

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

Meeting held on Wednesday, January 21, 2004, at
6:00 p.m. at the Oak Harbor High School, Oak Harbor, Ohio,
taken by me, Marie B. Fresch, Registered Merit Reporter,
and Notary Public in and for the State of Ohio.

PANEL MEMBERS PRESENT:

U. S. NUCLEAR REGULATORY COMMISSION

- John "Jack" Grobe,
Senior Manager, Region III Office
& Chairman, MC 0350 Panel
- William Ruland, Senior Manager NRR
& Vice Chairman, MC 0350 Panel
- Christine Lipa, Projects Branch Chief
- Christopher Scott Thomas,
Senior Resident Inspector
U.S. NRC Office - Davis-Besse
- Jon Hopkins,
NRR Project Manager - Davis-Besse
- Jack Rutkowski, NRC Resident Inspector
- Anthony Mendiola,
Section Chief PDIII-2, NRR
- Monica Salter-Williams,
NRC Resident Inspector

FIRST ENERGY NUCLEAR OPERATING COMPANY

- Lew Myers, FENOC Chief Operating Officer
- Mark Bezilla, Vice President
- Barry Allen, Plant Manager
- Kevin Ostrowski,
Manager - Plant Operations
- Dave Imlay, Shift Superintendent
of Plant Operations

1 MS. LIPA: I would like to
2 welcome FirstEnergy and members of the public for
3 accommodating this meeting tonight. This is a public
4 meeting between the NRC's Davis-Besse Oversight Panel and
5 FirstEnergy Nuclear Operating Company.

6 My name is Christine Lipa and I'm a Branch Chief for
7 the NRC in the Region III Office located near Chicago. And
8 I'm responsible for the NRC's Inspection Program at
9 Davis-Besse.

10 The first slide goes through the purposes of this
11 meeting, which are to discuss the NRC Oversight Panel and
12 NRC activities at the Davis-Besse facility; and then after
13 that, to allow FirstEnergy to present the status of
14 activities in their Restart Plan.

15 So, the next slide is the agenda. These are the
16 things we'll be covering tonight. We'll take a break after
17 about an hour and 15 minutes, wherever we need it
18 accordingly.

19 I would like to make some introductions for the NRC
20 side up here at the table. To my far left is Jon Hopkins.
21 He's a Project Manager for the Davis-Besse facility and
22 he's located out of Headquarters.

23 Next to Jon is Tony Mendiola. Tony is the Section
24 Chief in the Projects Department in NRR.

25 On my left is Jack Grobe. Jack is the Senior

1 Manager in the Region III Office, and he's also Chairman of
2 the Davis-Besse Oversight Panel.

3 Bill Ruland on my right is the Senior Manager in
4 Headquarters and he's the Vice Chairman of the Oversight
5 Panel.

6 Next to Bill is Scott Thomas. He's the Senior
7 Resident Inspector at the Davis-Besse plant.

8 And then next to Scott is Monica Salter-Williams.
9 She's a Resident Inspector at the plant.

10 We also have Jack Rutkowski, another Resident
11 Inspector, running the slides for me.

12 And we have Nancy Keller in the foyer welcoming you
13 on the way in.

14 Jan Strasma with Public Affairs is here.

15 And, I believe that's it for NRC tonight.

16 I'll let you introduce your folks.

17 MR. MYERS: Okay. Is this
18 working?

19 Okay. Before I do that, I would like to take just a
20 moment if I could. This week, I think the State of Ohio
21 lost a really fine citizen. We lost our Chief Executive
22 Officer and Chairman of the Board, Pete Berg. We were in a
23 meeting with you, Christine, when we got the news. I want
24 to take a moment tonight and just talk about that for a
25 moment.

1 If I look back at the restart of the Davis-Besse
2 plant and my career with FirstEnergy, there is two things
3 that came to my mind. The first one was approachable. You
4 know, Pete Berg was probably the most approachable CEO I
5 ever met. He spent many hours coming to our Davis-Besse
6 plant during the shutdown; stayed early in the morning
7 until late at night meeting with all of our employees. He
8 personally had me bring our SROs to meet with him and spent
9 a couple of hours during this extended shutdown. And he
10 was always concerned about the staff and the people at this
11 plant and throughout our company.

12 The next thing I think about is integrity. Through
13 my years at Perry or Beaver Valley and Davis-Besse, when he
14 came here, he always told us to take the time to do the job
15 right. That was always more important than anything else
16 in his leadership style was integrity.

17 I know Tony Alexander, our new CEO, and Pete worked
18 together for 30 years; and we at FirstEnergy are deeply
19 saddened by his loss. He passed away on January the 13th.
20 He was 57 years old. So, it's been a very, very trying
21 week for all of us. So, I just wanted to start out with
22 that.

23 With that, we have several people with us in the
24 audience tonight. Fred von Ahn is our Manager of Quality,
25 VP of Quality Assurance.

1 Gary Leidich is with us also, President of FENOC.

2 At the end of the table is Kevin Ostrowski, Manager
3 of Operations is with us.

4 Barry Allen, Plant Manager, to my left.

5 Mark Bezilla, site VP, to my right.

6 And Dave Imlay is next to him.

7 MS. LIPA: Okay, thank you.

8 Next I would like to offer any public officials to
9 introduce themselves.

10 MR. PAPCUN: John Papcun,
11 Ottawa County Commissioner.

12 MS. LIPA: Hi, John.

13 MR. KOEBEL: Carl Koebel,
14 Ottawa County Commissioner.

15 MS. LIPA: Welcome, Carl.

16 MR. ARNDT: Steve Arndt,
17 Ottawa County Commissioner.

18 MS. LIPA: Steve.

19 MR. WITT: Jere Witt, County
20 Administrator.

21 MS. LIPA: Okay, thank you,
22 Jere.

23 Okay. Then I would like to point out a few thing.

24 This meeting is open to public observation. This is a
25 business meeting between the NRC and the Davis-Besse or

1 FirstEnergy folks here. And at the conclusion of the
2 business portion of the meeting, but before the meeting is
3 adjourned, the NRC staff will be available to receive
4 comments and any questions from members of the public.

5 There are copies in the foyer of the January edition
6 of our monthly newsletter, and copies of both our slides
7 and the FirstEnergy slides for today, this meeting.

8 Let me just talk a little about the newsletter.
9 This provides kind of a summary of what's been going on
10 lately from the NRC perspective, what kind of activities
11 we've been doing and what's coming up. And there is also
12 information on the back page on how you can reach the NRC,
13 the Public Affairs staff, and also access to our NRC
14 webpage for additional information.

15 We also have in the foyer a Public Meeting Feedback
16 form that people can use to provide comments to us on how
17 this meeting goes.

18 Also, we're having this meeting transcribed today by
19 Marie Fresch, and that will maintain a record of the
20 meeting. Then, that transcription will be available on the
21 webpage within a few weeks. It's important that all
22 speakers use the microphone tonight, so the audience and
23 the transcriber can hear.

24 The next slide is a summary of the topics that we
25 had in our routine monthly meeting here last month, on

1 December 3rd. And the transcripts from that meeting are
2 posted on our webpage.

3 The next slide, I would like to talk a little bit
4 about some significant NRC activities since that December 3
5 meeting.

6 First item, we reviewed the Licensee's activities
7 associated with Restart Checklist on the Testing Program,
8 and this will be documented in the routine Resident
9 Inspection Report, which is scheduled to be issued by the
10 end of January.

11 Next, we had the NRC Inspection Team was on site for
12 the Restart Readiness Assessment. They completed several
13 of their planned activities on site the week of December
14 15, and they held a public exit meeting to discuss their
15 results on December 19th. And we're planning to bring back
16 most of the same team members at a later date to complete
17 the objectives of that inspection plan.

18 Next, we have the Management and Human Performance
19 Phase 3 Inspection. They also completed most of their
20 planned activities while they were on site the week of
21 December 15th, and they also held a public exit on December
22 19th. Members of that team were back on site last week and
23 that inspection continues, which is my next bullet, the
24 follow-up inspection.

25 So, the next slide will show some other NRC

1 activities since that December 3rd meeting. And this
2 describes three public meetings that we had in December;
3 and all those transcripts are available on our webpage.

4 And, the next slide is continuing activities. And
5 Operation's performance is being assessed by the Resident
6 Inspectors. And as I mentioned earlier, we plan to bring
7 back the Restart Readiness Inspection Team in the future.

8 And then the Resident Inspectors that we have on
9 site, our three inspectors that are here every day, and
10 they're stationed permanently at the site, and they inspect
11 a broad spectrum of activities; including engineering,
12 maintenance and testing in addition to operations, of
13 course. And the Resident Inspectors issue reports every
14 six or seven weeks.

15 And I think, yes, this next slide talks about the
16 upcoming inspection, which has not been determined when
17 that will be yet. And also public meetings, right now we
18 don't -- that's a tentative date, and we'll post everything
19 on the website once the dates for upcoming meetings are
20 firmed up. And, that's really all I have for now.

21 Lew, over to you.

22 MR. MYERS: Thank you,
23 Christine.

24 I always start out with some desired outcomes for
25 the meeting. Tonight our desired outcomes will demonstrate

1 that our Davis-Besse plant continues to take conservative
2 actions needed to support safe, a safe plant restart. And
3 we're going to brief you on some of the activities we've
4 accomplished during the month, and we continue to focus in
5 that area.

6 I want to provide information on the changes in
7 leadership in our programs that ensure the fleet
8 consistency in the Conduct of Operations. There has been
9 some changes and I'll discuss those later in our leadership
10 at our plant.

11 We want to demonstrate that the Operations
12 Improvement Action Plan supports meeting industry
13 standards, and it continues to support that. And provide
14 information on the recent NOP Normal Operating Pressure
15 Test -- not test, that we took the plant to normal
16 operating pressure and brought it back down. We have
17 information on that tonight, and the results of our
18 assessment during that time.

19 First up, I would like to take a few moments and
20 update you on some of the activities this month. Mark
21 Bezilla will discuss the present plant status. From an
22 Operations standpoint, Barry Allen, our Plant Manager, will
23 talk about the Operations issues that we've seen. And the
24 Operations Performance will be discussed by Kevin
25 Ostrowski.

1 So, I'll start out, if you would, talking about some
2 of the plant activities since our last meeting.

3 Go to the next slide.

4 The Davis-Besse plant continues to progress toward
5 restart. We sincerely believe that now. Successful heatup
6 was completed on January 5th. Let me talk about how it
7 really started out.

8 Back on December the 21st, we implemented the
9 Davis-Besse online weekly schedule, our normal work
10 scheduling process, which is a major step in getting us out
11 of the construction mode that we've been talking about,
12 high pressure injection pumps and everything for these many
13 months. So, we implemented that online schedule.

14 On December the 30th, at 2045, we started the plant
15 heatup into Mode 3. That heatup is, what I would call, a
16 complex evolution requiring manipulation of the plant
17 itself, because of reheating the plant up, starting it up,
18 and everything; placing into service and moving into
19 service many of the Operations systems and equipment for
20 testing. And we started our reactor coolant pumps on our
21 heatup, all four reactor coolant pumps. We took off the
22 RHR pumps, we shut the plant-- what I would call a complex
23 evolution. So, we started the heatup around 12:30.

24 On 12-30, 2115, myself and the site Vice President
25 had some discussions on the Operation activities and

1 completed some surveillances. After we changed modes,
2 there was a bunch of surveillances that come due.

3 We stopped the heatup at that time. We wanted to
4 demonstrate our conservative approach to this complex
5 evolution, so we didn't want to be doing the surveillances
6 and all these operational activities while we were heating
7 the plant up, a parallel path. So, we stopped the heatup
8 and that's the reason we did that.

9 We took a couple days; and on January the 4th, or
10 2nd, rather, at 2035, we resumed the heatup. We
11 then stabilized our normal operating pressure and
12 temperature on January the 5th at 9:55, with no major
13 errors.

14 The heatup was evaluated overall as successful.
15 That's not to say we didn't have some issues that we'll
16 talk about later, but there were no major errors that we
17 assessed the heatup as successful.

18 There were three operational issues we identified
19 between the time we heated up and we stabilized in Mode 3,
20 that normal operating pressure temperature. And then while
21 we were doing, after we heat up, we test our auxiliary feed
22 pump. And during the test, the auxiliary heat pump, we
23 identified a very, very small weepage in the casing. And
24 we went into a 72-hour action state on January the 7th.
25 So, we were at normal operating pressure until January 7th;

1 and at that time went to the 72-hour action stay.

2 We completed what I consider another very complex
3 evolution of cooling the plant back down, taking the pumps
4 off, and going through the operational modes, putting
5 through the RHR system back on. This is a, we completed
6 that evolution on January the 9th, back into Mode 4 at 2:33
7 a.m. This evolution was completed error-free. We think
8 that cooldown of the plant went extremely well.

9 At that time, Jack, I called you and notified you
10 that I think that we would need to delay the Restart
11 Readiness Assessment Team Inspection based on the cooldown,
12 and some of the issues affected the equipment; the Aux.
13 feed pump issue and other equipment issues we have, and
14 we'll discuss those tonight. And also to address the
15 administrative issue that we saw while we were up at Normal
16 Operating Pressure Test.

17 And today, I would status you that we've repaired
18 all the equipment. In fact, we didn't just go into one
19 auxiliary feed pump, we decided to go into the others ones
20 and do some extra maintenance on that to ensure that it
21 doesn't develop any casing leakage in the future.

22 And right now, as we sit here today, we're in the
23 final resolution of some door issue that we've identified.

24 And we are presently preparing to return the plant to
25 normal operating pressure temperature probably this

1 weekend. That would be our target.

2 During this extended time, we decided to go ahead,
3 as I told you all before, we intended to make some
4 additional leadership changes after plant startup. We
5 decided to go ahead and make those changes.

6 Since we had this delay, we wanted to strengthen the
7 operational leadership in our plant. So, with that, on
8 January the 10th, we had some new management assignments.
9 I'll share those with you.

10 Kevin Ostrowski down at the end of the table is our
11 new Operations Manager. Kevin has a really broad based
12 experience. Kevin has worked in all three of our plants.
13 In fact, he's the only one I know of that's worked in all
14 three of our sites besides me.

15 So, he is an SRO from our Beaver Valley Station. He
16 was a Shift Supervisor. He was an Operations Manager and
17 he was a Plant Manager. He then, after we took over the
18 operations of the Beaver Valley station, he went over as
19 Director of Maintenance and Nuclear Services to our Perry
20 station and worked there for a few years.

21 And then we brought him over, because we wanted to
22 increase our Operational strength, as a Regulatory Affairs
23 Manager about six months ago. So, we've now announced that
24 Kevin will be the new Operations Manager.

25 Next slide, please.

1 Additionally, we wanted, we made a change in the
2 Operations Superintendent area. Dave Imlay has been, is
3 now our new Shift Superintendent of Plant Operations. Dave
4 is at the end of the table.

5 Dave holds an active SRO, Senior Reactor Operator's
6 license of the Davis-Besse station. He's been the
7 Superintendent. He's been in Operations and been a
8 Superintendent of Maintenance. He's had 15 years of
9 experience at Davis-Besse and held several management
10 positions; the last one was in our training department.
11 So, he, if anybody, understands the complex operations and
12 what we're trying to accomplish.

13 I believe you set your standards through training.
14 Dave does that. And he also brings experience from other
15 plants in the industry with him. So, Dave is our new
16 Superintendent of Operations.

17 When we did that, we also took Bill Mugge, who we
18 sent off for some development at INPO for some time. We
19 considered that a really good way to gain broad-based
20 experience. Bill holds an SRO at the Davis-Besse plant.
21 He's got 16 years experience and held various management
22 positions in Operations, Training, and Security. In fact,
23 at that time, he was our security man.

24 So, he served as, the reason he came back to us a
25 year or so ago, and served as an Industry Evaluator at the

1 Institute of Nuclear Power Operations. He had actually
2 been out evaluating the operations of other nuclear power
3 plants. So, putting him in the Work Management position
4 strengthens our ability to coordinate scheduled work
5 activities at our station.

6 So, we went ahead and made those management changes
7 and I wanted to share those with you tonight. We think
8 those changes will really strengthen our operational focus
9 at our plant, and help us continue progress at our
10 Davis-Besse station.

11 That's all I have.

12 Mark.

13 MR. BEZILLA: Thank you, Lew.

14 Good evening. My desired outcome for this evening
15 is to provide you with an update of the plant status and to
16 demonstrate that the plant's material condition will
17 support safe restart.

18 Next slide, please.

19 First, let me discuss some items that we have
20 recently addressed. Lew mentioned a few of these. The
21 number one Aux. feedwater pump turbine was tested when we
22 reached normal operating pressure. We can test it on Aux.
23 steam, but until we get to normal operating pressure, we
24 don't have the ability to put main steam and test it at
25 normal conditions.

