible
22 condition report that showed that this could be

1 construed as retaliatory issue. So those are the
2 types of issues that the team will see and reject
3 as a result of that.

4 MS. PEDERSON: Is it an issue of there
5 actually are retaliatory actions that are being
6 proposed, or is it an issue more of the ability
7 to defend the position for a legal standpoint,
8 can you help us there.

9 MR. VON AHN: I think it's a bit of -- it's
10 unawareness on the managers' part, and so the
11 Review Team gives an additional look at the issue
12 and is able to provide a broader perspective than
13 possibly the manager might see by utilizing this
14 checklist, plus the team membership, you look at
15 the various human -- you have an HR
16 representative so you look at that aspect, you
17 have a legal rep so that aspect is looked at, so
18 you have a broader perspective on the issue than
19 just the individual manager could bring to bear,
20 and that is the cause for some of the rejection.

21 MS. PEDERSON: Are they brought back into
22 the Review Team and further approved, or are

1 these actions that are never carried out?

2 MR. VON AHN: The team would make a
3 recommendation based on their assessment of the
4 issue, and that action would be either changed or
5 deferred all together.

6 MR. BEZILLA: Cindy, I have been in on a
7 number of those at Davis-Besse in the last couple
8 of months, and typically it's -- the evidence
9 doesn't support the required action necessary
10 that managers need to either strengthen their
11 support or need to change their desired outcome.
12 And those cases, in fact, in I think all cases
13 they come back and there is additional
14 information, right, because we understand what
15 you want now or we reassessed this and talked to
16 our peers, and based on that, we want to take
17 this action, and then what the team does is make
18 sure that there is a preponderance of evidence
19 that support the desired actions, and also help
20 balance the action requested, okay, because we
21 can see if there is some kind of anomaly, and
22 provide that feedback to a manager and/or

1 director as appropriate.

2 MR. WRIGHT: Mark, as you -- what struck me
3 as you were describing a Department of Labor type
4 of review as opposed to a safety conscious work
5 environment review where you are looking at the
6 preponderance of evidence, you are looking at
7 these kinds of things, does the evidence support
8 the action being taken as opposed to a review
9 that says, even if I understand the action and I
10 can support the action and all the rest of that,
11 what impact is that going to have on the
12 organization or people within that organization,
13 and I think that is -- you know, HR does a lot of
14 things in supporting the justifiable action to
15 take. The SCWERT needs to be looking at -- what
16 we would look at is what impact is that going to
17 have on the organization from a cultural
18 standpoint, how does that tell me how you fit
19 that second piece in, given what you were just
20 talking about?

21 MR. BEZILLA: That's actually the primary
22 piece, Geoff. The question was when do these get

1 kicked out? Typically, they get kicked out for
2 the other piece, the piece about do you have
3 evidence, is this a balance, right? The first
4 piece is, hey, is there any harassment,
5 intimidation, retaliation or discrimination that
6 could be thought of, inferred or otherwise
7 observed either by the individuals or by others.
8 That is the primary focus, but then we also talk
9 about, does it sound right? So it's both those
10 pieces, checklist walks you through, and it
11 covers your piece you talked about.

12 MR. VON AHN: The primary checklist, the
13 checklist goes to the retaliatory issues
14 specifically, but as I said, the broader
15 perspective is legal and, HR is to get a good
16 broad look at the issue.

17 MR. WRIGHT: The second question I have is
18 one we have raised before, is that safety
19 conscious work environment is an umbrella over
20 the entire site that is, you know, your employees
21 as well as all contractors and the like. Can you
22 give us a bit about your perspective on how

1 SCWERT, you know, is or is not dealing with the
2 contractors' piece of this, beyond the reduction
3 in force kind of activity that you indicated as
4 being, you know, has been addressed.

5 MR. BEZILLA: We have not -- what we have
6 done is with our contractor we say, hey, how do
7 you handle potential harassment, intimidation,
8 retaliation, discrimination issues, and we listen
9 to what they do, and then from a SCWERT
10 perspective I believe to this date we have only
11 addressed the reduction in staffing. What is
12 your plan, is there any issues there, so we have
13 not gone on into individual issues with the
14 contractors and what they might have with their
15 management team, if you will, the supplier of
16 that resource.

17 MR. VON AHN: It's the up-front address of
18 ensuring that the contractor has in the program
19 adequate criteria and judgment in there, and if
20 there is a hiccup or a question about that, the
21 Safety Conscious Work Environment Review Team
22 would get involved, but we review that up front.

1 MR. WRIGHT: That is the program for laying
2 people off as opposed to taking some action
3 against an individual short of that, correct?

4 MR. VON AHN: Correct.

5 MR. MYERS: Correct.

6 MR. WRIGHT: Okay.

7 MR. GROBE: There is quite a few issues now
8 that have this type of a function, I'm not sure
9 they all called them SCWERTs, but have you
10 benchmarked your procedure against other sites
11 that have this type of program?

12 MR. MYERS: Yeah

13 MR. VON AHN: When the procedure was
14 developed, that was done.

15 MR. GROBE: Okay. Just one other question,
16 the -- originally when you looked at the chart, I
17 haven't looked at it recently, but I believe that
18 provided not only this activity-specific function
19 where if a personnel action is coming forward,
20 the Safety Conscious Work Environment Team would
21 look at that, but there was a quarterly overall
22 assessment and advice to management on the safety

1 conscious work environment?

2 MR. VON AHN: Correct, I have two issues,
3 April 21st, July 30th.

4 MR. GROBE: So that is now being
5 accomplished?

6 MR. VON AHN: That is correct.

7 MR. GROBE: What sort of considerations go
8 into it, is it simply a report out on the
9 specific personnel actions that have been
10 evaluated, or is it a broad assessment?

11 MR. VON AHN: Correct. It will assess and
12 evaluate a number of meetings, number of actions.
13 It will look at the number of rejections, the
14 types of rejections and evaluate those, and to
15 evaluate the program health. It also balances
16 the SCWERT people activity with employee concerns
17 and an allegation activity to see how we are
18 doing in all those arenas so we have a broader
19 picture.

20 MR. BEZILLA: The latest report tried to
21 expand on what they were providing to us, to
22 management, and what they do is -- here is the

1 words, it says provides a proper program for
2 corrective significance review and process based
3 on analysis, specific performance indicators. So
4 they take not only the things, but then they have
5 got some performance indicators now for each of
6 the pillars, and then they take a collective look
7 and try to provide us a collective significance
8 of here is what we are seeing among the pillars,
9 if you will.

10 MR. GROBE: Last fall, I believe it was in
11 August, and again in April, February, March,
12 April, I can't remember the exact month, you did
13 a safety conscious work environment evaluation.
14 Is that done on the auspices of this Review Team,
15 or do they consider those evaluations somehow in
16 developing their assessment, and when is the next
17 one you would be completing?

18 MR. BEZILLA: I can ask for some help?

19 MR. VON AHN: The next safety conscious
20 work environment survey will be done in November
21 after the roll-out of the Ed Ventures. Actually,
22 I have some discussion on my slide on the March

1 survey, some contrast of the 2002 survey.

2 MR. GROBE: Okay. So that is not under the
3 auspices of the SCWERT, the Review Team, or is
4 that survey being done independently?

5 MR. VON AHN: The survey is under the
6 umbrella of the four pillars, I believe it's
7 under Pillar 1 would be the survey results. Yes,
8 it's Pillar 1, health assessment results.

9 MR. GROBE: Okay.

10 MR. MYERS: When Gary started out, we think
11 we are building a proactive safety team that has
12 people who plan the process, and our present
13 stage, as you know, we just finished heating the
14 plant up for seven days, we saw some -- we saw
15 issues that we talked about earlier. From a
16 plant standpoint, our plant worked very well, it
17 was leak tight, we were very, very pleased with
18 the leak risk. We had -- we demonstrated a new
19 leak risk process that we have for identifying
20 very low leakage. It identified I think .001.
21 We can see that, and that worked well for us.

22 Additionally, if you go look at

1 the workmanship we saw, we packed a couple
2 hundred valves, and the problems we had, we
3 thought was good. The process that we saw, our
4 troubleshooting process -- troubleshooting
5 process and decision-making process worked well
6 for us.

7 Additionally, the work that -- the
8 new system that we installed, which is one of a
9 kind, it's unique in the industry, that people
10 can look to the flew system, will tell you which
11 one it is throughout the cycle. We did a cleanup
12 test and proved that it can detect very low
13 humidity, but overall we accomplished a lot in
14 the last seven days, from a transition from an
15 outage to an operational organization, we are
16 using the operating experience manual that we
17 talked about earlier.

18 We looked at the problems at the
19 other extended outages, specifically at Salem,
20 Fermi and whatever. During the seven-day test we
21 went back and did as much testing and we could on
22 the modifications. I think we closed that up. I

1 think workers -- there were lots of work orders
2 that were PMT testing, so that was successful.

3 The slow heat up and testing of
4 the equipment ensured that the equipment would
5 work well. And the most difficult thing, if you
6 look at that document for lessons learned, is the
7 transition to an operational phase attitude, if
8 you will.

9 One of the things that document
10 indicates is -- I looked at it this morning --
11 that we have to sharpen our skills as the
12 operators of a not operating plant in over 19
13 months now, so we think that even though we did
14 have some issues, that we are getting the issues
15 resolved, and we will be better for this
16 seven-day test.

17 That wasn't the total purpose of
18 that test, but there was some real lessons
19 learned on heating up the plant, getting to a
20 normal operating temperature and watching how our
21 program and processes and procedures work.

22 I will go to a couple of overall

1 indicators. If you look at, we are having
2 trouble with all the CRs, getting time to review
3 the CRs. We had a level of 95 percent, and we
4 are meeting that goal as we speak, and
5 consistently reviewing the CRs within one day at
6 the SRO level. Next slide.

7 The self-identified rate, you
8 know, we had a goal of 85 percent there and we
9 think that we are making good progress there.
10 We'd like to get up to 90 percent, and we are
11 close to that. We just need to keep trying to
12 lower that threshold. The next slide.

13 The area that we have concern
14 about is the root cause, and I would tell you in
15 my mind, root causes -- the root causes, even
16 though the quality indicator here would say that,
17 you know, that we have had a decline in the root
18 cause at the present time, I will tell you that
19 based on some of the comments we had after the
20 investigation, we have lowered that threshold
21 again, and that is causing a decline. We expect
22 to see that curve getting back to the right

1 direction, and -- in root cause, and we will make
2 sure that that happens, but that is not meeting
3 the goals that we would like now.

4 MR. THOMAS: Lew, what type of things are
5 they identifying that are causing rejections of
6 these root causes?

7 MR. MYERS: Scott, I think some of the
8 things I have seen is some of the causes -- not
9 addressing all the causes, not completely
10 addressing all of the causes. Another level
11 down, there's been some issues of that -- like
12 that where there has been some additional
13 contributing causes that were identified.

14 Additionally, there has been some
15 indications of where the corrective action cannot
16 directly link back to the root cause. We have
17 had some issues like that too.

18 MR. THOMAS: Are there any cases where the
19 individuals performing the root causes weren't
20 qualified to do so or don't have the proper
21 training to carry out those type of evaluations?

22 MR. MYERS: I've not heard of that lately,

1 no, no. Have you heard of that?

2 MR. BEZILLA: (Indicating.)

3 MR. MYERS: No, it's not something we have
4 seen.

5 Individual error rate, and that
6 has to do with the number of errors you see in
7 10,000 hours. We would like to get that down
8 further than what our goal is. Long-term goal is
9 .29. We start at .35, and -- but we are still
10 not happy with that. We are having too many
11 errors, and some of them were more significant
12 than we'd like to see.

13 Program and process error rate,
14 once again we are in the .3 of 10,000 hours, but,
15 you know, we think the last seven days we need to
16 improve on. Engineering quality of the products,
17 the average weekly score there is an -- is below
18 1. We are real pleased with that. That is
19 something we continue to work on to keep the
20 quality of our engineering products, and
21 especially in mods in good stead, but --
22 MS. PEDERSON: Can you tell me how you

1 determine the quality of these engineering
2 products?

3 MR. MYERS: Yeah, we have an Engineering
4 Review Board that reviews the engineering
5 products, the mods, if they are rejected then
6 that would be -- in other words they have to go
7 in there if they are rejected, if it's minor
8 comments, we wouldn't consider that in the number
9 of rejections.

10 Management observations, you know,
11 once again this is good news, that our management
12 observations were hitting the mark, and that we
13 are at a 12-week rolling average of those we are
14 scheduling is up above 90 percent. But once
15 again, if you ask this, are we getting the bang
16 for the bucks, we were not getting as -- we don't
17 think -- we think that people we bring in from
18 the outside are more critical than our own
19 managers in some cases.

20 Go ahead, I know you have a
21 comment.

22 MR. THOMAS: What does completed mean?

1 MR. MYERS: That means that the management
2 observation was performed in the data base.

3 MR. THOMAS: So if they filled out the
4 form, then that is completed? I'm trying to
5 understand.

6 MR. MYERS: Well, they did the things, did
7 you give the feedback questions on the form, did
8 you do -- yes, that is completed.

9 MR. THOMAS: So this doesn't give you any
10 information about the effectiveness, just tells
11 you they were done?

12 MR. MYERS: This indicator doesn't -- I
13 have a book here that gives you indications about
14 the effectiveness on coaching. There was
15 perceived increases in coaching that we didn't
16 see before, seeing improvements there, but I have
17 got last month's performance indicators. If you
18 want to see those afterwards, I have a got book
19 of my group.

