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

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Meeting held on Tuesday, July 13, 2004, at 6:30 p.m. at the Oak Harbor High School, Oak Harbor, Ohio, taken by me, Marie B. Fresch, Registered Merit Reporter, and Notary Public in and for the State of Ohio.

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PANEL MEMBERS PRESENT:

U. S. NUCLEAR REGULATORY COMMISSION

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

FIRST ENERGY NUCLEAR OPERATING COMPANY

Mark Bezilla, Vice President
Barry Allen, Plant Manager
Ralph Hansen, VP Nuclear Oversight
Kevin Ostrowski, Manager-Plant Operations

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MS. LIPA: Good afternoon. We'll go ahead and get started. I would like to welcome FirstEnergy and members of the public for accommodating this meeting. This is a public meeting between the NRC's Davis-Besse Oversight Panel and FirstEnergy Nuclear Operating Company.

My name is Christine Lipa, I'm a Branch Chief in NRC's Region III Office located near Chicago, and I'm responsible for NRC s' inspection program at Davis-Besse.

The next slide, we'll talk about briefly the purposes of the meeting; and basically those purposes are to keep the public informed of the ongoing NRC activities, discuss with the Licensee performance and other activities, and then, of course, to be available at the end of the business portion of the meeting for public questions or comments.

Can you guys hear me okay in the back of the room? Okay. Thank you.

Okay. So, the next slide is the agenda. And we'll start off with introductions and opening remarks. I'll talk about some recent NRC activities and some upcoming NRC activities. I'll turn it over to the Licensee for discussion of their part of the presentation for today. And then we'll adjourn the business portion of the meeting and we'll take a break, but then we will be available for

public comments and questions before we adjourn the meeting.

So, let me start with introductions over here on the NRC side of the table today. On the far left is Jon Hopkins. He's the Project Manager for Davis-Besse. He's located in headquarters, in Rockville, Maryland.

Next to John is Scott Thomas. Scott is the Senior Resident Inspector at the Davis-Besse plant.

Next to Scott is Jack Grobe. Jack is a Senior Manager in the Region III Office. He's the Chairman of the Davis-Besse Oversight Panel.

To my right is Jack Rutkowski. He's a Resident Inspector located at the Davis-Besse plant.

We also have some other folks from the NRC in the audience. We have Alex Garmoe. He's a Nuclear Safety Professional. He's new in my branch in the Region III Office.

Richard Smith. He's also new in my branch in Region III Office. Richard is a Reactor Engineer.

We have Nancy Keller out in the foyer with the handouts and greeting you all when you came in.

We have Viktoria Mitlyng. She's our Public Affairs Officer.

And I think that's about it for today.

Would you like to introduce your folks, Mark?

MR. BEZILLA: Thank you, Christine. To my right is Barry Allen, my Plant Manager.

To my far left is Kevin Ostrowski, my Operations Manager.

To immediate left is Ralph Hansen, our Vice President of Oversight.

And I'm Mark Bezilla, the Site Vice President.

MS. LIPA: Thank you. And I know we have some public officials in the room. Would you like the stand up and introduce yourselves.

MR. KOEBEL: Carl Koebel, County Commissioner.

MR. ARNDT: Steve Arndt, County Commissioner.

MR. PAPCUN: John Papcun, County Commissioner.

MR. WITT: Jere Witt, County Administrator.

MS. LIPA: Great. Thank you.

Okay. As I mentioned before, this is obviously open to public observation, but it is a business meeting between the NRC and FirstEnergy, so before we adjourn today's meeting there will be time for comments and questions for the NRC folks, and we'll be available for anybody who has

questions.

I wanted to talk a little bit about some handouts that you saw when you came in. We have a public meeting feedback form that we've been using to get feedback on how this meeting goes. So, if you want to make comments, just fill this out and send it back to us.

There is one-page two-sided NRC update. This has kind of replaced the monthly newsletter we were using before restart. It has a lot of good information on it, as well as the bottom of the second page, information on how you can contact the NRC if you have comments or questions. Also, the website where we have a lot of documents that are publicly available.

There is slides that I'm going through for the NRC portion of the meeting and then also the FirstEnergy slides are available.

Okay, we're having this meeting transcribed today by Marie Fresch is here. We'll have a recording of this meeting and it will be available on the Web site about three or four weeks after today's meeting. So, it would be important to use the speakers so we can hear what's being discussed.

And I would like to go to the next slide, which is recent NRC activities.

The government accounting office was requested by

several congressional representatives to review the NRC activities prior to the discovery of the vessel head degradation, and that report was issued on May 18th. And the Chairman of the NRC has also responded and those documents should be available on the website.

The next item, on May 20, the NRC commissioners spoke at a hearing that was held by the Senate Environment and Public Works Subcommittee; and a transcript of that hearing should also be publicly available.

The third item is there was a hearing request submitted in March. That was after the restart approval and the Confirmatory Order that was issued as part of the restart. There was a Hearing Petition submitted on those documents and that was under review of the Atomic Safety Licensing Board and was denied recently. And the petitioners have appealed that decision and that is with the Commission at this point in time.

The next bullet is, there was a site visit by our new Deputy Executive Director for Operations. His name is Ellis Merschoff. He was out at the site on June 16th touring the facility and meeting with the Resident Inspectors.

And then the next bullet is, we recently issued a Resident Inspection Report. That's publicly available.

The next slide shows some other recent NRC

activities. We continue to have a lot of interest from Congressional Representatives. The first two bullets, on June 22nd and June 24th, members of the Davis-Besse Oversight Panel met with some of the staffs for those Representatives on the Hill.

The third visit was a lead, one of our Lead Inspectors for the Management/Human Performance area was on site on June 23rd to attend a meeting that was held to discuss performance in that area.

On June 30, the Resident Inspectors held their routine Exit Meeting with Licensee management.

And then on July 2nd, there was a team of five or six member team from the Region III Office on site looking at modifications, commitments in the engineering area and safety evaluations. And that report is due out in mid August.

Some upcoming NRC activities. There will be a Triennial Fire Protection Inspection later this summer. There is, that's a large inspection, a team inspection to look at fire protection systems at Davis-Besse.

The second item is part of the Confirmatory Order that I mentioned earlier that we issued, along with the Restart Approval documents, requires FirstEnergy to hold four separate comprehensive independent assessments in each of the four areas; Operations, Corrective Actions,

Engineering and Safety Culture. And the way those independent assessments work is the Licensee is required to submit to us 90 days ahead of time their plan for that assessment and the people that will be on the assessment team. Those are planned for starting in August, one a month for the rest of the year. And two of the plans have already been submitted and those are under review by the lead inspectors.

Then, finally, one of the leads for the Corrective-- the Management and Human Performance area will be on site the week of July 19th with his team to look at effectiveness of actions that have been taken in the Management and Human Performance area. That's Geoff Wright and his team.

So, those are the main points I wanted to cover.

Any other discussion from the NRC folks at the table here?

Okay, with that, I'll turn it over to you, Mark.

MR. BEZILLA: Thank you, Christine.

Before I get started, I would just like to introduce Lew Meyers, FENOC's Chief Operating Officer. He just came in, so I would introduce Lew.

Next slide, please.

Our Desired Outcomes for this evening are to demonstrate that Davis-Besse's operations continue to be

safe and conservative; we would like to provide you with an overview of our performance since the last public meeting; briefly overview the new FENOC fleet organization; and status you on our improvement initiatives and Confirmatory Order activities.

Next slide, please.

Barry will start things off with an Overview of Plant Performance. He will then move into Improvement Initiatives, Performance, utilizing information from some of our performance indicators; and then discuss our upcoming Independent Assessments.

I will then spend a few minutes providing information and insights from a number of recent Assessment Activities.

We will have Kevin Ostrowski spend some time on discussing positive areas and areas for continued focus in Operations. And we wanted to spend a few minutes in this meeting in this area, because we'll be conducting our Independent Assessment of Operations in accordance with the Confirmatory Order and our Implementation Plan in August. And then we thought we would then discuss those results at a future, maybe the next public meeting.

I will wrap up the Assessment portion of the presentation, and then talk briefly about the Mid-Cycle Outage.

Then, I'll turn it over to Ralph Hansen who will provide oversight's perspective, before wrapping up our presentation.

With that, I would like to turn it over to Barry.

MR. ALLEN: Thank you, Mark.

The plant status for Davis-Besse; the unit is at one hundred percent power, generating approximately 925 megawatts electric. The station is at 107 continuous days of service, and we have 22 continuous Human Performance success days.

MS. LIPA: Can you talk a little about what that last bullet means?

(sound adjustment)

MR. ALLEN: Let me cover that again. The plant is currently at one hundred percent power. We're at approximately 925 megawatts electric generation. Currently at 107 continuous days of service. And we have 22 Human Performance success days.

I believe you had a question about that. I've actually got that in the presentation, and I'll cover some of that later, Christine, if you would like.

MS. LIPA: Okay.

MR. ALLEN: Some of the noteworthy items at Davis-Besse that we would like to cover relate to our plant performance since the last public

meeting. In accordance with Coast Guard and in cooperation with them, we placed buoy markers in Lake Erie. That provides a permanent waterside security zone visible to boaters on the lake.

Also on May 19th, we performed a monthly assessment of our Safety Culture, and have those results in discussion later in the presentation.

May 19th, we had a floor plug which was not reinstalled in a grapple hole, a ~~6x6~~ 6"x6" hole in the floor; the result of some maintenance activities. We did have a employee turn and stepped into that depression, slip down. And that was something that we took and considered for a site clock reset.

So, it's not our desire that things happen, but occasionally things do. And then we look to respond appropriately and aggressively where required. And site clock reset is one of those tools we utilize, because it allows us to communicate quickly and broadly on whatever has occurred, and then allows us to, it is a good tool to share those lessons with the station.

So, we use the site clock reset for what we think is an appropriate level and that allows us to focus on preventative efforts in a lower level to help us prevent events, is what we do with those clock resets.

Also in May, we successfully completed an Emergency

Plan Drill. And Mark has some of the particular information we would like to share on that drill later in the presentation.

Additional items. On May 20th, the American Society of Mechanical Engineers, the National Board authorized our nuclear repair stamp and also repair stamp, which was a big milestone for us. And we have a few more particulars, we'll share on that later.

Also, in May we had our monthly performance review of our performance indicators and that's where the Executive Leadership Team coming independently to review our station for four months, challenges our performance and understanding relationships. So, we had a monthly meeting on May 20th.

On May 21, we had the Ohio Environmental Protection Agency come perform their annual inspection of Davis-Besse. There were no violations identified by the annual inspection. I had a recommendation we'll take a look at, but overall very pleased with the results of the annual EPA inspection.

Then we had the opportunity on May 25th to provide a station tour for one of the Energy Aides to one of our State Senators at their request.

Early in June, I had additional officials come in from the State of Ohio in the areas of Security and

Emergency Preparedness. Those individuals got a tour of the station. You can see that photo there, part of that tour.

And we were very pleased early in June to find out that 8 of 8 license candidates who stood for NRC exams successfully passed their examinations. So, that will give us essentially five more Senior Reactor Operators coming on board and three new Reactor Operator licenses. So, we're very pleased with a hundred percent success rate on those candidates.