1 A slight casing leak was observed. We made initial
2 attempts to address the slight leak without success. We
3 then decided the right thing to do was pull the plant down
4 to Mode 4 where the Aux. feedwater pump is not required and
5 perform an inspection and repair.

6 We mustered vendor support, as well as FENOC
7 support, and determined that there was a better way to seal
8 the joint on the turbine casing. We then decided to
9 disassemble and make the same improvements on the number 2
10 Aux. feedwater pump turbine casing seal. We believe these
11 efforts will provide for leak tight seal and will improve
12 the reliability of the Aux. feedwater pumps.

13 The next item I would like to cover is Number 2
14 Containment spray pump motor to pump coupling problem we
15 encountered. During a run of the containment spray pump,
16 we noticed a rise in bearing temperature. The operating
17 crew took prompt action to secure the pump, declare it
18 inoperable, and request a problem-solving and
19 decision-making effort.

20 The problem-solving and decision-making team set
21 about to determine what could be the cause of the rise in
22 bearing temperature. We found the motor to pump coupling
23 had slipped. We solicited vendor and FENOC help and
24 subsequently repaired and we believe improved the coupling
25 fit.

1 We then inspected the Number 1 Containment spray
2 pump motor to pump coupling and saw no evidence of a
3 similarly nature on this component. We will be prepared to
4 enhance this component's coupling at a future planned
5 outage. I believe that's within the next month or two.

6 The next item I would like to speak about is a
7 reactor coolant root isolation valve that was noted to have
8 a slight leak at its body to bonnet seal weld. And these
9 are a little fuzzy (indicating). It's hard to see, but
10 that seal weld is in this vicinity of the valve itself.
11 Okay.

12 This was found during our normal operating pressure
13 walkdowns. We subsequently repaired by rewelding this seal
14 weld area.

15 Additionally, we noted that this was the second of
16 this type valve to leak. We had found another valve
17 similar to this one leaking at the same area during the
18 first Normal Operating Pressure Test back in the fall. We
19 then noted that we had replaced eight of these valves
20 during the outage.

21 So, we decided to go and do additional inspections
22 on the remaining six valves. We performed dye penetrant
23 tests on the remaining six valves body to bonnet seal area
24 and found them to be satisfactory. This effort provided us
25 with additional confidence that these valves would be

1 leak-free through the next operating cycle.

2 Finally, I would like to take a moment and briefly
3 mention a project that we're currently working on. We're
4 in the process of strengthening nine doors in our turbine
5 building. We determined if there was a main steamline
6 break in our turbine building, some of the doors normally
7 providing access to important equipment could be opened by
8 the initial pressure wave of the break.

9 So, we're taking actions to strengthen the affected
10 doors to minimize the impact of some important equipment.
11 We believe we're improving safety margin of the plant.

12 The last item I would like to mention is the
13 formation of a Mode 2 and Mode 1 Look Ahead Team.
14 Although, we have had the plant in normal operating
15 pressure a couple of times, when we receive permission to
16 restart, there will be additional pieces of the plant that
17 will be put in service for the first time in a couple
18 years. For example, the main feedwater pumps using main
19 steam, the main turbine, and the main generator associated
20 with the main turbine.

21 This Look Ahead Team is taking a systematic look at
22 what equipment problems might arise during restart. The
23 team is then formulating contingency plans. We believe
24 this will position us to be ready and able to quickly
25 respond to any additional equipment issues that might

1 arise.

2 MR. RULAND: Mark.

3 MR. BEZILLA: Yes?

4 MR. RULAND: Just two

5 questions. You said you were going to prepare the Number 1
6 Containment spray pump motor coupling at a later outage?

7 MR. BEZILLA: That's correct. We
8 inspected it, saw no evidence of a similar nature to the
9 slippage we had seen on Number 2, and we have planned for
10 the next time we take that component out of service to make
11 the improvement to the coupling. I think that's in the
12 next couple weeks.

13 MR. ALLEN: Bill, that's
14 currently scheduled for February 16 is the current time for
15 that activity.

16 MR. RULAND: This is a routine
17 outage that you take on the systems on a weekly basis;
18 that's the kind of outage you're referring to?

19 MR. BEZILLA: That's correct.

20 MR. RULAND: And could you
21 refresh my memory about why you were looking at the turbine
22 building doors; why you were doing that analysis?

23 MR. BEZILLA: Yes. I'll do my
24 best, but I have somebody who is probably better in the
25 audience to help me answer that question right.

1 During the outage, we had been looking at high
2 energy line breaks, we were focusing on the auxiliary
3 building and also on the auxiliary feedwater pump area of
4 the turbine building because it has specific like
5 communications to the turbine building proper. And, we
6 assessed those areas.

7 We had made upgrades to some of the equipment
8 associated with the auxiliary feedwater pumps to upgrade
9 their environmental qualifications through the outage, but
10 when we had looked at the turbine building within our
11 updated safety analysis report, we had said in there
12 looking backwards in time that if we had a main steamline
13 break in the turbine building, the pressure increase,
14 because of the volume of the turbine building, would be
15 insignificant and shouldn't pose a threat to any
16 equipment.

17 Well as a follow on to that activity, our engineers
18 were working with a computer model; Gothic Program is what
19 it's called. And as they were working to improve that
20 model, in looking at our turbine building and its main
21 steamline break, we got some information that said, uh-oh,
22 the pressure might be higher than what we had assumed in
23 our Updated Safety Analysis Report.

24 Initially, we had one door that we thought was a
25 problem. So, we took action, I believe it was over this

1 past weekend, to address that one door, but we continued to
2 look at other doors. And then what we saw is that we
3 weren't assured that the pressure pulse that we would see
4 with that break wouldn't affect other areas.

5 And, so, while we were looking at the analysis in
6 parallel, we said, let's just go strengthen the doors and
7 harden the facility in case the analysis shows that we need
8 to withstand a higher pressure. So, we're currently
9 working both paths. We're strengthening the doors to have
10 them withstand a higher pressure shock wave due to that
11 break, and then we're also working on the computer model to
12 see where the pressure is actually at and did we have to
13 make the improvements. But that's where we're at.

14 MR. RULAND: Thanks. So, to
15 summarize; while you've made these fixes now, you haven't
16 reached your final conclusion of how necessary or to what
17 extent those doors need to be strengthened. They may need
18 to be strengthened, but it sounds like you're making those
19 modifications preemptively. Is that, maybe that's the
20 word.

21 MR. MYERS: That's correct.
22 Everybody is nodding their head, that's correct.

23 And we're also doing this, we're taking these
24 actions, the reason we got to look at this, it was an
25 evaluation of a bullet we put in our Corrective Action

1 Program. So, we're taking the actions as part of our
2 Corrective Action Program. That's where we're at at this
3 time.

4 So, we thought it was a really good catch by our
5 engineers. I would compliment them on that.

6 MR. RULAND: If I'm not
7 mistaken, Scott, you can refresh my memory. The NRC, we
8 haven't inspected this area; we have done some preliminary
9 looking about the matter, but --

10 MR. MYERS: That's correct.

11 MR. RULAND: -- we still need
12 to do some inspections in the area.

13 MR. MYERS: That's correct.

14 MR. THOMAS: You still need to
15 finish the root cause.

16 MR. MYERS: Right.

17 MR. RULAND: Okay, thank you.

18 MR. BEZILLA: Okay, next slide,
19 please.

20 Now let me speak of the current plant status. We
21 are in Mode 4 with the Reactor Coolant System at
22 approximately 250 pounds per square inch and approximately
23 260 degrees Fahrenheit. We have two reactor coolant pumps
24 in service and the other two are ready for service. The
25 steam generators are moving heat and the secondary plant is

1 in service with condenser vacuum status. Our safety
2 systems are ready to support Mode 3 and normal operating
3 pressure. And we are working on strengthening the turbine
4 building doors, as I spoke.

5 Next slide, please.

6 In conclusion, the material condition of the plant
7 is good. We will support safe restart. And, as Lew
8 mentioned, as issues arise, they will be addressed through
9 our Corrective Action Process with the focus on improving
10 our margins of safety.

11 Any questions?

12 MS. LIPA: Yeah, Mark, you
13 talked about the nine doors, but also that other plant
14 systems are ready for Mode 3. Are the doors the major
15 restraint from Mode 3 from a hardware perspective at this
16 point?

17 MR. BEZILLA: That's correct,
18 Christine. We had addressed the equipment issues that were
19 initially on our radar screen when we reduced from Mode 4--
20 or Mode 3 to Mode 4, and there's been a couple other items
21 that we've taken care of. The doors are essentially the
22 last hardware item that we need to take care of prior to
23 heating the plant back up.

24 MS. LIPA: Okay. Then Bill
25 talked a little about the doors and why you were looking in

1 that area, but I guess I'm wondering if you can tell
2 whether there might be any similar issues like that that
3 will come up before Mode 3. If you're looking at that
4 issue, and based on why you were looking at that issue, do
5 you have any other issues that are in the same type of
6 not-completely-reviewed-yet category? Do you know what I
7 mean?

8 MR. BEZILLA: Christine, that's a
9 very good question. We have a high volume, low threshold
10 Corrective Action Program. As we do our Restart Readiness
11 Reviews, we scrub those. The management team reviews
12 those; their people review those. And we have affirmations
13 that say, hey, we've looked, we've looked at our workload
14 of corrective actions that are outstanding and we believe
15 that we're acceptable to move forward.

16 Now, can I sit here and tell you absolutely there
17 are no issues in that backlog, no, but I have a high
18 confidence that we have all the issues addressed and are
19 appropriate before we heat the plant back up to Mode 3 and
20 to normal operating pressure and temperature.

21 MS. LIPA: Okay, thank you.

22 MR. MENDIOLA: If I could ask a
23 question about the, related to the reactor coolant valve
24 and the Look Ahead Team. What process did you use to say,
25 hey, we've had two of these valve fails, or two of these

1 valves we replaced now, and then realize you had all this
2 other, all these other valves that need to be looked at and
3 then you went to go look at them. Which one in your plant
4 currently in place programs did you use in following
5 through on that?

6 MR. BEZILLA: That's also a good
7 question. I would say there were two things. We had the
8 first seal weld issue, right. We had walked down the
9 remainder of the Reactor Coolant System, had seen no other
10 issues with these valves. Believed that to be an isolated
11 case within our Corrective Action Process. Took care of
12 that as a go fix-it item. All right.

13 During the second walkdown, when we had a second
14 valve that we found, again, through our Corrective Action
15 Process and through Management Review, we said, hey, this
16 is the second item. Hey, it's similar to these other six
17 valves that we put in. Let's not wait. Let's go take some
18 additional action.

19 So, it was our Corrective Action Process that we as
20 management team meet every morning. We review the
21 Condition Reports and we also look for trends and/or things
22 that may require additional attention.

23 MR. MENDIOLA: Is this something
24 that the Look Ahead Team may be addressing or would
25 address?

1 MR. BEZILLA: Yes. What the
2 Look Ahead Team did is, we took some previously or
3 currently licensed individuals and, from various
4 disciplines; put them together and said, hey, based on some
5 of the things we've seen through the first normal operating
6 pressure test and the second rise in normal operating
7 pressure, take a look at all of our equipment that has not
8 yet been placed into service or other equipment that we
9 will, when we get permission to restart, be putting into
10 service. What problems have we seen in the past? What
11 problems has the industry seen? And are there things that
12 we can either go check or have contingencies in place that
13 are more probable to occur as we start placing those into
14 service.

15 So, that was the charter of the team.

16 MR. MENDIOLA: Okay, I understand
17 the difference, thank you.

18 MR. BEZILLA: Okay.

19 MR. GROBE: Before you go on,
20 Mark. Two, actually one question about two items on slide
21 number 10.

22 The first one was the Aux. feedwater casing leak and
23 the containment spray pump motor coupling problem. What
24 were the causes of those two issues?

25 MR. BEZILLA: Jack, the first

1 one is the Aux. feedwater pump turbine casing leak. This
2 is like a metal to metal fit. Okay. We had used some
3 Electric Power Resurge Institute, EPRI. We had used EPRI
4 guidance and Terry Turbine to assemble our component. I'm
5 getting into sort of the bug dust, right, but you put down
6 this glue, if you will, and then you put this bead of
7 sealant material in there. And we did that during the
8 outage. We also did that after the first NOP test, right.
9 We still had a slight case leak.

10 So, this time, what we did is we got the vendor of
11 the person that makes this sealant media, if you will, this
12 material. We had them and we had the turbine vendor in.
13 What they said is you need two beads of this stuff. You
14 need to double this up. They gave us like an engineering
15 joint, if you will, which went beyond the guidance. The
16 EPRI guidance that was out there.

17 So, we used vendor intelligence as well as the Terry
18 Turbine vendor in intelligence and we believe we have a
19 stronger, and we have more confidence in the joint. Again,
20 I won't be a hundred percent competent until I get up to
21 NOP, normal operating pressure, and run my surveillances
22 and put steam through the turbine, but we believe it just
23 wasn't a good enough joint, and that was based on the
24 information we got from the vendors.

25 MR. GROBE: Is this a commonly

1 used sealant material?

2 MR. BEZILLA: This is commonly
3 used sealant material and we were using industry guidance
4 to make this seal. We will give feedback to the industry,
5 if we see that the seal doesn't leak when we get up to NOP,
6 we will send that out on generic guidance.

7 Now, from a containment spray pump motor, the pump
8 coupling --

9 MR. THOMAS: Before we leave,
10 the Aux. feed pump, there was also a moisture and lube oil
11 issue associated with this low pressure steam leak. Have
12 you conclusively determined that that issue was a result of
13 this low pressure steam leak or, I guess have you
14 determined the cause of that yet?

15 MR. BEZILLA: Right. Scott's
16 question has to do with moisture intrusion into the bearing
17 housing that houses the oil for one of the bearings
18 associated with the turbine. The steam leak was in the
19 vicinity of the bearing. And that bearing has a dust cover
20 and has a labyrinth seal to keep the oil in and keep stuff
21 out. But the steam moisture could come over there, we
22 believe was migrating into that myriad housing.

23 Scott, we're taking samples. We took samples when
24 we ran Aux. feed. We also take samples when we get up to
25 NOP and do the testing in NOP. We believe that that slight

1 casing leak in the bearing was causing the water
2 intrusion. We'll take samples to assure ourselves and once
3 we're able to get back to test the component at normal
4 operating pressure.

5 MR. MYERS: (inaudible)

6 MS. FRESCH: I'm sorry. I couldn't
7 hear you.

8 MR. BEZILLA: Lew was talking about
9 the volume of water. We started out at like 80 part per
10 million, just fresh out of the barrel. And after we had
11 run the components, we saw like 160 parts per million and
12 then it was up to 180 parts per million. That equates to
13 maybe six drops of water, from a quantity and volume
14 standpoint.

15 MR. GROBE: And the cause of
16 the containment spray pump to motor coupling issue?

17 MR. BEZILLA: Yeah, containment
18 spray pump, Barry, you may be more knowledgeable than I am
19 on that. Do you want to address that?

20 MR. ALLEN: Sure. Jack, the
21 containment spray pump coupling, the way that coupling was
22 designed to be installed on shaft was an interference fit,
23 and it only had one set screw, but the set screw did not
24 actually go down to the shaft itself; it actually went to
25 the key, to kind of help secure the key.

1 And so we disassembled that -- actually before we
2 disassembled it, we just kind of quarantined it to do an
3 investigation. You can see where we hit, it's blue
4 originally, and you can see the offset of marks where it
5 had moved, the coupling had moved.

6 So, what we found is we did not have the desired
7 interference fit on it. I don't know the exact, it's been
8 in service a long time, so over many years. It had
9 essentially, I think that coupling had moved to the point
10 where it got us off our, you know, our magnetic center
11 versus our thrust on our pump.

12 So, we went to inspect the other containment spray
13 pump, verified that there had not been any movement there,
14 but again, we plan on dealing with that issue in February,
15 to protect the tray, which is a good time from a safety
16 perspective to go work on that pump.

17 But essentially, we wound up coming back, remachined
18 the couplings, with the vendor got the design interference
19 fit we needed for the coupling, and then reinstalled that
20 back on the shaft.

21 MR. GROBE: Okay, thank you.

22 MR. BEZILLA: Okay. If no more
23 questions, I'll turn it over to Barry Allen, my Plant
24 Manager.

25 Barry.

1 MR. ALLEN: Thank you, Mark.
2 Good evening. As the new Plant Manager at
3 Davis-Besse, my desired outcome tonight is to update you on
4 the actions I've taken since our previous public meeting.

5 During the recent plant heatup, I monitored the
6 implementation of our operational administrative controls,
7 and through that observation I concluded that while our
8 existing procedural controls were adequate, our
9 implementation of those controls did not meet my standards
10 for performance.