20 From the 4-Cs meetings, once again
21 I met with my 700 employees, you know. If you
22 look at our 4-Cs it has had an open forum. Let

1 me tell you how this works. We bring in a
2 facilitator, facilitator meeting with a team,
3 they address a list of questions, which is
4 provided to me prior to the meeting, and then I
5 go down and meet with the employees for about
6 four hours. One of the things that I always
7 focus on in those meetings is safety conscious
8 work environment and safety culture. Those are
9 two main topics, that even if they don't ask
10 questions on, I make sure I cover. Before I
11 leave the meeting, I give my employees a copy of
12 our business plan, it's marked up, talks about
13 safety. I give them a copy of some other
14 performance things that have recently happened.
15 I found those meetings to be very,
16 very good, and I have gotten overall good
17 comments back from those. From those meetings
18 we've captured -- one of the things that we take
19 actions on. One of the things that we are
20 getting feedback on is some method to see the
21 company -- see the actions that were taken. I
22 have not formalized that process, but at our

1 other two plants we take the actions from the
2 4-Cs and put them on the web page, and we are
3 starting to do that, and the people are tracking
4 what we do.

5 There's been actions we have taken
6 to change the meeting, you know, and we have
7 taken those actions, but I don't think I'm
8 feeding back where that came from, as well as I
9 just know it's happening.

10 Management review items to
11 consider improvements, coming out of those
12 meetings, they have given me a whole bunch of
13 actions that were taken, and from a management
14 standpoint, we have taken those actions. Some of
15 the big things is like the 6/30 meeting, you
16 know, making sure that we focus on the problem or
17 goals of not shooting the messenger necessarily,
18 so we are real blunt in those meetings about some
19 of the things you should do. And we have taken
20 actions in each one of those areas.

21 That finally concludes my
22 presentation. I'd like to turn it over to Fred

1 Von Ahn if you don't have any questions.

2 MS. JARRIEL: I have a question before we
3 go on to the next area. It's Lisa Jarriel at
4 headquarters.

5 In regard to SCWERT, I think a
6 question was asked about the effectiveness of the
7 SCWERT in avoiding discrimination issues and
8 claims, and one of the attributes in the restart
9 readiness review plan is just that, effectiveness
10 of SCWERT in avoiding discrimination complaints.
11 Revision 6 -- between Revision 6 and -- 5 and 6,
12 the criteria was changed, and I wanted to
13 question why specifically. Red used to be that
14 there were five or more N.R.C. allegations or ECP
15 concerns of discrimination submitted within the
16 past year, and now it's within the past six
17 months, so you have made it harder to get red,
18 and I wondered why you changed that criteria.

19 MR. VON AHN: Could you just repeat that
20 one more time? Initially we had if there were
21 five N.R.C. allegations within a year we would
22 turn red, correct?

1 MS. JARRIEL: Yes.

2 MR. VON AHN: Now in a shorter period six
3 months, if there is five allegations, we would
4 turn red?

5 MS. JARRIEL: Right.

6 MR. VON AHN: So, in fact --

7 MS. JARRIEL: You have had five allegations
8 at the N.R.C. in the first three months of 2003,
9 you have one more in the next three months, and
10 so it's gotten harder to get red, and I just
11 think that is a less conservative attribute,
12 criteria, I'm wondering how you came to that
13 decision.

14 MR. VON AHN: I need to review that with
15 you off-line because I'm not understanding. If I
16 have five cases, now I've shortened that to six
17 months, I must be misunderstanding something.

18 UNIDENTIFIED SPEAKER: It turns red
19 quicker. If you have three allegations in the
20 first six months of a year and then you have
21 another three allegations in the second six
22 months of the year, you don't hit red and yet you

1 have had six allegations in one year.

2 MS. JARRIEL: It now makes you yellow or
3 white.

4 MR. VON AHN: We will look at that and
5 correct that, Lisa.

6 MR. MYERS: That's a good comment.

7 MR. VON AHN: That was not the intent, as
8 evidenced by my response. We will correct that.

9 Today I'd like to discuss
10 oversight effectiveness of some of the actions to
11 improve safety culture at the Davis-Besse
12 station. There are four areas in assessment of
13 safety culture effectiveness I'd like to address
14 today.

15 The first area is station
16 attention to safety conscious work environment.
17 This is such an important subset of safety
18 culture. The second item I'd like to discuss are
19 the actions leading to Mode 4 as they relate to
20 safety culture. The basis for these discussions
21 will be the quarterly assessments as well as
22 special assessments completed during -- prior to

1 Mode 4 testing by quality assurance.

2 Next I will discuss the
3 observations during Mode 4/3 execution. These
4 will be discussed as they relate to the model
5 developed to observe the normal operating
6 pressure, normal operating temperature testing
7 activities. And finally I will draw conclusions
8 as to what our observations are telling us with
9 the data to date. Next slide, please.

10 In the area of safety conscious
11 work environment, some of the primary actions
12 that have been completed are an Employee Concerns
13 Program initiation, completion of two safety
14 conscious work environment surveys, and Safety
15 Conscious Work Environment Review Team
16 initiation.

17 The ombudsman program was a
18 program that was transported in late 2002 to a
19 more formal employee concerns program. The
20 ombudsman program was more of a referral type
21 program, transformation to an employee concerns
22 program, gives a more independent organization,

1 as well as resolution to the issues. The
2 performance indicators on this program show that
3 it is positively influencing safety conscious
4 work environment.

5 Two surveys have been constructed,
6 one in August of 2002 and a second in March,
7 2003, to determine what kind of safety conscious
8 work environment exists, and the trends of that
9 safety conscious work environment going into
10 little more detail into those late into the
11 presentation.

12 Finally, the Safety Conscious Work
13 Environment Review Team has been established in
14 the fourth quarter of 2002. This review team
15 reviews all disciplinary activity above a verbal
16 reprimand to ensure that a healthy safety
17 conscious work environment is upheld.

18 Effectiveness of the actions are
19 measured by quarterly performance indicators that
20 are rolled up to the four pillars seen earlier.
21 These performance indicators show improving
22 trends.

1 The next slide shows employee
2 concerns contacts versus N.R.C. allegations, and
3 from the year 2003 there is a couple of takeaways
4 from this slide. First, you see that the
5 employee concern contacts is very high. This
6 shows that the employees are using the normal --
7 the Employee Concerns Program, which shows a high
8 level of trust for that program. You can see
9 there is 157 year-to-date employee concerns
10 contacts and 16 through July N.R.C. allegations.

11 Does that answer your question?

12 MS. PEDERSON: It does. It brings up a
13 follow-up question though. Have you looked at
14 this to gain insights as to why people are using
15 the ECP versus the CAP or another mechanism?

16 MR. VON AHN: The preponderance are
17 management issues. We slice these into
18 mechanical and technical issues, probable HIRD
19 issues and retaliatory issues. The clear
20 preponderance is management issues where there is
21 a problem between management and worker, and
22 these are addressed at various levels. In some

1 cases, the manager is counseled, some cases it's
2 through HR and other mechanisms.

3 MS. PEDERSON: For those that may be
4 technical in nature, is there a way in which
5 those things get reviewed in a timely fashion to
6 ensure there is not a safety issue, a technical
7 issue that is being in this program versus being
8 in another program?

9 MR. VON AHN: Yes, and we would also --
10 yes, they are reviewed on a timely basis. We
11 would also look at the reviewer to make sure he
12 has the appropriate skill level to review those
13 types of issues.

14 MS. PEDERSON: Okay.

15 MR. BEZILLA: These would typically show up
16 in -- like if it's a technical item, that would
17 show up in the corrective action process, if
18 anonymous, if you will, and find out the
19 technical piece of that, and if there is
20 disagreement, we'd have a different professional
21 opinion process we can use to get it raised up
22 even farther, if needed, from a technical

1 perspective.

2 MS. PEDERSON: The thing I want to ensure
3 is that if someone utilizes this process for a
4 technical issue that was examined by the right
5 kind of people and the right time frame to ensure
6 it didn't linger out there in a different
7 process, the ECP process.

8 MR. MYERS: We go over each one of these
9 with the -- we go over each one of those in the
10 report ourselves monthly, so if there is nothing
11 lingering around by the end of that session, we
12 have a good idea what we have, you know.

13 MS. PEDERSON: But if somebody raises an
14 operability issue through the CAP, you wouldn't
15 want to wait for a monthly report.

16 MR. VON AHN: If there's a safety issue we
17 would address it through the corrective action
18 program anonymously, rate the technical issue,
19 but not obviously compromise the individual
20 confidentiality.

21 MR. GUDGER: What Fred is saying, the
22 investigator will issue a report and separate the

1 two issues, but the technical goes into the

2 technical corrective action program.

3 MS. PEDERSON: Thank you.

4 MR. PHILLIPS: You are monitoring this

5 program for trends?

6 MR. VON AHN: Correct.

7 MR. GRANT: Along those lines, any time you

8 give a bar chart like that, you do some trending.

9 It looks like it's trended to ECP I read. If

10 it's trending down over the year, and how do you

11 -- how do you assure yourselves that that is --

12 that that is positive as opposed to people giving

13 up on the program and just not coming to it

14 anymore?

15 MR. VON AHN: In general what we do is go

16 back to the individuals and do a post survey with

17 them, and try get the information back, was the

18 ECP helpful, did it answer your concerns, were

19 your concerns addressed? And in general we have

20 had positive comments when we have gotten those

21 surveys, post-usage surveys returned. There is

22 no -- we have asked the question, is there other

1 ECP data out there to benchmark against, see how
2 we are doing, and that is not something that is
3 out there in the industry.

4 MR. MYERS: There is about four questions
5 about how effective this is, how you trust it and
6 everything else, so because of the threshold,
7 because of the numbers being low, a lot of people
8 feel --

9 MR. GRANT: And you feel you are getting
10 feedback that says that they trust the program,
11 they believe it's worthwhile in lowering numbers
12 in this regard?

13 MR. VON AHN: We feel the lower numbers are
14 positive. We also feel because of the positive
15 feedback, the workers will go to a co-worker and
16 say, hey, use the Employee Concerns Program if
17 you have a concern, if you feel that that
18 methodology is a good, you know -- by the
19 positive feedback for others to use.

20 MR. GRANT: Thanks, Fred.

21 MR. GROBE: Fred, do you have a sense for
22 how this performance of the Employee Concerns

1 Program compares with your prior ombudsman
2 program?

3 MR. VON AHN: There was less trust,
4 especially for confidentiality in the ombudsman
5 program, and there is trust of the
6 confidentiality of this program than an
7 independent investigation, and also the folks get
8 feedback upon resolution of this issue, so I
9 think this is a better program from all those
10 aspects.

11 MR. GROBE: Do you have a sense of the
12 ombudsman program of the number of contacts per
13 year?

14 MR. VON AHN: It was less. I don't know
15 the exact numbers, but I know they were less.

16 MR. MYERS: At one time the number of
17 N.R.C. allegations was much higher than our
18 contacts. That is completely flipped around, and
19 if you go look right now and you ask people about
20 the quality of the program and the survey
21 results, it's over 95 percent of the people would
22 not hesitate to use that program if they wanted

1 to. That is what I'm really pleased about more
2 than anything else is that a year ago they would
3 go to their supervisor, but would not go to the
4 managers, today they would go to the managers or
5 supervisors in over 95 percent confidence level,
6 so we are real pleased with that.

7 MR. GROBE: Thank you.

8 MR. VON AHN: Next I'd like to go into the
9 March, 2003 safety conscious work environment
10 results. There was significant improvement over
11 the results of the 2002 survey, we generally saw
12 improvement in the categories. However, there is
13 continuing need for site-wide improvement in
14 management espousal of basic principles in
15 dealing with workers. These principles are
16 designed to help focus on issues and resolutions
17 rather than people and personalities. They are
18 posted throughout the site. These need to be
19 reinforced. There was also indication of
20 continuing need for management to reinforce
21 safety over cost and schedule.

22 Continuing on to the next slide,

1 there was the need for rigorous follow-through on
2 Corrective Action Program improvements. It was
3 acknowledged that the Corrective Action Program
4 changes had occurred, but there was need for
5 follow-through indicated.

6 There was -- there was also
7 continuing opportunities for site-wide management
8 of safety conscious work environment with
9 contractors. Contractor responses in general
10 were more negative, specifically in the
11 retaliatory and HIRD questions, and we will go
12 into the slide. There is a slide later that
13 shows that, and we will go into that a little
14 more.

15 The survey also showed pockets in
16 plant engineering, radiation protection and
17 chemistry and maintenance with a higher negative
18 response rate. This concerned us, so we did
19 follow-up pointed surveys with our employee
20 concerns manager to these areas specifically, as
21 well as the contractors issue to find out what
22 that was telling us.

1 MS. PEDERSON: Will you be telling us what
2 you are doing in response to those?

3 MR. VON AHN: Yeah, I could tell you right
4 now. Specifically the issues in radiation
5 protection and chemistry and plant engineering
6 had to do with leadership in place, as well as in
7 the case of plant engineering, the lack of
8 leadership. That has since been stabilized, and,
9 in fact, when the follow-up surveys were done,
10 there had been a change out in leadership and
11 radiation protection, and was pretty much an
12 immediate turn-around. And that was fed into the
13 follow-up survey, so the follow-up survey showed
14 that there was adequate action taken already with
15 leadership changes to correct the problem.

16 MS. PEDERSON: How about contractors?

17 MR. VON AHN: The contractors -- and I'm
18 going to go into that on the next slide a little
19 bit. I'd like to go to the next slide, which
20 actually shows 2002 and 2003 comparison of survey
21 results, and these have to do with the negative
22 responses to the retaliation questions and the

1 HIRD, which is harassment, intimidation,
2 retaliation and discrimination behaviors.

3 You can see that in Questions 7,
4 30 and 36, the contractors' responses were more
5 negative in the 2003 survey than in the 2002
6 survey. Follow-up -- again, follow-up pointed
7 questions were asked, follow-up surveys were done
8 of the contractors to find out what was going on
9 here, because it did trouble us, and there was
10 some questions by the contractors on what the
11 question meant, that is -- in their mind it meant
12 had anybody ever been subjected in the last month
13 to HIRD activity, and this meant at other sites
14 as well as the Davis-Besse site.

15 The contractors indicated that
16 there was that question, or showed some confusion
17 in that area, and our follow up question showed
18 that there were not 50.7 issues, but more issues
19 of management-worker relationships.