June 5th, we had an occurrence of utilizing incorrect procedure, just a revision. We actually used a procedure that was written for Modes 4 and 5, ~~or~~ vice the one for Modes 1, 2, 3 and 4. And, again, we took the opportunity and reset our station clock based on that, so we could assure we had discussions and Lessons Learned for all the stations there.

And I believe, Christine, you mentioned your presentation on June 16th, we had the Deputy Executive Director for Reactor Programs, Mr. Ellis Merschoff, visit the Davis-Besse station and met with some of the Leadership Team on the site.

On June 20th, performed basically a safety valve testing. We utilized a set pressure verification device to do that test; and we had an occasion where we input an

incorrect valve factor in the software. So, you input, depending on the valve you're testing, a valve factor in the software program; we did not perform an adequate peer check to catch that prior to implementation. We caught that during the performance of the testing. And, again, we'll use that as a Lessons Learned for the station.

In addition to the eight candidates I mentioned who just recently passed their NRC exams on June 23rd, we had our 2005 class take their Generic Fundamental Examination. And of those 17 candidates, all 17 passed the NRC Generic Fundamental Examination. So, we're very pleased with the candidates we had coming through the SRO, RO at this point.

On June 23rd, we conducted a Safety Conscious Work Environment Follow-up Assessment. Mark will provide some specifics on that assessment later in the presentation.

And on July 1st, we did enter an Off-Normal Procedure. And this was where we had isolated impurifications, demineralized or filtered for replacement; and we did not allow a great deal of time between that isolation and when maintenance went to work to replace that filter.

So, we isolated that filter on night shift. Day shift got right on the job, went to replace the filter, remove the filter, put it in the transfer ~~cast~~ cask, and then

the maintenance personnel left the area.

Subsequent to that, we did have a radiation element in the radiation -- emergency ventilation system detect some very low levels of iodine which was coming out of the storage container off of the filter, which did cause an alarm; and did cause us, did cause the ventilation to be secured; and we aligned our emergency ventilation system, which is filtered.

And per our procedures, Operations crew responded appropriately on our procedures; ensured people were out of the area, and allowed us to go back and do a survey to understand exactly what was going on.

And, so, we looked at how the event unfolded. Both the equipment and the personnel involved responded as expected. There were no internal contaminations. We did whole body counts on individuals involved. There was no contamination deposited in the building. And in fact, the added effluent was like ~~0.00005 milligram~~ 0.0005 millirem. So, very, very low levels.

We did take a look at that, to see what we could learn from that. And, probably the most significant learning we got from that is, when isolating a filter, we should probably allow at least 72 hours for the short-lived isotopes to decay, which we typically had done that in the past, just more through happenstance of good planning.

So, we modified our administrative controls to ensure when we isolate the filter, we allow shorten the isotopes to have a relatively short half life before we go to proceed next time to transfer the filter to a transfer pit.

MR. HOPKINS: Barry, have you looked to see if there are any other procedures that you need to do a review for that?

MR. ALLEN: John, good question. John's question was, have we looked at similar filters to see if we have similar Lessons Learned that we can share; is that correct?

MR. HOPKINS: Yes.

MR. ALLEN: There are other filters, and probably the most common place to catch that right at the start is the RWP. So, the first thing we did was the radiation work permit for changing filters was suspended until we went through and had a chance to capture those Lessons Learned.

And, in fact, we had discussions this morning about additional filters that we were looking to change in the station; and then scheduled ones, they've been isolated for a week or two already to meet the 72 hour threshold. So, we do have those filters. So, the added controls either in the procedures, the work documents, and/or the radiation

work permit, is what we utilized.

MR. HOPKINS: Okay. Thank you.

MS. LIPA: Barry, on the filter, did this ever happen before when replacing filters caused those radiation elements to alarm?

MR. ALLEN: Actually, Christine, we've changed this filter out twice during the cycle, I believe, during this year, and did not have this occurrence. So, in those cases, looking back, what we saw was, we isolated it for maintenance; not in a hurry, because it's not a time critical evolution. So, we had isolated it; at some point later come in and actually swapped the filter out.

Again, we weren't driven by an undue sense of urgency. It was tagged out. Maintenance was prepared to change the filter out the next morning in this case. So, we didn't have controls in place to prevent that, because we had not really had this occurrence on this filter occur before.

MS. LIPA: So, you're not aware of any previous instances where this happened?

MR. ALLEN: No, ma'am.

Also, on July 2nd, we did have the NRC modification of 50.59 Inspection Exit. We got a very thorough inspection there in those areas; and the inspection report

is not yet issued. We are discussing two outstanding items and one potential on-site violation, we're still working with your organization for that additional information for that inspection report.

MS. LIPA: Barry, back on the first item, the incorrect valve factor; which activity was that? Which valve was that or what was that activity where you had the wrong valve factor?

MR. ALLEN: The incorrect valve, that was a main steam safety valve set point test, Christine.

MS. LIPA: You found that error just through normal review and approval process of looking through results?

MR. ALLEN: No, we discovered it during field implementation, during performing the test, Christine.

MS. LIPA: Thank you.

MR. ALLEN: Okay. Next slide, please.

In conclusion, Davis-Besse operations continue to be safe and conservative.

Unless you have more questions, I will turn the presentation back to Mr. Bezilla.

MS. LIPA: Yeah, one more

question. Back on the main steam safety valve testing. Had any of the valves been returned to service and declared operable before you found this error or did it happen right in the middle of the testing?

MR. ALLEN: We had adjusted one valve, Christine, and gone to a second valve. And in the process of adjusting the second valve, stopped, something does not appear to be right. So, therefore, we had two valves; one we were under adjustment, one we had just finished checking the set point on. So, for a limited time there, we were dealing with that issue on two valves.

MS. LIPA: So, for the first valve, had that already been through the whole testing review and approval or was it in the intermediate steps when you went on to the second valve?

MR. ALLEN: It was complete, because any time that you're doing main steam safety valve testing, you complete your performance on one valve before you proceed to the next valve, so we were complete with the first valve.

MS. LIPA: So, none of the steps on the first activity found the error; it wasn't until you went to the second valve that you found the error.

MR. ALLEN: That's correct.

MS. LIPA: Thank you.

MR. BEZILLA: Okay, Christine, are you prepared to proceed?

MS. LIPA: Yes.

MR. BEZILLA: Okay. Before I move on to the details of our FENOC Fleet Standard Organization, just let me spend a minute on the what, the why, and the how.

First the what. The reorganization of FENOC to the Fleet Standard Organization, if you will, we believe is an enabler to allow us to better focus on fleet wide performance, that's going to allow us to have attention on potential safety issues, we'll better standardize to the industry best practices, and we'll utilize a heavy benchmarking to make this all happen.

Next the why. With a common organization or structure, we'll be able to improve efficiency and effectiveness through a creation and continued creation of common processes. We will better be able to facilitate personnel development, and we will focus on getting the right people with the right skills set in the right place.

And, third the how. We're using the FirstEnergy selection process. This is a proven process used by other sectors of FirstEnergy. We'll come back to it at another time. We'll also utilize the Safety Conscious Work Review

Team at the site. We've chosen the directors, managers, and superintendents; and we're currently in the process of selecting supervisors and individual contributors.

Our plan has us being ready to implement the new organization by the end of August this year. Now, realize, some of the transitions, meaning personnel transitions, into the new roles will occur earlier; some may occur a little bit later, but in total we should be ready to implement before September of this year.

Okay. Our next slide, please.

The first, I got two slides, these are fairly high level generic. The first one is on the FENOC Organization. And you can see, we have the FirstEnergy Chairman and CEO, that's Mr. Alexander. We have our President and Chief Nuclear Officer, that's Gary Leidich. Reporting to Gary directly is Vice President of Quality Assurance Oversight, which is Mr. Ralph Hansen.

From a Fleet perspective, we have a Senior Vice President of Engineering and Services, that's Joe Hagan. And Joe's role has expanded a little bit. We have a Regulatory Affairs group, we've got Security, and we've also got Saxton/TMI-2 which are part of the FENOC organization. So, they're all important to Joe Hagan.

Then, we have our Chief Operating Officer, Lew Myers. And reporting to Lew are the three Vice Presidents;

Davis-Besse, Beaver Valley and Perry respectively. And then to Gary, he also has some direct reports. We have a Business Director, a Fleet Assessment Manager and Organizational Effectiveness Manager reporting to Gary.

And what we did, we did benchmarking of other Fleets through the country; chose this organization, which is close to a couple of the other Fleets that we looked at. And as I said before, I think this is going to help us moving forward from a safety perspective and efficiency perspective and being able to achieve excellence.

MR. HOPKINS: Let me ask you, Mark, could you give me a little detail like what is Operations Support going to be doing?

MR. BEZILLA: In Operations Support -- the question was, what is Operations Support going to be doing from a Fleet perspective?

In Operations Support, what we have there, we have various program managers. We have like an Ops Program Manager, a Maintenance Program Manager, a Work Management Program Manager, an Outage Programs Manager, and others. Those are individuals, a number of those will be brought in from the outside that have, I'll say, the big, the good plants, the performing plants; and they will help us do benchmarking and implement the best as far as standards go, as far as processes go within the Fleet.

MR. HOPKINS: Okay.

MR. BEZILLA: So, as an example, the Ops Program Manager would be an equivalent to like Kevin Ostrowski or Perry or Beaver Valley Ops Manager, such that we could rotate those individuals through for personnel growth, development, et cetera. Does that answer?

MR. HOPKINS: That answers my question. Thank you.

MR. BEZILLA: Next slide.

This is the standard site organization. And what we have at the sites; we have Vice President. Reporting to the Vice President directly is a Director of Site Operations. For Davis-Besse, that will be Barry Allen.

And, we have Director of Performance Improvement, which will be Bob Schrauder. You guys I believe are familiar with Bob Schrauder.

You can see Barry's span of control has expanded in the new world, in the new organization. He'll have Maintenance reporting to him, Radiological Protection, Chemistry, On-Line Work Management, Outage Work Management and Operations.

Reporting to Mr. Schrauder under our Performance Improvement, we'll have Training, Regulatory Compliance, and Special Projects.

Now, additionally, or reporting indirectly to the Vice President at the sites, would be Director of Engineering, and Manager of Site Protection, which is our Security Manager.

Jack and Christine, we just wanted to portray this. At the next public meeting, we can go into a little more detail, we'll have additional names, et cetera. And we'll cover that at the next meeting, but I just wanted to let you know this was on the horizon and we have efforts in place to put this in place.

When I talk about the Safety Conscious Work Environment Review Teams report a little bit later, I'll talk a little more about the organization and some of the cautions they provided to us as far as implementation of the organization.

MS. LIPA: So, is this the organization you plan to implement in August?

MR. BEZILLA: That's correct.

MS. LIPA: And we'll talk names and experience levels at that meeting?

MR. BEZILLA: At the next public meeting, that's correct.

Okay, with that, I would like to turn it back over to Barry.

MR. ALLEN: Thank you, Mark.

This slide illustrates we continue to make progress in accordance with the Integrated Restart Report. It's going to catch us up to date on Appendix A commitments, of which we closed 24 out of 38 commitments today. And then in Cycle 14 Operational Improvement Plan, equivalents of 94 commitments; out of there, we completed 51. Those are closed today. So, we continue to make progress there.

There is also six commitments in the Confirmatory Order, and those related to assessments and inspections, and we'll cover those later in the presentation also.

MR. HOPKINS: Just confirm; are there any late commitments that have not been met?