11 Next slide.

12 During the heatup, I saw three administrative
13 control issues which concerned me. The three issues are;
14 first, our operational-type activities were not adequately
15 detailed and described in our integrated work schedule to
16 the level they needed to be. Second issue I saw was we
17 failed to recognize and appropriately log one technical
18 specification entry. The third issue we saw was one
19 instance of technical specification action not being
20 completed within the allotted time.

21 What I want to share with you tonight is the actions
22 that I've taken to improve our operational control and
23 elevate those up to meet my standards.

24 In order to thoroughly evaluate our operational
25 control issues, I chartered a very small, but experienced

1 Root Cause Team to assess our performance against FENOC and
2 industry standards. The team was set up to assess the
3 issues, determine the causes, and recommend corrective
4 actions.

5 We had an 18-member team assembled and we asked Jim
6 Powers, who is here, who is our Director of Engineering, to
7 sponsor that team. Jim is not in a direct chain of command
8 with the Operations organization, so it gave us a good
9 independent look for response from that team.

10 We had an extremely strong team, and the team leader
11 we utilized was Russ Kearney, who is our Operations Manager
12 of our Perry station. We also brought over the Operations
13 Manager, Pete Sena, from the Beaver Valley station. Also,
14 listed several Shift Managers there from FENOC plants that
15 were on the team: Ray Hruby also from Beaver Valley. They
16 also included Tom Veitch. He's our FENOC Operations
17 Programs Manager. So, he's kind of common Conduct of
18 Operations individual from the corporate perspective.
19 Again, other individuals on that team are listed that we
20 used to form that Root Cause Team.

21 The FENOC Team independently identify three root
22 cause issues. The first issue is Operations shift
23 personnel did not consistently implement our standards and
24 qualities. Second issue they identified was our Operations
25 shift supervision did not consistently enforce our roles

1 and responsibilities. And the third issue they identified
2 was our Operations leadership was ineffective in correcting
3 the inconsistent performance.

4 Next slide.

5 MS. LIPA: Barry, before you
6 move on. Maybe you'll get into more details later, but
7 with root causes you also say why, why, why. Do you have
8 some reasons why these things occurred or will you get into
9 that later?

10 MR. ALLEN: I think I'll cover
11 that, Christine, if you give me a little more time.

12 MS. LIPA: Okay. Go ahead.

13 MR. ALLEN: Let me back up.

14 Just go back one slide.

15 I think it's probably best to answer that here,
16 Christine. That's a good question. If you look at the
17 first bullet up here, it says, "Our shift personnel did not
18 consistently implement our expectations and standards in
19 the field." And you ask why? That will drive you to the
20 second bullet, which really is "Our shift supervision was
21 not holding our folks out in the field accountable to
22 properly enforce those roles and responsibilities." And if
23 you ask why that occurs, then you really come down to the
24 third bullet in the root cause which was "Our leadership
25 was ineffective in holding the organization accountable to

1 correct the deficiencies we identified."

2 MS. LIPA: Thank you.

3 MR. GROBE: Let me take that

4 just a little bit further, Barry.

5 The first bullet, "Inconsistent implementation of
6 the work control and surveillance test." I think actually
7 the wording in the Root Cause Report, it says, "Operations
8 shift personnel are not consistently exhibiting
9 accountability and ownership to perform the requirements of
10 the Work Control Process, Conduct of Operations, and
11 Surveillance Test Program."

12 Is that because they didn't know what the
13 requirements of those programs were?

14 MR. ALLEN: Jack, I believe in
15 most cases, I believe we understood what the requirements
16 were. I think we challenged the organization some. For
17 instance, I'll go back to the, not having the proper level
18 of detail in the Operations schedule. I think in some
19 cases we did not have owners assigned to those activities.
20 We did a poor job of executing those in some cases.

21 In other cases, I believe we knew what the
22 requirements were and met our procedural requirements.

23 In some cases, we saw other tech instances, where we
24 saw not procedural requirements, but expectations as
25 something to strive for, not necessarily something we saw

1 at the site level rigor or procedure requirement, so we
2 were not executing those as we should have. And we were
3 not holding folks to meet those standards.

4 MR. GROBE: So, some
5 scheduling issues and work assignment issues, people didn't
6 fill ownership for certain activities and they did not
7 follow your procedures; and then management, your
8 supervision and also your management didn't adjust that to
9 oversight and mentoring and training or whatever was
10 necessary?

11 MR. ALLEN: That's correct.
12 You know, for example, we debriefed some of the
13 information of the RRATI Team had previously. Some other
14 things, like prejob briefs, you know, not consistently
15 using the format in prejob brief and some of those type
16 issues also.

17 MR. GROBE: Right. I think
18 also with respect to prejob briefings, all the right people
19 weren't necessarily at all the briefings.

20 MR. ALLEN: That is correct.
21 In the third bullet we had there on the tech spec aspect,
22 which we did not complete within the allotted time. The
23 Maintenance personnel did not attend the same brief that
24 the Operations personnel did. So, we did not meet our
25 expectation.

1 MR. GROBE: How does this
2 relate to the issues regarding inadequate prejob briefs
3 that you previously identified in taking actions to
4 address?

5 MR. ALLEN: I believe we have
6 made tremendous progress on our prejob briefs, Jack. And I
7 think they've been very consistent. Previously, we had not
8 identified an issue with not involving, like the test down
9 in Maintenance up in the control room face-to-face with the
10 reactor operators, and with the senior reactor operators.

11 So, this was not an issue I had seen before;
12 however, in the missed tech spec action, in one action,
13 that was pretty clear once we took a look at that event,
14 that we had a good brief from a Maintenance perspective in
15 the Maintenance shop, but they did not have really the tech
16 spec knowledge and training to understand where they were
17 in terms of technical specifications in that mode.

18 And then, whereas, the operators, the licensed
19 operators had knowledge and responsibility, they did not
20 communicate that information to Maintenance personnel. So,
21 we started that activity not being on the same page as we
22 should be.

23 MR. GROBE: Okay. Good.

24 There was just one other technical specification
25 action statement represented a unique opportunity for you

1 to observe your staff.

2 Feedback is a challenge. (microphone)

3 And it was in this short time frame emergent-type
4 issue that these deficiencies manifested themselves. Do
5 you have plans to observe activities over the next several
6 weeks, similar activities?

7 MR. ALLEN: Jack, we are
8 observing those activities every day. Kevin is going to
9 talk in great detail about that.

10 MR. GROBE: Okay.

11 MR. ALLEN: In fact, for the
12 last several days, every time we get entered, an action
13 statement, tech spec, or fire hazard analysis, any type of
14 license requirement or have exited that, we begin to
15 acclimate. So, all throughout the day, we're able to
16 observe, even if we're not in the plant site, because we're
17 entering and exiting LCO for that. So, we have quite a bit
18 of rigor instituted on that.

19 MR. GROBE: Okay.

20 MR. MYERS: You know, it's
21 important to say too, as we come through this entire heatup
22 and everything, that we've done all the surveillances we
23 talked about. There were probably hundreds of
24 surveillances and these are the three issues we saw on the
25 surveillances. We did the others successfully.

1 Even though the one you were just talking about,
2 there was communications between Operations and
3 Maintenance; and Operations told Maintenance to put the
4 transmitter back in service. Well, Maintenance did that.
5 They did exactly what they were told, but they took longer
6 to do it than the one hour.

7 And they went through a, they went and did a formal
8 procedure change process. We really have been focusing on
9 procedure adherence. They went through the normal
10 procedure change, and got that completed and went and put
11 that valve in.

12 What we felt happened is communications of the need
13 of urgency wasn't there. So, there was dialogue between
14 the Shift Manager and the Maintenance Craft, but it wasn't
15 good, close, good communication. You have a one hour
16 action, we need this put back right now. That failed.

17 MR. THOMAS: But the flip side
18 of that is, it wasn't followed up by the Operations' staff
19 to ensure. There was no time clock running for them to
20 ensure that action, because it's their responsibility.

21 MR. MYERS: Right, right, we
22 would agree with that. We've done some things that Barry
23 talked about. We're increasing the barriers, that
24 institution of responsibility shift. Barry discussed
25 that.

1 MR. ALLEN: Actually, I'll
2 let Kevin speak to that too. I think that's a good example
3 now, for instance, when we do that, we actually designate a
4 reactor operator to be responsible to track that. And,
5 then, the other day, we exited two reactor operators with
6 two independent timers, you know, timing an action
7 statement. So, I think we've come a long ways in that to
8 involve the reactor operators in that oversight.

9 MR. MYERS: One of the things
10 we wanted to do was strengthen our leadership. It's our
11 experience at the other two stations that the reactor
12 operators perform that function. We don't see the same
13 function being done exactly the same way at the Davis-Besse
14 plant. We can't see that until we get up into these
15 situations.

16 So, what we've done, that's one of the reasons we
17 have to make the moves, put Kevin in charge of Operations,
18 because he's worked in all three of our plants and knows
19 how we take, take information out, how the roles and
20 responsibilities are consistent with all of our other
21 plants. We think that will strengthen our leadership at
22 the plant.

23 MR. ALLEN: Next I would talk
24 about actions taken. First thing we did was charter a High
25 Impact Team to assess our Conduct of Operations.

1 Essentially we assessed our Conduct of Operations
2 against FENOC standards and against industry standards. We
3 found some areas that we could improve in, but it
4 essentially showed me that if we consistently implemented
5 existing procedures or processes that we had in place, we
6 should have gotten a satisfactory performance.

7 Okay. We found some areas to improve, but we
8 overall had a pretty good process. Nevertheless, based on
9 the deltas that this High Impact Team found, we've taken
10 actions to form additional rigor in our operational
11 administrative controls and talked about a couple of those
12 briefly; let Kevin talk about those in more detail in his
13 presentation.

14 Also, I think in regard to this, that we've had
15 significant changes in Operations leadership with Kevin and
16 Dave here tonight presenting that change in leadership.

17 Also we chartered and implemented a new Shift
18 Manager Peer Verification Program to provide effective
19 review of our operator action and corrective actions
20 taken. I think we discussed before about our oversight
21 managers and how we've had those folks in an oversight role
22 back, fairly nonintrusively from a crew standpoint. What
23 we've done now, we're using shift managers from other
24 stations, top individuals, and they're actually providing
25 peer verification to the shift managers and senior reactor

1 operators in the control room.

2 So, we're not monitoring these monitor activities
3 throughout the plant. As the shift manager now, SRO gets
4 out the tech specs to look at actions he's taken, we're
5 actually requesting an independent peer verification from
6 this shift manager. So, that's helping us ensure we're
7 doing a good job in meeting our standards and
8 requirements.

9 So, we're utilizing those individuals as we enter
10 the next tech specs, place systems in and out of service,
11 to perform surveillances, as we perform post-maintenance
12 and post-modification testing, we're getting a peer
13 verification. It's not a peer check, they don't sign on
14 our process and procedures; we are getting a peer
15 verification.

16 Also assign managers to monitor specific corrective
17 actions, so as we laid out corrective actions to take to go
18 deal with our Conduct of Operations, we've assigned
19 specific line managers with specific activities and
20 functions to go monitor and assess our effectiveness in,
21 and then to provide feedback to Kevin.

22 I won't go through all of them, but for instance,
23 are we actually getting peer check on tech specs? Is a
24 reactor operator actually authorized to do maintenance work
25 to stop. We're getting the reactor operator to sign at the

1 same time the senior reactor operator signs the work
2 order.

3 Is the shift manager actually spending, is he
4 actually maximizing the amount of time he can spend in the
5 control room as opposed to being involved with other
6 activities? So, managers have those specific records to go
7 out and monitor and then document that for observation data
8 base, but yet relay to Kevin and he'll have that on a
9 timely basis.

10 And we've added more detail of our operational
11 activities into the integrated station work schedule. So,
12 if you look now, you'll see, you can see procedure status
13 even in our work schedule. We may have swung a little too
14 far, but you'll see things like initiate mod, temperature,
15 and pressure to Attachment 18. You'll see the Reactor
16 Coolant System gets to this temperature, close this valve.
17 So, we actually have a very fine level of detail for many
18 of the operations out here.

19 Next slide.

20 MS. LIPA: Barry, you talked
21 a little about benchmarking with the other FENOC plants.
22 How do you see these actions; bringing you in line with the
23 other plants, or improving things, so that Davis-Besse is a
24 leader among the other plants; where do you see this in
25 regard to that?

1 MR. ALLEN: Well, I think, I
2 think -- why don't you back up a slide, Kevin. We'll go
3 back and look at the actions talked about.
4 The Impact Team that we chartered, that was made up
5 of, that was made up of folks, we had a Beaver Valley shift
6 manager, actually two Beaver Valley shift managers, a
7 Davis-Besse instructor, Perry shift manager and Davis-Besse
8 shift manager on that team. They work pretty much in
9 parallel with the Root Cause Team, so we have folks in that
10 group.

11 What we were looking for was not just how does
12 Davis-Besse's Conduct of Operations with a capital C,
13 Conduct of Operations, compare with FENOC, but at the same
14 time we took, like, INPO, Institute of Nuclear Power
15 Operations, publishes a Conduct of Operations guide.

16 So, we also, when we were looking at deltas, it was
17 not just what's our delta between ourselves and Perry or
18 our delta between ourselves and Beaver Valley, but also
19 what's our delta between the industry standards in our
20 Conduct of Operations.

21 So, it's a tool utilized not only to help
22 Davis-Besse see if we have some areas we could improve from
23 a FENOC standpoint, but also what can we do to align with
24 the optimum best in the industry.

25 MR. THOMAS: Did this Root

1 Cause Team and High Impact Team, did they give you any
2 specific examples of where Davis-Besse was outlayers?
3 Let's limit it to FENOC, when we compare it to Beaver
4 Valley and Perry.

5 MR. ALLEN: Yes, Scott, we
6 have about, it's about a three or four page list. When I
7 look through it, one of the things that, from a Davis-Besse
8 perspective, okay, checked out was, we had not done as
9 clear a job of, say, defining our roles and
10 responsibilities as our sister units had done. Okay.

11 So, the other FENOC stations had more clear roles
12 and responsibilities for reactor operators, for instance,
13 to say, hey, that individual needs to help monitor, or that
14 individual specifically will be assigned a track action
15 statement, for a short duration on CO's. The reactor
16 operator then will get the annunciator, will actually get
17 the annunciator response procedure out and go through it as
18 opposed to the unit supervisor.

19 So, they had some, I mean, we had all those actions
20 described for someone in our organization to do, for
21 instance, but we didn't have it at the same level and
22 descriptiveness as our sister stations did.

23 I mean, there's some deltas there, I think we'll
24 take advantage of. Now, we have Tom Veitch, who again is
25 on the Root Cause Team, who is the Operations Program

1 Manager for FENOC. So, he's taking all that information
2 back I believe the first week of February, and the
3 Operations for FENOC will get together to work on some of
4 the common Conduct of Operations. So, we would take
5 advantage of that information.

6 MR. THOMAS: Okay.

7 MR. ALLEN: In conclusion, our
8 implementation of our Operational Administrative Controls
9 during the recent heatup did not meet the standards that I
10 require.

11 The FENOC Root Cause Team essentially handed me a
12 platform that I could utilize to drive immediate
13 significant improvement throughout the Operations
14 Organization from the top down and then to anchor that
15 policies change and the Conduct Of Operations in our
16 programs and processes.

17 I believe I've taken strong actions to strengthen
18 our barriers, which will help provide our defense of depth,
19 to help discover, get to the error and event situation.
20 The competent individual barrier, if you take a look at
21 that, I think we strengthened and formalized our roles and
22 responsibilities of both our Reactor Operators, our Senior
23 Reactor Operators and our Operations leadership to improve
24 our individual performance there. Kevin will again talk
25 about some of that in more detail.

1 And although our operational administrative controls
2 were adequate, we have implemented more formal control and
3 rigor to strengthen those Conduct of Operations programs
4 and processes. And, again, Kevin is going to give you more
5 detail what we've done specifically to help shore up and
6 strengthen and broaden that wall.

7 We believe we strengthened our management barrier by
8 placing Kevin and Dave in key leadership positions. And
9 they're in positions in which they have previously been
10 successful. So, we feel extremely good about the
11 experience that we've had in our Operations Manager and
12 Operations Superintendent.

13 We've also strengthened our independent oversight
14 barrier, through our more intrusive Shift Manager Peer
15 Verification Program, and through our line manager
16 monitoring specific corrective actions for consistency and
17 for effectiveness, and timely feedback to both the
18 Operations Manager and myself.

19 Any questions?

20 If not, I would like to turn the presentation over
21 to the Operations Manager.

22 MR. GROBE: Barry, I just have
23 one. The words you used was Operations Peer Manager, Shift
24 Manager Peer Verifiers.

25 MR. ALLEN: Shift Manager Peer

1 Verifiers, that's correct.

2 MR. GROBE: Could you explain
3 the difference between the Operations Oversight Manager and
4 this position in a little bit more detail, and share with
5 us where these Shift Manager Peer Verifiers are coming
6 from.