20 MR. THOMAS: Can we go back to -- you
21 mentioned corrective actions for -- to improve
22 rad protection performance was change out of --

1 put in place new managers, senior manager level
2 individuals, and one individual in particular
3 that I think you are referring to was an inactive
4 position and not going to be there permanently.
5 I was wondering if the other individuals that you
6 put in place are sufficient to maintain
7 improvement performance in that area, or when
8 that individual leaves, will the performance
9 start to decline?

10 MR. LEIDICH: I can address that. The
11 individual you are referring do is really a new
12 hire from several months ago, that was our --
13 really a corporate RP manager, RP programs
14 perspective, so his overall assignment, we were
15 in the process of recruiting for that position
16 outside the company for an RP manager for
17 Davis-Besse. But his follow-up assignment would
18 be a corporate oversight for RP across all three
19 of our stations, so even though he is performing
20 in a function now at Davis-Besse, when his
21 replacement is named he will be performing in a
22 broad spectrum across all three plants, so he is

1 not going to let go of that overall
2 responsibility when that occurs though. That is
3 our game plan in terms of that job.

4 MR. VON AHN: And obviously we will
5 continue to monitor and see if there is -- next
6 slide. Activities leading to --

7 MS. JARRIEL: Before you go on, this is
8 Lisa Jarriel again. The two HIRD questions that
9 you explained were not well understood you
10 believe by the contractors answering them. What
11 do you plan to do for your October/November
12 survey with those two questions?

13 MR. VON AHN: We will clarify the questions
14 to make sure that is understood or get the
15 responses that are particular to the Davis-Besse
16 station.

17 MS. JARRIEL: You will ask the questions
18 but in a more clarifying manner?

19 MR. VON AHN: That is correct.

20 Next, activities -- are there any
21 other questions on that particular slide?

22 (No response.)

1 MR. VON AHN: Next is activities leading to
2 Mode 4 as they relate to safety culture and
3 safety conscious work environment. First,
4 operations leadership. Operations leadership has
5 made headway in terms of leading the station in
6 safety culture in activities leading up to Mode
7 4. We see this is QA mode, operability
8 evaluations and restart readiness, supporting
9 groups, engineering, maintenance. Other groups
10 have had a positive contribution to support of
11 pre Mode 4 activities.

12 However, station safety culture in
13 some areas has some improvement to be made.
14 Positives seen were the restart oversight plan,
15 management oversight of critical activities.
16 However, areas for improvement were managers
17 challenging one another, specifically in the
18 morning condition report categorization meeting,
19 managers tend not to challenge one another. They
20 will come prepared on their condition reports,
21 but not challenge each other, probe into
22 condition reports, categorization of other areas.

1 And in initial restart readiness
2 meetings we saw a little -- or we would have
3 liked to have seen more challenging between the
4 managers in other areas than their own.

5 Next slide, please. Next is Mode
6 4 execution. What I'd like to talk about in the
7 upcoming slide is our measurement model, the
8 observations during Mode 3 -- Mode 4/3 and final
9 conclusions. The next slide, please.

10 This slide depicts the model used
11 during the execution of the seven-day normal
12 operating pressure, normal operating temperature
13 testing. The overall concept here was to have a
14 series of checks and balances, so that data was
15 obtained from various sources so we could get a
16 balanced view of the station's performance.

17 Working briefly in the model, if
18 you go to the center, the center shows the
19 plant's staff, the plant's staff responsibility
20 to the safe, conservative plant operation,
21 management oversight of the plant staff was
22 expected during the evolution, as well as

1 exterior line assessment of both plant management
2 and plant staff.

3 Overseeing plant staff activity is
4 independent internal oversight, quality
5 assurance, looking at plant staff activities, and
6 then finally looking down below in the box,
7 external operational assessment. External
8 operational assessment was to look at both
9 quality assurance and the plant staff to assure
10 that root cause issues had been addressed or
11 looked for deficiencies in either of those areas.

12 The products from each of these
13 activities is a report that will be funneled into
14 a final readiness report, and these final reports
15 are being drafted at this time. Next slide,
16 please.

17 With regard to Mode 4/3
18 observations, external observations were
19 conducted by senior executives from various
20 stations, most have previous senior reactor
21 operator licenses. External observations
22 generally lined up with oversight observations,

1 and I will actually cover these in tandem since
2 they are the same type of observations. External
3 operations also noted one area for improvement in
4 quality assurance, which I'm going to address.
5 It addressed the familiarity of the quality
6 assurance individuals with the folks that are
7 overseeing because of previous activities, and we
8 are going to look at rotations within quality to
9 address that issue.

10 On the positive, what was seen is
11 rapid elevation of issues related to safety, to
12 appropriate levels of management to address.
13 Also seen was the ability of the shift managers
14 to challenge and push back to senior managers
15 when needed. Additionally, a positive was needed
16 on the suspension of heat-up activities when the
17 potential for plant equipment problems to
18 challenge safety was seen.

19 Additionally, recognition of the
20 opportunity to use decision processes was a
21 positive. However, there was a downside to this
22 demonstration. There was a demonstrated

1 unfamiliarity with the use of the problem-solving
2 process. Quality assurance would not have
3 expected to be on a learning curve for this
4 activity and would have expected that the
5 problem-solving process would have been well in
6 hand since it had been in place for about a year.

7 Additionally, standards needs
8 improvement, standards in the way of three-way
9 communication, use of the phonetic alphabet, and
10 procedural issues were at a level of detail and
11 procedure needs to be improved, all of these
12 standards need to be improved.

13 And you ask, how does standards
14 relate to safety conscious work environment or
15 safety culture. Standards are the key, they are
16 a leading indicator, if you will. If the
17 standards start to break down, that safety
18 culture safety conscious work environment could
19 be soon to follow. So there is improvement
20 needed in the standard.

21 Additionally, the ability of
22 operations to look ahead and anticipate

1 operational challenges was inconsistent. This
2 was seen both with the core flood issue, as well
3 as a myriad or significant number of other
4 issues, more than we would have expected for this
5 activity.

6 With regard to internal
7 management. The assessment by external
8 management and quality assurance is that the
9 internal management self-criticality needs
10 improvement. The management observations were
11 not critical enough from the internal management.
12 External observations were significantly more
13 critical, so that needs improvement.

14 MR. THOMAS: Can you help me understand
15 what you are hoping to see, or the product of
16 what the internal management is?

17 MR. VON AHN: We were expecting to see
18 significantly more condition reports generated as
19 a result of management observations. We were
20 expecting to see more unsats as a result with
21 coaching opportunities, and we didn't see as much
22 of that as we did with the external observations.

1 The external observations were more critical, and
2 that will go to some of the conclusions I will
3 talk to you about, or some of the recommendations
4 we have made to station management about what
5 they need to do to take care of that activity.

6 MR. THOMAS: That was going to be another
7 question, so you say you are going to cover that?

8 MR. VON AHN: That will be in the next
9 slide.

10 These are the types of
11 observations we saw during Mode 4 testing. Our
12 conclusions based on this were that in general
13 the station demonstrated improving safety culture
14 in pre Mode 4 activities. With regard to Mode 4
15 activities from a safety culture standpoint,
16 quality assurance observed vigilance in elevating
17 emergent issues to the appropriate level of
18 management. The organization stopped to address
19 emerging issues with potential to have safety
20 impact, and the -- however, quality assurance
21 also observed that the organizational address of
22 issues can be improved.

1 The station uses the
2 troubleshooting procedure, but it needs -- the
3 addressing of those procedures needs to be
4 improved somewhat in timeliness, and actually,
5 continuing along with the extent of condition and
6 the total evaluation of the issue, there can be
7 some improvement there.

8 With regard to safety culture and
9 safety conscious work environment, there will be
10 a follow-up survey, but we have seen improvement
11 in safety culture and safety conscious work
12 environment, both by our performance indicators
13 and by the surveys given to the station. The
14 recommendations that oversight has provided to
15 the station are as a result of the deficiencies
16 we have seen in the Mode 4 activities. Those
17 recommendations are to strengthen some aspects of
18 operational training, to improve management
19 observation skills, to implement the fleet-wide
20 condition report trending program and to augment
21 plant staff with external observers to act as
22 coaching mentors to improve the criticality or

1 self-criticality of the internal management

2 staff.

3 MR. THOMAS: Will that be documented in the
4 final report?

5 MR. VON AHN: They will be documented as
6 part of our final ratings, and the appropriate
7 corrective action process will be used.

8 MS. LIPA: You talked about another survey
9 in safety conscious work environment.

10 MR. VON AHN: Correct.

11 MS. LIPA: Is that plan sufficient for
12 restart, factoring in results for the assessment
13 for restart?

14 MR. VON AHN: We are looking at that, and
15 if it's not, we will adjust the schedule, because
16 that needs to be done.

17 MS. LIPA: Thank you.

18 MR. VON AHN: Other questions?

19 MR. RUETER: On the radiation protection
20 management -- I'm Jack Rueter, I work for
21 radiation protection. Seeing how that is my
22 boss' boss' boss, I work in radiation protection.

1 The other radiation protection managers that are
2 not currently there, they led to a bit of
3 confusion and not proper leadership. The current
4 person we have now does provide very good
5 leadership and management. He has in place two
6 superintendents, one over RP manager operations
7 and over the ALARA people that plan to stay, so
8 that will provide some continuity when we get
9 another manager in place. So I'm confident that
10 when we do get another manager in place, we will
11 fit in, or as Mr. von Ahn said, the indicator
12 will indicate that management needs to correct
13 the situation.

14 MR. VON AHN: Thanks, Jack.

15 MR. MYERS: Okay. Mark?

16 MR. BEZILLA: Thanks. Next slide, please.

17 What I'd like to address is the
18 safety culture remaining actions for restart, and
19 they are as follows: First we need to complete
20 our 50.9 completeness and accuracy of information
21 training for all of the Davis-Besse employees,
22 and we are doing training to ensure the people

1 understand the importance of writing to you all
2 with complete and accurate information and to
3 ensure that they understand the importance of
4 making sure our records and documents are
5 complete and accurate, whether that is logs,
6 rounds and readings, corrective action
7 documentation.

8 The second thing is we are going
9 to complete an assessment of our calculations
10 program. What we did was we contracted Sargent
11 and Lundy to perform an assessment and provide us
12 with recommendations to strengthen the program,
13 and they will do calculations. They also
14 benchmarked us against Exelon, and I believe they
15 are going to provide us with those conclusions
16 and recommendations tomorrow, I think is when we
17 are supposed to get that report. I think an
18 advance copy already went to my boss, but --

19 MR. MYERS: I got an advance copy.

20 MR. BEZILLA: I know that is soon to be in
21 our grasp. The third thing is that we are going
22 to strengthen our corrective action process, and

1 the first piece of that is -- what we are going
2 to do is provide condition report evaluators with
3 apparent cause training, and the purpose of this
4 training is to reinforce our expectations of them
5 in regard to their efforts and conducting
6 apparent cause evaluations, and that being their
7 investigation is of sufficient depth to invite
8 identification of event specifics and those
9 probable cause associates causal factors, related
10 industry and safe operating experience in an
11 evaluation of generic implications.

12 The corrective actions developed
13 address identified cause or all causes and
14 corrective actions developed don't necessarily
15 guarantee events or conditions will not recur,
16 but it may be expected to reduce the risk
17 associated with recurrence. So we want to make
18 sure we have a clearer picture of what we are
19 looking for from an apparent cause evaluation
20 standpoint, so we are going to go and give them
21 specific training.

22 And then the second piece from a

1 corrective action program strengthening is that
2 we are going to put a group together to review
3 apparent causes, and this review group is going
4 to consist of a number of our condition reports
5 analysts, these are our sort of technical
6 experts, and their focus is going to be content
7 and quality of the apparent cause evaluations.
8 And then we will have that group provide feedback
9 to the condition report evaluators to help us get
10 consistency in our content and our quality, and
11 -- in regard to apparent causes.

12 MR. THOMAS: Mark, let me clarify a
13 previous question that I asked about
14 qualifications of the individuals doing root
15 cause analysis. I was more interested in the
16 apparent cause level, I wasn't real clear about
17 that as far as that, has that been a factor in
18 the quality of how the apparent cause --

19 MR. MYERS: Absolutely.

20 MR. THOMAS: That was more my question.

21 MR. MYERS: And we've also got to limit
22 that population, of course we've got plans there.

1 MR. THOMAS: Okay.

2 MR. BEZILLA: Okay. The next slide. That
3 fourth thing is that we are going to conduct
4 alignment and team work sessions with all of the
5 Davis-Besse employees, and what we did was we
6 contracted with a firm called Ed Ventures, and
7 this firm, in conjunction with the Senior
8 Leadership Team at Davis-Besse create learning
9 maps, and I will show you that in a minute if we
10 have time to do that.

11 The purpose of the sessions with
12 our folks is to focus the organization on the
13 future and the key role everyone must play to
14 guarantee Davis-Besse has made plans and can move
15 safely to the desired outcome of the sessions to
16 gauge our progress on establishing a number of
17 identifying programs toward nuclear safety,
18 understand and align with our FENOC vision and
19 strategic objectives and roles the departments
20 play in helping to achieve them, to understand
21 that we must rethink how we do business and model
22 others at top fleet performance, to understand

1 how top fleet performance does not diverge from
2 safety performance, to identify barriers to top
3 fleet performance, to discover how what we do
4 every day directly impacts the success of our
5 station and our fleet, to recognize and
6 appreciate completion of key milestones over the
7 past 18 months at Davis-Besse and within FENOC,
8 to individually complete and hold ourselves
9 accountable for making the required behavioral
10 changes to prevent going back to the way things
11 were and to recognize that this day, meaning the
12 day of the session, is just the first step on the
13 journey. Okay.

14 These sessions are going to be the
15 start of what we are calling a new beginning, and
16 these session we believe will raise our
17 awareness, and that it's now up to us to
18 demonstrate through our attitudes and behaviors
19 that we are to operate Davis-Besse safely and to
20 assure the health and safety of the public.