MR. ALLEN: No, we've had no late commitments.

MR. HOPKINS: Okay, thank you.

MR. BEZILLA: Jon, we have moved a couple of those based on, I'll say, our observations and assessments, so we've adjusted some of those dates, but we met our current due dates.

MR. HOPKINS: Okay.

MR. ALLEN: Next slide, please.

We've used this barrier slide before, but we like to utilize this slide because this illustrates that we continue to focus on improving our performance through

strengthening our individual programs, management and oversight barriers. And those are the barriers we've worked to strengthen to prevent events.

Next slide, please.

Within the area of Plant Operations, we've seen good performance in the areas of Dose, Personnel Contamination Events. Also Containment Health is in very good shape. And also myself, Mark, and Kevin can attest to the health of Containment because we've noted the Containment ~~increase~~ cleanliness in the last month or so, because we personally inspected Containment. So, we go out and look.

We've inspected pressurizer the best we could; popping the valves off of the pressurizer in RCS were successful. And done Containment tours. And one of the things that we found through the first set of tours were taken, was we've taken contamination smears throughout containment. Containment is as clean today as it was when we started the plant up coming out of the outage.

So, we're very pleased the state of Containment, and the tightness of the Reactor Coolant System and how clean we've been able to maintain that Containment Building during the Operating cycle.

Also among work management, we still have a lot of work to do on On-Line Work Management; however, we have made some progress; for example, last week we had a 95

percent schedule adherence rate. So, we're pleased with some of the results we're getting. Still a little rough getting to that final good performance. And we're working on those processes and behaviors to help us be even more successful in the area of Work Management.

MR. THOMAS: Barry, is 95 percent typical or is that a high point or?

MR. ALLEN: Scott, when we first transitioned from the refuel outage, end of outage, to the on-line process, we were averaging at about 65 percent. What we're seeing is slow incremental steady improvement, 90 to, I would say, 87 to 95 percent, is probably what we've seen the last several times. 95 percent is about as high as we typically got.

MR. THOMAS: So, you're confident it's sustainable.

MR. ALLEN: We're confident it's sustainable. And also we've had to get some help to track all the work as it goes through the Work Management Process. So, we can see as work is planned, as it's reviewed, as parts are obtained, as the work groups walk those jobs down, and then as they're prepared to work, we can see the status of those jobs as they move through that work week, twelve-week process.

And, so, we think that's the key to being successful

earlier on and not having to work quite so hard at the end to have good performance.

We continue to focus on site clock resets. Again, that's a tool we utilize. Something happens, we're not pleased with that; it's something we do consider. Again, that does help us leverage that end, a greater learning for the organization. And that attaches some significance from a management prospectus to allow us to maximize our opportunities learned from those occurrences.

Jack, we talked a little about preventative maintenance back in the last meeting.

MR. THOMAS: Can we go back to the site clock resets? How many this year?

MR. ALLEN: I've got that. We had five clock resets this year.

MR. THOMAS: Do you see any common causes or trends that are common between each of those events or are they fairly separated instances?

MR. ALLEN: If you look at it on the surface, Scott -- the question is, do they appear related or do they appear to be individually unique events?

MR. THOMAS: Or have common causes. I understand each one is an individual event, but are there common causes that contribute to each of those?

MR. ALLEN: We've not seen

what I would say are common causes. One of the things that we have observed, however, is that some of the events that we would reclassify as a station is the site clock reset; may be attributable to individual performance, on behalf of an individual, attention to detail, something happened during the individual performance of the task.

And so, like in the Operations area, for example, we are backing it up. We're going to do a Collective Significance Review of all those that don't appear to be related, but we do want to do a Collective Significance on those just to see if there are some common threads through there.

So, we had the same question you have. And Kevin is going to lead the effort, has already initiated an effort to look at that in the Operations area, for example.

MR. GROBE: I'm going to lose some money here, because Scott bet me I couldn't go the whole meeting without saying something.

But I know that you initiated a Condition Report on July 6th to conduct a Collective Significance Review in order to look for common causes. I would be interested in comprehensive dialogue at the next meeting, particularly focusing on alignment of the first supervisors with your expectations and what's going on at the first line supervisor level that allows these things to occur.

MR. ALLEN: So, at the next public meeting you would like us to have some comprehensive dialogue particularly related to supervisors, back to the July reset, and any other issues that we see related to the collective significance.

MR. GROBE: I'm not sure what the feedback is.

Particularly on the July Condition Report, the comprehensive assessment of five different, recent past station clock resets.

MR. ALLEN: I look forward to that discussion.

MR. GROBE: Okay.

MR. ALLEN: Anything else before I discuss Preventative Maintenance Backlog?

MR. GROBE: No.

MR. ALLEN: We discussed that briefly at the last meeting and did not have any data with me at that meeting, so I just wanted to give you a little update on Preventative Maintenance Backlog.

In May, when we had the last public meeting, we were talking about PM Backlog. I would like to help everyone understand what that is. Those are PMs that as the outage extended we were not able to perform those preventative maintenance tasks, equipment was not in service, not

available, couldn't be run.

So, as the outage extended, that created a backlog of PM activities. A lot of those PM activities have been worked off; however, a number of those PM activities we had to take a look at when we would reschedule those out, when is the proper window when we have the resources to perform those PM activities.

So, that backlog was approximately 176 PMs, the last time we spoke. We had 176 PMs that had been evaluated and deferred and gone through our deferral process, and targeted at a new home in the future.

The number of PMs in that category as we reported last week in our weekly morning meeting was, had gone from 176 to 103, so we're making progress there.

Jack, I believe you asked me how long we thought it would take to work off that backlog. I had thought probably running through the whole twelve-week process would probably take us at least, say, three months or so. We do have those targeted and laid out; and we would expect that the 103 would be all worked off by the end of November. We would expect to have that backlog worked out.

MR. GROBE: I'm sorry, I missed that. Could you say that again, please?

MR. ALLEN: The current

projection for working off the 103 remaining PM activities which had been evaluated and deferred, we have that now targeted and scheduled to be completed the end of November.

MR. THOMAS: So, the 103 are deferred PMs. What is the total PM backlog? Do you have a time frame that those may be completed?

MR. ALLEN: Scott, if you want to talk about a PM backlog; you never get rid of your PMs, all right, because if they're not corrected or left to be worked on later on, because as soon as I work on them, it gets in my backlog again, because I'm going to work on it again in a year or six months. So, when they're in the cycle, they're scheduled; it's work. It's coming through the Work Management Process, but it's just workload, right, it's not backlog in a literal sense.

MR. THOMAS: So, you consider your backlog as those PMs that have been deferred.

MR. ALLEN: It's that burden of work that was pushed out by the delay in the restart that just accumulated, because during the two years of the outage, their due dates had come due, but that equipment was not available to PM, to run, to put in service, all those kinds of activities that you would do in a PM. So, that amount of work then pushed out ahead of the refuel.

Once we got to restart, and then we got our twelve-week processes going, then we look to see when are the functional equipment group weeks planned to take systems, trains, components and other -- and take equipment out of service. So, when is the right time to perform those PMs? That's what the schedule ought to be; continuing to work that collection of PMs that were evaluated and deferred off until that approaches.

So, once that work is gone, there is no PM backlog. It's just normal PM routine activities at whatever period they're scheduled to be performed.

MR. RUTKOWSKI: Barry, have you been able to keep up with the PMs or have you had to defer others that have come due?

MR. ALLEN: It's a challenge for the organization to keep up with the PMs. Most of the Maintenance shops are working primarily preventative maintenance tasks. So, it's a significant resource load on the shop.

On the ~~FEN~~ FIN team, the primary target is emergent work, as you know, and those kinds of things to keep that load off the shops, but we have been pretty successful on working the PMs as they're due coming in.

We have another population we track. Where they're scheduled within their normal grace period to work, but

they're scheduled a little later in that grace period than we would like and we have to watch that. So, if we had some emergent plant issues, had the deferred resource to emergent issues, we may have some PM come up that we can't work in the schedule, and we may have to evaluate those and retarget for the next train one or train two work week. But, by and large, we have been pretty successful.

MR. RUTKOWSKI: And roughly how many PMs do you do in a year?

MR. ALLEN: Roughly how many PMs do I do in a year? In a typical week, and this is just last week, so I don't want to put a lot of confidence in the number; we scheduled 38 preventative maintenance tasks last week. So, the 35 to 40 per week range is pretty typical, is what we see. Mark's math is approximately 2000 preventative maintenance activities.

MR. THOMAS: Do you have any groups of preventative maintenance upcoming that would challenge, be a significant challenge -- I should ask my question better.

Is there any group of maintenance activities upcoming in the next six months, twelve months, that will significantly challenge you either to sheer numbers or resources available to work them, challenge it from a backlog perspective?

MR. ALLEN: Scott, I guess the best way to answer your question is, since the last meeting, the backlog we've gone from 176 to 103. So, we see some significant effort being expended in improvement to get that down to where it's smaller and smaller and a more manageable population. If it was five hundred preventative maintenance activities, I would be more concerned and feel more challenged, but when we get down to a hundred, it should be hopefully less than a hundred this weekend because of the progress, it's getting down to a smaller more manageable number.

MR. THOMAS: So, MOVs or AOVs or breakers, that are done on a cyclic, every two years, every three years, there is nothing upcoming that would challenge you?

MR. ALLEN: Scott, not that I'm aware of. Although, laying them out there in November, the intent of that is, like, let's say I have MOV testing on a particular system. Well, when does that system plan to have a scheduled maintenance window down the road? Well, if that's in the second week of October, we plan to take out that train of service for instance, then we take this breaker work, whatever the work is, in that PM backlog, and assign it, tag it to that functional equipment group work week.

So, you know, we don't, it's not so much I have so many MOV, motor operated valve PMs or I have so many recent inspect, or clean and lube, as much as we just look at what is the right way from a safety perspective, because we want to work off the preventative maintenance tasks. The key is to ensure what's the right time to perform the activity.

And, so, we need to look at our scheduling process to lay out when would those system windows be, and we put that work in the windows, and go plan that in accordance with its -- how it is at that time.

MS. LIPA: Are you saying you actually have all 103 of those scheduled, an actual date when the system will be ready to do the plan?

MR. ALLEN: Yeah, I have, I would be glad to share current with you, if you like. I have a little older historical data than the projection going out. But the work, the On-Line Work Management Process is really intended to do that, to be looking out on a twelve-week process.

And so, the start of that is today; what are we going to work twelve weeks from now. And, of course, the windows are laid out through the entire cycle so we know what our windows are for the entire cycle. And, then the twelve-week process comes and takes that and refines those activities and makes sure we are thoroughly prepared to go

execute them by the time we get to that date twelve weeks later to execute that task.

MR. RUTKOWSKI: Barry, am I correct, I think this is correct, you do look at your resources and manload your schedules?

MR. ALLEN: Yes, we do. The maintenance disciplines, the folks that manage the craft resources provide the information to the planning and scheduling organization. That's because the disciplines know when they plan an outage, when folks have vacation; they have all the resource information.

Then that's provided, and we go up to the twelve-week process. You have to manage your resources with the tasks that you have. So, we do manage that, yeah.

MS. LIPA: Barry, can you tell from our questions, the backlog is important to us. And, it sounds like you were prepared today to talk about preventative maintenance backlogs, but there is other backlogs; I see on the next slide you talk about corrective actions.