7 MR. ALLEN: Yeah, Jack, I
8 would be glad to. The Operations Oversight Managers were a
9 combination of FENOC employees, typically shift managers
10 and industry folks we brought in. And we essentially put
11 those individuals in a position where we asked them, and we
12 targeted them, depending on what we were seeing at
13 different issues that we wanted to get some independent
14 looks and oversight.

15 Those individuals were tasked really with providing
16 coaching to the shift manager. Okay. So, they were
17 nonintrusive. Essentially asked them to not be disruptive
18 of controller crews. To take notes and feed us those
19 observations on observation cards. And when appropriate,
20 in quiet time or whatnot, they provide some input, coaching
21 to the shift manager and/or the unit supervisor, if the
22 shift manager was not available.

23 So, we clearly had them in a classically defined
24 oversight role, if you would like to think of it like
25 that.

1 The Shift Manager Peer Verification Charter was
2 written up. And, again, that's not intended to provide
3 oversight; it's actually intended to structure an informal
4 peer verification of licensed activities that our shift
5 managers and supervisor are taking.

6 So, an Operations Oversight Manager might have stood
7 back and after an evolution occurred might have made a
8 comment that said, "I think you should have gotten the tech
9 specs off the shelf and looked at them as opposed to
10 relying on memory." That might have been an observation.
11 And, we might have taken that and dealt with it, you know,
12 as we gathered that.

13 The way this is structured, when that SRO is
14 actually making a tech spec entry or exit, he actually has
15 to turn to the shift verifier and ask him for verification
16 that he's, he's basically taking correct action. So, it's
17 just a much more intrusive verification of not only, Jack,
18 I think, the actions we're taking, but the thought
19 processes we're taking in ensuring that we do have the
20 right individuals actively engaged in that.

21 So, the things that Kevin is going to talk about,
22 we're involved with our reactor operators and all of those
23 kind of folks to make sure they're helping us be successful
24 and not relying on one individual in the control room to
25 make a call. They're there verifying, if it's my

1 responsibility as unit supervisor, the designated reactor
2 operator to track his time clock, they're there to verify
3 that we're there to do that, log that appropriately in the
4 unit log who did that. So, they're given a very intrusive
5 look in that respect.

6 MR. GROBE: And who are these
7 people, the peer verifiers?

8 MR. ALLEN: There will be one,
9 at this time it will be one outside FENOC individual from
10 Entergy, who has been here as an oversight manager. The
11 others, we're utilizing FENOC employees, the majority of
12 which are coming from Beaver Valley and Perry stations.

13 But one of the things we did validate and we went
14 back in the Operations Oversight Manager Data we had
15 gotten. We got quite a bit. There was a mixture of FENOC
16 employees and also industry folks from the outside. We
17 saw, looking at that data, that our FENOC folks were as
18 critical or more critical on average than what we were
19 getting from the industry folks.

20 So, we got quite a bit of run time over the
21 Oversight Manager Program. Looked like we were getting
22 pretty consistent valve results from both FENOC and
23 external employees; and, therefore, we elected to let the
24 majority of the independent folks return to their home
25 stations, and we're utilizing FENOC.

1 MR. GROBE: And the principle
2 focus of these peer verifiers is going to be Conduct of
3 Operations and not operational decision-making; is that
4 right?

5 MR. ALLEN: That's correct.

6 MR. GROBE: Because these guys
7 are not licensed on Davis-Besse?

8 MR. ALLEN: That's correct.

9 And the rules of engagement are, Jack, it does not alter
10 responsibility of the licensed operators to take
11 appropriate action to protect the health and safety of the
12 public. And if there is any question about action to be
13 taken, the licensed folks on shift, it's their
14 responsibility to make that decision. They do not need
15 concurrence from a shift manager, peer verifier. They are
16 merely put in there to help us improve our performance and
17 to coach us through everything we can to verify one on
18 one.

19 But they are clearly not of our shift, they have no
20 responsibility, authority, or accountability for actions of
21 the shift, other than they report to me as Plant Manager
22 and they provide me feedback, and feedback to Kevin, on a
23 daily basis.

24 MR. GROBE: Okay, thank you.

25 MR. THOMAS: Before we leave

1 the root cause, did the Root Cause Team provide you any
2 assessment of the quality of the Corrective Actions
3 developed as a result of the issues that you, that occurred
4 during the Normal Operating Pressure Test?

5 MR. ALLEN: The Root Cause
6 Team looked at not only this event, but they did go back
7 and look at a couple other events. And what they said was,
8 some actions that you had out there looked like they might
9 have been affected, but we did not implement them yet.
10 They identified some other actions that we had not done an
11 effective job of implementing. So, we got some feedback
12 from the team, that's correct.

13 And, again, as Lew said, they gave us some feedback
14 on some actions that they felt like we implemented very
15 well.

16 MR. THOMAS: Did they come to
17 any conclusions or opinions on whether if you would have
18 carried through and implemented them correctly, did they
19 believe that, how would that have impacted your performance?

20 MR. ALLEN: Scott, I think I
21 go back to what I said earlier, if you laid out our rules
22 for Conduct of Operations, had we done a good job of
23 consistently performing in the requirements we had, of
24 holding ourselves accountable for that performance, we
25 would have been successful.

1 That's what I got from that team. Yeah, we can
2 improve our Conduct of Operations, Procedures and
3 Standards, but if you've done a good job with consistent
4 implementation, you know, you should be successful.

5 So, that's really I think more, we got that insight
6 from the Root Cause Team and again from the High Impact
7 Team. We went and looked at the deltas between us, and
8 those between FENOC.

9 MR. THOMAS: All right.

10 MR. MENDIOLA: Jack's question
11 put a thought in my mind. Specific question is, did this
12 Root Cause Team provide any operational improvement
13 specific actions to take versus these global generic
14 actions to take?

15 MR. ALLEN: Yeah, that's
16 really the thrust of Kevin's presentation, Tony. Kevin
17 will go through those in some detail.

18 MR. MENDIOLA: I'll hold the
19 questions until then.

20 MS. LIPA: Any other
21 questions for Barry?

22 What we're going to do now is take a ten minute
23 break and then we'll go to Kevin.

24 Thank you.

25 (Off the record.)

1 MS. LIPA: Okay. Go ahead,
2 with Kevin.

3 MR. OSTROWSKI: Thanks,
4 Christine.

5 Good evening everyone. My name is Kevin Ostrowski.
6 I'm very excited to once again be part of FENOC
7 Operations.

8 This evening, I'll be communicating to you my
9 charter from my management, my assessment of Operations,
10 strengthen controls and accountability for strict
11 compliance in the implementation of the Conduct of
12 Operations, and the Corrective Actions Effectiveness
13 Assessment during our heatup to normal operating pressure.

14 My charter for Lew, Mark and Barry is simple and
15 it's in alignment with our FENOC position. That is
16 "Safety-focused plant operation through consistent
17 implementation of a rigorous Conduct of Operations."
18 I'm committed to this charter, and every day keep focused
19 on nuclear, industrial, and radiological safety.

20 My Assessment of Operations is based on three
21 tools. First, the Operations Improvement Plan
22 Assessments. These were done during the Normal Operating
23 Pressure and Temperature Tests. I also have received
24 feedback from the on-shift management observers, and I'm
25 also using my daily face-to-face communications and

1 observations with my Operations group staff.

2 My initial observations is that there was improved
3 performance in the most recent heatup and cooldown, based
4 upon the Operations Improvement Assessment.

5 I've also observed improved organizational
6 leadership by the shift managers. For example, in the last
7 eleven days, I've observed the shift manager and just
8 recently demand that a nitrogen bar be replaced on the
9 service water valve to preclude that particular system to
10 becoming inoperable.

11 I also noted another shift manager concerned with
12 the return to service and safety-related equipment that
13 demonstrate focus on the schedule for return to service of
14 that piece of equipment.

15 And also on a daily basis I hear the equipment
16 operators routinely communicate to the shift managers the
17 need for timely equipment return from Maintenance. For
18 example, this morning, an equipment operator noted that
19 there was timely maintenance required on a control room
20 drive mechanism fan and the reactor coolant system vent
21 valve.

22 I have observed that the, there has been
23 improvements in the shift turnovers, the prejob briefings
24 and log injuries, specifically of tech spec actions have
25 been taken.

1 I have observed shift managers engaging the
2 organization in plant issues. Last week, we had a shift
3 engineer that asked for and received timely resolution to a
4 bolt inspection problem that was identified. And recently,
5 I heard a shift manager get timely response from the lube
6 oil system engineer and the system engineer for the motor
7 vehicle feedwater pump on a question he had with an
8 observation of the local lube oil level indication.

9 The Operations Improvement Assessment Plan also
10 identified that the operators have been adhering to the
11 plant procedures, and it was noted that their operating the
12 plants was consistent with the training.

13 There have been a noted couple of areas where there
14 are opportunities for improvements, specifically in the
15 area of Conduct of Operations. The Conduct of Operations
16 did not meet our fleet standards. In the recent example of
17 the tech spec action not completed in the time allotted,
18 we needed to improve the tracking of tech spec actions by
19 the shift manager, the unit supervisor, the reactor
20 operator, and include emphasizing this information in the
21 prejob briefings.

22 There have also been inconsistencies in the
23 ownership and accountability as evidenced in the various
24 issues identified during the Normal Operating Pressure and
25 Temperature Tests.

1 MR. RULAND: Kevin?

2 MR. OSTROWSKI: Yes, sir?

3 MR. RULAND: As I understand

4 it, these initial observations were based on what you

5 described in the previous slide about the assessment tools;

6 is that, on slide 23, you discussed these observations?

7 MR. OSTROWSKI: That's correct.

8 MR. RULAND: The previous

9 slide, you listed the assessment tools. I'm inferring from

10 that, these are the tools that ultimately led to these

11 observations.

12 MR. OSTROWSKI: That's correct,

13 Bill. The Operational Improvement Assessment Plan

14 assessment, I was able to read through and get the feedback

15 from the oversight managers and the assessors on a couple

16 of those items; namely, the heatup and cooldown

17 performance, as well as the adherence to plant procedures

18 and the consistency of the operation of the plant with the

19 training.

20 MR. RULAND: From those three

21 different assessment tools, is there any differences in how

22 those three different tools, the conclusions, the

23 conclusions or the, I should say the outputs that you're

24 getting from those tools? Do you see any discrepancies

25 where one tool might say that, just hypothetically, that

1 operating the plant consistent with training, and maybe
2 another tool said something slightly different.
3 I'm just trying to understand if there was any
4 differences between what those tools had been telling you?

5 MR. OSTROWSKI: Bill, I
6 can't think of any specific examples with things that would
7 have demonstrated inconsistencies between the tools.

8 I know that the two items, the oversight managers,
9 the on-shift observers, were a large input to the
10 assessment plan as well. That data has been fairly
11 consistent with regards to the observations, and it's those
12 observations that help build the assessment.

13 So, I can't say there was any significant
14 differences in those assessment tools. In most of the
15 items I have on my initial observation is from my first
16 eleven days of actual personal contact with the shift crews
17 in day-to-day operation. And that is the items that I can
18 say have been encouraging to see that there have been
19 improvements in some areas. Nonetheless, there is still a
20 need for improvements in the consistency of the Conduct of
21 Ops.

22 As had been previously mentioned, the analysis of
23 the Conduct of Ops that was done between the three stations
24 and the INPO Conduct of ops, does contain and show that
25 there are numerous areas where we need to be more specific

1 and more rigorous with regards to our approach to the
2 Conduct of Operations. As well, we need to continue to
3 emphasize and drive the ownership and the accountability
4 for the operation of the station.

5 We need to be an Operations driven organization.
6 And I see in the last eleven days, I've seen, as I pointed
7 out in the examples, things that have told me that we are
8 moving in that direction. So, it has been encouraging to
9 see the shift managers, the operators, the unit supervisors
10 and equipment operators are showing that they do have
11 ownership for the station. And I've certainly committed to
12 them my support to help them become an Operations driven
13 organization.

14 MR. RULAND: Thank you.

15 MR. OSTROWSKI: Barry spoke about
16 the Root Cause Analysis on the tech spec action that was
17 not taken in a timely fashion. As a result of that root
18 cause analysis that Barry spoke of, we took Barry's
19 corrective actions. Today, the reactor operators co-sign
20 for the authorization of maintenance on safety-related
21 instrumentation.

22 Just yesterday, we had two reactor operators work
23 closely with the shift manager in looking at a specific
24 tech spec for a reactor protection system channel. It was
25 the reactor operators who helped the shift manager work

1 through the tech specs and actually made a very accurate
2 determination of the requirements for the tech spec. As it
3 turned out, it was not necessary to enter the tech spec
4 because we had the appropriate number of channels, but it
5 was the involvement of the reactor operators that was
6 different, certainly demonstrating ownership and teamwork
7 with the application of tech specs.

8 Today we require peer checks on technical
9 specification actions. We ask for a member of the
10 operating crew to peer check the individual reading aspects
11 and require that they actually log the name of the peer in
12 the station log.

13 We have improved turnover of tech spec actions. If
14 a tech spec action goes through a turnover, we are
15 requiring that the, that the owner of the tech spec action,
16 in this case, for example, the reactor operator, to log the
17 name of the next reactor operator that has taken the
18 turnover and the ownership for the tech spec action.

19 We have improved the log injuries for the tech
20 specs. We require more explicit details with regards to
21 the time of injury, exit, the required actions, and as I
22 said, the owner for the tech spec action and the tracking
23 for that.

24 As Barry mentioned, we also set a timing. It's
25 another reminder, another defense mechanism to alert us

1 before a tech spec action will come due. As example of a
2 tech spec action were to be a one-hour action, the timer
3 may be set for a half an hour. And, understand where
4 you're at halfway through that period so you can take
5 appropriate action before the one hour comes due.

6 Barry also mentioned the use of the peer reviews.
7 And I can very firmly answer your question, Jack, with how
8 these peer verifiers are being used. I've had the
9 opportunity in the last three days to talk to all of the
10 licensed operating crews, where we discussed the
11 expectations of both the peer verifiers as well as the
12 operating crews.

13 I was very passionate about this particular item and
14 I've very strongly communicated the fact that these peer
15 verifiers are peer verifiers; they are not members of the
16 line organization; and as such, the shift manager and the
17 crews have the ultimate responsibility and the ownership to
18 operate the station in accordance with the license and by
19 technical specifications.

20 The peer verifier is a peer. They will help us and
21 if they are not present, we are to operate the station in
22 accordance with our license.

23 So, that role and responsibility has been clearly
24 communicated to the operating crews. As a peer is
25 available, they can use and they should use that peer.

1 It's another defense mechanism.

2 Currently, I'm handling the individual
3 accountability in accordance with FENOC policies,
4 including Human Resources and the use of the Safety
5 Conscious Work Environment Review Team. I feel strongly
6 that these and other Corrective Actions support plant
7 heatup.

8 MR. THOMAS: Kevin, can I ask
9 you a question real quick?

10 MR. OSTROWSKI: Yes.

11 MR. THOMAS: Two of the
12 specific Corrective Actions out of the Root Cause, let's
13 address them one at a time. One, was the Ops Manager will
14 typically spend a portion of each day monitoring, mentoring
15 shift personnel. This will be documented by field
16 observation card.

17 MR. OSTROWSKI: Correct.

18 MR. THOMAS: I guess, would it
19 be a correct statement to say that some of the things that
20 you have pointed out in your presentation are observations
21 on your -- while you were conducting this and have been
22 documented on observation cards?

23 MR. OSTROWSKI: I didn't hear the
24 last part of the question, Scott, please repeat.

25 MR. THOMAS: You've pointed out

1 a number of things. And, I was wondering if some of those
2 have been documented on field observation cards as part of
3 this corrective action?

4 MR. OSTROWSKI: In my specific
5 case, yes. The item I mentioned with regards to the
6 assistance by the reactor operators on the tech spec which
7 occurred yesterday, and that was documented on the field
8 observation card. As well as the briefings that I
9 conducted with the operating crews; those briefings were
10 also documented as monitoring and mentoring the shift
11 operator.

12 MR. THOMAS: Typically, as part
13 of this monitoring/mentoring shift personnel, how much of
14 that on a day-to-day basis would be control room type
15 observations?

16 MR. OSTROWSKI: For the Corrective
17 Actions include -- first of all, the shift managers spend a
18 portion, a majority of his time in the control room, his or
19 her time. The Operations Superintendent, Dave, in this
20 case.

21 MR. THOMAS: I'll get to Dave
22 in just a second.

23 MR. OSTROWSKI: I'm just saying,
24 in each case, the monitoring and mentoring the shift crews
25 includes both control room time as well as field time.

1 MR. THOMAS: Right.

2 MR. OSTROWSKI: I typically visit
3 the control room once or twice a day, and get into the
4 function of various levels of activity. And those are the
5 times I get to monitor the shift personnel.