21 MR. MYERS: Let me comment on that, please.

22 We don't find too many things we are excited

1 about. We think this is unique and new, but we
2 brought up after the report, and some of the
3 safety culture assessment we did. Alignment of
4 the organization went forward, and the things we
5 have to do in the next couple of years, we are
6 going to start up a little larger backlog than we
7 had before. We have got a lot of things to get
8 done in the next couple of years, we've got to do
9 this effectively and efficiently, and primarily
10 safely.

11 And that being said, we -- one of
12 the comments we have got out of the Haber report
13 is make sure your organization understands it's
14 -- the future is not what it looks like. We
15 brought this team in to work our and they showed
16 us this product, and Senior Leadership Team, and
17 we were so excited about it, we didn't want to
18 quit, it was really exciting, some of the things
19 that we went through and to figure out ways to
20 improve the delivery processes and everything
21 else, so, you know, we think this is going to be
22 a good tool for the employees, and of all the

1 things we have done, I'm really excited about
2 this program. I invite you to come and watch.

3 MR. BEZILLA: Jack and Jim, bear with us
4 two minutes.

5 MR. CALDWELL: What is the name of the
6 company --

7 MS. BEZILLA: We contracted with Ed
8 Ventures, E-D Ventures, like adventures, like
9 Educational Ventures is what I think it's short
10 for, and then these are the products. Randy,
11 you've got to speak loudly.

12 MR. FAST: Let me spend a couple of
13 minutes. This is not a vision map, what this is
14 is a map of current reality that brings groups
15 together in groups of about eight to ten
16 facilitating sessions, and there were cue cards
17 and reading for each of the participants, and
18 they come from all over the organization. We
19 have trialed this four different times in the
20 development of this product, but what it does is
21 it really leads the people through a clearer
22 understanding of what current reality is.

1 This is modeled after the Nuclear
2 Energy Institute model for how to operate a
3 plant, the configuration management, work
4 management, equipment reliability and the support
5 functions necessary for safe, reliable
6 operations.

7 So what we do is, we -- a lot of
8 people at the plant take for granted, well, I'm
9 in my area, but I really don't know how I
10 interface or reactor responds to others, so there
11 is a lot of dialogue, conversation actually
12 amongst the participants that talks about who
13 delivers products to me, who I deliver products
14 to and what is the outcome.

15 So we talk about our current
16 performance and the processes that we use to
17 operate the plant. And that sets a standard at
18 least for people to understand the way we operate
19 a nuclear power plant. Let me go to the next
20 one.

21 These are a little different, I
22 have 20, 25 sets of these in production, and we

1 will start this on the 12th of this month to roll
2 out. We have seven scheduled sessions. Now,
3 what you will notice here is that on the overlay
4 is the NEI process. But what it says is to start
5 a new beginning, exploring our future. So these
6 are the first steps in a journey moving forward.
7 This talks about FENOC vision is people with a
8 strong safety focus delivering top fleet
9 operating performance. These are the elements of
10 success that will take our plant forward, our
11 company forward, because this is a FENOC process,
12 so it's one that we are not only using at
13 Davis-Besse, but one that we will use fleet wide
14 in developing really the right standards of
15 operation. This has the values that are
16 developed by our company that talk about what we
17 are all about, what we stand for.

18 We talk a lot about stakeholders,
19 and then the stakeholder analysis and evaluation.
20 We benchmark against standards that the industry
21 has, what are the expectations. Certainly the
22 Nuclear Regulatory Commission is a stakeholder,

1 you are in on this, we have cards and we talk
2 about that. What are your expectations of us to
3 safeguard the health and safety of the public.

4 The last, we have behavioral
5 changes going to, hey, I just work in my own
6 little world, I don't work with others to work as
7 a team. So there were behavior changes, so this
8 is a self-revealing process, and I can tell you
9 that I'm excited about it because I saw what I
10 will say are individual transformational changes,
11 not to mention, certainly I wouldn't talk about
12 individuals, but we had one individual, probably
13 the biggest nay sayer came in, hands folded,
14 didn't want to participate, sat on the side, and
15 we said we are going to proceed on, we are going
16 to figure out what's going on here.

17 The individual was drawn into the
18 process, and by the end of the process, which
19 takes -- this is an eight-hour session -- actual
20 maps take about 90 minutes apiece, and there are
21 some other elements, but by the end the
22 individual was so enthusiastic, he was clearly

1 sitting in the middle of the group and became the
2 natural leader and kind of the rah rah and the
3 charge forward, so it's kind of an exciting
4 process.

5 And so again, not vision maps,
6 these are learning maps, they become
7 self-revealing, and understanding what it takes
8 to operate properly, and then what our standards
9 and expectations are, what our vision is and what
10 it's going to take to accomplish that vision. So
11 we are excited about it, and I think it's going
12 to be an excellent tool in kind of then aligning
13 our folks, we call it alignment and team work
14 session. It's team work, because as we have put
15 these groups together -- I watched four sessions
16 -- I saw people that had not worked together in
17 records management, I'm in operations, I'm an
18 engineer over in configuration, in design
19 engineering, those groups then actually bonded
20 together to form that alliance, and part of the
21 product, the result of that is actually an
22 affirmation by the individuals and the team

1 members, and I actually saw that process where
2 somebody said, hey, I have a problem with the
3 procedure, call me, I can get the procedure,
4 whatever you need, and so we saw that kind of
5 team building that was going on during this
6 process. So we are excited, we would invite you
7 as well to come and observe the process.

8 MR. BEZILLA: Randy, what about the safety
9 culture? I thought there was like surveys.

10 MR. FAST: There sure is. This process is
11 that when we have the alignment and the --
12 understanding the next steps that we go through,
13 which I don't have the maps for because they are
14 really not maps, but it's a, let's go back to
15 basics about what is the safety culture, what is
16 the model, what is the definition, how do we
17 gauge safety culture and so we are going to have
18 an interactive dialogue amongst these teams, and
19 then there is a product that is delivered from
20 that, and that is the -- each individual then can
21 actually make their own proclamation about where
22 do I believe the management and individual

1 contribution to safety culture is and rate that
2 anonymously, and then take it down, I work in the
3 maintenance department or I work in operations, I
4 work in engineering, and then we will direct
5 that, so we are going to get about 800 plus
6 pieces of data, which then we will dissect,
7 evaluate and roll out to the managers, because
8 really that is coming from our work force that
9 said, here is where we think we are, and they can
10 write suggestions, comments down and see if they
11 think that we are not talking the talk, we were
12 not demonstrating the basic contributions, they
13 can write that down, and that's okay, we want
14 that feedback, we need that feedback, that will
15 really help us to perform a better assessment for
16 Mode 2.

17 MR. PHILLIPS: Did I understand you to say
18 the groups that are involved in this whatever you
19 want to call it, training session, are
20 selectively picked to have cross departmental --
21 MR. FAST: Yes, sir, yeah, I wouldn't -- we
22 won't have two mechanics sitting next to each

1 other, we are going to have --

2 MR. PHILLIPS: Mechanics?

3 MR. FAST: They are assigned to a table,

4 the table has a facilitator, we've got about 30

5 to 35 facilitators, they start training on

6 Monday, so I'm excited about that part as well.

7 MR. MYERS: This is an interactive process,

8 I can assure you.

9 MR. FAST: It's very interactive, it's

10 based on conversations, and you think about what

11 changes culture, what changes culture is what is

12 talked about at the water cooler, it's

13 communications, conversation between employees,

14 that is what drives organizations, and this

15 creates the opportunity for conversation.

16 MR. BEZILLA: Thank you. Thank you, guys.

17 Two more of the five items, to

18 identify and reflect and act on the lessons

19 learned from the recent normal operating pressure

20 test. We will address plant people and process

21 issues throughout the normal operating pressure

22 test period we have identified through

1 observation, data base and your corrective action
2 process.

3 Opportunities for improvement,
4 Frank talked about the internal management
5 observations, the quality observations as well as
6 the external observations, we will also have that
7 product, which is currently being drafted up, and
8 it will be finalized I suspect in the next week
9 or so. And what we will do then is we will
10 capture all those opportunities for improvement,
11 and then we will address those issues as
12 appropriate prior to restart.

13 So the operating pressure test
14 before gave us a real good opportunity to check
15 out the plant, check out our people, check out
16 our processes. I think we have like 80
17 observations over that period for management, we
18 have got a Q.A. observation, we have got external
19 observations as well as self-revealing events
20 that we have captured, either in the observation
21 process and/or corrective action, observation
22 data base or corrective action process, so we

1 think we have got a real good pool of information
2 to figure out what we want to do between now and
3 restart from a plant people and process
4 standpoint.

5 And then the last thing from a
6 safety culture readiness for restart standpoint
7 is we will, when appropriate, conduct restart
8 readiness reviews, and I will say this is our
9 final assessment and checks of our plants, other
10 people and processes readiness for restart.

11 And that review process also
12 includes a review and recommendation for restart
13 from our Station Review Board, which is our
14 internal safety and operational review group, our
15 Company Nuclear Review Board, which Lou talked
16 about earlier. That is our external safety
17 operational review group, and then our Restart
18 Oversight Panel, which is an external group we
19 put together here to monitor performance through
20 this outage period and through the restart
21 effort.

22 So these are the items from a

1 safety culture perspective that we feel need to
2 be completed prior to restart. If there are no
3 questions, I will turn it over to Gary.

4 MR. GROBE: Gary, it may be time to stop
5 for another break. You've got several slides
6 here, and then we go into the presentation by
7 Randy. I'm not sure, I will leave it up to you
8 as to when you want to break, I'm not sure if it
9 makes sense to break now.

10 MR. LEIDICH: I think we can do that
11 because really we are going to go to having said
12 all that, where are we going long-term, so this
13 is a suitable time.

14 MR. GROBE: Great. Let me make a couple of
15 observations before we break. We have several
16 public meetings next week. On Tuesday there is
17 an afternoon business meeting with First Energy,
18 which will be conducted at Camp Perry. The
19 significant focus of that meeting is going to be
20 on the results of the normal operating pressure
21 test, both from a standpoint of the results of
22 the test itself, leakage results of the test

1 itself as well as other recommendations that came
2 from that, and we are going to get into great
3 detail in that meeting on the normal operating
4 pressure test.

5 And then a public meeting in the
6 evening, meetings with the public in the evening,
7 and then the following day we have public
8 meetings at the Davis-Besse administration
9 building on-site to discuss the results of two
10 recent inspections, and we have kind of touched
11 on those issues throughout the first part of this
12 presentation.

13 Those two inspections, one covers
14 the corrective action program effectiveness and
15 the other one has to do with systems readiness
16 for restart. So we will have that public
17 dialogue and the result of those inspections
18 Wednesday morning at the Davis-Besse
19 administration building. So those are two
20 meetings where we are going to get into a lot
21 more detail -- or actually three meetings where
22 we will get into a lot more detail on some of the

1 issues we barely touched on during this
2 presentation.

3 So why don't we take a ten-minute
4 break and be ready to go at ten to 4:00.

5 (Whereupon, a recess was
6 had, after which the
7 meeting was resumed as
8 follows:)

9 MR. LEIDICH: We'd like to shift to longer
10 term focus, a couple of pieces of that, and the
11 piece I'd like to cover is really from a
12 corporate perspective, and as has already been
13 alluded to we have a revised vision for the First
14 Energy Nuclear Operating Company.

15 The Executive Leadership Team met
16 at the end of June in an off-site meeting to work
17 through that vision, and that vision is on Slide
18 63, as can you see, people with a strong safety
19 focus delivering top fleet operating performance.

20 There are several messages in
21 there. Of course, first and foremost is people,
22 but the strong safety focus is integral to our

1 vision going forward. It's about delivery, it's
2 not about efforts, it's about results. It's
3 about top performance from an operational
4 perspective, and it's about the fleet -- taking a
5 fleet-wide view in everything we do. So that
6 vision was carefully structured over that two-day
7 period with the process of rolling that out. So
8 as you visit the stations, you will see the
9 signage accordingly. Page 64 talks about our
10 approach, and our approach is really a very
11 simple template.

12 Given that vision, we have
13 developed five strategic objective areas, safe
14 plant operation, people development and
15 effectiveness, excellent material condition,
16 improved outage performance, fleet efficiency and
17 effectiveness.

18 At this stage we have developed 18
19 performance metrics. In those five areas,
20 working our way through those goals and metrics,
21 and definitions of this period of time, and what
22 you will see is really an integrated approach to

1 accomplish a vision across the fleet and all
2 three stations, in the corporate office and
3 through the teams and metrics across the entire
4 organization.

5 If you saw Randy's map, that is
6 really an integral part of what we are rolling
7 out at Davis-Besse, and really in the process of
8 doing that across the fleet, what it really looks
9 like from an organizational effectiveness
10 perspective is really identified on Slide 65, and
11 these are the things that we keep an eye on.

12 First of all we have got trust.
13 In our work force, we've got leaders that are
14 trusted by the employees. You know, 90 percent
15 of what we do is just communications, so if you
16 are into a vision, you understand standing in a
17 different place, if you will, the way to effect
18 that is through open communication, and what you
19 say, what you do to listen. We have demonstrated
20 respect for each other, we have a team to
21 evaluate feedback and input, have we got good
22 accountability, team work across the

1 organization, of course, with the safety
2 conscious work environment. Do we have a
3 willingness to go up here and address problems,
4 and are we involved, is management involved in
5 activities and decisions.

6 And I think across the fleet we
7 have got a renewed interest and high level of
8 involvement with daily telephone calls. From an
9 operational standpoint we are actively engaged as
10 executives in running this fleet.

11 And one of the things that we are
12 doing going forward is we are transitioning to a
13 corporate organization, and one of the jobs that
14 we recently announced is an organizational
15 effectiveness director. And that individual is
16 Randy Fast. And, of course, Randy has been
17 actively engaging in the Davis-Besse culture
18 change, if you will, and his assignment is to
19 finish that work at Davis-Besse and then take
20 that work and approach that on a fleet-wide basis
21 to ensure that we have got long-term, solid
22 staying power with what we are doing across the

1 fleet.