I was also looking at your commitment book for May; Post Restart Cycle 14 commitments. And this is another thing in my mind that's part of backlog. For operator workarounds and for control room efficiencies, your own

performance indicators have shown those as red; January, February, March, April, May.

So, I guess I'm wondering what your focus is on improving this backlog, if it is a backlog for workarounds and deficiencies, kind of a hold-back on. And I don't know how many details you have today. Perhaps this could be a topic for the next meeting.

MR. ALLEN: Christine, we'll be glad to go into that next time. An example, just maybe a quick comment on operator workarounds, for instance.

There is a level one operator workarounds, which are, really if you look across the industry, that's what you really go to any station and see the progress of operator workarounds.

And, we have no level one operator workarounds. So, there is nothing in an abnormal event or emergency operating procedure would require an operator to take action. So, we have that magnitude. We do have some level two operator workarounds, as we define them currently. Substations define those as operator burden on those things. Those are more routine tasks that operators will perform just on daily rounds and those kinds of things. But we'll be glad to provide you some more information.

MS. LIPA: Do you have any more information on the control room deficiencies today,

because that's been in the red month after month also?

MR. ALLEN: I don't know that I have that with me, Christine.

MS. LIPA: Okay. Let's talk about it next time. And, you know, assuming backlog and backlog management, you know you need to prioritize what's most important. We're just kind of looking at which ones that were maybe left off on the side for awhile when you're focusing on other things. As long as we understand what you're doing on backlog, and how you're prioritizing, so we can understand it.

MR. ALLEN: We do discuss, internal things. Operators do talk about, here are the control room deficiencies, and let's say control room and those kinds of things. We do take those as a station and we assign them a priority; okay. So, the priority is assigned based on the significance of the issue to the Operations Department.

So, if, for instance, it's extremely significant, we'll assign a high priority, which could be up to and including working 24 hours a day on the clock. But each of the issues get evaluated. Operations looks at them and helps us on priority. And some of them, the significance is not such that we need to resolve them today. They best fit in that twelve-week process.

Then we look, when is the right home; when is the right time to perform an activity. Even though you may identify something as control room deficient or operator workaround, you still have to assess the safety significance and assure that your plan is for the right time to go work the activity, you know, in accordance with training weeks and equipment outages and training outages.

MS. LIPA: Absolutely. And then the initiative comes to mind, recently there was a missed surveillance because of an instrument that was not working properly in one of the back panels. Does that sound right, Scott, one of the instruments was not working properly?

I would hope that that instrument had been flagged as either a workaround or deficiency or some kind of higher priority maintenance since it was relied upon for surveillance.

MR. ALLEN: And it was not flagged earlier on. It is being worked this week. That should be resolved tomorrow.

MS. LIPA: So, you're saying that was initially not properly prioritized?

MR. ALLEN: That's a question, that's a question we're asking ourselves. It's possible that, it's possible that we should have given it a higher

priority. That instrument not being available, you still have computer ~~ports~~ points being available that give you the same information.

So, the information is available to the operator even if the indicator itself is not functioning, but that's a challenge for Kevin and his Operations crew. And you got to do this every so often; is my threshold at the right place. Then, as you set your threshold and work these systems off the list and you clear out, your operator workarounds, deficiencies, and those kinds of things, you need to look at driving that down to a lower threshold and just keep working through that process. So, it's a good question.

Kevin did ask the work on that be completed, and we do have plans in place to complete that this week.

MS. LIPA: Thank you, Barry.

MR. GROBE: Just a question or two. With respect to surveillance tests, do you manage to get those, is it your management goal to accomplish surveillance tests on the due date or before the end of the grace period?

MR. ALLEN: We target surveillances on the due date. Preventative maintenance tests, Jack, again, we look at the latitude we have there, but surveillances, like if it's a weekly surveillance, what

we want to do is perform it the same time every week. Okay. We just want to hit the date, and look at that. So, it's not our desire to use up that extra grace period and extend surveillances through the grace period.

MR. GROBE: From a preventative maintenance perspective, you manage to the grace period?

MR. ALLEN: From a preventative maintenance perspective, we target the date. So, if something is due 6 months from now, what we'll do is go out and tell the organization we'll work it 6 months from now. It's possible it may move up two or three weeks; it may move out two or three weeks depending on what the right time to perform that activity is and/or depending on enough resources available to balance the workload between the work weeks.

So, preventative maintenance tasks; look at the due date, and use proper flexibility to move it around. We would prefer on preventative maintenance tasks, even if you look at the additional 25 percent grace period, we would prefer to schedule with only using say half or 60 percent of that, even if we schedule a passed. We don't want to be scheduling extremely late in the grace period. We want to stay closer to the mid point of that grace period to be sure we don't get into issues of not being able to complete

preventative maintenance tasks.

MR. GROBE: I understand the preventative maintenance tasks as far as the periodicity of them is not a requirement, as the surveillance tests. But, do you have some sort of a metrix on your expectation of how many preventative maintenance tasks are conducted in grace period and how many are conducted beyond that?

MR. ALLEN: We track that. We do track the preventative maintenance tasks that are completed in grace period. And, again, I've got that information. I'll be happy to share that with you.

It's our expectation that a lot of PMs are going to be performed within that grace period, just depending on how it falls out. Right now our real focus is, two items in the PM work. Those were deferred. We talked about that.

And we're also monitoring a handful of PMs, 70 something, I believe, that are scheduled late in their grace period. We want to get those, because those have the greatest threat in not completing, in case emergent issues or parts issues or other things.

So, what we want is, get rid of those two piles of preventative maintenance tasks, work those off. Schedule close to the due date, so that we don't get into issues with having those.

MR. GROBE: I do have the date, you did share, at least as of May. And what that data shows is that the deferred past the late date is on a study decline, but the preventative maintenance use of the grace period is essentially flat, and it's flat at ten times your weekly work rate. You work off about 40 PMs a week, and your grace period is about 400. That doesn't seem to me to be a healthy situation. There are risks of not being able to accomplish work activities during the past -- of the deferred past activity.

But, I think, to follow up a little on Scott's question earlier, it's my understanding, I believe, that by the end of August you're going to have identified the first line supervisors as well as the size of the various organizations, and some of it bigger and some of it smaller, which we understand.

I think it would be healthy to have you give us your perceptions on discipline, routine work, and deferred -- or excuse me, backlog work, where you see discipline challenges; electrical engineering, structural engineering, mechanical engineering, electrical shop, mechanical shop; wherever you see challenges to your organization. I would be interested in that, and what you're doing with that.

MR. ALLEN: Got that, I understand.

Next slide.

Okay, within Engineering, we're making progress on your Corrective Action backlog. Just to share a few numbers with you.

Once a week we do generate a matrix of what open items we have in the departments to be working on. So, we track, we look at our backlog, a whole list of the work. We're probably as concerned about tracking a backlog and understanding it as we can be.

So, if you look at the rest, the Engineering corrective backlog. I'll go back to May 23rd. We had about a little over 2700 open corrective actions, 2742 to be exact. As of last week, we had reduced that by 212. Now we're at 2500.

So, what we're seeing, for instance, our Corrective Action backlog has steady improvement, steady working at it with a trend in the right direction.

Condition Reports also trended down about 103 decrease over that same period. So, we're seeing progress. We have resources targeted to backlogs. We are seeing improvement in that Corrective Action backlog, so we're pleased Maintenance has been able to do that.

MR. HOPKINS: Let me just ask, Barry, it seems a little inconsistent -- jump down a slide, and your opportunities for improvement where it says,

backlog reduction effort, based on what you just said.

MR. ALLEN: Just give us, again, we think we're seeing some progress, Jon. We'll talk about it a little more. That doesn't mean that we're necessarily satisfied or achieved the overall results we hope to achieve.

MR. HOPKINS: I'll let you go through the slide.

MR. ALLEN: Okay, thank you.

Training, engineering has expended some pretty good areas in training of their Design Control, Configuration Management Control. Feedback from the interior management and engineers who participated in that training has been extremely positive from all the feedback I've received.

Fuel Reliability. We have good fuel. Monitor that on a daily basis. Pleased with that. We had good fuel performance and we look for that to continue.

And we already discussed the Design Modification and 50.59 Evaluation. I think we had a good inspection there. We had three issues to work on with you, but pleased overall with those results from that team. That was a pretty strong team.

MR. HOPKINS: So, let me cover fuel reliability. So, that's up there because you've

experienced no leak in the fuel so far?

MR. ALLEN: That's correct.

MR. HOPKINS: And so, if you look at like the core operating limitations report, your measurements of fuel performance have been good. With respect to that, is that what that's trying to show?

MR. ALLEN: Fuel performance has been good as expected. We see no leakage in the fuel. So, thus far, we're very pleased with fuel performance.

MR. HOPKINS: Okay.

MS. LIPA: Are you still on this slide? Are you in the middle of your slide?

Before you move on, let me ask my question so I don't miss it. Do you have a qualified system engineer for each of the maintenance rule systems?

MR. ALLEN: Each is a pretty inclusive word. I have to check.

MR. BEZILLA: Jim, can you help us out?

MR. POWERS: I don't know the specific answer to that today on a system by system basis, but I know we made big strides in getting our system Engineers qualified over the past first half of this year, made great strides on it. So, I would have to get back to you on specifics on that, whether we have one or each

maintenance rule systems.

There is approximately, I think it's 30, 34 approximately, maintenance rule systems. So I need to go down that list.

MS. LIPA: Well, the reason I ask, is I know we talked about this in December; we had a public meeting in December. We talked about qualified engineers, and you had taken some short term actions at that point.

MR. POWERS: That's right.

MS. LIPA: And I know you had a longer term action to make sure you've got more qualified system engineers.

MR. POWERS: Right.

MS. LIPA: So, yeah, we could even talk about this at the next meeting or get back to me or maybe both would be better since we brought this topic up at the table; let's talk about this next month too.

MR. POWERS: One of the actions that we did do is to ensure that each one of the system engineers had a qualified mentor, an engineer for each one of those engineers who were not qualified at that point. So, we took that action, plus we completed training for the vast majority of those engineers.

MS. LIPA: Okay, thank you,

Jim.

MR. ALLEN: Thank you, Jim.

Thank you, Christine.

We'll continue to focus on the backlog reduction effort. Although we've made some progress, talked about that, we still have a lot of work on our plate, so we've got to maintain a focus on work improvement of the entire backlog. So, that just has to be an area of focus for us.

We have to maintain progress. We're making progress. We're headed in the right direction. Trends are pretty good. And we're pretty pleased with the progress, the trend we've got, but we have just a lot of work today.

For example, in system reviews, and that's where we get a group of engineers together and look at our backlog of the system by system, so we can do it for higher risk systems; give us an opportunity to work through our backlog from that perspective.

We started off with very good results, pretty aggressive, got some things rolling. Now we're kind of in the summertime vacations, folks are off doing other things. So, we kind of plateaued flat a little bit, and now we're going to reinvigorate that process and continue to make more rapid improvement there. So, good results, but we'll just have to reinvigorate and stay focused on execution.

MR. GROBE: Barry, before you go on to the next slide, have you resource loaded the Engineering Corrective Action backlog?

MR. ALLEN: Jack, Engineering does have, and I'm not into those, they do have some software that they utilize to lay out their resources. And it's not just, it's to look at their entire backlog. So, we do try to manage that and schedule that and resource load the Engineering workload the best we can. Some groups you have to have more allowance for emergent work and emergent issues, that kind of thing, so that's going to vary somewhat throughout the organization.