6 MR. THOMAS: Okay. Dave,
7 pretty much the same question. There is a very similar
8 Corrective Action that addresses the observation. And what
9 observations, while carrying out this Corrective Action,
10 what observations have you noted and were they documented
11 on observation cards; and typically, how much of your day
12 is spent in the control room observing shift personnel?

13 MR. IMLAY: Okay. I've been
14 spending two to three hours a day, since I've been
15 reassigned to the job, in the control room observing the
16 operation of the crew, and spent a lot of time talking with
17 the shift manager about his role; and specifically, I've
18 been charged with implementing several of the actions
19 directly related to the technical specification, increasing
20 the rigor formality tech spec of requirements; and I have
21 documented my observations in the Operations cards for the
22 turnovers and the control room observations.

23 MR. THOMAS: Thank you.

24 MR. MENDIOLA: Can I ask a
25 question about the computer reviews? You may have stated

1 and I apologize. How many peer reviewers or peer checkers
2 are you adding per shift?

3 MR. OSTROWSKI: We anticipate
4 there will be one peer verifier per shift.

5 MR. MENDIOLA: What, would that
6 person be licensed at any level or is it required to be
7 licensed or is it an SRO or RO?

8 MR. OSTROWSKI: The individuals
9 that have been the peer verifiers, as well -- and the
10 transition was made from oversight managers to peer
11 verifiers, typically have Senior Reactor Operator licenses
12 at Beaver Valley, Perry and the other stations.

13 MR. MENDIOLA: So, this peer
14 review will be, if you will, reviewing at the SRO level
15 with the other SROs in the plant?

16 MR. OSTROWSKI: That's correct.

17 MR. MENDIOLA: Or the ROs in this
18 plant?

19 MR. OSTROWSKI: They have the
20 ability to be used as peer in all positions. The primary
21 individual it was intended for was the shift manager.

22 As an example, on Sunday, there was an individual
23 from the Beaver Valley Station in the control room. The
24 shift manager was performing some notifications to
25 management of a first-aid that was taking place in the

1 mechanical shop.

2 During the notification process, after the shift
3 manager had made the notifications, the peer verifier in
4 this case asked the shift manager if he had made all the
5 proper notifications and what procedure he was using. The
6 shift manager responded, he was using this procedure and
7 notified this level of management. And that was the extent
8 of the peer check.

9 So, in that case, it was, again, nonintrusive. He
10 did not interfere with what the shift manager was doing,
11 but at the completion of the task, questioned him on the
12 details of what he had just done.

13 MR. MENDIOLA: Did he have any
14 peer disagreements, where the SRO shift manager said, I'm
15 going to do this, and the peer disagreed; or do you have in
16 place a process to resolve that issue?

17 MR. OSTROWSKI: I'm not aware of
18 any disagreements. I do know that as part of the charter
19 and also as part of my briefings and communications with
20 the shift crews, it's very clear that in the event of a
21 disagreement with a peer, that the shift manager again
22 holds the license, and has the ultimate responsibility for
23 the safe operation of the station, in accordance with that
24 license.

25 So, while we do get different opinions based on how

1 the other stations do business, we have our own procedures
2 and that is what we expect our operating crews to operate
3 by.

4 MR. MENDIOLA: And, lastly, is a
5 peer reviewer work station, if you will, only in the
6 control room or is it also outside on the plant as well?

7 MR. OSTROWSKI: The peer reviewer
8 can peer check outside of the control room as the shift
9 manager also does some of his tasks outside of the control
10 room. The primary individual we have asked him to peer
11 check has been the shift manager, so that particular
12 function can be carried wherever the shift manager goes,
13 but as well, still available in the control room proper to
14 assist as a peer check for any of the other positions.

15 MR. MENDIOLA: Okay, there is one
16 last question. How long are you going to have peer
17 reviews?

18 MR. OSTROWSKI: Peer verifiers
19 will be in place through a hundred percent power.

20 MR. MENDIOLA: Okay, thank you.

21 MR. OSTROWSKI: Lastly, I feel
22 strongly that these and other Corrective Actions support
23 the plant heatup, but I also noted our Operations
24 performance during the Normal Operating Pressure Assessment
25 period will confirm our effectiveness and our readiness for

1 restart.

2 In summary, I have my charter, and I'll continue to
3 perform assessments and implement Corrective Actions. I
4 recognize that I need to demonstrate our readiness in
5 Operations to safely heatup and start up and operate
6 Davis-Besse.

7 Are there any additional questions?

8 MR. GROBE: Yes. Kevin, I
9 have one or two. In your Ops Improvement Implementation
10 Action Plan, I think you're on Revision Four of that. It's
11 been updated since this most recent Root Cause. And there
12 is a number of Corrective Actions in this plan that have
13 been completed in October and November and December. There
14 are some that are listed as completion dates in January,
15 and I think there is even one or two in February.

16 These have dates on them, but not milestones. If I
17 understand you correctly, from slide 25, all actions
18 necessary to support mode change and heatup to normal
19 operating pressure have been completed. Is that what
20 you're saying?

21 MR. OSTROWSKI: No, they have not,
22 Jack.

23 MR. GROBE: Okay.

24 MR. OSTROWSKI: We still have to
25 complete some -- we still have actions to complete prior to

1 heatup, and startup, and then into a hundred percent
2 power. One specific item is to include some of these
3 Corrective Actions into our, the one that specifically I'm
4 thinking of is the one I need to complete, where our formal
5 documentation of the instruction to the Superintendent, the
6 Op Superintendent, Dave, needs to be documented. So, while
7 we verbalize it, I need to document that on a piece of
8 paper and put it in, in part of our Performance Management
9 System before I can close out that specific Corrective
10 Action.

11 There are other Corrective Actions that are
12 scheduled right now prior to the plant startup, and those
13 have yet to be completed. As an example of one of those,
14 we are working towards scheduling our operating crews to a
15 visit to the Perry station or to the Beaver Valley station
16 in order to work shoulder to shoulder with one of the two
17 operating plants. We have to work through the complexities
18 of the shift crew schedules and look for opportunities to
19 get them there. That's one example of something we want to
20 complete before we take the reactor critical.

21 MR. GROBE: Thank you. It
22 would be helpful to me if you could at some time, I'll be
23 on the sight tomorrow also, to annotate the Ops
24 Implementation Action Plan for which actions are required
25 prior to Mode 2. That would be of interest to me, because

1 all it has in here is dates and it's difficult to tell what
2 your activities are required prior to Mode 2, what you're
3 holding yourself accountable to.

4 Dave, on slide 23, Kevin provided a number of
5 observations and a number of those were positive
6 observations since you and he have taken over your new
7 roles in the Operations organization. The last bulletin on
8 slide 23 were some statements regarding areas where Conduct
9 of Operations did not meet expectations.

10 I was wondering if you could share with us a couple
11 of observations since you've taken over as Operations
12 Superintendent areas where you've observed activities that
13 were not consistent with your expectations and what actions
14 you took in response to them.

15 MR. IMLAY: Okay. Again, I've
16 been working closely with the shift managers to ensure that
17 they understand their roles, that they're, they'll coach to
18 uphold and implement all of their tasks in a manner to
19 support safe and event-free operation.

20 We've had a shift manager meeting and I have weekly
21 shift manager phone calls, where I go through and discuss
22 issues that they have that might be affecting performance
23 or just a review on expectations.

24 There was a night when the crew was working to
25 restore Containment Spray Pump 2. And the task was

1 completed at around 2100 hours. And we expected and I
2 expected that the crew would promptly receive the work
3 orders from the Maintenance organization. And they would
4 have a debrief from the field technicians, the operator and
5 engineer who were at the Containment Spray Pump observing
6 the maintenance test to ensure all issues were identified.

7 Well, it was, come to find out, that there was one
8 transmitted, not two, to the operators in a timely manner,
9 so several hours had passed. So, to get to the point, when
10 I came in on days and ended up finding out what the facts
11 were, I coached the shift manager on what the expectations
12 would be.

13 We had a good discussion to agree on the facts
14 associated with the events that transpired that night, and
15 then offered examples of things to do in the future. One
16 thing that has been very effective for me is to bring on
17 the support that you need, have a clear agreement on the
18 three-part communication on what that is you're requesting,
19 clear ownership and due date on when it's going to be
20 done.

21 So, I offered the shift manager some expectations
22 for performance in the future, and we'll continue to
23 monitor and give the shift manager feedback, both positive
24 and further opportunities to improve.

25 MR. GROBE: Thanks, Dave.

1 MR. IMLAY: Do you have
2 any questions about that one anecdotal example?

3 MR. GROBE: No.

4 MR. IMLAY: There are, again,
5 I can go on, maybe not in such specific detail, but again,
6 my role has been to manage and implement the change as
7 we've gone through and raised the rigor and formality of
8 our tech spec implementation. So, I've been spending a lot
9 of time with the crews. Again, the craft, the words, to
10 change words into the expectation documents that they're
11 going to read and understand what that looks like, you just
12 can't do that and mail it in; you have to spend time with
13 the crews, talking with them, coaching them as they go
14 through it, sitting down looking at log entries after and
15 provide them feedback.

16 As we started doing the logging requirements that
17 Kevin has discussed in detail, the coaching was necessary
18 to ensure that the peer check was received before you
19 removed a tech spec or license requirement equipment from
20 service. If a piece of equipment is in standby, people
21 performance and function, we want the peer check before the
22 crew takes that action to remove equipment from service.

23 And there was several examples of where the log
24 entry ties might not indicate that the peer check was done
25 prior to that action. So, I coached several operators in

1 that regard.

2 MR. GROBE: Okay. Thank you.

3 MR. IMLAY: My pleasure.

4 MS. LIPA: Any other

5 questions?

6 MR. MYERS: Okay. Let me take

7 a few moments to close. Now, I was asked several questions

8 during the break, maybe this will clear it up.

9 We hope, we will continue to implement our current

10 Return to Service Plan and Operations Improvement Plan.

11 We improved our heatup assessment today, and

12 Revision 4 of our Operations Improvement Plan, which

13 implements the actions, the actions taken since Restart

14 Readiness Review Inspection, and the actions that were

15 taken due to our own internal assessments.

16 In general today, we talked about material

17 condition. Material condition of our plant is good. The

18 Reactor Coolant System is tight. Our equipment is

19 generally operating very well, considering a two-year

20 extended shutdown. In fact, when we heat the plant up, we

21 did detailed calculations of our Reactor Coolant System

22 leak rates and our calculations indicate zero leak rates,

23 which indicates a very tight Reactor Coolant System.

24 We continue to demonstrate improvements in our

25 implementation, complex evolutions. A complex evolution is

1 starting a major piece of equipment, heating the plant up,
2 shutting the plant down, return, you know, shut the plant
3 down, or making a reactivity change or something like that,
4 some surveillance test. Those are all complex evolutions.
5 We continue to show good performance in those areas.

6 We have taken strong actions to validate and
7 implement our Conduct of Operations, went step-by-step
8 through each and every part of it. We are receiving good
9 feedback and demonstrating improvement in prejob briefs,
10 shift turnover and procedure usage. In fact, we're seeing
11 very good procedure usage at the present time.

12 Our overall assessment of the recent heatup and
13 cooldown was satisfactory. What does that mean?
14 Perfection? No. We demonstrated three issues tonight that
15 we want to discuss. That means performance was acceptable
16 with a few criteria requiring some management attention.
17 That's what we're doing; giving those criteria management
18 attention.

19 Next slide, please.

20 We have developed at FENOC some NOP assessment
21 criteria. We believe that this, this criteria is good and
22 would help us in requesting restart. Let me share some of
23 the criteria with you.

24 No inadvertent -- the first four things: No
25 inadvertent safety system actuations, no significant

1 events, no integrated plant operating procedure content

2 errors, no unplanned entry into technical specifications.

3 Attached to that are Human Performance issues, so we

4 would not expect to see Human Performance issues in those

5 areas.

6 Consistent implementation of Conduct of Operations,

7 actions taken by management that show an improving trend.

8 That, we would say, that's where we go back and look at a

9 corrective action we're taking and see if they appear to be

10 effective.

11 The work implementation schedule adherence is at 90

12 percent or above. And then we do what we call a risk

13 profile. That is how we operate the plant within, and

14 moving the equipment within the risk assumed by the design,

15 and we would expect that to match the scheduled adherence.

16 Our approach at FENOC we feel is strong and has

17 strong safety focus and demonstrates our commitment to

18 conservative operations and conservative return to service

19 at our plant.

20 Our ratings that satisfy these criteria, we believe

21 will result in a successful restart. We have. That

22 doesn't mean every specific piece of criteria has to be

23 perfect, but we'll rate our overall performance prior to

24 requesting restart from the NRC.

25 Thank you very much.

1 MR. THOMAS: Lew, can I ask you
2 a question? Along with these Normal Operating Pressure
3 Assessment Criteria, there is, I'll call it, a grading
4 scale that uses colors; green, white, yellow and red. I
5 would just be curious how using that grading scale, how you
6 would assess your last heatup?

7 MR. MYERS: The heatup we
8 assessed as white, which is satisfactory. And the
9 definition I gave during my presentation was performance is
10 acceptable with a few criteria requiring management
11 attention. That's exactly the definition I use for
12 satisfactory.

13 MR. THOMAS: Okay.

14 MR. HOPKINS: I have a specific
15 question, Lew. And someone else may. The definition of a
16 significant event for this assessment criteria.

17 If you have all control rods inserted and receive an
18 unplanned scram signal, such that no control rod scrams
19 because it's already at the bottom, would that qualify as a
20 significant event?

21 MR. MYERS: I would have to
22 sit here and go through that. The way we would evaluate a
23 significant event would be an event that we used our
24 Corrective Action Program in and we define as significant
25 adverse to quality. If it fits that criteria once we went

1 through it, it would be yes. I can't sit here and go
2 through that.

3 MR. HOPKINS: You go through
4 that criteria, that's acceptable.

5 Along the same line, just a detail and question
6 though. Risk profile that matches the schedule. If you're
7 doing diesel generator surveillance, plant surveillance,
8 and you get a loss of all offsite power, would that
9 automatically cause you a problem with the risk profile or
10 would it be a matter of how fast you could return your
11 diesel generators?

12 MR. MYERS: What that would
13 do, what we mean by that, every time we take a safety
14 related piece of equipment out, we take it out in specific
15 order. We would not take, for instance, probably an Aux.
16 feed pump probably the same time as a high head safety
17 injection pump because they're both designed to run decay
18 heat.

19 That being said, we take a HPI pump for routine
20 maintenance, we would assume we take it out at a certain
21 time, put it back in. If we assume that it's going to be
22 24 hours, or be out 7 days, that would not match up with
23 the profile. I would say that would be a failure.

24 MR. HOPKINS: Okay. Thank you.

25 MR. RULAND: Lew, you said

1 that, that you're going to rate yourself against these
2 criteria before you ask, come, approach the NRC. Now, is
3 that for, to schedule the restart meeting or ask our
4 permission to restart, Restart Assessment Team showing back
5 up?

6 MR. MYERS: We would come up
7 and start, you know, we think the heatup and cooldown that
8 we performed, we rated satisfactory, white. Now, that
9 being said, we have to go do our own assessment before we
10 come to you and ask you to, if you want to bring the RRATI
11 team back in. That's your choice. If you didn't want to
12 bring them back in, I wouldn't complain to you about it.

13 If I come to you and tell you we're ready, we would
14 tell you, you could bring the RRATI Team back in or you can
15 tell us to start up, whatever you want to do.

16 MR. RULAND: So, let me ask
17 this question again. So, it sounds like to me, if I'm
18 hearing you right, that you're going to rate yourself
19 against this criteria --

20 MR. MYERS: Yes, sir.

21 MR. RULAND: -- at some stage.

22 And based on your assessment, if you're satisfied that
23 you've made, that you've passed this criteria.

24 MR. MYERS: Yes, sir.

25 MR. RULAND: You've met the

1 acceptance criteria, you're then going to say, you're going
2 to ask us to send our inspectors back on site, and we'll do
3 the inspection; that's kind of the way you see it?

4 MR. MYERS: Yes, sir. If you
5 don't want to do that, that's okay.

6 MR. RULAND: No. I appreciate
7 your -- never mind. (laughter)

8 MR. THOMAS: Back to the
9 grading. Are you through, Bill?

10 MR. RULAND: For now, yes.

11 MR. THOMAS: Okay. One of
12 your, as part of this grading scale, this green, white,
13 yellow, red; one of the criteria, if you will, is greater
14 than one unacceptable criteria means the overall rating
15 could be no better than yellow.

16 I was curious, one of the criteria is consistent
17 implementation of Conduct of Operations, so your assessment
18 is that that was effectively implemented during the last
19 NOP?

20 MR. MYERS: Overall, we would
21 say after we got the NOP/NOT, that we had some issues.
22 But, our heatup and cooldown we rated overall satisfactory,
23 yes.