2 So I'm going to turn it over to
3 Randy, and he is going to talk about the actions
4 that he's up to, not only at Davis-Besse, but
5 across the entire organization. So, Randy?

6 MR. FAST: Thank you, Gary. First, I'd
7 like to say I'm excited about this opportunity
8 for me personally, and working with each of our
9 stations.

10 I'd like to spend a few moments to
11 review the actions that we have taken, First
12 Energy Nuclear Operating Company, to anchor
13 long-term improvement. Anchor is an interesting
14 word, isn't it, that I kind of learned. Lou used
15 to talk about hooks and procedures or places
16 where you have point of connection. The anchor
17 is a term that we are using in 50.9. I went and
18 looked at all of our documentation in preparation
19 for this, is it backed by procedure, by policy,
20 by a practice that is institutionalized in the
21 way that we are going to do our business, and can
22 I give you my personal assurance we have got a

1 machine here that we put together that is -- it's
2 up to Lew, things like 4-Cs meetings, it's not
3 just something that Lew espouses and participates
4 in, but it is a business practice, so it's
5 institutionalized and it's anchored.

6 The first thing I was going to
7 talk about, just reiteration, but our new
8 officers at the corporate level, Gary, Lew, Joe,
9 Mark, Fred, are all examples of an organization
10 that is built to last. So a lot of things that
11 we have done in the improvements are in the plant
12 systems.

13 Davis-Besse is an older station,
14 and some of the lessons that we have learned we
15 are sharing with the industry, but the
16 containment sump improvements that we have made
17 here, the containment air-coolers, boron
18 precipitation, high pressure injection
19 recirculation, the things that we talked about,
20 we were the first domestic company in the United
21 States to have a leak detection and monitoring
22 system, a diesel air start, as well as programs.

1 So those are -- material discussions continue,
2 but we have what I think are industry-leading
3 boric acid corrosion control program, operating
4 experience program we use internally and
5 externally, and the fleet detection and latent
6 issue programs that are institutionalized,
7 proceduralized for Davis-Besse and for First
8 Energy Nuclear Operating Company. The next slide
9 please.

10 Improvements in personnel
11 performance, just a laundry list, just get some
12 of the highlights back in the case study, there
13 was a bit of a water shed and really defining
14 clearly what were the conditions. We provided
15 individuals clarity and understanding of what led
16 to that event, and so that we were able to then
17 capture the attention of our folks, and then that
18 built a framework then going forward.

19 New training for managers and
20 supervisors on nuclear safety focus and
21 professionalism, that is institutional
22 identification in our leadership or action

1 programming that the development of our new
2 supervisors, but as well as in our what was
3 called ownership for excellence transition is
4 part of the First Energy process in performance
5 management.

6 Department level expectations
7 across the board that really demonstrate what our
8 standards and our expectations are, so every
9 organization that is there has documented the
10 standards and expectations for the department and
11 employee performance.

12 Improvements in communications and
13 teamwork, 4-Cs, the all-hands meetings, all
14 examples of where we are trying to communicate
15 with our folks the alignment of our management
16 personnel. Lew talked about the executive
17 leadership team and getting together and forging
18 a new future as well as the Senior Leadership
19 Team has gotten together, really talked through
20 roles and responsibilities, actions that we are
21 going to take going forward, we have extended
22 that to our managers and talked about the

1 learning maps, extending that on to all of our
2 personnel.

3 The improvements in personnel
4 evaluations, I talked about that ownership for
5 excellence, that really was developed as part of
6 our First Energy Talent Management Group,
7 leadership development using the RHR, really that
8 close scrutiny in our personnel performance and
9 understanding what things we need to do to have
10 what RHR calls the right stuff.

11 Our operations leadership plan
12 started with just turnover process, where, when,
13 what are we going to talk about, who are we going
14 to involve, and then it permeates the whole
15 organization. We talked about the new employee
16 orientation manual, but that's why we
17 institutionalized the new employee orientation
18 manual, because that's a challenge for the folks
19 that have lived through this. We have a pretty
20 good understanding about what's transpired, but
21 what about that new employee, that new engineer,
22 that new non-licensed operator, that new

1 instrumentation control technician, they need to
2 understand what our standards and expectations
3 are, so that is institutionalized, our new
4 employee orientation manual. The next slide,
5 please.

6 Program reviews and benchmarking,
7 and I just can't say enough about the corporate
8 oversight, and as I have had several days
9 experience in Akron working with the folks there,
10 they focused on industry best performance and
11 then bring it to the fleet.

12 Corrective action program
13 improvements, we have talked about our employee
14 concerns program, and I do believe as well from
15 my discussions with employees that there is a
16 great understanding and a belief that the
17 Employee Concerns Program will bring them relief
18 to the questions and concerns that they have.

19 Our operating experience program,
20 radiation protection program, Jack talked about
21 that. We really -- we know the procedures and we
22 have some -- we have state-of-the-art equipment

1 in the organization, so that has created
2 alignment and high standards going forward.
3 Boric acid corrosion control and
4 leak detection, I believe that these are industry
5 best, one of the -- one I will say foundational
6 thing that was done which really built teamwork
7 and alignment from operations and support
8 organizations, principally engineering was our
9 operability evaluations, and we did two days
10 training on that. I participated, the other
11 directors at the site, managers, and key
12 individuals. We had over 100 people that went
13 through that training, but really a team approach
14 to solving problems, and we know based on
15 regulatory feedback that operability evaluations
16 were -- they needed a lot of room for
17 improvement.

18 We have not arrived, but we are
19 continuing to grow, and we are working on that as
20 a team. Many examples, we have talked about the
21 problem-solving and decision-making. Next slide,
22 please.

1 MR. THOMAS: Randy, on the slide prior, you
2 had talked about operations leadership, and I was
3 wondering if you, or not necessarily you, but any
4 member of FENOC can have an assessment to the
5 degree which they believe that operations has
6 assumed that leadership role?

7 MR. LEWIS: Art Lewis, shift manager of
8 operations. Mike Router has put out a document
9 not very long ago that listed numerous instances
10 where shift managers have had to stop work
11 because everybody is trying to get a job done,
12 get the plant on line. Operations, as
13 illustrated in a couple of the slides, has
14 elevated the review. SRO operability for
15 condition reports, operations has stepped forward
16 and the equipment operators auxiliary operators
17 have just said -- I asked my crew if we couldn't
18 deal with a concern that you have as an employee,
19 what would you do with it? He said we'd bring it
20 to you. What if I can't resolve of it? They
21 will take it up a notch to the superintendent or
22 operations manager. And I said, if you can't get

1 resolution there, what do you do with it?
2 Employee Concerns Program. So even the lowest
3 denominator to very important person still has
4 stepped forward and is trying to lead the
5 facility and step it up a notch to meet the
6 requirements, and that is required of us.

7 MR. THOMAS: And when they do that, what
8 type of response do they get from the
9 organization? Is the organization receptive to
10 those concerns, or --

11 MR. LEWIS: Very much so. There was a
12 concern about a leaky pipe, he submitted a
13 condition report, brought that to a shift
14 manager, shift manager elevated it and
15 engineering walked out in the plant with an
16 equipment operator that identified it, it was a
17 design engineer. To make a long story shorter,
18 isolated the system, cut the pipe out. It was
19 nearly plugged, corroded with corrosion products,
20 it was because of that and the engineering
21 involvement that made that system successful
22 again. Quite a bit -- 200 feet of pipe got

1 replaced. Other EOs have told me about
2 engineering getting involved, coming out to seek
3 understanding on condition reports that they have
4 submitted, and that interaction is getting more
5 and more predominant, and everybody's learning
6 curve increases.

7 MR. THOMAS: Okay.

8 MR. GUDGER: I will add to that, in
9 regulatory affairs we see the shifting down and
10 making assignments to the staff engineer, as well
11 as the regulatory affairs for past operability
12 issues or issues that they want followed up, and
13 they put time clocks on those, we are seeing a
14 much greater increase in that activity, and in my
15 organization in the plant. So we are real
16 pleased to see that, because that leadership role
17 really does define the marching orders for the
18 rest of the plant involved, and they understand
19 the priority and importance when we get a phone
20 call, and that hasn't always been the case.

21 MR. THOMAS: Okay. Thank you.

22 MR. MYERS: You were the senior resident,

1 and you know there was a lot of things that we
2 fixed during that outage that weren't restart
3 items, you know, we -- the diesels, they are
4 going to be leak free. We have added -- we have
5 put air dryers in the diesels, that's been a
6 long-term problem. Reactor cavity, which was not
7 a restart item, but it was the right thing to do,
8 you know, and we should have put that in years
9 ago, so, you know, I think that message is that
10 we are going to maintain our plant, not as quo
11 for 1970, but we have got to have a process in
12 place so we can find and fix problems, and not
13 justify the problems.

14 And I think we have demonstrated
15 that over and over again, and I think people can
16 see that.

17 MR. THOMAS: I don't disagree that you have
18 made a number of improvements to the facility,
19 but what I was trying to say is that -- to get
20 your opinion about is to what degree do you think
21 ops has assumed the role of leadership of the
22 facility?

1 MR. MYERS: I think what I was trying to
2 say, though, is if you go fix the problem, they
3 will assume the role. It's when you beat them
4 into the ground so they lose confidence in
5 management that they lose that role. You know,
6 we've got to find and fix the problem and take
7 them seriously, and I hope that -- our belief is
8 they are addressing that because they know that I
9 take it seriously.

10 I don't expect to walk in the
11 control room and find a recorder is not working,
12 I don't expect it, you know, so --

13 MR. FAST: Okay. Slide 70, please.

14 MR. LEWIS: Again, I have got a document
15 that -- I will get it out -- I didn't bring it to
16 this meeting, I didn't get it out before I left
17 the plant last night, but this document is called
18 Command Responsibilities dated January 30th. And
19 I didn't do anything special to it to make it
20 look old, I tried to refer to this eight, ten
21 weeks, and it tells me I'm the plant manager's
22 direct representative two-thirds of the time. I

1 will speak for myself and I will put words in the
2 my peers' mouths, we do take that serious. And
3 when he is not there, I have had numerous
4 instances where we have had to make phone calls
5 to activate the management team, and I have never
6 had anybody turn me down. So I think that is
7 demonstrating a change in the culture. Like Dave
8 said, people listen to us, we activate when we
9 need to and move forward.

10 MR. MYERS: Once again, I don't think
11 anybody goes out on a limb by himself, we have
12 got 800 people outside, I have got a beeper 24
13 hours a day, and we always had a duty management
14 team. They need to be able to utilize that team
15 whenever they need to 24/7, and that is the
16 expectation, you know.

17 MR. FAST: Monitoring and oversight are
18 obviously part of the process to ensure that we
19 continue to go in the right direction. The
20 management observation program has been cited and
21 recently benchmarked by Exelon as leading the
22 industry. Now, we know from a process standpoint

1 it's good, now we need to be able to bind the
2 results of the observations, and we need to
3 become more critical as they are identified, but
4 a program is in place, and I can tell you if an
5 individual does not perform an observation as
6 scheduled, they get a letter.

7 Now, that is the outcome, that is
8 just accountability, but that's why we demand
9 participation, and we get good participation, so
10 I believe that is a part of the management
11 intervention and interaction with the employees,
12 that is absolutely critical to success for the
13 future.

14 We have performance indicators
15 that are located in each of the key areas of the
16 plant, and these shadow boxes are demonstrations
17 of the performance within the individual work
18 group, whether it be design engineering or
19 regulatory affairs or the radiation protection
20 organization. Those are performance indicators
21 that that organization is tracking and trading on
22 a monthly basis, and they are very prominently

1 displayed.

2 We talked a lot about our safety
3 culture assessment, and we feel good about that
4 assessment. We feel that that is -- that
5 assessment has been well developed. It's got
6 room for improvement, it's an interactive
7 process, but we believe that we have a process
8 that will work well for demonstrating the future.

9 Engineer Assessment Board, we have
10 talked about our quality assurance organization
11 improvements we have made that accompany the
12 Nuclear Review Board.

13 The next slide shows that here's
14 where the rubber meets the road, what are we
15 going to do to ensure that we keep going in the
16 right direction. We have business practices that
17 are in development that do have two key
18 attributes, one is to assess the organization on
19 a regular basis, and the other is that it
20 monitors through a monthly performance indicator
21 the performance of the station.

22 So those are in development and I

1 have those actions. We will perform the line
2 organization safety culture assessment prior to
3 Mode 2, use the restart readiness review process.
4 We talked about the Rev 6, we have got some
5 opportunities for improvement, we are working on
6 some new input for the Rev 7, but that is -- that
7 will be done in accordance with the restart
8 readiness review.

9 The line management safety
10 assessment, we will be doing that every two
11 years, that business practice, so it's something
12 that will be institutionalized going forward.

13 As Fred had talked about, we are
14 doing a safety conscious work environment survey
15 fourth quarter 2003, looks like November and
16 annually thereafter. Quality assurance also is
17 part of the process to ensure that there is
18 alignment between line management, and then
19 internal independent assessment in the fourth
20 quarter of 2003.

21 We will do a quality assurance
22 independent assessment, and the model for that

1 really was one that was developed from Dr. Haber
2 and her team, and we have used it once, and it
3 did provide good feedback and it did show good
4 alignment with the line management assessment,
5 and we will be doing that annually thereafter.

6 And then lastly, just to make sure
7 that we have an outside perspective, we will go
8 use an outside independent safety culture
9 assessment in the last quarter of 2003. That is
10 our outside consultant using their process, not
11 ours, and then look at our station and
12 determining are we continuing to make the
13 progress in safety culture. That concludes my
14 presentation.

15 Are there any questions?

16 MR. GROBE: I have got one, Randy. The
17 second and third bullet on that slide. The line
18 organization safety culture assessment prior to
19 Mode 2 and line safety management, safety
20 assessment every two years, are those the same
21 as --

22 MR. FAST: Jack, to answer the question,

1 they are not the same, because the line
2 organization safety culture assessment is part of
3 Davis-Besse business practice. That restart
4 readiness review has three key elements, safety
5 culture assessment, a system health report, and
6 then an organizational affirmation readiness
7 going forward.