MR. GROBE: One of the tendencies, and I suspect this is the case also with Engineering, there is certain Corrective Actions that are easy to accomplish and some are more complex. You've cut roughly ten percent of the Corrective Action backlog in the past. I can't remember what the period of time is, but I would be interested in your perceptions next month.

We talked earlier about resources, those things on routine backlog. I would like to understand that comprehensively and where you see the rough.

I recall that FirstEnergy committed 20 million dollars over this operating cycle; ten million per year for backlog reduction. And I think you've divided that up

between Maintenance, Engineering and Organization Operation. I would like to understand if that's enough to accomplish the backlog or whether or not there is some binds in the organization.

Obviously, the focus on the backlog; we did a very thorough review as, prior to restart and from a safety prospective. We did not find any risk significant individual items or synergisms between items.

The key here is being able to get this work completed and still maintain your strong operation of safety and not have a distraction. That's why we focus on resource questions. Not so much with the perception on backlog, making sure it doesn't completely hurt the organization such as focus involved of operation safety.

MR. BEZILLA: Jack, you'll see a little bit later in Barry's presentation, we're focused on those things that we believe are risk significant or pose the most risk to us.

And, as a result of that, some of our timeliness, that we're not as timely because we have some more items that their low significant and low risk. And they're there and we'll get to them, but probably not until like next year or near the end of next year.

And, we've chosen, said that's okay, because they're low significance. We're going to work on the more

significant ones; whether they're new ones or whether they're older ones. And you'll hear a little more about that in Barry's presentation.

We're not out there just picking the cherries. We're out there working what we believe are the risk significant items. Okay?

MR. ALLEN: Jack, from a risk significant perspective, the system reviews, when we get those teams together, they look at a system or go through all the open action items. What we've seen typically come out of those is, out of all those open items in the system, we started with Aux. feedwater. Approximately 68 percent of those items got resolved through that process. So, we got a good effort.

So, that ten percent, what you see overall, that might be what we resolved 70 percent of the issues that were in that system, such as Aux. feedwater. So, just some anecdotal evidence to share.

MR. GROBE: Okay.

MR. ALLEN: Next slide, please.

The area of Corrective Action Program. Once again, we talked a little about this. We are seeing progress on reductions since mid May. As to last week, number of Condition Reports reduced by approximately 829. And

Corrective Actions reduction about 162 during that same time frame.

So, we're making progress, trending the right direction, and continued focus is on effectiveness and assuring we target ourselves most effectively on the issues that have the most safety significance.

Mark pretty much addressed timeliness. We're not just starting to work on the oldest issues in the backlog, we're working at what is truly most significant. And timeliness, where we track ages of our actions, timeliness on the indicators, will show it's an issue for us, but that's somewhat because we think we're right based on the significance more than time.

MR. THOMAS: When we talk about Corrective Action Program, what would you say is the percentage of issues that are upgraded to management discussion of the issue, like the originator of past condition reports is one classification; how many have you upgraded with that?

MR. BEZILLA: Scott, we have an indicator on that. If my memory served, I don't have that in front of me, I didn't bring it with me, but I think it's less than ten percent that we upgraded based on our supervisors initial cut and level of threshold. I believe that Condition Report showed the attention it should

receive; I think it's a little less than 10 percent.

MR. THOMAS: I guess the fair follow-up question would be how many are downgraded?

MR. ALLEN: Just from discussions in the board when we review Condition Reports, I think it's probably pretty similar, probably pretty similar numbers, Scott, less than ten percent.

MR. THOMAS: All right.

MR. ALLEN: Next slide, please.

MR. THOMAS: Let me ask one more question. Are you comfortable with your staff's level of focus or their ability to correctly classify issues that they're placing in the Corrective Action system?

MR. ALLEN: Scott, I believe what we see is our people typically do a pretty solid, pretty good job by suggesting a classification. I don't think that gets changed terribly frequently. I think we do a pretty good job with that.

MR. THOMAS: Okay.

MR. ALLEN: They seem to be pretty consistent, probably over 90 percent of being successful with the originator and supervisor suggesting a classification.

MR. THOMAS: Okay.

MR. BEZILLA: Typically, Scott, we have anywhere from I'll say 30 to 40 Condition Reports come through each morning. And we may change a classification on two to four of those on any given day. So, they do pretty good.

We'll provide them feedback to let them know that it was changed one way or another, if we make a change to it. So, we get back to the originator and give them back to the supervisor.

MR. THOMAS: Okay.

MR. ALLEN: Okay. In the area of Safety Culture, maintain our commitment to continuous improvement. So, that's our focus on backlogs, self-identification rate, Condition Reports, PM backlogs restarted. And we have a plant health committee we have invigorated and got going, that Mr. Ostrowski chairs.

Within Safety Culture, we continue to focus on individual commitment area, so site clock resets. Again, we looked at those individually. We now look at those collectively from a collective significance standpoint.

We have a tremendous amount of Corrective Action Program data. We're working hard to ensure we develop appropriate insights on the Corrective Action Program. We believe we're improving there.

And in June, Safety Culture Self-Assessment. I know

Jack has started doing internal self-assessments on a monthly basis. We'll talk about the fact, and those may vary somewhat, pretty tight snapshot, but in June, we did rate ourselves critically in a couple of areas.

One was due to the individual misstepping and falling, which I discussed earlier. Did not feel good about that as a station, but the fact the assessment was not too long after that, so we didn't feel like we had good positive performance in that area.

Also, we had some Apparent Cause Evaluations that were performed prior to developing Apparent Cause Training, and changing the strategy of the Corrective Action Review Board and bringing some of those older apparent causes through. They did not meet the current muster and the board said they weren't happy that we didn't recognize that when we ran them through; and assessed ourselves critically in that area.

So, overall, we assessed ourselves as stable and improving. We tend to go ahead and do at least one more monthly review in July. And then we'll take a look and see whether we should be doing that on quarterly basis, because one of the things we want to see is that monthly look does not provide one time or enough data to really do a real thorough assessment of that area.

So, still doing monthly. Again, pretty erratic.

Once you decide on any given day is close to what's happened in the last few days, and you don't have much of a time frame, Safety Culture is a pretty broad area. So, we're not sure we're getting what we hoped to get out of the monthly assessments. We may look in the line of the Fleet Standard, which is performance on a quarterly basis.

MS. LIPA: Barry, on the business practice, there is, I was trying to understand what the commitment was in the Cycle 14 Plan versus this tracking tool.

This tracking tool talks about an annual assessment of Safety Culture using the business practice.

MR. ALLEN: Correct.

MS. LIPA: The commitment on the docket talks about assessing culture using the business practice being due by December 2005.

MR. ALLEN: That's correct.

MS. LIPA: So, which one is it?

MR. BEZILLA: Christine, we're going to do annual assessments, right, in accordance with the business practice, which is where you take additional data and additional criteria, right, and take it over a one-year snapshot. We'll do one this year and we'll also do another one at the end of next year.

And then the monthly one, we wanted to do it on a monthly basis to see how we were doing; and we talked about that today in the Senior Leadership Team Meeting. When we did the April one, it was from November to April; we felt pretty good about that one. There had been, enough time had passed that we could say, okay, here's where we were. Here's where we are today. We did one in May. We did one in June. We're going to do another one in July.

You don't get the same feeling, because you only got like 30 some days between the snapshots. And monthly is probably too frequently. Quarterly is okay, but quarterly is probably a quick check. The annual one is more detailed.

So, we're going to do it on an annual basis in accordance with our program. We think the commitment was to do it by 2005. We'll have met that also.

MS. LIPA: That's why I'm asking, because the printed commitments just say perform it, and then they give a completion of fourth quarter 2005, but we were under the impression that is an annual assessment.

MR. BEZILLA: It is. Just another piece of info; we're trying to adjust its timing, so we do our annual assessment and then we'll do our independent outside assessment and we'll be able to compare

the results and see how we did.

MR. GROBE: I had discussed this conflict between the documents last month with Clark and got the same answer. I thought that the Segment 14 was going to be revised with your next meeting, which I think is fairly recent.

MS. LIPA: June 23rd is the last revision.

MR. GROBE: Cycle 14 Plan doesn't capture your commitment. It says Safety Culture Assessment is going to be done in two years. It's not due until December, or fourth quarter of '05. I think that's a typo. So, you might just capture that in your next update.

MR. BEZILLA: I'll follow-up with Clark.

MR. GROBE: Okay. I'm a little curious as to what's driving your focus.

On June 15th, you did your Internal Monthly Safety Culture Assessment and identified contrasts in rigorous work control and nuclear professionalism. And that was, I think if I read your documents correctly, it was driven by kind of a continuing low level number of human errors, rather the focus wasn't correct. Is that?

MR. ALLEN: We have a slide,

if you don't mind, Jack.

MR. GROBE: I'm sorry, am I getting ahead?

MR. ALLEN: This was the May assessment we performed. As you can see, we have in our Safety Culture models, we have three primary elements; individual, plant management, and corporate level; and each of those have some subsections under them that feed up to that.

And the May assessment, again, this was on 30 days run time; most everything was stable, maybe a little improving, that's kind of what we got on the month.

If you go to the next slide, it will actually show the June assessment that you were referring to, Jack.

MR. GROBE: Yes.

MR. ALLEN: If you look under the individual commitment area up in the upper right-hand corner, you'll see that there are two of the arrows which are at slight angle fronts. One is the third one down, Rigorous Work Control and Prudent Approach; and the fifth one down, which is Nuclear Professionalism.

And the feeders to those, the Rigorous Work Control, Prudent Approach was the misstep, that was the individual that slipped in the plant and fell. And then the Nuclear Professionalism, that really was the five apparent causes

that we sent to the Corrective Action Review Board to review, without recognizing we should have scrubbed the new standards before we sent them.

And so we felt like CARB exhibited good standards. They did what they should, but we probably should have recognized that those needed to be updated in current standards before the review. Even though CARB looked at them. They said, gee, at today's threshold, these would not even be apparent causes, we don't believe. I still felt like we should have recognize that.

MR. GROBE: Thank you for catching up with me. I apologize for getting ahead.

June 15th, you did an internal assessment when you documented the Condition Reports, the declining trend in the Individual Commitment area; and that was based on a series of issues that occurred over a period of time.

Then on July 6th, when another Human Performance error occurred, and this had to do with, I believe it was testing, the channel check on the RPS flow surveillance. That occurred three or four, three weeks after your Condition Reports were initiated based on your Safety Culture Review. And, at that point, you concluded that you needed a Collective Significance Review.

I was wondering, what was driving, there wasn't a whole lot of official information on July 6th when you

initiated the Collective Significance Review. What did you initiate as the result of the June 15th Condition Report that was assigned to the Vice President's office on the declining trend?

Do you understand my question? What's driving the human performance improvements? You identified the problem on June 15 with a Condition Report. Another event occurred on July 6th. Then you decided on a Collective Significance Review, wrote another Condition Report. Seems like there is a lot of Condition Reports, I guess.

I'm trying to figure out what's driving your improvements, this monthly review that's conducted, or does it take more events after the monthly review is completed for trends to identify to get things going?

MR. ALLEN: If I understand, I'm not sure I understand all your question, Jack, I'll try to attempt it. If I don't cover it, please come back and ask me a more defining question.