24 The cooldown was error-free. The heatup, we did
25 have one issue in the heatup, but we rated those two as

1 white. Then when we stabilized that, we'll look at an
2 assessment period there too.

3 And, we did add some new criteria also. The
4 criteria I just gave you is what we're going to use going
5 forward. It's not the same criteria we used for the recent
6 session. We added some organizational criteria; is that
7 right?

8 MR. BEZILLA: Yes, that's
9 right.

10 Scott, I was just helping Lew there. That specific
11 consistent implementation of Conduct of Ops, that's new for
12 moving forward, okay, that was not part of what we had had
13 set up as our criteria for the most recent heatup and then
14 subsequent cooldown that we've conducted.

15 MR. THOMAS: Well, the original
16 criteria was just go/no go type of criteria. These had
17 this grading scale, so I'm just trying to understand how
18 this factors in, trying to match the criteria to what's
19 acceptable performance by the grading scale.

20 MR. MYERS: We added this
21 particular one, additional criteria, because of some of the
22 assessments we did. So, we want to make sure we're
23 focusing, down at the bottom we've added additional
24 criteria. I haven't gone back to do a detail assessment,
25 but based on the assessments we performed, we would say

1 satisfactory heatup and cooldown.

2 That's all I can say.

3 MR. THOMAS: So, just one more
4 question. So, acceptable performance for requesting
5 restart would be yellow or greater; yellow, white, green?

6 MR. MYERS: We would not, we
7 rated ourselves yellow, we would take some action and
8 validate the effectiveness of that action before we came to
9 you for restart. So, we may rate ourselves as yellow, but
10 we would take some actions and look at the effectiveness of
11 that action before, before we came to you all for restart.

12 MR. THOMAS: Likewise for
13 white, would that be an acceptable threshold to --

14 MR. MYERS: White would be an
15 acceptable threshold, but we still may take some action.

16 MR. THOMAS: Okay.

17 MR. RULAND: Lew, I'm
18 encouraged by this assessment criteria. While we haven't
19 looked at this in great detail, I'm encouraged that this
20 sounds about right for the type of things you are looking
21 for yourself -- looking at yourself about. That's a
22 sense.

23 You know, we're not satisfied yet, because frankly,
24 we don't know how this is going to turn out.

25 MR. MYERS: Right.

1 MR. RULAND: And, of course,
2 Scott and his team, the inspectors, you know, other
3 inspectors are going to come down and test you on this, on
4 how you're doing in this area, but I'm encouraged by this.

5 MR. MYERS: Thank you.

6 MS. LIPA: Okay, any other
7 questions?

8 MR. GROBE: Just a couple of
9 observations. The last 30 days have been interesting 30
10 days.

11 MR. MYERS: Yes.

12 MR. GROBE: The Restart
13 Readiness Assessment Team performed an inspection. On the
14 19th of December, they had a public exit and provided a
15 number of observations that indicated that there were some
16 performance issues. You acknowledged that those issues
17 existed and prepared to respond to them.

18 Then, we had a meeting late December that presented
19 your progress in those areas. Also late in December, Lew,
20 you and Mark decided that some performance issues continued
21 and you suspended progress in the Operations activities,
22 you conducted a thorough Root Cause Assessment. I believe
23 that Root Cause Report is now issued; is that correct?

24 MR. MYERS: That's correct.

25 MR. GROBE: Good. You brought

1 in good people to do that assessment, and they drew some
2 conclusions that were insightful. One of them was, had the
3 Corrective Actions from the Corrective Significance
4 Assessment in October been more thoroughly implemented,
5 that these issues shouldn't have occurred.

6 You've begun to implement some actions and Kevin and
7 Dave are part of that. It was good to hear from them
8 tonight.

9 The discussion tonight I think was very good. I
10 want to go back to a couple of points though. One was the
11 discussion focused very heavily on technical specification,
12 limiting conditions for operation and performance. And
13 while that's important, that's the latest greatest
14 example. It is gratifying to hear Dave's comments that
15 certainly your improvement actions are not limited to that
16 area. I appreciate your example regarding the interface
17 between Maintenance and Operations and their expectations.

18 You have a number of criteria here on page, slide
19 27, and those are all good criteria. In my mind, the most
20 important one is the fifth one; that's consistent
21 implementation of Conduct of Operations.

22 MR. MYERS: Mine too.

23 MR. GROBE: Careful,
24 deliberative, safety-focused Conduct of Operations day in
25 and day out. That's a precursor to prevent all of these

1 other conditions. And, a specific hit on any one of these
2 may or may not be important. What's important is why. And
3 I heard a number of the folks here at the table asking why,
4 why did these things happen.

5 That's a question that we're going to be continuing
6 to ask ourselves as we observe activities, as to why this
7 activity is going on and why this activity was going right
8 and why this activity may not be going right, as we
9 continue to do our inspections. That's the key. It's not
10 whether or not any of these individual criteria are green,
11 white, yellow or red. I don't want to diminish the
12 importance of the criteria in doing these assessments, but
13 it's the, it's what's beneath the performance that is going
14 to be the telling factor as to whether or not these
15 corrective actions are going to last into the future.

16 That's the challenge that this panel faces. It's
17 not only, is your Operations during the five days that
18 you're going to be observing activities or during the five
19 days that RRATI Team will be observing activities, but
20 whether or not your performance will be continuing at a
21 consistent level in the future. So, that's our restart
22 criteria.

23 The bottom line and I think you know me, Lew, is
24 we're all born and raised in Missouri. So, our goal is you
25 need to show me. And we'll be inspecting with the Resident

1 Inspector Staff augmented with the folks from around the
2 country.

3 Anything else, Christine?

4 MS. LIPA: No.

5 MR. GROBE: Okay, thank you.

6 MR. MYERS: Thank you.

7 MS. LIPA: Okay. This

8 concludes the business portion of this meeting.

9 Before we take a break, I wanted to address a couple
10 of questions that had come up during the break. On our
11 earlier slides we talked about a potential next public
12 meeting in March. We didn't address February. There is no
13 February meeting set yet. We may still meet in February,
14 but we're holding a meeting late in January, so we'll be
15 sure to give the proper ten days notice, but that's really
16 all I can say at that point.

17 Then, the second question was, we had planned to
18 provide some results of our follow-up to the
19 Management/Human Performance Phase 3 tonight. They were on
20 site last week and they're not completed yet. So, we will
21 be providing the results of that inspection at a later
22 public meeting.

23 So, that answers a couple questions we had. What
24 we'll do now is take a ten minute break and come back for
25 public questions and comments.

1 MR. GROBE: I hope nobody
2 took that literally. I don't know if any of us were born
3 or raised in Missouri. (laughter)
4 (Off the record.)

5 MS. LIPA: Okay, we would
6 like to invite anybody who has a comment or question for
7 the NRC to come up. And as is our usual custom we would
8 like to start with local members of the public first. So,
9 just come up and sign in and state your name for the
10 transcriber. And let us know what's on your mind.

11 MS. WHARRY: Good evening,
12 ladies and gentlemen. My name is Elizabeth Wharry, and I
13 live in Carroll Township. I am pro nuclear and I have been
14 since I was in short pants. I am retired. I am a domestic
15 goddess. My husband happens to work at Davis-Besse.

16 What I have to say this evening is purely
17 rhetorical, but I am here to tell you that I have absolute
18 confidence in the employees being able to bring this plant
19 on-line. I have maintained my position that they are
20 intelligent, well-educated individuals; and I'll still say
21 that to this very day. But let me tell you the human side
22 of being a spouse of a Davis-Besse employee.

23 Clara at the NRC made a comment as I walked in that
24 I was living with a stranger. In some ways, yes, that's
25 very true, but fortunately, we have a strong enough

1 marriage where we are able to rely on each other, turn to
2 each other, and support one another.

3 During the time that Davis-Besse has shut down, I
4 have been a single married parent. And in September of
5 2002, we had a new baby come into our home. My toddler was
6 34 months old.

7 In the last two years, I have put up with having our
8 lives turned topsy-turvy. I won't go into the specific
9 details, but suffice it to say that there are times that I
10 have to remember that I am dealing with human beings and
11 that we all make mistakes. And if today is a line that
12 you're going to make mistakes, you're going to be
13 forgiven.

14 In part, I hold the NRC responsible for some of the
15 insanity as far as the working hours go at Davis-Besse.
16 And if you'll excuse the absolute total crassness of this
17 expression, I am here to tell you ladies and gentlemen to
18 stop picking the fly shit out of black pepper when it comes
19 to Davis-Besse, and understand that these are fine,
20 intelligent, capable human beings.

21 Thank you.

22 MS. LIPA: Thank you for
23 your comment.

24 MR. KOEBEL: Good evening. My
25 name is Carl Koebel, Ottawa County Commissioner. And I

1 know that I speak on behalf of my cohorts, John Papcun and
2 Steve Arndt, when I ask to be put in the record that we
3 have observed that management through their own
4 self-assessment has recognized their weaknesses and have
5 taken the appropriate action to correct it.

6 We applaud them in their efforts to seek perfection
7 before startup. We know, we believe in the ability of the
8 employees, the leadership of management, the dedication and
9 commitment of ownership, and the support of the NRC
10 overview committee, that by working together, Davis-Besse
11 will be the most effectively operated and safely operated
12 nuclear power plant in the nation, and we look forward to
13 its restarting. Thank you.

14 MS. LIPA: Thank you, Carl.

15 MR. GROBE: I think it's
16 appropriate to recognize that Carl was just recently
17 elected President of the Ottawa County Board of
18 Commissioners. So, those of you that live in Ottawa County
19 congratulate him when you get a chance.

20 MS. LIPA: Anybody else have
21 any comments or questions from the local community? And,
22 now we'll go to others.

23 MR. RIDZON: Paul Ridzon,
24 McDonald Investments. I came here looking for some
25 feedback on what you had seen as far as Human Performance,

1 and you've indicated that you're not going to comment on
2 that tonight. Just wondering if there is some specific
3 reason and the time frame for when we could get some
4 comments from those inspections.

5 MS. LIPA: Well, I mentioned
6 earlier that the Management and Human Performance Phase 3
7 Follow-up Inspection, they were on site last week; and they
8 accomplished most of the activities that they had on their
9 inspection plan, but they were not able to complete all of
10 those activities. So, we've decided it is best to wait
11 until they're done before we talk about their results
12 publicly. So, that's really not much more to it than
13 that.

14 Right now, we're looking at the next public meeting,
15 which I don't have a date for you today, unfortunately, but
16 it shouldn't be too long. So, the next public meeting will
17 be when we're likely be talking about those results,
18 provided they're completed with their inspections by then.

19 MR. RIDZON: Is that the late
20 January meeting?

21 MS. LIPA: No, today is the
22 late January meeting I was talking about. What I was
23 saying earlier, since we're already late in January, that's
24 why we didn't have a date picked in February yet.

25 MR. RIDZON: Thank you.

1 MS. LUEKE: My name is Donna

2 Lueke and I'm a local citizen.

3 There has been some speculation recently that

4 Davis-Besse may be sold, or that FirstEnergy might merge;

5 at least in print anyway. What would happen to this

6 process if either of these things would happen? I know

7 you said that FirstEnergy is the Licensee and the only

8 Licensee for Davis-Besse. So, what, what would happen if a

9 new owner?

10 MS. LIPA: I'm just

11 struggling to make sure I know the best answer right now.

12 We have a process for license transfers, if it would come

13 to that, but the 0350 Process would continue to do what

14 we're doing with our Restart Checklist and our inspections

15 and our activities. So, I think that that would go through

16 its process and we would continue on our process. I can't

17 think of anything right now that would affect one or the

18 other.

19 MS. LUEKE: So, a license

20 transfer doesn't necessarily mean relicensing; is the only

21 procedure just like a paper transfer or what?

22 MR. RULAND: The NRC has a

23 process that we use for license transfers. And a number,

24 as you're well aware, a number of plants, much more,

25 increasingly greater frequency of, in the last two years,

1 plants have changed ownership. The plants operate the day
2 before, if they happen to be operating. If they're
3 operating the day before the license is transferred, they
4 continue to operate after the license is transferred.

5 So, it's, the 0350 Process is focused on operational
6 safety. We have separate folks that worry about the, the
7 financial aspects of it. We would still have to make sure
8 that the buying entity would be qualified, but we have a
9 separate, you know, branch of folks to do that review, but
10 for me personally, we would continue to observe operational
11 safety and I don't think there would be a significant
12 change in what we're doing.

13 MR. LUEKE: Okay. Just two
14 more questions.

15 MR. GROBE: Donna, before you
16 go on, I think it's important to make it clear that we have
17 not heard anything about any license transfer activities or
18 indications of that whatsoever.

19 MS. LUEKE: I was just curious
20 is all what would happen.

21 MR. GROBE: Would you move the
22 microphone closer.

23 MS. LUEKE: Closer? Okay.

24 We hear a lot about the stress that everyone has
25 been under, people with Davis-Besse, and I would imagine

1 that the NRC personnel aren't immune to that either. And,
2 in my experience, in corporate America, you can only
3 undergo stress of long hours for so long before it affects
4 performance.

5 Has this, I haven't heard FirstEnergy address that;
6 and I wondered if, if you are looking at that when you're
7 looking at FirstEnergy's personnel?

8 MS. LIPA: Well, I know that
9 part of our Management and Human Performance Inspections
10 look at the whole picture, as far as what all the Root
11 Causes were and what the Corrective Actions were. And I
12 know that as part of our inspections, we look to see if
13 there are operational problems; and if there is one, what
14 the causes were. And, as far as I know, we don't have any
15 examples where we see that there have been performance
16 problems as a result of this stress that you're referring
17 to.

18 MS. LUEKE: It seems that
19 there have been several problems with the control room
20 operators. Do you think that is all contributing?

21 MS. LIPA: Well, we looked
22 for the operational performance problems that have been
23 discussed. Some of those, the Licensee's completed their
24 Root Cause, and we've taken a look at their Root Cause
25 Assessment. There were a couple of recent ones. I'm not

1 sure if you've had a chance to thoroughly look at their
2 Root Cause to understand what all the contributors were.

3 We were talking about why do those things happen;
4 again, why, why, why. But based on what we have seen so
5 far, we haven't seen that stress was a contributor to any
6 of the performance problems we've been discussing.

7 MS. LUEKE: And the last we
8 heard that the degraded reactor head was still being
9 studied. Is that process still going on? Has it been
10 completed?

11 MS. LIPA: I don't have a
12 good status on the, where that project is at.

13 MR. GROBE: The only
14 information I could give you is probably four to eight
15 weeks old, shortly after some information showed up in the
16 newspapers regarding some preliminary conclusions. I know
17 that there was, a decision made to do some additional
18 testing and some additional analysis of data before any
19 conclusions could be drawn on the research results. So, I
20 don't have any further information beyond that.

21 MS. LUEKE: Are you in the
22 loop on that? Does that come to you automatically, those
23 results, or how does that process work?

24 MR. GROBE: The ongoing
25 research into cladding behavior is really unrelated to what

1 we're doing here, in a sense that the purpose of that
2 research is to better understand metal performance under
3 those conditions for future use. It really doesn't have
4 anything to do with Davis-Besse. It's related to
5 Davis-Besse in the sense that Davis-Besse provided an entry
6 opportunity to think about those kinds of questions, but
7 it's not critical to the activities that the panel, the
8 panel stays closely connected with, simply because the
9 potential for public interest and in the issues that we
10 stay closely connected, because we're so closely connected
11 with you.

12 The second activity that's ongoing in research is
13 what's called an accident sequence precursor analysis; and
14 that's a broad risk analysis, much more broad than the type
15 of risk analysis that we do as part of our inspection
16 finding assessment. We call this a significance
17 determination process.

18 The accident sequence precursor, again, is related
19 to future-looking activities and whether or not there is an
20 opportunity to learn something about operating performance
21 or our regulatory activities, not necessarily related to
22 the plant itself.

23 So, again, we maintain awareness of those
24 activities. Both of those are looking forward and they're
25 research activities that are focused on what can be learned

1 and applied elsewhere across the board at nuclear power
2 plants, across the board with respect to how we do our
3 regulatory oversight programs.

4 MS. LUEKE: When the used
5 reactor head was removed, there was also a lot of residue
6 from the Boron. I don't know if you call it Boron powder,
7 whatever it is. What happened to that? Is there like a
8 giant shop vac they sucked it up with, or is that, is it
9 radioactive, and how was that disposed of?

10 MS. LIPA: You're talking
11 about the boric acid in the Containment Building?

12 MS. LUEKE: I would imagine it
13 was in Containment. It was shown in photographs and they,
14 the filters were catching part of that.

15 MS. LIPA: I don't know
16 specifically. The Licensee has a normal radioactive waste
17 process that they use. I know we've had inspectors look at
18 the radioactive waste process. I don't know if it was
19 specific to how they handled the boric acid, but they would
20 have a process for what to do with that. As far as I know,
21 they followed that process and disposed of it properly if
22 that's what they did.