8 So those are the three key
9 elements. The safe line management safety
10 assessment will be a business practice, which is
11 a stand alone for safety culture only, though
12 that's done while we are operating the plant, we
13 will compile the information and then perform the
14 review of the safety culture.

15 MR. MYERS: That is going to be in all the
16 fleet.

17 MR. FAST: Right, but it's in Davis-Besse
18 right now.

19 MR. GROBE: Will it be different in its
20 scope and depth and technique than what is the
21 safety culture piece?

22 MR. FAST: No, it's the process, it just

1 does not have the other two elements, does not
2 contain -- now, there is many inputs to safety
3 culture that come from maintenance rules, system
4 health, maintenance backlogs and things like that
5 because those are key indicators of
6 organizational effectiveness, so -- but the
7 elements of the safety culture piece are going to
8 be lifted entirely into a new business practice,
9 which is used in our FENOC stations for doing an
10 assessment every two years.

11 MR. GROBE: When will the quality assurance
12 and independent assessment fourth quarter of '03,
13 when is that scheduled?

14 MR. FAST: I have just started some
15 dialogue with the quality assurance manager, and
16 we think that November is approximately the right
17 time to do that, so he's aligning the resources
18 necessary.

19 MR. GROBE: Okay. And if I understood
20 correctly, there will be a line organization
21 safety culture assessment prior to Mode 4, and
22 then a revisit prior to Mode 3, is that right?

1 MR. MYERS: That is prior to Mode 2.

2 MR. GROBE: Thank you, right. When will
3 the business practice to monitor safety culture
4 monthly be available for review?

5 MR. FAST: I'm committed to have those out
6 by end of year, because they are really going to
7 be in place for 2004. However, I'm working
8 through a plan to get those piloted at our other
9 stations, so I haven't been -- I can show you
10 what I have in draft, Jack, but I would not
11 expect them to actually be assigned business
12 practice. What I would commit to is the end of
13 year.

14 MR. GROBE: Is there a procedure that Q.A.
15 has for the assessment, is that already in place?

16 MR. FAST: I don't know if that is a
17 procedure.

18 MR. VON AHN: There is not a specific
19 procedure. We do that in accordance with the
20 assessment. It will be a focused assessment to
21 that particular attribute.

22 MR. GROBE: I apologize, I thought I heard

1 you say that was going to be modeled after some
2 other assessment or something like that.

3 MR. FAST: The process that was put
4 together by Q.A. has been done one time, took
5 some of the elements that were developed by Dr.
6 Haber in interviews, surveys, monitoring of team
7 meetings, and then worker performance. So those
8 were some of the -- it's not as well defined with
9 what they call BAR and -- behavior or whatever,
10 something, I can't remember the acronym, but it's
11 not as well developed, but it has some of the
12 same attributes.

13 MR. GROBE: Okay. Any other questions?

14 MR. HOPKINS: We have a question at
15 headquarters.

16 MR. PERSENSKY: This is J. The business
17 practice to monitor what you said, they were
18 going to be out by the end of the year, what form
19 are they going to take? Do you have any idea in
20 terms of how would it relate, for instance, to
21 the safety culture assessment as part of the --

22 MR. FAST: J., it takes some of the key

1 attributes, most are more objective than
2 subjective, so it takes maintenance rule
3 temporary modifications, operator work arounds,
4 maintenance backlogs, things that are really
5 things that we can create a compilation of
6 indicators that will feed into a monitoring tool,
7 so it's more like an -- so that's why it's called
8 a monitoring tool, it does assess, it just takes
9 key elements, aggregates them, provides a
10 numerical rating, and that numerical rating is
11 discussed as part of the monthly performance
12 review, so that's the process that we use.

13 Now, what you do is if you saw a
14 decline in trends based on inputs that were, say,
15 growing backlogs or things of that nature, then
16 the management team would take corrective action
17 to get that back in line. So it has some very
18 specific -- but it's more objective than
19 subjective, so it's not an assessment, it's a
20 monitoring tool that aggregates numerous inputs.

21 MR. PERSENSKY: So more the P.I. level?
22 MR. FAST: That is correct.

1 MR. MYERS: That's right.

2 MR. PERSENSKY: Your Mode 2 safety culture,
3 I heard that the quality assurance, that is going
4 to be done from your interim Q.A. group?

5 MR. FAST: That is correct.

6 MR. PERSENSKY: That's all I have right
7 now, thank you.

8 MR. RULAND: This is Bill Ruland. As far
9 as this business practice monitoring system that
10 you are developing, let me ask you somewhat of a
11 hypothetical question. Let's suppose that you
12 had the circumstances of the hole in the head,
13 you were -- you had that same circumstance
14 happening in the future, what part of this
15 monitoring system would pick that up?

16 MR. FAST: Well, I will try to provide you
17 something tangible. If you look at engineering
18 backlogs and the modifications, timely
19 implementation of modifications and corrective
20 actions would be, that is something objective
21 which we can look at what are the numbers of
22 modifications that are out there. In the case of

1 the reactor vessel head, we had proposed a
2 modification to provide viewing ports years
3 previous to the event back -- I think 1990 was
4 the first time. So now, would that individually
5 solve the problem? The answer is no.

6 However, if you have backlogs of
7 engineering design changes, that can be an
8 element that would feed into this type of event.

9 MR. RULAND: Thank you.

10 MS. GOODMAN: This is Claire Goodman. I'd
11 like to confirm, I think I heard you say that the
12 second one, the line organization safety culture
13 assessment, and then the third one, the safety
14 assessment every two years, that the same
15 assessment, or it's just -- you called it safety
16 culture assessment in the second one and safety
17 assessment in the third, but I heard you say it
18 was the same thing.

19 MR. FAST: Claire, the line organization
20 safety culture assessment Prior to Mode 2 is
21 called a restart readiness review, and it has
22 safety culture as one of three elements in it,

1 and then the line organization safety culture
2 assessment every two years is only that safety
3 culture portion.

4 MS. GOODMAN: Okay.

5 MR. MENDIOLA: This is Tony Mendiola. I
6 want to make sure that of the six items on this
7 page, four of them are continuous, will be
8 continuous items. The first item and the third,
9 fourth and fifth item. The second and sixth item
10 are one-time-only items?

11 MR. FAST: That is correct.

12 MR. MENDIOLA: Thank you.

13 MS. GOODMAN: As a follow-up, No. 6 is a
14 one-time only. Is there any thought to that that
15 might be repeated again if the trend was not
16 going in the right direction or something?

17 MR. FAST: Claire, I believe if we do not
18 get the results that we would have expected,
19 certainly we would have corrective action, and
20 then the natural outcome would be that we'd have
21 to go back and reassess at some time later.

22 MR. MYERS: You know, I guess the ACRS, a

1 long time ago they were talking about a
2 regulatory standpoint, from the N.R.C.
3 standpoint, would -- how would the industry
4 monitor this into the future. So one of the
5 things that we are looking at is the Institute of
6 Power Operations' process, and if that comes
7 about, then we would join the industry, you know,
8 so, you know, is this one time only? I don't
9 know. If it does come about that that is part of
10 their normal observation process of monitoring
11 safety culture, then we would allow ourselves
12 that.

13 MS. GOODMAN: Thank you.

14 MR. FAST: With that I will turn it back
15 over to Lew.

16 MR. MYERS: In conclusion, I'd like to take
17 few moments. I don't intend to cover every one
18 of these slides, Jack, I put them in here for you
19 to sort of look at. Before I showed you the
20 barriers that -- I think to an event challenge.
21 I think there is four barriers that we look at,
22 the individual itself performing, in a quality

1 manner, the programs and procedures that we have
2 in place. If you go back and look at the issue,
3 every one of these barriers, you know, our
4 procedure was poor, our training on the
5 individual was poor, and I went and looked at
6 each one of them. And then the management
7 itself, of assuring that you have got the right
8 oversight, and then the independent oversight
9 process itself. When those barriers fail, I wind
10 up with a challenge, resulting in an event.

11 What I did was, I used this
12 before, but I went back into something a little
13 different this time. Under each one of these
14 areas I went back and tried to correlate that
15 with the criteria that feeds the safety culture
16 model, and -- for example, on the individual
17 barrier, if you look, you say what is the
18 criteria? Well, there is four of those -- five
19 of those criteria, drive for excellence,
20 outstanding attitude, questioning attitude,
21 rigorous work control, open communications and
22 nuclear professionalism, that thing sort of fits

1 that barrier.

2 Now, in the first one here under
3 individual commitment area we have taken a lot of
4 actions, I told you some of them, evaluate
5 supervisor, provide the head case study,
6 refresher training for the leadership, safety
7 conscious work environment, we covered that, town
8 hall meeting, all-hands meeting. We strengthened
9 the pre-job meeting at our plant, and I believe
10 we have really strengthened the reverse breaches
11 that we have to work on.

12 We have implemented the operations
13 leadership plan, and then we went back and
14 requalified all our root cause evaluators, and we
15 are going to do some training on a limited number
16 of people in the apparent cause too. If you go
17 look at the next couple of slides, what I did
18 there was I just went back and looked at the
19 attributes that feed each one of the criteria,
20 and so I'm not going to cover that in the
21 individual areas, but, for instance, in the drive
22 for excellence, there is a whole bunch of

1 attributes.

2 In the the next one down, under
3 questioning attitude, you know, pre-job
4 briefings, condition recording system, number of
5 programmatic CRs. There is all these attributes,
6 and what I found is that those things, when you
7 look at them, really correlate very well, it was
8 just a different way of looking at this.

9 And so right now I will go on and
10 skip on to the programs area, program, policy and
11 procedure. If you look at say what have we done
12 there, we have taken, I think, the statement of
13 policy, the management value structure resources
14 issue and criteria, and the oversight would fit
15 that barrier very well.

16 We have taken a lot of actions
17 there. First Energy Board of Directors passes a
18 resolution, you know, there is a really strong
19 commitment from our board and our Nuclear CEO
20 visited the site several times, the Board of
21 Directors are down there, the Nuclear Committee,
22 the Board has been at the plant. We have

1 established a policy on safety culture that we
2 didn't have before that enhances the FENOC
3 values, and we think that our last visit was, you
4 know, excellent, and there is a lot of questions
5 about what that means to the safety in our
6 investigation, you know, that is really a strong
7 message, we are concerned about the employees,
8 strengthens our incentive programs to ensure they
9 tie with safety.

10 We have ensured we've got the
11 right resources, the executives, we have
12 established an independent level of quality
13 assurance, and I think we have greatly, greatly
14 strengthened our Employee Concerns Program and
15 our Safety Conscious Work Environment Policy.

16 So, once again, I won't cover each
17 and every one of the things that we have
18 completed in the various programs, program areas,
19 but another thing that I think has been extremely
20 powerful for us is the 4-Cs meetings. To me that
21 is a direct way of bypassing it all and getting
22 the questions right to the site CP, and have him

1 at the end of each meeting look at them in the
2 eyes and say, these are what I understand are my
3 actions, and you follow through on those actions.

4 And in the management area, we
5 have -- there is four or five of the criteria I
6 think fit that very well, emphasis on safety,
7 clear responsibilities and cohesiveness,
8 acceptance of responsibilities, qualification and
9 training, high organizational commitment and
10 finding and fixing problems.

11 But we have taken a lot of actions
12 there. We have improved our management technical
13 policy, we demonstrated that in the slides that I
14 showed. The team I think is -- the team is as
15 strong as any in the country. Most of them have
16 advanced degrees, SRO experience, they are
17 quality managers, so I really feel fairly good
18 about the management team.

19 We strengthened our Corrective
20 Action Review Board, we have established -- we
21 have anchored that Engineering Assessment Board
22 that we had at our other plants that wasn't in

1 place at the Davis-Besse plant. We have revised
2 our competencies on appraisals, that is a major
3 issue, and we used that first last year, but we
4 now have two new competencies that evaluate each
5 and every professional, new leadership in action,
6 competencies in action are being used.

7 One of the things we found when we
8 got to Davis-Besse is we have a leadership in
9 action program, walked around the plants, and you
10 see the ways that we are supposed to do business.
11 That's true at Perry, it's true at Davis-Besse,
12 it's true at Beaver Valley. We found that when
13 we got to Davis-Besse that they had had a
14 different vision, and none of that stuff was
15 there, you know, it was like not there. And so,
16 once again, it was like an isolationist corporate
17 organization. We put in place -- my new job was
18 to prevent that from happening so we have made a
19 lot of advances in the management area to ensure
20 something like these vessel head issues don't
21 happen to us again.

22 Once again, I'm not going to cover

1 each one of the attributes, I just thought those
2 were interesting to put in the slides. If you go
3 look at independent oversight, you know, we have
4 created new jobs, enhanced the quality assessment
5 organization, we took quality control -- I mean
6 quality control and went back and looked and what
7 we found was that our plants if you had problem
8 in the field, provided you fix the quality
9 control, did not write a CR, so what was the
10 error rate? It wasn't there, you didn't know.
11 And so we've taken quality control and took them
12 out of the line of organization and put them
13 under Fred to get them that independence, and we
14 think that is a really positive move.

15 The Nuclear Committee on the Board
16 of Directors, you know, Bill Call is now the
17 chairman of that board. Bill comes to us from
18 the South Texas project, he's well known, I think
19 he will require some really high standards. Let
20 me tell you, he's involved with the plant too,
21 because he calls Gary and I every other day, I
22 think, to find out what we are doing and how we

1 are doing it, gives us a lot of feedback, and

2 he's at the plant.

3 The Employees Concerns Program is
4 once again under Fred, and I think we made great
5 progress there. The INPO assist visits brought
6 us out of isolationism. We had a visit from the
7 independent team of executives this week that was
8 extremely hard hitting and -- really hard
9 hitting, and next week INPO in our plant again
10 with all the regulatory assessments that we have
11 going on now. But it's going to be good for us,
12 and we have got a really strong team coming to
13 our plant to make sure that they help us with the
14 assessment before we write the report, and we are
15 ready for restart.