Our Corrective Action Program typically drives what we're doing work on across the board. So, something occurs, write a Condition Report. Something else occurs, write a Condition Report.

If I have several of those, I say, gee, I would like to look across the board and see if there is something there that's common to all those, that appear to be

discreet issues, but I would like to see if there is something in common.

I will look at those from a collective significance standpoint, and we would write a Condition Report to either drive that or capture those results, but we use that Corrective Action Program to keep feeding it into that program, because it's common, it's accessible, people are comfortable using it. It has great track and trend for us to help spot those issues.

At the same time, any time we have the Leadership Team get together to perform any exercise, whether it's just a collegial discussion on any topic or we do a review of information just to have discussions; if during that discussion we feel like there may be something as a leadership team, say, gee, I'm not sure we looked at that from that perspective. Let's write, we'll initiate a Condition Report then and go look at that.

So Condition Reports may be initiated, you know, based on several different perspectives. See, I thought you were asking what would drive that. I guess what I'm trying to say is many, many different inputs could cause you to initiate a Condition Report, to go evaluate any condition or trend or collective significance assessment.

MR. GROBE: I guess my question is, you talk about and I fully understood the

focus of reducing the frequency of these Safety Culture Reviews. It's kind of hard to get a picture on the 30-days data. On your June 15 Safety Culture Review, you identified a decline in trend.

In my mind, that sets off buzzers that something is not expected to go; and based on the data, I understand why you identified that declining trend. Yet it took another issue to happen on the 6th of July or the 4th of July, to generate a collective significance review of why this repetitive human performance errors were occurring.

What was the priority that you placed on the results of the Safety Culture Review in June that identified this declining trend? What actions were taken following that identification of the declining trend in performance?

MR. BEZILLA: Jack, let me try to answer that. On June 15th, we had our Safety Culture Assessment. We had two areas that we said were declining or had less desirable performance. So, that overall gave us a decline in Individual Commitment area.

For a program we wrote a Condition Report that said, hey, in our assessment we saw two declines, we had an overall decline. We wrote that. As Barry said, that was due to the misstep, clock reset, and it was due to the five apparent causes that were not up to snuff, wouldn't stand alone is what the issue was with those five apparent

causes. So, we wrote the Condition Report.

If you look at those collectively, it doesn't look like a tie. Okay. Three weeks later we have a human performance error, right, where we had this tech spec, we said we had a person misstep, right. We also had people not put this plug back in and allowed this step to occur. Now, we had a tech spec issue.

We said, hey, are there more performance issues? Kevin actually looked at that and said, hey, I'm going to generate a Collective Significance Report and we're going to look at those and roll those together.

Kevin will talk about those more in his presentation, so we'll finish it more with some of the presentation, if that's okay. So, we'll have that Collective Significance Review.

The other thing we did, Jack, is we dealt with those specific individual issues, okay, and then we also had in the works a new Human Performance Program from a FENOC standpoint, which we're looking at rolling out this fall. Again, Kevin is going to talk about that.

So, we took some immediate actions on the individual items. We know we have this Human Performance Program that's just about ready to roll out. We saw that as another tool on reviews to help overall human performance. We also took and focused our management

observations on those critical activities, things we wanted to make sure went flawlessly, didn't have any issues.

So, those are some of the things we did. It took a second, I'll say, personnel event after the CR that we wrote the Safety Culture. In the initial Safety Culture, we didn't see a link between the two things that caused us to write that CR.

I don't know if that answers your question, but that was the process.

MR. GROBE: It does answer my question, and in fact, I think you just made a good argument for the fact that you may be doing these Safety Culture Assessments too frequently, that you did not see the trend. If you're going to do them monthly, maybe it needs to be a rolling three or six month assessment.

MR. BEZILLA: That's correct.

MR. GROBE: Maybe, had you done that, had a rolling six month assessment every month, you would have picked up this trend before the July 6th event and not had to wait for another event to initiate the Collective Significance Report.

MR. BEZILLA: You've come to the conclusion that we've come to, right, more is probably better.

MR. GROBE: I just offered a

different option, that was a monthly rolling six month assessment. You might want to think about, but you folks need to figure out what's best for your organization and let us know what you think.

MR. BEZILLA: Okay.

MR. ALLEN: Next slide, please.

In the area of Independent Assessments that we have here, is our current schedule for the four assessments that we have for the year, in reference to the Confirmatory Order.

Operations Performance is the first one, which the schedule begins the week of August 16th. Some high level details on the Operations Performance Assessment divided down below. Of course, we provided that information to you.

Corrective Action Program, Engineering Program, Organizational Safety Culture Inspections we'll follow-up with.

And if there is no other questions, I'll turn the presentation back to Mark.

MS. LIPA: Well, I was thinking this would be a good time for a break, if it's all right. Ten minutes. It's 8:00 sharp. 8:10, we'll resume.

(Off the record.)

MS. LIPA: Okay. Go ahead.

MR. BEZILLA: Okay, thanks, Christine.

Now I would like to provide some insights from some additional assessments conducted since the last public meeting.

Next slide.

First, the National Board of Boiler and Pressure Vessel Inspectors Review, and Barry briefly talked about this, and I'll be brief.

During the week of May 17th, we had inspectors from the National Board review our American Society of Mechanical Engineers, ASME, Quality Assurance Program for renewal of our nuclear repair capabilities and issuance of our repair capabilities, and that would be nonnuclear equipment. We were successful and received our NR and our R stamps or certificates of authorization in June.

And I'll say, this is a measure of maintenance capability. We feel good that we have both the NR, which is nuclear repair and the R which is nonnuclear repair authorizations. What that means is we can do maintenance on vessels, on manways, or on equipment, so we feel pretty good about it.

MS. LIPA: What's the renewal

frequency for that, Mark?

MR. BEZILLA: Periodic, Christine, I don't know how many year period it is before they review.

EARL: Peer review frequency is three years, Christine.

MS. LIPA: Three years?

EARL: Three years; that's correct.

MS. LIPA: Thank you.

MR. BEZILLA: Thank you, Earl.

Earl is involved in the efforts. Thank you.

Next slide, please.

Now let me talk about our Integrated Emergency Plan for that drill that we conducted. We conducted this drill on May the 20th. It was observed by the Residents and by county officials. It was a successful drill.

And the part I liked was we got twelve new emergency response organization members. So, Barry was one of the graduates, and he's now qualified to be an Emergency Response Organization member.

Next slide, please.

The next item I would like to briefly talk about are our Collective Significance Self-Assessments conducted in May. Collective Significant Self-Assessment is an

assessment where we look at Condition Reports, Quality Assurance Assessments, NRC Inspection Reports, Assist Visit Reports, and other documents and tools. We look at them in total.

These assessments are designed to take a collective look using various other assessment documents to see if there is some collective issue that may not already be being addressed. This was our first Davis-Besse use of this tool. What I did was I subsequently had each of the managers report out at a Senior Leadership Team Meeting; their conclusions of their assessments.

Some of the sections did a pretty good job. Some of the sections need some work on their collective assessments. In each case we provided feedback. And in some cases, like there was additional work required, it might be a revision to the Collective Significance Assessment; might have been the issuance of some Condition Reports based on a theme that we saw.

Next slide, please.

MR. GROBE: Mark, before you go on, just give me a little more detail of what you mean "need some work." Were they not sufficiently self-critical?

MR. BEZILLA: Jack, yes. What we did was when we brought them in, we had their peers

there, the managers would go through and say, here's the stuff I looked at, here's some strengths, here's some noteworthy items, here's some area of weakness. Then we challenge that manager; and in a couple of cases the manager said, hmm, I need to go back and take a little more look, a little more detailed look.

Like I said, some did a real good job, some needed improvements. Okay?

MR. THOMAS: Mark, did you say what periodicity these assessment were?

MR. BEZILLA: These are twice a year, Scott, semi-annual.

MR. GROBE: It's Self-Assessment, Quality Assurance Assessment, all of these are very important; and contributed significantly to the situation of the performance decline prior to March of 2002; contributed to your failure to understand and recognize.

I think you share this concern. It's very important that you don't have a mile-wide, quarter-inch deep self-assessment effort. You're doing a lot of self-assessment, and the effectiveness isn't the volume, it's the quality. And our concern at this point is that you may not have the volume and quality adjusted properly in your symphony of self-assessments. Boy, we're getting a

little melodic here; aren't we?

But we had a similar observation. We attended a number of these Corrective Significance Meetings, and felt that some of them weren't sufficient and self-critical.

I'm glad you're sensitive to that. The independent assessments, one of the focus of those that were required by the order is intended to evaluate your effectiveness in this particular area, your ability to find and fix your own problems.

So, it's absolutely paramount that the work gets done right first and also if there is problems in the organization where things aren't consistent with your expectations, that your line assessments, your self-assessments, as well as your independent assessments, Quality Assurance, Corporate Nuclear Review Board, ferret those out in the service.

Thanks.

MR. BEZILLA: Thank you, Jack.

Some of the common -- let me continue. Some of the common themes noted were in the positives that the Fleet Procedures and Guidelines were noted, as I'll say, making things better. And it was making it easier for the various sites, I'll say, to work together and/or to help each other. If I would travel to Beaver Valley, my job would be better because I had a common process and knew how to do

the job over there also. So, that was one of the positives we saw.

The Observation Program is a good tool and provides invaluable insights on those areas requiring management focus. We get like a monthly report out of that. We use that to focus our management observations.

Corrective Action Program is being rigorously used. We have a very low threshold in a high volume system.

And that Dose Control and focus on Personnel Contamination event-free days is causing improvement in those areas. So, those were some of the positive common themes.

Additionally, some common themes in areas of continued focus and improvement were Backlog Reduction. We've already had a lot of discussion on that. We are making progress if this area continues to require management attention.

Work Order Quality can be improved. This is, I'll say, fleet-wide focus item for us and that requires management attention.

Emergent issues can impact planned work. We've got to manage that appropriately. That's not new, but that was a common theme that the managers talk about.

Then, finally, that we could improve in the Conduct of Training, and that included preparation, delivery, and

effectiveness, and that additionally requires management attention.

And as an example in that area, we now have daily management observations on targeted training activities to provide critical feedback to the instructors, to the students, and to management.

MR. HOPKINS: One last question there, Mark. Maybe I missed this, but back to the fleet engineering concept in your corporate organization, back to that Operations Support; is there going to be a training person in the area of your Operations Support to help with this?

MR. BEZILLA: Yeah, Jon, in regard to the fleet support, the Organizational Development Director is chartered with Training, Human Performance Improvements, those type of activities. That's a direct report to Gary Leidich.

MR. HOPKINS: Okay.

MR. BEZILLA: That's got additional focus beyond the Program Manager.

MR. HOPKINS: Okay. So, you can get help from corporate besides just --

MR. BEZILLA: Absolutely.

MR. HOPKINS: All right.

MR. THOMAS: One of your good

common themes had to do with good use of Corrective Action Program. I was curious where you're at or if trending was included as part of using the Corrective Action Program? How far along is your trending program? It stopped for awhile during the outage. You fairly recently reimplemented trending of Condition Reports. Have you gotten to the point where they can be effectively used to spot things like tech spec issues or, you know, specific issues, not just there were 50 Condition Reports written with, you know, this cause or this trend? Where is the trending program now, I guess is what I'm asking?

MR. BEZILLA: You'll hear a little more from Ralph, so I won't steal his thunder.