23 MS. LUEKE: I was just curious
24 because I assume that is something that is relatively
25 uncommon that you hadn't seen in other plants before, so I

1 didn't know if there was a specific process for that.

2 MS. LIPA: No, it wouldn't be
3 anything different than any other, than a utility would do
4 to dispose of things they don't need. So, it would be
5 nothing special.

6 MS. LUEKE: Okay, thank you.

7 MR. GROBE: We have to be a
8 little careful. I've not thought of that question. It's
9 an interesting question. I'm not sure if the RAD Waste
10 Manager is here, but low level radioactive boric acid might
11 be considered mixed waste, so it might require special
12 handling.

13 It's not something we inspected per se, but it's an
14 interesting question. If you want us to get back to you,
15 we can do some looking into that, and get back to you
16 separately.

17 MS. LUEKE: Yeah, I would
18 appreciate that. Thank you.

19 MR. GROBE: Yeah, Bill asked
20 me to define what mixed waste is. There is different
21 requirements for different types of hazardous materials.
22 Radioactive material is a certain type of hazardous
23 material. Medical wastes are a different kind of
24 hazardous material. Chemical wastes are a different
25 kind.

1 And, there is occasionally a situation where you
2 have a type of waste that crosses boundaries. Might be,
3 for example, a medical waste that's radioactive; or an acid
4 or strong base that is a certain type of chemical waste
5 that's radioactive; and that's what's referred to as a
6 mixed waste. It has different handling requirements.

7 So, it's an interesting question. I hadn't thought
8 of that one before. Thank you.

9 MR. WHITCOMB: Good evening. My
10 name is Howard Whitcomb, and I'm a resident of Ottawa
11 County. I have some prepared comments, a couple of
12 questions that I formed tonight from what I heard from the
13 presentation from FirstEnergy.

14 The reason we are all here at these public meetings
15 is because of FirstEnergy's failure to implement existing
16 site procedures. The failure to implement the Boric Acid
17 Monitoring Program resulted in the hole in the reactor
18 vessel head. Arguably, I guess it could have been debated
19 whether that was a significant procedure that was being
20 violated at the time, but it did result in a hole in the
21 reactor vessel head; and we're here, tonight, 23 months
22 after its discovery, discussing it.

23 I'm concerned when I hear the minimization of
24 management, "Well, okay, it's a failure to follow up or
25 implement procedures, but we've corrected it." Well, 23

1 months have passed and we shouldn't be failing to implement
2 procedures.

3 I also challenge the validity of using nonlicensed
4 operators as peer reviewers, peer verifiers, whatever the
5 term is, in assessing the performance of your licensed
6 operators at Davis-Besse. Even as a resource, I question
7 their value.

8 With respect to the improved safety culture we've
9 heard in the last several meetings that FirstEnergy claims
10 has occurred, I offer the following:

11 FirstEnergy is logging political support of its
12 restart efforts through the endorsements of individual
13 politicians as well as township committees. FirstEnergy
14 does so by inflating its perceived contribution to the
15 local economy, rather than its ability to meet or exceed
16 the specific safety mandates which protect the health,
17 safety, and welfare of the public at large.

18 While the local involvement of our community
19 leadership is noteworthy, we must exercise caution and
20 avoid a blind acceptance that Davis-Besse is once again
21 safe simply because our community leaders say so.

22 A production over safety mentality still persists
23 within FirstEnergy management as exemplified through
24 FirstEnergy's recent promises to Wall Street analysts that
25 it is ready to restart the Davis-Besse Nuclear Power

1 Station. Said promises are predicated upon unrealistic as
2 well as unapproved schedules.

3 Additionally, the recently highlighted employee
4 survey results indicate that four critical departments,
5 that is Operations, Maintenance, Plant Engineering, and
6 Quality Assurance still present serious doubt regarding the
7 effectiveness of the touted improvements in safety culture
8 at Davis-Besse Nuclear Power Station.

9 Intimidation of the work force through threats by
10 senior management staff, including the Chief Operating
11 Officer, have recently occurred. Additionally, recent
12 staffing changes involve the same persons who held similar
13 positions of authority during the events immediately prior
14 to the discovery of the hole in the reactor vessel head.

15 The Quality Assurance Department is still in the
16 mode of explaining away identified anomalies, rather than
17 establishing and maintaining a strong independent position
18 which reflects an achievement of higher standards of
19 performance.

20 During the meeting on December 29th, 2003, the Vice
21 President of Oversight reported that the plant Engineering
22 staff did not have confidence in the work schedule because
23 management continued to practice purging or deferring a
24 significant number of preventative maintenance activities
25 from the schedule.

1 The deliberate and conscious refusal to perform
2 maintenance is the reason why a hole in the reactor vessel
3 head occurred. It remains obvious to even the casual
4 observer that FirstEnergy's superficial maintenance
5 practices formally identified in 1985 continue to this
6 day.

7 The recent Auxiliary Feedwater System problems are
8 the most recent example. Problems with the Auxiliary
9 Feedwater System have occurred and repeated themselves in
10 1985, 1987, 1994, and last week.

11 The time to properly re-evaluate and reshape
12 FirstEnergy's maintenance practices is long overdue. Most
13 importantly, the Quality Assurance Department has failed to
14 recognize the continuing maintenance problems and has even
15 recommended to the NRC that the Davis-Besse Nuclear Power
16 Station is ready to support restart.

17 FirstEnergy has failed to identify the establishment
18 of any meaningful improvements to its corrective or
19 preventative maintenance program over the last 23 months.
20 As previously reported, by myself, at prior meetings, of
21 NRC's findings contained Harold Denton's August 14, 1985,
22 letter to the Toledo Edison Company; formally identified
23 serious deficiencies in Maintenance's practices at the
24 Davis-Besse Nuclear Power Station.

25 Mr. Denton generally characterized the longstanding

1 maintenance practices as being superficial. The same
2 principles apply to FirstEnergy's deliberate refusal to
3 inspect and clean the reactor vessel head of boric acid
4 prior to its discovery of a pineapple size hole in the
5 reactor vessel head in March of 2002.

6 With respect to its deficient maintenance practices,
7 FirstEnergy has failed to identify any specific safeguards
8 that have been established and implemented to prevent a
9 relapse of old habits that put off until tomorrow what
10 could be done today.

11 FirstEnergy has simply failed to identify those
12 corporate management mechanisms that have been changed and
13 improved. Further FirstEnergy has additionally failed to
14 provide demonstrative evidence that any problematic changes
15 that have resulted in any quantifiable improvements as it
16 relates to the overall status of the material condition of
17 all plant equipment.

18 Finally, the public has been apprised of the NRC's
19 home progress regarding the identified nuclear regulatory
20 failures as contained in the Lessons Learned Task Force
21 Report issued in October 2002.

22 There still exists a public perception that the root
23 causes underlying the weaknesses of the NRC actions which
24 in effect contributed to the creation of a hole in the
25 reactor vessel head have not yet been satisfactorily

1 corrected to a degree that adequate assurance now exists
2 that a breakdown in the regulatory process does not recur
3 in the future.

4 While it appears that the NRC has recently taken a
5 hard-line stand by openly challenging the true
6 effectiveness of FirstEnergy's improved safety culture
7 claims, such position is very late in coming. An
8 understanding of the lack of safety culture problems at the
9 Davis-Besse Nuclear Power Station has been known to the NRC
10 for some time. It is now questionable whether the NRC
11 truly understands the depth and breadth of this
12 historically elusive and recurring issue.

13 To the NRC, walk through the plant and make note of
14 how many deficiency tags which are greater than two years
15 old still exist on equipment. Determine why the
16 philosophy of only supporting the accomplishment of work
17 necessary to support the restart of the plant still exists
18 today.

19 Examine the unusually high number of rework
20 activities performed by the Maintenance Department over the
21 last two years. Examine the number of deferred and/or
22 delayed preventative and predicted maintenance activities
23 during the last two years. Interview the work force and
24 determine why there still remains a significant number of
25 people who are either hesitant to report problems to

1 management, or are indifferent to do so.

2 Finally, the results of the investigations of both
3 the Office of Investigation and the Federal Grand Jury in
4 Cleveland have not yet been made public. It is premature
5 to hold any public meeting regarding the restart of the
6 Davis-Besse Nuclear Power Station until such time that
7 members of the public may make inquiry and analyze the
8 results of those investigations, as well as present any
9 questions and submit any concerns they may have to the
10 NRC.

11 Additionally, the status of the material condition
12 of the equipment at the Davis-Besse Nuclear Power Station
13 remains unknown. The Corrective Action Program remains
14 incomplete and therefore cannot be audited for accuracy.

15 These issues collectively suggest the restart of the
16 Davis-Besse Nuclear Power Station is not possible at this
17 time.

18 Thank you.

19 MS. LIPA: Thank you for your
20 comments, Howard.

21 MS. TRENHOLME: My name is Liz
22 Trenholme.

23 MR. GROBE: Could you just --
24 I have a couple of observations in response to the comments
25 that Howard made.

1 The one, I believe we've talked about this
2 inspection in the past, and the report has been issued. We
3 specifically conducted an inspection of the activities that
4 are in what's referred to as the backlog; those are
5 activities that are not planned to be completed prior to
6 restart; to ensure that FirstEnergy has properly
7 prioritized those, there is no undue risk associated with
8 those backlog activities.

9 As I mentioned, that inspection was completed. I
10 think the report was issued in December -- no, January
11 5th. Very good. And, certainly, you're welcome to read
12 that inspection and get a sense for how we assessed
13 specific issues you were talking about.

14 One other activity that I just wanted to comment on
15 that you raised, that's the ongoing investigation. It's
16 very important to recognize that the Oversight Panel and
17 the NRC more broadly has been deeply involved in assessing
18 the results of the Office of Investigations' work, and has
19 concluded that there is no need for immediate safety
20 action, enforcement action based on safety concern from
21 those results.

22 We appreciate the results of that investigation have
23 not been shared publicly because of the ongoing activities
24 of the U. S. Attorney's Office. So, it's, this is an
25 activity and an issue that has been fairly studied by the

1 NRC, and the ongoing investigation is continued to be
2 monitored by a senior executive from the Office of Nuclear
3 Reactor Regulation to ensure that if any information
4 emerges from the ongoing investigation that could indicate
5 a potential safety issue at Davis-Besse or any other
6 nuclear plant in the United States, that that's promptly
7 brought to the attention of the Regulatory Commission.

8 So, I think those are the two issues I wanted to
9 clarify.

10 MR. RULAND: As I look down
11 this list of -- I think I was keeping relatively good
12 notes, Howard. Based on my observation of this list, I
13 don't think there are any substantive new issues that
14 you've raised. Clearly, you've spoken about these issues
15 in the past. And I think in a number of areas, I frankly
16 think you're wrong.

17 You said the NRC was late in coming to the safety
18 culture issue. As you know, Davis-Besse identified
19 themselves the safety culture was part and parcel of the
20 cause of the reactor vessel head problems. It was
21 something that we have been inspecting, in spite of the
22 fact that our guidance is not clear. We felt frankly an
23 obligation to go after this issue, and go after it we did.

24 The NRC continues to struggle with how to inspect
25 this, and how to ensure ourselves that we ferret out the

1 issues that are out there; and we continue to do that.

2 So, I frankly don't think we've come late. And I
3 assert, contrary to your assertion, that we have been
4 actively involved in this issue, and spent significant NRC
5 resources.

6 Secondly, I think -- by the way, these are only
7 mine, the two most significant comments I need to make. I
8 think you said, "no quantifiable improvements in the
9 material condition of the plant." As somebody that has
10 toured the plant personally on several occasions, frankly,
11 that's bunk. It just isn't true. There is significant
12 material improvement in this plant, and it's just an
13 incorrect assertion.

14 MR. GROBE: I think there is
15 one other observation. I apologize for making you stand
16 there for a few minutes. I think it's important to note.

17 The safety is taken very seriously learning from the
18 past. In the specific case of Davis-Besse, we had the
19 Lessons Learned Task Force that was completely independent
20 of what was going on here at Davis-Besse, which took a very
21 thorough look of what happened in the past. That's the way
22 we approach all of our business.

23 It's important that we learn from the past, but live
24 in the present. And our inspections and our assessments
25 that are being done today and have been done since the

1 shutdown of this plant in February of 2002 formed the basis
2 for the conclusions that we make. And, as I said, it's
3 important that you learn from the past, where we draw our
4 observations and conclusions for the present.

5 Go ahead, ma'am.

6 MS. TRENHOLME: My name is Liz
7 Trenholme, and this is Theresa Szentendai. We're
8 representing Ohio Citizen Action.

9 We would just like to deliver some letters to
10 Mr. Caldwell and they're letters from citizens from around
11 the State of Ohio.

12 We would also like to quickly read two letters which
13 we feel represent some of the key public views.

14 MS. LIPA: If you could speak
15 up just a little or get a little closer to the microphone.

16 MS. TRENHOLME: I'm sorry.

17 We would just like to deliver these letters to
18 Mr. Caldwell. They're from citizens around Ohio and how
19 they feel about everything. We would just like to quickly
20 read you two letters that we feel represent some of the key
21 public views.

22 The one I'm going to read is from Beth Harrod.
23 She's from North Olmsted, Ohio.

24 "Dear Mr. Caldwell: My family lives in a western
25 suburb of Cleveland, Ohio along Lake Erie. We also

1 maintain a summer home on the southwestern shore of the
2 Sandusky Bay. Directly across the bay stands the
3 Davis-Besse Power Plant. The plant has always been a
4 concern for both my family and neighbors and we are
5 concerned with the problems and mismanagement at that
6 particular plant.

7 It has been nice to have that plant closed. I'm
8 most afraid of the situations that we are not aware of.
9 May I remind you that public safety should definitely have
10 priority over big business. I am currently concerned with
11 the fact that FirstEnergy may be reactivating FirstEnergy.
12 FirstEnergy does not appear to be capable of effectively
13 and safely operating some of their facilities, let alone
14 starting up Davis-Besse.

15 Now, it is my understanding that you have the
16 authority to keep Davis-Besse closed. I would ask that you
17 use this authority wisely and prudently, keeping in mind
18 the safety of these people who live and work near that
19 plant. It would be comforting to know that if Davis-Besse
20 were to reopen, that it would be run by a company which is
21 better capable of operating it in a safe and effective
22 manner.

23 Thank you for your consideration. Beth Harrod"

24 MS. SZENTENDAI: My name is
25 Theresa. I'm going to read you a letter from Fred Chase

1 Steiner, he is from Bay Village, Ohio. I'm just going to
2 read a couple paragraphs from this.

3 "The people at FirstEnergy have been far from
4 outstanding in both their business practices and their
5 facilities operations. While I understand that there have
6 been inroads made in the physical fortitude of the plant to
7 Davis-Besse, there are certain questions about the
8 procedures and operations and the veracity of FirstEnergy's
9 commitment to the proper operation of nuclear facilities.

10 Even if a plant makes the grade in terms of
11 construction in grading facilities, it also receives a
12 grade in personnel and management. After all, you build a
13 Ferrari, but it's not worth anything if you don't know how
14 to drive it. Operation of a nuclear plant, such as
15 Davis-Besse, should not be any different. Accountability
16 is not required, it is demanded by those of us who would
17 move throughout our home out of harm's way should
18 FirstEnergy fail in their responsibilities."

19 We also have some copies of these letters sitting up
20 there in case you would like to read them yourself.

21 MS. LIPA: Okay, those
22 letters will be included in the stack.

23 MS. SZENTENDAI: Yes.

24 MS. LIPA: Thank you for
25 coming. Since I haven't seen you guys here before. I want

1 to point out the monthly newsletter that we have that has a
2 lot of good information in it. That will help, I think,
3 illustrate for you the breadth and depth of the NRC's
4 activities with respect to Davis-Besse, especially the
5 Restart Checklist that we have in here, just to give you
6 the idea of the types of thing we're doing before we
7 consider restart. We have, you know, a formal process; the
8 0350 Process is what it's called, and a lot of NRC
9 activities before we would consider restart.

10 MS. WEIR: Hi, my name is
11 Shari Weir. I have an observation and a question. The
12 observation is, that on Saturday, it will have been two
13 months since FirstEnergy initially submitted paperwork to
14 the NRC indicating it was ready for consideration for
15 restart. And yet, in the two months, an amazing amount of
16 activity has happened, both in terms of blunders and in
17 terms of operational and procedural changes.

18 Clearly, FirstEnergy on November 24th was not ready
19 to restart Davis-Besse, yet they thought they were. And
20 the only reason that the changes were made is because the
21 NRC is carefully scrutinizing all phases of the efforts of
22 the Davis-Besse.