16 Restart oversight plan is
17 independent, at those meetings you can tell those
18 people have got a mind of their own, it's not a
19 group you can control, so -- but they have
20 brought a lot to the plate and are a very
21 experienced team.

22 And then our safety culture

1 assessment, you know, we think that this process
2 is a strong process, and I'm excited about it.
3 It's a different management tool, different way
4 of looking at things, but I'm really excited
5 about using that management tool in the plant and
6 in the future, and one -- you know, I have
7 participated with a lot of industry people at
8 other meetings that I know you know about, and I
9 have looked at their progress each and every one
10 of them, but, you know, I think that taking the
11 best of all their processes, and we have got a
12 good correlation, we have got convergence, and
13 the thing I think is more important than anything
14 else is we have alignment ownership of our
15 issues, and we are going to fix those issues.

16 From the seven-day test, I will
17 move on to that, you know, from the seven-day
18 test we accomplished a lot, took the plant up to
19 normal operating pressure temperature, you know,
20 the plant was leakproof, it really was tight, and
21 better than I'd hoped. As a matter of fact, you
22 know -- and so I was pleased with that. A lot of

1 the new monitoring and equipment that we fixed,
2 you know, we put the new seals in the tool pumps,
3 they staged well, ran all those, you know, and
4 were pleased with the performance of a lot of
5 equipment.

6 We did have some issues along the
7 way, we mentioned some of them, breaker spray
8 pumps, and then the auxiliary feedwater pump had
9 been around since 2000. We fixed it and we fixed
10 it because we put our troubleshooting team
11 together, and, you know, I called the shift
12 supervisor one night late and I said, you know we
13 have two hours, if we have to cool down, it's
14 okay, you know, it's okay, we will cool down and
15 we will start up event free and we will come
16 back, because we have learned a lot, and we will
17 just do it better next time, but we will go fix
18 this problem before we start back up.

19 That being said, you know, we were
20 able to realign the pump, start it before we took
21 the cooling pump off and when we looked at the
22 traces, we could immediately see changes in the

1 traces of eight linkages, you know.

2 So I think we really got off that
3 problem, and the troubleshooting team and
4 decision-making team service. If that team had
5 been in place and that approach had been taken
6 and we had the right management ownership, we
7 would not be sitting here today.

8 Going back and looking at the work
9 activities, you know, there's been several times
10 each work activity was stopped on discovery, you
11 know, we stopped what we were doing, and, you
12 know, when we were heating up, Jack, I talked to
13 you and I mean we made a decision to quit heating
14 up, we made the decision to go back the other
15 way, and we thought about it, we thought there
16 were more risks to that than where we were at,
17 and looked at that in great detail and got
18 management in on it, put our team together and
19 assembled that team and got the right management
20 program, so those are the things that I think
21 have worked well for us in the past seven days.

22 If you go look, we started the

1 test September the 21st, we ended it last night
2 at 1600, you know, and by tomorrow sometime or
3 late tonight, we start cooling back down.

4 But in summary, you know, I'm
5 pleased a lot of the process improvements we have
6 seen, I'm pleased with a lot of the team
7 improvement, and I'm also pleased overall with
8 the involvement of the management team and also
9 the oversight organization, I have been pleased
10 with them, so with that, that's all I have.

11 Thank you.

12 MR. LEIDICH: I think just in closing
13 overall, first of all, we appreciate your time
14 today. I think as we got together, we didn't get
15 through all 91 slides, but we -- there is a lot
16 of material here, but we do appreciate the
17 opportunity to present this sort of whole picture
18 safety culture and what we are trying to do
19 across the fleet, particularly at Davis-Besse.

20 You don't make a cultural change
21 overnight, and we don't come in on Monday morning
22 and say it's a whole new culture. Our

1 perspective at this point is that we have made
2 tremendous progress, we have got a ways to go, we
3 have got a process system management team in
4 place as far as where it needs to be, and we
5 appreciate your time, Jack.

6 MR. MYERS: Can I add one thing? We said
7 something in the meeting a while ago, we started
8 the plant back up, we come to you for restart.
9 The message is it's a new beginning, I don't
10 think we would have everything fixed so it's
11 perfect, but I do think that people have a new
12 beginning so that the trends will be right and
13 the ownership and management team will be right
14 to keep us going forward, and we will be built to
15 last.

16 MR. GROBE: Okay. Any final questions?

17 MR. PASSEHL: Dave Passehl, project
18 engineer. A little earlier in this meeting you
19 mentioned you were going to be doing your next
20 safety culture assessment in Mode 3 prior to Mode
21 4 and then and spot-check this Mode 2. Did I
22 misunderstand that? Because your later slide

1 said were you doing it prior to Mode 2.

2 MR. MYERS: We will be going by what you
3 said at first. We will be doing a detailed one
4 at Mode 3 and then come back before we start Mode
5 4, and when we get to Mode 2 and make sure we
6 feel fine going forward. If we see anything
7 limiting, we will turn around and go the other
8 way.

9 MR. PASSEHL: Okay, thank you.

10 MR. ZUICHOWICZ: My name is Ray Zuichowicz,
11 I have been at the plant since Day 1, part of the
12 original start-up crew. One thing they didn't
13 mention earlier is -- I'm also the chief steward
14 at the plant, I represent maintenance. The
15 maintenance organization is ready go forward with
16 restart. We've taken ownership of the problems,
17 we have tried to address the situations. You
18 have heard Gary, Mark and Lew talk about the
19 things they put in place. I'm not saying they're
20 all effective, I haven't seen all of them in
21 action, because lot of things we haven't tested
22 yet.

1 Some of the things I have seen,
2 speaking of the safety culture, the one single
3 thing that comes up in my aspect, from my
4 standpoint we -- I can see are just coming into
5 where we do our most work in this plant, we have
6 the ability from the apprentice to the top
7 journeyman to stop our job at any time that we
8 are uncomfortable with it, if we are not clear on
9 it. We stopped the progress several times during
10 this Mode 4 startup, we stopped the progress of
11 the plant because we had a problem with our job.

12 And you asked earlier how was that
13 received? It is not always received with open
14 arms when they are trying to do something and
15 there is resistance because there is a problem,
16 but never once have they not resolved the
17 problem. They resolved the problem and there is
18 a culture change taking place. It's not an
19 overnight process and there is still people that
20 are uncomfortable with it, but it is there and
21 there is nobody that I represent in my
22 organization that hesitated at bringing forth

1 the problem and also does not have the ability to
2 stop the job when it becomes necessary. I just
3 wanted to bring that up.

4 MR. GROBE: Thanks a lot.

5 Any other questions from here in
6 Region III?

7 (No response.)

8 MR. GROVE: Bill Ruland, do you have
9 anything else in headquarters?

10 MR. RULAND: Any questions? We have some
11 questions from the media, but we will hold off
12 until we have gotten around to everybody else.

13 MR. GROBE: We will get those in a minute,
14 thanks.

15 I do appreciate your time, Gary,
16 and I appreciate your coming over. 91 slides was
17 impressive, but I think we got a lot of
18 information. The one slide that there was a lot
19 questions on was the monitoring going forward,
20 and I think we are going to need to see a little
21 bit more detail on that, and I'm not quite sure
22 how we are going to do that, but I will get back

1 with you.

2 MR. LEIDICH: That's fine, we will work
3 with you ourselves.

4 MR. GROBE: With that, Jim, do you have any
5 comments for them?

6 MR. CALDWELL: Just to say thanks for
7 coming to give us this briefing and bringing us
8 up to speed on where you are on the safety
9 culture. There is a lot of problems obviously
10 that resulted in the shutdown, beginning of which
11 was the cavity vessel head, but root cause
12 involved technical issues, and the main one, the
13 hard one, the one that is going to be difficult
14 to close out -- the technical issues you can fix,
15 and it's pretty clear, but the one that had both
16 management and on down is putting production over
17 safety was the -- is the real problem and also
18 making sure that the information you are
19 providing is complete and accurate. That is an
20 issue that we still have to deal with.

21 But at Davis-Besse we talked --
22 you guys talk about safety culture and the safety

1 conscious work environment, and one thing you
2 didn't mention is that it goes back to the
3 fundamentals, I'm not sure that folks could
4 actually identify safety issues. Whether they
5 would bring it up or not is a different thing,
6 it's actually understanding what safety issues
7 are, and then being willing to bring them up. So
8 you need to make sure that you understand that
9 people can understand what the safety issues are.

10 And then you talked about the
11 alignment, and making sure folks are aligned and
12 have a common understanding and ownership of the
13 issues going forward. You have meetings,
14 discussions, but in the end it will be the
15 actions, walking the walk that will determine
16 whether or not the folks buy into this safety
17 culture, and understanding that that is the
18 direction that management is taking in the
19 plants.

20 So those things -- Geoff brought
21 up a good point earlier when he talked about your
22 -- the assessment tool that you have. There are

1 a lot of opportunities going forward where you
2 will make decisions that -- the decision you just
3 made recently on the seven days, was it
4 consecutive? It was broken up because of some of
5 the problems that I heard. When I mean we looked
6 at it from this side and determined that it was
7 equivalent or better than, but the first
8 discussions we had from your side was we didn't
9 commit to seven consecutive days, and we
10 discussed that you look at it from an engineering
11 perspective to make sure it's at least equivalent
12 or better, and that is the type of communication
13 that not only do we want to hear and the public
14 wants to hear, but your staff needs to hear that
15 the decisions you are making are related to
16 what's best for the safety of the plant. And so
17 those -- so you have a number of opportunities.

18 This assessment tool, you have red
19 issues, or issues that would appear to be
20 showstoppers, those are -- you not only have to
21 convince us in the public, you need to convince
22 your staff that you thoroughly reviewed it and

1 understood it, and that it's not a safety issue
2 going forward.

3 So there is a lot of opportunities
4 you have to reinforce your standards and
5 expectations, and they come in the guise of
6 communications not only to us in the public, but
7 to your staff as well. And those are all the
8 management issues.

9 Scott touched on the operations
10 issue, and in reality when it comes down to the
11 operators, all the plants in this country that
12 have been successful are successful because they
13 have a strong ops organization that leads the
14 plants, sets the standards, will not accept
15 degraded conditions, and you can see for a couple
16 of years the plant that engineering leads or
17 maintenance leads, in a couple of years it will
18 be okay, and then it will degrade, not because
19 those people are doing anything wrong, but
20 because they don't have the same insights that
21 the operators have on what's acceptable to
22 operate the plants, so it has to be op lead, and

1 like you said, in the middle of the night those
2 are the folks that are going to be making the
3 decisions. I know you are on your beeper, but
4 they are still going to make the decisions. And
5 we have the plants that in the middle of night
6 that the operator makes bad decisions and those
7 decisions resulted in the plants being shut down
8 for an extended period of time. So you set the
9 standards and expectations with your actions as
10 well as you were words, but mainly your actions.
11 And then operations has to reinforce that on a
12 day-to-day, continuing basis.

13 Anyway, we appreciate your coming,
14 and like I said, 90 slides is a lot to go
15 through, but we will spend some more time trying
16 to work through this. Thank you.

17 MR. GROBE: We are going to take just a
18 couple of minutes to get reorganized here and
19 then take questions from the public.

20 (Whereupon, a recess was
21 had, after which the
22 hearing was resumed as

1 follows:)

2 MR. GROBE: Okay. I think what we'd like
3 to do is I'd like to start with questions from
4 anybody here in the Region III office. If
5 anybody has any questions, approach the
6 microphone and we'd be glad to answer them. And
7 then, Bill, we will move to headquarters, and
8 then we will move to the phone line.

9 So is there anybody here, a member
10 of the public that has a question or comments
11 that they'd like to address to us?

12 (No response.)

13 MR. GROBE: It's a quiet group today.

14 Okay.

15 Bill Ruland, is there anyone at
16 headquarters that has questions?

17 (No response.)

18 MR. GROBE: We will go to the phone lines.

19 THE OPERATOR: Our first question comes
20 from Ashar Kahn. You may ask your question.

21 MR. KAHN: Our first questions, I guess,
22 after hearing very comprehensive dialogue

1 regarding the safety culture issue, can I just
2 ask from N.R.C. or management who was there that
3 -- do they believe that based on today's
4 discussion and findings, whatever the findings
5 are of the M.P. test that the management still
6 believes they will be able to restart this plant
7 in the fourth quarter of this year?

8 MR. GROBE: Mr. Kahn, this is your
9 opportunity to ask the N.R.C. staff questions,
10 and I can respond to your question. The schedule
11 is not something we focus on with the N.R.C. What
12 we focus on is safety, and I can tell you the
13 plant is not ready to restart today, there is
14 still a number of activities that have to occur
15 before restart would be considered.

16 The steps that would be gone
17 through include internal assessments and
18 evaluations that the company will do within their
19 organization, and then providing a final report
20 to the N.R.C., followed by a meeting with the
21 N.R.C. to discuss progress step by step, and
22 eventually, if appropriate, a decision by the

1 N.R.C. that restart should occur.

2 We don't tie ourselves to a
3 schedule, that will happen when it's appropriate
4 and when the N.R.C. believes that the plant can
5 be safely restarted and safely operated into the
6 future.

7 MR. KAHN: But if I heard right, is there
8 going to be another public meeting on the safety
9 culture, I guess the management coming back with
10 certain assessments and reviews?

11 MR. GROBE: We have public meetings all the
12 time, usually several a month, and one of the
13 discussion items we talked about was getting more
14 detail from the company on the assessment process
15 going forward. Some of the assessments are still
16 in the developmental phase, and we have a number
17 of questions in that area in addition to our
18 safety culture assessment. Our inspection team
19 is continuing its work, and when they complete
20 their work, we will have a public dialogue
21 regarding the inspection findings at that time.
22 So we --

1 MR. KAHN: If I can end up by saying, what
2 does the N.R.C. staff feel where we are at at the
3 present moment as far as whether things have
4 progressed well and are things are going in the
5 right direction as you see them as you have
6 discussed today with what they presented and what
7 you have seen and inspected over the last, you
8 know, several months?