MR. THOMAS: I'll wait.

MR. BEZILLA: I'll let Ralph cover that, Scott. It is part of our program. We are trending. I think we're 50 percent of the way on where we want to be and Ralph could give you more detail in his presentation.

MR. GROBE: Mark, before you go on, on slide 19, we were talking about Performance Summary, and the focus on 19 was the Corrective Action Program; and you indicated that one of your opportunities for improvement was Corrective Action Program effectiveness. And here on the Collective Significance

Self-Assessments by department, you indicated that the Corrective Action Program is being used well.

Could you help me understand what might be apparent dichotomy between those two observations?

MR. BEZILLA: All right. Rigorous use of the Corrective Action Program for identifying problems, Jack, we have like no threshold. We're writing Condition Reports for essentially anything.

From a Corrective Action Program effectiveness, the attributes in there include timeliness. And we talked about our timeliness. We said, hey, we're sacrificing some timeliness to make sure important things are getting the attention that they're due.

And as Barry identified, we had those five apparent causes. And when we took those into the Corrective Action Review Board, they would not have stood alone. And that's one of our expectations for today; you have to be able to pick that up and read through the Condition Report and it has to be able to stand alone and not reference you out on other things. That's the dichotomy.

MR. GROBE: I understand.

MR. BEZILLA: Now, these areas for improvement, I believe each of these items are being addressed through our Operational Improvement Plan and our 2004 Business Plan. I also believe that the Collective

Significance Assessments will enable us to get a holistic view of ourselves. We'll get better. This was the first time, rough, but we'll get better at it, and it's a good tool, and I think it's going to help us improve our performance.

Now, what I would like to do is turn it over to Kevin and let him talk about Operations performance.

MR. OSTROWSKI: Thanks, Mark, and good evening.

In plant operations, continuing with the implementation of my charter, that being "Safety-focused plant operation through consistent implementation of a rigorous Conduct of Operation."

In the area of safe and reliable operations, we have demonstrated safe, conservative, and event-free operation. That existed through the startup and also through power operation.

I have recognized and approved accountability and ownership of plant operations on the part of the shift managers. Specific examples include shift turnovers, crew performance, and also the engagement of the organization for emergent issues.

We've taken the opportunity to use Just-In-Time Training. The most recent being simulator training for turbine valve test.

We've recently received performance feedback that our operators awareness of nuclear risk and the use of the crew updates was a positive. The crew update is a form of an on-the-spot control room crew communication to update the crew on plant status and the progress of an evolution.

We have recently implemented an electronic method of tracking limiting conditions of operation or LCOs. This is a tool used to track tech spec required actions and associated compensatory actions.

Myself and the shift managers have recognized improved support from the site organizations in the use of Problem-Solving and Decision-Making Teams and Duty Teams. Both the Problem-Solving Teams and the Duty Teams have proven effective in addressing any emergent equipment issues.

The Duty Teams perform observations of key activities, as Mark had made reference to, and participate in shift manager led daily conference calls.

My first area for operations focus is to discuss -- yes, sir?

MR. GROBE: Yes, before you go on. The Problem-Solving and Decision-Making process you implemented here is somewhat unique by my experience at other plants. I have not seen it crafted quite the way you folks have your procedure written.

The one thing that always puzzled me is your entry criteria. What is it that causes you to decide to do a Problem-Solving Decision-Making Team or what is it that causes you to not do one. What threshold do you have? That's not always clear and we've been watching how you implement it and it is quite effective.

You've got quite a bit of run time now on this procedure, several months anyways, you've used it quite a few times. Have you been able to identify possibly some entry criteria guidelines that can be provided to have consistent entry into the Problem-Solving Decision-Making process?

MR. OSTROWSKI: I'll give you my perspective on that, Jack. First of all, the shift manager can decide when and if a Problem-Solving Team is warranted, based upon the complexity of an event, or the scope and nature and impact of the potential problem; whether it be emergent equipment issue or otherwise.

As part of our Operations procedures, during the notification of the Duty Team, shift manager will get on a conference call with the Duty Team, and one of the questions asked of the shift manager is, is a Problem-Solving Team warranted based on the nature of the event, or nature of the equipment problem. At that time, the Duty Team, including managers and the shift manager can

provide input and establish the need for a Problem-Solving Team.

So, that would be one criteria driven by events which, or problems, even equipment problems that perhaps are complex or have impact to the station that would warrant a team approach.

So, that's one criteria. The particular procedure itself is driven by, again, a very systematic approach to problem solving, but included in that, is a, a number of questions which originate from the INPO document on conservative plant operations and decision-making. So, with that, we see a challenge within those questions that may also trigger the need for a Problem-Solving Team.

Management also has the ability to pull the trigger on a Problem-Solving Team for any issues we feel warrant a team approach. In some cases, a team may consist of one or two individuals, when a problem has lingered longer than our threshold for what I'll call quality.

For example, we currently have a Problem-Solving Team outstanding for our Number One Chiller Operation. We've had some difficulties with that Chiller tripping in the last two weeks.

We have a Problem-Solving Team on algae forming on our intake screens. Those are just two examples where we believe that a Problem-Solving Team approach would be

beneficial in going through this rigorous methodology to identify the problem and to eliminate and to identify causes as well.

So, can I tell you clear definitive criteria, no, but those are the kinds of things we have used to employ the Problem-Solving Team at the plant.

MR. BEZILLA: Jack, it's a good question. Let us think on that a little bit, okay, and see.

MR. GROBE: Yeah, I don't want you to get the impression that what I'm suggesting is there is some black and white binary decision-making tool to be used. I'll go back and look at the procedure again. I haven't read it in probably three or four months. My recollection is there wasn't a lot of entry guidance. And maybe you don't have enough run time yet to provide some guidance, but it make sense that there would be guidance on when it is effective and what kind of situations you would expect people to automatically go into that.

At some point, all of this should be more automatic without senior level engagement on this. I think maybe that kind of guidance on your expectations would be helpful.

MR. OSTROWSKI: My first area for Operations focus is attention to detail on routine

tasks. My threshold needs to remain low as this has been the source of some of the section inside the clock resets that I have discussed previously.

While each of the resets and the occurrences have been individually addressed, I have initiated a review of the collective events to ensure we have addressed all of the contributing causes and identified any common causes.

In addressing Operation staffing, Barry has already mentioned the eight new licensed individuals. We are incorporating these new Senior Reactor Operators and Reactor Operators into our Operations staff. We will implement a five-crew rotation versus our current four-crew rotation in the fall of this year. This will assist us in reducing Operations overtime and will allow us to strengthen our support in Operations training, work management, and outage preparation.

My focus in training is centered on the implementation of a long range staffing plan starting with 17 new students currently in training, all of which recently passed their generic fundamentals exam, as has been mentioned. These twelve Senior Reactor Operator and five Reactor Operator candidates are to take their license exam in July of 2005.

I also need to maintain my focus however on license requalification training of the current staff of licensed

personnel in preparation for reaccreditation of Operations training in the spring of next year.

While we have improved our prejob briefings, we need to maintain focus on briefing quality, specifically on key performance steps, contingencies, and the need for the use of the Human Performance tools.

Finally, as is part of my charter, we have focused on our Conduct of Operations and we will be transitioning to a FENOC Standard Conduct of Operations this coming fall. With the help of our support organization at a corporate level, and Jon, specifically, this is an example of, we have an Operations Program Manager in that area that has helped perform benchmarking of our Conduct of Operations to that of the industry. We will be making some changes that will improve our performance and align us to industry best practices with the Conduct of Operations.

Some areas affected include reactivity management, alarm response, and alarm procedure usage; and as Mark had referenced, the use of various human performance tools.

In closing, while we have seen improvements in our performance, we also know that we have more work to do. I'll continue to remain focused as my charter states on safe, conservative, and event-free operation.

MR. THOMAS: Over the last 6 or 8 months, give or take, maybe a little longer than that,

there have been a number of Collective -- or not Collective Significance -- but Root Cause Evaluations associated with Condition Reports that were classified as significant conditions adverse to quality in the area of operator performance.

The latest one that you'll be evaluating deals with four or five issues involving operator errors associated with tech spec related surveillances.

I guess I'm curious what -- two questions; why you don't believe that the Corrective Actions taken as the result of these other collective significant -- or these other root cause reports have been effective, and what you'll be doing differently, or be focusing on differently for this one to correct the root cause, the issue?

MR. OSTROWSKI: One of the goals of the Collective Significance is to understand just that. Each of the individual events had been addressed on an individual basis. The root cause identified individual performance; and as such, the individuals were held accountable using our current performance systems.

We recognized some contributing causes. Things like the clarity of procedures or the guidance that is provided; however, we believe it came down to an individual performance, and that's what was immediately addressed.

Collective Significance Review will be looking at

those Root Cause Evaluations, validating that, and identifying anything that we may have missed.

So, in terms of effectiveness, we've shared these events and these instances of lack of attention to detail with the rest of our operating staff; and, we'll continue to look at, are there any additional things that we missed, any contributing causes.

MR. THOMAS: Okay.

MR. RUTKOWSKI: Do you have a rough target when that will be complete?

MR. OSTROWSKI: We're estimating by the end of September. Our program, I believe, defines 30-day turnaround time on Collective Significance Review. In this case, it's a condition adverse to quality at a fixed level, Jack.

MR. BEZILLA: Okay?

Okay, what I would like to do is spend a minute on the results of our recent industry review. This is the Institute of Nuclear Power Operation summary; and these are the summary items from the assessment that was conducted in April and May of this year.

First, the following beneficial practices and accomplishments were noted. Intensive monitoring and involvement by the site leadership, as well as sound Operations performance, contributed to the safe startup and

power ascension following the extended shutdown.

Safety margins in the event of a loss of coolant accident were increased by significant improvements to containment material condition and emergency sump capability and by installation of advance leakage detection systems.

Many important components, such as high pressure injection pumps, reactor coolant pumps, and containment cooling units have been refurbished or redesigned to improve performance and an aggressive, involved quality assurance organization has helped line managers identify areas needing improvement through effective assessments and day-to-day monitoring of safety activities.

Areas in need of improvement were also identified. Those being operational focus, site departments, plus work as a team to ensure the operational needs of the station are addressed.

Work management. Work management implementation of the process must be improved to ensure operational needs are addressed and backlogs are sufficiently reduced.

Training. Traditional training must be rejuvenated.

Barrier improvement. Improvements in three barriers, or tools will accelerate the progress towards excellence. Those being procedure quality, prejob briefs,

use of operating experience. These are tools and barriers to help the people successfully execute their tasks.

And individual performance. Improvement in individual rigor and accountability; for their performance and results is needed to achieve higher levels of performance.

This assessment, these positives and areas for improvement, I believe, are in alignment with what we believe our strengths and challenges are, and I believe we have these areas for improvement covered in our Cycle 14 Operational Improvement Plan and our 2004 Business Plan.

Next slide, please.

The last assessment I would like to cover is our Safety Conscious Work Environment Survey. That was conducted by our Safety Conscious Work Environment Survey Review Team and this was a follow-up assessment by essentially the same team that took a look at us in the December of 2003 time frame. And that was following our November 2003 Safety Conscious Work Environment Survey where there were a few sections with less positive results to a few of the survey questions.