23 So, the observation is that, frankly, this is very
24 scary. And, I just wanted to point that out.

25 The question that I would like to raise involves

1 the-- on the weekend, there was a quick news item in the
2 newspaper indicating that the NRC is conducting an
3 investigation of overtime at Davis-Besse.

4 In May of 19-- May of 2002, Citizen Action asked
5 the NRC to look into the overtime at Davis-Besse. Then,
6 Sonja Haber in her report also noted the overtime that was
7 rampant at Davis-Besse and pointed out that over a long
8 period of time this could cause a number of significant
9 problems.

10 Month after month at these meetings we hear workers
11 and family members talk about exhaustion and frustration,
12 and now the NRC is doing an investigation. And I would
13 like to know the scope of that investigation, and also how
14 that investigation interacts with the 0350 Panel.

15 MS. LIPA: Let me take an
16 attempt at answering your question. I know I have seen
17 some news articles that talked about the issue of overtime
18 and some specifics, but I wasn't aware of that it said the
19 NRC was doing an investigation.

20 MS. WEIR: It was in the
21 Plain Dealer on Saturday.

22 MS. LIPA: Okay. We do
23 inspections, so let me talk a little about inspections and
24 maybe there is something else that you're talking about.

25 We have, we did an inspection on overtime that was

1 documented in a report last fall. I believe, Scott.

2 MR. THOMAS: 15 or 17.

3 MS. LIPA: Yeah. 15 or 17,

4 one of our routine inspection reports, where we looked at
5 some overtime issues and how they were controlling overtime
6 and whatnot, and published the results of that review.

7 And we haven't determined exactly what we plan to do
8 in the near term, but it's definitely on the agenda for the
9 0350 Panel to determine what needs to be done, if anything,
10 with respect to another inspection on overtime.

11 So, I can't tell you today specifically what we plan
12 to do, but I don't know of any investigation. That's a
13 completely different realm. I don't know of anything
14 myself.

15 An investigation would normally be by the Office of
16 Investigations, where they would come out to see if there
17 is any, any wrongdoing or any issues that are beyond the
18 scope of what we would do for an inspection report.

19 MS. WEIR: So, it could be
20 something that's just beyond the scope of this panel?

21 MS. LIPA: Well.

22 MR. GROBE: It's several
23 things. We have an ongoing Management/Human Performance
24 Inspection, and the focus of that inspection currently is
25 evaluating the Licensee's assessment as to why results of

1 their November Safety Culture and Safety Conscious Work
2 Environment surveys showed a decline in some departments in
3 the response levels, positive response levels with the
4 staff of those departments.

5 FirstEnergy completed assessment that was led by the
6 Vice President of Oversight, Fred von Ahn. He had a number
7 of people on that assessment as to why there was declines
8 in a number of departments, while the overall indication
9 was an improving trend; several departments showed
10 declines.

11 So, the Management/Human Performance Team is looking
12 into that issue. FirstEnergy concluded that, in talking
13 with the people, feedback that they were getting from the
14 people, was that to some extent decline in the positive
15 response of the surveys was related to the extended work
16 hours.

17 It is important to note that we have not observed
18 any particular safety issues that either FirstEnergy or we
19 have attributed to fatigue, but FirstEnergy is evaluating
20 the impact of work hours on their staff and taking
21 actions. We're also evaluating them.

22 So, I'm not sure what the Plain Dealer was talking
23 about. We don't have any particular investigation into
24 work hours, overtime usage currently. What we do have is
25 an examination of the November Safety Culture and Safety

1 Conscious Work Environment survey results and what might
2 have contributed to the declines in feedback from various
3 departments, and what actions FirstEnergy is taking,
4 whether or not those actions seem appropriate.

5 You raised another issue that I had on my little set
6 of notes here that I wanted to mention in my closing
7 remarks at the first part of this meeting. I really
8 appreciate you raising that issue. That has to do with the
9 importance of the capability of self-assessment. You're
10 absolutely correct. November 23rd, FirstEnergy sent us a
11 letter that said that they had taken appropriate actions
12 and they were ready for restart.

13 Since then, we've had a lot of interesting
14 experiences and observations. We have had a number of
15 opportunities where the RRATI, Restart Readiness Assessment
16 Team Inspection was delayed, and then we had that
17 inspection on site with some negative findings, and
18 FirstEnergy continues to take actions.

19 We've requested FirstEnergy to consider
20 supplementing that report, particularly focusing in the
21 area of effectiveness of self-assessments, and why we
22 should have confidence in their self-assessment.

23 They just completed a Root Cause Evaluation on the
24 most recent operational issues, and that was done by a
25 number of people from outside Davis-Besse. And I've

1 personally reviewed that assessment, and heard the results
2 of that assessment, and it was a very thorough and
3 comprehensive assessment.

4 As I indicated earlier, I didn't want to use the old
5 adage "I'm from Missouri" or "The proof is in the pudding",
6 whichever one you want to choose, the bottom line is, had
7 they identified the right corrective actions and do they
8 implement them properly and are they able to effectively
9 assess their performance once those corrective actions are
10 implemented. And those things, we're going to be taking a
11 very careful look at, so I appreciate your comments.

12 MS. BUCHANON: My name is Sandy
13 Buchanan. I have a couple of other comments and questions
14 about the Safety Culture Assessment. First is, I'm
15 wondering if you've had a chance to interview any former
16 employees on this question of how the extended hours may
17 have effected safety. We, for example, have a gentleman
18 who has come to us that wasn't able to make it tonight, was
19 going to contact you separately, who left Davis-Besse
20 because of the extended hours. He felt he wasn't
21 performing well and could have been making some poor safety
22 decisions. He fortunately was able to find other
23 employment, but I wonder if you might not get more evidence
24 of possible problems by talking to people who are not
25 currently employed at the plant.

1 MS. LIPA: I can tell you
2 that I'm not aware that we have interviewed anybody who has
3 left the plant. So, so far we haven't. And, if this
4 person that you're talking about has any concerns, they can
5 certainly call us, because we won't find him. If he wants
6 to find us, he has to find us.

7 MS. BUCHANON: I was just saying
8 as a category that might be an important group of people to
9 look at, because as we know also some of the most critical
10 comments have come from outsiders, outside the industry or
11 people who have may left the facility.

12 As we all know, mistakes are made when you're
13 tired. They may show up in a situation like this and we
14 might not know about them for quite awhile.

15 The other thing I would like to ask about was this
16 whole evolution of personnel and safety culture. And as it
17 was said more succinctly, I would like to quote Port
18 Clinton's recent editorial, which is titled "FirstEnergy
19 fails to restore any public confidence."

20 And in part it said, "Late last week, FirstEnergy
21 announced another realm of management changes at
22 Davis-Besse. These in response to "incidents" in which
23 workers did not properly execute, "administration
24 controls."

25 "What are we to make of this? Well, it seems that

1 from February of 2002 until December of 2003, FirstEnergy
2 had failed to fix these problems, which of course are
3 management problems. Now FirstEnergy wants to convince the
4 NRC that it has done in a handful of weeks what it couldn't
5 accomplish in about 22 months. We're not buying it."
6 Unquote.

7 And they go on to say the plant should restart, but
8 not with FirstEnergy in charge.

9 The recent management changes that were made appear
10 to be all personnel who have either been working at FENOC
11 for many, many years or even working at Davis-Besse
12 itself. And the question I have comes from having worked
13 with some other companies who I have actually seen change
14 their safety cultures, but it takes a lengthy amount of
15 time. It is a whole process of moving through the
16 operations.

17 And as your evaluation goes on of safety culture,
18 personnel that was changed last week, how long will it take
19 to figure out whether new promises of changes in safety
20 culture are going to go by the boards the same way as we
21 saw the last round of management. Can you analyze in two
22 weeks or four weeks whether there has truly been a change
23 at this operation?

24 MS. LIPA: Well, I can't give
25 you a specific answer today. Obviously, we have more

1 inspections planned. The major focus of what we were
2 talking about today were the Licensee's Root Cause
3 determinations, some recent errors that were made, and root
4 causes for those errors.

5 And, yes, we asked a few questions about why. We do
6 a lot more than just talk about it in this meeting. We'll
7 look at their root cause document, understand the
8 specifics. That's what the inspectors will do.

9 And, so, we have plans to look into detail, more
10 detail on what the Licensee is telling us. So, I can't
11 answer your specific questions today.

12 MS. BUCHANON: But I question, my
13 question has more to do with how you as evaluators can
14 evaluate what is really a very thorough culture, that's the
15 word, cultural change in an operation on the basis of, you
16 know, a few weeks of so-called changes. How do you tackle
17 that?

18 MS. LIPA: I don't think we
19 would attempt to try to determine the impact of this
20 particular change on safety culture. What we're looking at
21 is what are they doing in the Operations area to improve
22 the performance. What have they done so far? What are
23 they doing in the future?

24 And we have a different team that's looking at the
25 Safety Culture. What we're really doing at Safety Culture

1 is looking at the Licensee's own things that they have in
2 place to measure and monitor and improve Safety Culture.
3 We're not doing an independent Safety Culture Assessment
4 ourselves. Do you understand the difference there?

5 MS. BUCHANON: I do, but as a
6 member of the public, that doesn't make me feel a whole lot
7 better.

8 MS. LIPA: Right. Well, Bill
9 talked a little earlier about this whole Safety Culture
10 area being new to us and something we spend a lot of time
11 and have spent resources on. And we really do have, we
12 spent a lot of time looking at what the Licensee is doing
13 to monitor Safety Culture and to assess changes that have
14 been made, but we're not doing an independent Safety
15 Culture Assessment.

16 MR. GROBE: Sandy, I think,
17 first off, I appreciate you coming to our meetings. And I
18 know you are busy. I'm glad to see you here.

19 I think we're connecting together a couple of things
20 that are not properly connected.

21 The Management and Human Performance Building Block,
22 I think is what FirstEnergy calls it, and we have an
23 inspection that mirrors that building block, has been an
24 ongoing effort over the past two years to improve the area
25 of Safety Culture. And there is some, I think the number

1 was over 130 specific actions that have been taken.
2 FirstEnergy has been monitoring on a regular basis their
3 performance in that area. And performance might not be the
4 right word; it's more of a set of behaviors, organizational
5 behaviors.

6 The issues that are going on in the Operations
7 Department are really different types of issues. These
8 aren't organizational effectiveness and organizational
9 cultural issues. I believe they are individual performance
10 issues, more on a micro scale as contrasted with a macro
11 scale.

12 It doesn't really matter to us which manager is in
13 one position, as long as those individuals have integrity.
14 What matters to us is performance. And what we will be
15 measuring is the performance of the organization. And we
16 won't make a determination as to whether or not this plant
17 is ready to restart until we're able to see performance
18 that is, that is at a consistent, acceptable level, such
19 that we have confidence that in the future will remain
20 consistent and acceptable.

21 Performance has steadily improved over time. And
22 there is no relationship whatsoever between performance
23 today and performance that resulted in the degradation of
24 the head. The question is, is it at a level that gives us
25 confidence in the future that should we authorize this

1 plant to restart, that it will be restarted safely and
2 consistently operated safely in the future.

3 So, I hope that helps clarify the issue.

4 MS. BUCHANON: I certainly agree
5 that's the question, whether the changes are sufficient.
6 And it's very hard from a public point of view to get a
7 handle of how you're evaluating all that, and I know you're
8 struggling with that too, so I appreciate that you share
9 with us as we go through this process the different
10 criteria. And I guess we'll hear more about it in March.

11 Thank you.

12 MR. GROBE: Thank you.

13 MS. LIPA: Anybody else have
14 any comments or questions for us?

15 MR. MATHERBY: Good evening, I
16 would like to thank you, the NRC 350 panel for showing up
17 tonight.

18 MS. FRESCH: Excuse me. Your
19 name, please?

20 MR. MATHERBY: Including the
21 public in this whole discussion as we go through the
22 restart. I'll get to it. My name is Greg Matherby, I'm a
23 operator at Davis-Besse.

24 MS. LIPA: If you want to
25 pull your mike up, so you can stand tall.

1 MR. MATHERBY: As I said, first
2 of all, I would like to thank you for coming out tonight,
3 and over the last 22 months involving the public in this
4 whole restart effort.

5 I am an operator at Davis-Besse and I'm also a local
6 citizen of Ottawa County. And, I've gotten up and spoken
7 several times before and my first and foremost thing is, I
8 am a family man, and ensuring the safety of my family is my
9 first and foremost thing.

10 I go to Davis-Besse, I work to earn a paycheck to
11 have a life outside of my work. Over the last two years,
12 correct, there have been a lot of hours. A lot of people
13 have worked hard to bring this plant back to where it's
14 at.

15 But I would like to address several of the things
16 that some people brought up, as an operator person down in
17 the trenches working on a day-to-day basis. One of the
18 things that's been brought up is this whole thing about the
19 change, the delta between the margin of November Safety
20 Conscious Work Environment survey.

21 I was one of the operators, because we are one of
22 the groups that was identified that had a decline. And I
23 had a decline. Some of it was perceived, some of it was
24 real based on basically the NOP Test. And I would like to
25 bring that up. Because to me a Safety Conscious Work

1 Environment is if you have a problem, you bring it up, and
2 you're not afraid to bring it up.

3 Before the whole thing with the head happened, I
4 think a lot of people would have just, yeah, we're doing
5 okay because the plant is running good; we have no
6 problems. Operations, we don't stand like that anymore.
7 If we have a problem, we're not afraid to bring it up.

8 And therefore that's the reason I think you saw some
9 of the declines. We've had questions. Those questions
10 have been addressed. This has been seen in the last two
11 months, because management has not been afraid to say,
12 "Okay, we don't have this working just the way we expect it
13 to. We won't go any further until that's taken care
14 of." or "The attitudes that we have here, we want to make
15 sure that we're all on the same book, working out of the
16 same book, before we go forward."

17 We brought up, as far as the Conduct of Operations,
18 I'm in the licensing class that's going right now.
19 Hopefully, in about six months, I'll be one of the people
20 in the reactor, in the reactor operator shoes, that the
21 public will be relying upon to ensure that we are operating
22 within our technical specifications in accordance with our
23 license. We take that very seriously.

24 Whenever I first started the training program, which
25 is before the whole head degradation incident came into

1 fact or into effect, whenever we would be training, we
2 would operate out of knowledge. Not anymore. If there is
3 ever a question when we're down in the simulator, going
4 through some areas, we have little green book. It's called
5 our "Operations Expectations Excellence Handbook." And if
6 there is a question, we look it up. We want to see exactly
7 what the expectation is, because unless you train the way
8 that it's written, you're not going to operate the way that
9 you're supposed to.

10 So, I would like to bring that up, that first of
11 all, for working very diligently as far as our Conduct of
12 Operations. Second of all, with your Safety Conscious Work
13 Environment, how do you get better? You bring up things
14 that you feel need to be addressed and they're addressed;
15 whether that be in this survey certain things that happen
16 during the NOP test, as I said were real or perceived, but
17 they have been addressed.

18 Second of all, Mr. Whitcomb brought up as far as
19 green tags, material deficiency tags, notifications as
20 they're now called. It's funny he brought that up. He
21 said, "How many are two years old?" Because in my
22 particular shift, we started doing little things, because
23 we wanted to see how many we could find out there that were
24 greater than two years old. Miraculous, kind of funny that
25 you brought that up at this particular time. We found

1 two. I'm not saying that's all there is, but we looked
2 diligently for them.

3 We also write quite a few now, because before where
4 we would accept stuff. We don't do that anymore. Whether
5 it be a broken lining or anything else, we're going to
6 write a deficiency because we want those things addressed.
7 Because if you look out for the small things, you won't
8 accept whatever small things lead to bigger things, such as
9 why are we having this boric acid showing up in our
10 radiation samples. We don't understand it, but we're going
11 to live with it, because we think it's this. Now we're
12 pushing the issues.

13 I hadn't planned a speech, so I'm a little nervous.

14 Lastly, I would just like to say, as I said, I'm a
15 family man first. I love my job. I love what I do. I go
16 to my job each and every day. I put my 110 percent forth.
17 But I do that so that I know that my family is safe. We
18 live near the plant. I would never do anything to put them
19 in harm's way.

20 I go home. I enjoy the time I have with my family.
21 I look forward to more time. But until we restart this
22 plant, I understand the commitment I have to make to get to
23 that point.

24 I appreciate your time. Thank you.

25 MS. LIPA: Thank you.

1 Anybody else have any comments or questions for us?

2 Okay, I guess not.

3 Well, thank you all for coming. Good night.

4 (Off the record.)

5 ---

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

1 CERTIFICATE

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

8 IN WITNESS WHEREOF, I have hereunto set my hand and
9 affixed my seal of office at Norwalk, Ohio, on this
10 31st day of January, 2004.

11

12

13

14

Marie B. Fresch, RMR

15

NOTARY PUBLIC, STATE OF OHIO
My Commission Expires 10-10-08.

16

17

18

19

20

21

22

23

24

25