9 MR. GROBE: That's a very general question,
10 it can only be answered with a very general
11 answer, and that is that progress continues to be
12 made.

13 MR. KAHN: I appreciate it.

14 THE OPERATOR: Our next question comes from
15 Paul Patterson. You may ask your question.

16 MR. PATTERSON: Hi, can you hear me?

17 MR. GROBE: Yes, sir.

18 MR. PATTERSON: Just to sort of follow-up
19 on the previous question, in terms of the issues,
20 I mean, there were clearly some issues that both
21 you and the company, the N.R.C. and the company
22 felt that there needed to be improvement, but

1 prior to restart were there any specific issues
2 that you guys identified that had to be
3 rectified, or did you feel that the presentation,
4 the 91 slides, which unfortunately we weren't
5 able to see, gave you enough comfort to feel that
6 they at least with the specific issues are ready
7 to restart, if you follow me?

8 MR. GROBE: Hopefully you can gain access
9 to an Internet connection, the slides are
10 available on the N.R.C. web site.

11 MR. PATTERSON: Okay.

12 MR. GROBE: Specific to your question,
13 there is a restart checklist that the N.R.C.
14 issued, I think it was in the fall of 2002, it's
15 been updated several times since then. That
16 restart checklist includes specific items that
17 need to be completed prior to restart and a
18 number of areas first. Root cause assessments
19 area; second is systems readiness; third, have
20 programs readiness; fourth is the management and
21 human resource performance and refocused a lot of
22 attention in that area today.

1 The further area is operations
2 readiness, and then the sixth and seventh areas
3 are any licensing actions that are necessary for
4 restart and completion, confirmatory action
5 letter. So there is quite a few specific items
6 that need to be completed before restart.

7 Currenty I believe there is 18 of
8 31 of those checklist items have been closed out
9 formally, and actions are underway on most of the
10 rest of them to evaluate licensing progress.

11 MR. PATERSON: So in terms of issues that
12 you guys addressed today, that doesn't
13 constitute, I guess, things being checked off,
14 there is still some work to be done?

15 MR. GROBE: That is correct.

16 MR. PATTERSON: And I'm wondering if you
17 can give us an idea as to whether we will get a
18 better picture on that in terms of that portion
19 of the checklist being resolved, the safety
20 culture issues?

21 MR. GROBE: You are correct that part of
22 the checklist has not yet been resolved. There

1 was several items in that area, one was whether
2 or not their evaluations were adequate, that
3 that's been closed out and adequately resolved.

4 The second item was whether or not
5 the plans to improve safety culture were
6 sufficient. It appears to be sufficient, and
7 that also has been addressed and closed out. The
8 third item is the effectiveness of those
9 activities, and that item is still open, the
10 inspection is ongoing, and as soon as the
11 inspection is completed, we will report the
12 results of that inspection publicly.

13 MR. PATTERSON: Thank you, very much.

14 THE OPERATOR: Once again, if anyone would
15 like to ask a question from the audio portion,
16 please touch Star 1 on your telephone. One
17 moment.

18 The next question comes from Paul
19 Branch. You may ask your question.

20 MR. BRANCH: Good afternoon, Paul Branch.
21 I think most of you know who I am and you know I
22 have looked at all the slides today, and I think

1 that Davis-Besse is right on, they have good
2 plans. But what I also looked at is what are the
3 results of these plans? If we look at the --
4 both the Davis-Besse and the N.R.C. data, this
5 year there are seven allegations of harassment,
6 discrimination and intimidation as of the end of
7 August. This is the highest in the country.
8 There are still 23 open allegations, and again
9 No. 1 in the country. There are 22 allegations
10 total of just technical, general allegations, and
11 this is the highest in the country.

12 I think the most bothersome thing
13 was the Question No. 35 that appeared on Slide
14 No. 53, and the question was -- which was to me
15 the one objective question, and the question or
16 the statement was, "I have been subjected to
17 harassment, intimidation, retaliation or
18 discrimination in the last six months, and I'm
19 just looking at the FENOC, the Davis-Besse
20 employees, five percent or 34 employees in the
21 last six months perceived they have been the
22 subject of retaliation. You know, in my many

1 years, that is a very high number, that is five
2 percent, 1 out of 20. And, again, those are just
3 statements. I'd like to hear any comments on
4 that, but I'd also like to ask the question about
5 the completion of the safety conscious work
6 environment or safety culture assessment team
7 that's been ongoing since last June. When is
8 that expected to be completed?

9 And the second question is, who is
10 in the Employee Concern Program at Davis-Besse
11 that didn't come across or make -- I missed that,
12 so I will wait and relisten to the response.

13 MR. GROBE: Thanks, Paul. That is several
14 questions, let's see if I can capture them.
15 First, the inspection into the area of safety
16 culture and safety conscious work environment
17 will be completed when the company finishes the
18 work that they need to finish, and we need to
19 assess and we have an opportunity to assess that,
20 so that will be done when it's done.

21 The second question you asked I
22 think concerned several questions on the survey

1 that was done regarding safety conscious work
2 environment earlier this year. Your questions
3 were identical to questions that the N.R.C. staff
4 asked -- well, first insurance asked them
5 questions regarding what the meeting was, of
6 those results, they shared some of that today and
7 indicated that they were planning another survey
8 before restart, which will have clarifying
9 questions in those areas to ensure that the data
10 that is collected is as meaningful as need be.
11 So we will get additional input on that.

12 I think I have answered your
13 questions.

14 MR. BRANCH: Well, the other question was,
15 I guess I'm not clear who is leading the employee
16 concerns program out at Davis-Besse.

17 MR. GROBE: I don't have specific names,
18 it's under the vice-president of oversight, Fred
19 von Ahn at the corporate office.

20 MR. BRANCH: Okay. Thank you.

21 THE OPERATOR: At this time have I no
22 further questions.

1 Thank you, sir.

2 MR. GROBE: Bill Ruland, we have you guys
3 back on the line.

4 MR. RULAND: We have questions from the
5 media here, he is repositioning himself.

6 MR. HORNET: Dan Hornet from McGraw-Mill
7 Publications.

8 Could you clarify a bit on the
9 schedule of the meetings that need to take place
10 before restart, because you mentioned another
11 safety culture meeting before Mode 4, and it
12 wasn't clear to me if that was part of this
13 overall assessment once FENOC has submitted its
14 report, or if it's a separate meeting and how
15 that worked, because I understand it's also
16 supposed to be a meeting on the HPI pumps, I
17 believe, so can you sort of lay that out and give
18 us a clear idea?

19 MR. GROBE: I can tell you what I know,
20 Dan, and I will tell what you I don't know. The
21 answer to your question regarding additional
22 information on safety culture, I'm not sure when

1 that will occur, whether it will be one of our
2 routine monthly meetings or a separate focused
3 meeting. But as of right now, next Tuesday,
4 which is October 7th, we have a meeting at 2:00
5 o'clock in the afternoon and another one at 7:00
6 in the evening concerning -- this is our routine
7 monthly meeting or set of meetings, and a
8 significant portion of the agenda will be focused
9 on the results of the normal operating pressure
10 test and the evolutions that went into conducting
11 that test.

12 Then the following day we have a
13 meeting to discuss two topics, and that will
14 concern the results of the inspection of the
15 corrective action program and the systems health
16 readiness of the systems to operate. Our
17 November meeting, November 4th is the next set of
18 routine public monthly meetings, and those will
19 be, I believe, at the high school in Oak Harbor.

20 The meetings on Tuesday next week
21 are at Camp Perry in Port Clinton. In addition,
22 there is a meeting that is scheduled -- going to

1 be scheduled in headquarters, I don't believe we
2 have a final date, it's around the 20th of
3 October, and the subject of that meeting is going
4 to be the high pressure injection pump's design
5 modification and the results of the testing that
6 is being done on those pumps in Alabama.

7 We also had a tentative date for
8 routine monthly meeting in December, so as far as
9 when we are going to discuss safety culture
10 topics, I'm not sure if that will be a separate
11 focused meeting or one of the monthly meetings.

12 Of course, in addition, that
13 confirmatory action letter contained, as a
14 condition, that the company would meet with
15 N.R.C. prior to restart, and First Energy has, in
16 response to that, agreed to provide a
17 comprehensive restart report prior to that
18 meeting, and that meeting is not currently
19 scheduled or contemplated. But prior to the
20 meeting, we will receive a comprehensive report,
21 and then conduct a meeting. A decision will not
22 be made at that meeting, whatever occurs, but

1 that will be a final bit of data that the N.R.C.
2 will be considering, along with all of the other
3 inspection results that we have been collecting
4 over a lengthy period of time. The panel will
5 consider all of that input and then decide
6 whether it needs additional information or
7 whether it's ready to make a recommendation to
8 the Regional Administrator, Jim Caldwell, if the
9 plant is ready to restart. At this point Jim
10 will consult the panel and consult with Jim
11 Dwyer, the director of reactor safety in
12 headquarters, as well as Sam Collins, the deputy
13 executive director for reactors, and he would
14 make a decision on restart.

15 So that last bit of information I
16 can share with you is the date or schedule for
17 that is not contemplated yet.

18 MR. HORNET: I did go to a safety culture
19 meeting before Mode 4. Is there some formal
20 approval coming out of that meeting that FENOC is
21 required to have before they can enter Mode 4
22 regarding their safety culture other than the

1 overall approval that is pursuant to the
2 confirmatory action letter that you mentioned?
3 MR. GROBE: I think the meeting is an
4 internal FENOC meeting, it's not a meeting with
5 the N.R.C., it's an internal meeting where First
6 Energy evaluates its -- their readiness in three
7 areas, one is safety culture organizational
8 readiness, the second one is equipment readiness,
9 and the third is programmatic readiness. Those
10 are kind of broad concepts, but that is the
11 purpose of that meeting. They will conduct
12 meetings internal to their organization prior to
13 Mode 4, and then again prior to Mode 2.

14 In addition, they had internal,
15 within their organization, a series of approvals
16 that they need to go through, and those include
17 their external oversight restart oversight panel,
18 the corporate Nuclear Review Board, that is a
19 restart oversight panel that is comprised of
20 individuals from around the industry, the
21 Corporate Review Board is an internal FENOC
22 entity that is independent of the site, as well

1 as the Senior Management Team in the FENOC
2 organization both on-site at Davis-Besse and
3 off-site at the corporate office.

4 So they have a number of reviews
5 and approvals that they do go through before they
6 would come to the N.R.C. for a restart
7 recommendation.

8 MR. HORNET: Okay. Will that be
9 continuing, because I know that at least --
10 continue in existence for quite a while after
11 restart, so will there be -- continue to be
12 safety culture meetings at least these same
13 meetings after restart?

14 MR. GROBE: The company described in some
15 broad context what it plans to do to assess
16 safety culture after restart, and they will be
17 meeting regarding operational performance and
18 organizational performance, and as appropriate
19 those meetings will include dialogues on safety
20 culture, but the frequency of those meetings
21 hasn't been determined yet, but following restart
22 I anticipate retaining fairly frequent meetings

1 to share with the public operational performance,
2 and as you indicated, the panel will remain in
3 existence until the point in time that the panel
4 believes Davis-Besse performance warrants return
5 to the routine oversight process that the agency
6 uses for normally operating plants.

7 MR. HORNET: Okay. Thank you on that line.

8 A second line, there was several
9 points that FENOC mentioned in the Sonja Haber
10 report. Can I ask you to say a little bit about
11 how you are using it at this point, because using
12 it as a yardstick against which to measure FENOC
13 on how are you using it, I guess are the FENOC
14 representatives still --

15 MR. GROBE: They are still here, but you
16 are asking me questions, and I can answer the
17 question from the N.R.C. context. The report is
18 being used for a number of purposes, one is to
19 get a benchmark on safety culture in the plant,
20 and the second is to gain insights on evaluation
21 techniques and alignment between the internal and
22 external evaluation tool that is used as the Dr.

1 Haber tool, as well as the various internal FENOC
2 tools that they are using, and the third was to
3 evaluate the adequacy of their root cause
4 assessments and their corrective actions going
5 forward. And so that the independent assessment
6 report is being used as well as their internal
7 assessment in a number ways.

8 MR. HORNET: Is there ongoing contact with
9 her or her organization to get her feedback as to
10 how well they are addressing the issues that she
11 raised in the report?

12 MR. GROBE: I don't know if First Energy is
13 having any contact with her. Our inspection team
14 had quite a bit of interface with Dr. Haber's
15 team in evaluating the assessment that was
16 conducted, so I can't answer your question
17 regarding First Energy.

18 Is there anybody else there that
19 has any questions?

20 MR. RULAND: No, there is no one else.

21 MR. GROBE: If you have anymore questions,
22 let's get them quickly and see if there is

1 anybody else on the phone lines before we

2 adjourn.

3 MR. RULAND: I think that should do it.

4 MR. GROBE: Okay. Anybody else here in

5 Region III?

6 (No response.)

7 MR. GROBE: Let's go to the phone lines one

8 more time.

9 THE OPERATOR: Once again if would you like

10 to ask a question, please press Star 1 on your

11 touch-tone telephone. Sir, I have no questions.

12 Thank you.

13 MR. GROBE: Okay. Thank you very much.

14 With that we stand adjourned.

15 (Which were all the

16 proceedings had and

17 testimony taken in the

18 above-entitled matter at

19 the time and place

20 aforesaid.)

21

22

1 STATE OF ILLINOIS)
) SS.
2 COUNTY OF KANE)

3 I, ELLEN E. PICCONY, a Notary
4 Public duly qualified and commissioned for the
5 State of Illinois, County of Kane, do hereby
6 certify that subject to the usual terms and
7 conditions of County Court Reporters, Inc.,
8 reported in shorthand the proceedings had and
9 testimony taken at the hearing of the
10 above-entitled cause, and that the foregoing
11 transcript is a true, correct and complete report
12 of the entire testimony so taken at the time and
13 place hereinabove set forth.

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22

Notary Public

My Commission Expires
October 15, 2003.