This team, that being the Safety Conscious Work Environment Review Team, completed their follow-up assessments on June 23rd. Their observations were that Corrective Actions previously put in place in the December

and January timeframe were generally effective, and they, the Review Team, saw improvements in all five cross-cutting issues. Those issues being communications, work hours, schedule credibility, management comment and low threshold for reporting in regard to Condition Report generation.

The team did have one recommendation of note; that being to ensure that we communicate, communicate, communicate our pending implementation of the FENOC Standard Organization.

A note, in regard to that, we do have a change in management and communication plan that we are implementing that's in regard to that implementation of the Standard Organization. And, feedback from my communications team is that we've gotten positive feedback based on the communications that we put forth to-date in regard to that organizational change.

Finally, the team, that being the Review Team concluded that the Safety Conscious Work Environment at Davis-Besse supports safe operation.

MR. GROBE: The heavy lifting on the change management is yet to come. The changes that you've announced so far at the director level, and I think the next level down, were fairly small numbers of people. The change in management going forward is going to effect a much larger number of people in the organization. We'll be

having new direct supervisors or the same supervisor with different section signs and all sorts of things are going to be happening.

So, I just want to emphasize the importance of recognizing the heavy lifting as far as effecting a changed management, which is yet to come which I think you recognize.

I do have a question though. What role does SCWERT, I love acronym, the Safety Conscious Review Team; what role does it play in the development and implementation of this change in management structure for the organization?

MR. BEZILLA: Jack, that's a good question. What role does SCWERT play in this role management process.

What we've done is at each of the selection levels, we made those selections, we then took that to the Safety Conscious Work Environment Review Team and ran those selections through that body, if you will, identifying who was chosen, who wasn't chosen, the basis for that. And then there was dialogue that occurred as to, is that acceptable, isn't it acceptable, is there any chilling effects that might occur, what would those be, what actions need to be taken, et cetera. So, that's how we've used that process.

We've actually, for the first level, we picked the

directors, and we had a three-site Safety Conscious Work Environment Review Team, and now that we're into the, I'll say, manager, superintendent, and then supervisor level, we've also run that through SCWERT.

MR. GROBE: So, the SCWERT focus is more a narrow focus on the individual selections as contrasted with a broader focus on the ramifications of changes on Safety Conscious Work Environment decision?

MR. BEZILLA: No, I would say they're looking at the detail, but they're also taking a holistic look at what kind of impact could this have on the organization, so it's both.

MR. GROBE: Geoff Wright and one of his team members, Dave Persinski, were out here observing the results of this assessment, and evaluating what activities had been performed. I believe beginning next week one day, the entire team will be out here doing our independent evaluation to validate or identify discrepancies in the result of this assessment.

This is an area of very high importance to us, and folks that will be out here are the same folks that were out here before. I want you to make sure that we have comparability in that system.

MR. BEZILLA: Okay.

Next slide.

What I would like to do now is briefly talk about the Mid-Cycle Outage.

Next slide, please.

The current start date for the Mid-Cycle is January 17th. The duration is about 20 days; it's a little less than 20 case. The key items in the outage are boric acid corrosion control inspections, reactor head, control rod drive flanges, bottom mounted instrument nozzle and pressurizer nozzle inspections, once-through steam generator inspections, and reactor coolant pump group 2 gasket inspections. Those are the key items.

We currently have about 120 corrective and elective maintenance items, 34 preventative maintenance items, 130-ish surveillance and test items, and about six modification items in scope in that outage. And what you can see there is, that it's pretty much an inspection test outage.

Our focus is going to be on safety, the work being performed, as well as how we do the work, and equipment reliability. We're going to be doing those things that are required to ensure safe and reliable service at Davis-Besse until we get to the next refuel. The next refuel is currently targeted for the spring of 2006.

One last item of note is, we have a fleet review of our readiness scheduled for July 30th. This is a chance

for us to present our preparedness and obtain feedback from the fleet; Lew, Joe, some of those program managers that I talked about, some of the other sites; on our readiness, areas of continued management focus, or maybe new areas of management focus.

If there aren't any questions, I would like to turn it over to Ralph.

MR. HANSEN: Okay, Mark, thanks.

Okay. Three things I would like to discuss; positive trends that we've seen, some areas that we're continuing to focus on, areas that we're going to be looking at more in the future.

In the area of positive trends, we've seen improvements in the area of Operations Support. Two specific things, we've seen good team response to some emergent issues. One we kind of discussed here was the elevated radiological levels in the plant. So, a good team response to that event.

The other area that we've noted was good sensitivity to potential increase in Reactor Coolant System leakage. There was plant conditions, it could indicate some potential increase. The plan was put together and the team went into Containment. They made some inspections to see if there was any evidence that there was a conditions

change in there.

Also, we've seen recently improvements in management focus on the health in training program. That's a starting point. What we see there, is that the, through the extended outage, we had reduced the emphasis on training, seen the management team response. We've got to bring that forward, so that they use training to drive sustained performance in the plant. What we need to see now, what Oversight is looking for, is a good plan and execution of that plan.

The area of Work Management. We've already heard that we've seen, in the area of work completion and work management process, we see the percentage of completion improving in both the execution and in the countdown areas; however, we see that as positive because that builds rigor into the execution of the process; however, what we need to see now is improvements in the efficiency of the execution of the process. So, we'll be looking at that also.

In the area of Corrective Action Review Board, we've seen a strong questioning attitude displayed. As you heard, we've seen some increase in the number of rejections, which this in and of itself may not necessarily be something we want to see. It's an indication that that barrier process is effective.

MR. GROBE: Who chairs that

now; is that Mike Ross?

MR. ALLEN: Typically, it is Mike Ross that chairs.

MR. GROBE: Just a question, Ralph. I think I agree with you that at the end of the assessment -- by Reactor Coolant System leakage, were you referring to the question that came up on pressurizer boric acid?

MR. HANSEN: Yes, the stratification.

MR. GROBE: I think as it turned out, that problem was thoroughly evaluated and the solution was identified, but I'm curious as to your thoughts on the time between the Condition Report was initiated, which was an excellent Condition Report, and the initiation of the Problem-Solving Decision-Making, what's your assessment of that?

MR. HANSEN: I don't have the data together, Jack, I would have to look back and review that.

MR. BEZILLA: Let me answer that for him, Jack.

We had an issue with the pressurizer delta and pressurizer Boron, RCS Boron. We believe we understood that and it was not an issue. Scott asked us a number of

questions. We gave answers. Scott, I don't want to say refuted, but put on a doubting Thomas. No pun intended.

Based on that feedback, we said, hey, we need to package this thing up, let's write the Condition Report, let's get the Problem-Solving and Decision-Making Team in place, let's put this thing to bed. We did that.

That also included a Containment ~~exit~~ entry, which we had planned on making, we did earlier because of the additional sensitivity. I'll say what I got out of that, even though we -- I may have that squared away. Until I document it so that others can review it and understand the same thought patterns and processes, that's not good enough.

So, my lesson on that is put the team together, document it, and leave it available for others to review. So, that was a Lessons Learned.

MR. GROBE: As I said, I thought the Condition Report was just outstanding. The individual clearly had understood what his responsibilities were. Was tracking what was going on. And at the point where it got to his level of, hey, there might be something wrong here, he issued a Condition Report.

I thought the Problem-Solving Decision-Making, I actually got a copy of that and read it, final report. I thought that was well done. It seemed like there were, prior to initiation of Problem-Solving Decision-Making

Team, there were maybe not sufficient challenge to the assumption or beliefs in what was going on.

And Scott asked a lot of questions. We were asking him a lot of questions. But it seemed like the easy answer was sought instead of being sufficiently challenged to believe assumptions. So, I'm glad you got to the Problem-Solving Team, and the team did a good job. There was some question in my mind at that time.

Okay. Thank you.

MR. HANSEN: Next slide, please.

MR. RUTKOWSKI: Before you go on. You mentioned on work management problems, that you're going to be looking at efficiency. Could you help me understand a little more what that is?

MR. HANSEN: You can see we're completing a high percentage. What you can see is the number of tasks we're completing per week is the amount of out of service time for the plant is being reduced, the amount of time in elevated risk, well managed. Those are the efficiency elements.

Then, that all plays into an overall material condition improvement. As you do that better, you should see the system health improve, backlogs reduced, these issues like we've talked about with the work request

backlog, the preventative maintenance issues. You should see that become less of a challenge for the organization. That's what efficiency looks like in a process to us in Oversight.

MR. RUTKOWSKI: Thank you.

MR. HANSEN: The area that we're continuing to look at, we were seeing issues in the procedure use adherence and content. One of the reasons I did this, Mark, we didn't see a correlation, but we saw that a number of these areas were centered around the surveillance program.

So, we're going to look at the Collective Significance Assessment, plus look at it from our own viewpoint and see if we can see inside that issue from our viewpoint.

We also noted that there was some procedure, what I call compliance areas, in areas such as chemistry, radiologic controls, security, that we would characterize at this time as attention to detail issues, and the organization is aware of those.

In the area of Engineering rigor, we note that Engineering is doing a lot of work. This is an organization that works a lot of knowledge base. So, we're executing that work. We want to see that quality is kept at a high level. And right now we don't have any strong

concerns, but we want to continue to look at that.

In the area of Corrective Action Program, we discussed that and we've seen that the -- we talked about trending. There is a piece that I'll talk about later.

We carried an issue into oversight about the trending program not being effective. What we've seen is that we've taken measures, we've put CR analysts in place, we've done training. We've yet to see the results of a really well executed trending process. So, we need to see that issue across the line. And we need to see the results from that.

MR. THOMAS: What are the stumbling blocks, what are the challenges that prevent that from occurring?

MR. BEZILLA: I'll answer that, Scott. At first we had to get the tool in place. I'll, when I say the tool, it's taking the data, slice and dice the data and providing a trend that's usable. Okay? We believe we have that in place.

Step two now is having the management, the managers review that and say, okay, what is this information telling me. There is so much that analysts can do and then the managers have to take ownership. We're into the managers taking ownership phase.

Now that we have a good tool and we have a product,

now they need to take it and see what it's telling me; is there an area that I need to focus on that I might not be currently focused on; there is some low level trending here that I need to be taking action on, so they don't have some challenge later on down the road. That's where we are with that.

MR. THOMAS: Okay.

MR. HANSEN: In addition, we mentioned before, we're seeing challenges coming to the Corrective Action Review Board. We need to see that the quality of documents reaching that level of review, improvement in those documents. We still want to see the core challenge them and eject them, if necessary, but you should see less challenges to that barrier, effective crossover.

In the area of vendor control, there is two pieces of that. We have an upcoming outage and a lot of vendors. We've seen some problems. An example recently, did some oversight of a vendor who was fabricating relays for the safety feature actuation system.

We saw some issues where he was having failures. We challenged him on that, and really weren't looking at the reasons for those failures as it might apply to the ones they were building and were passing the test.

So, it's just one area that that's being looked at

now, but it's just, as we get into it, we have a lot more of this business, and we have seen some various type of under control issues, so we look deeper into that from an oversight standpoint.

MR. HOPKINS: Is that oversight standpoint just Davis-Besse or also vendor?

MR. HANSEN: We're looking at that. We have issues we've looked at, at the Beaver Valley and we have some recent issues at the Perry facility too, with recent pump issues we've had there.

So, yeah, that is a, a three-site area, but specifically, we're going to look at some specific attributes of that here at Davis-Besse.

MR. HOPKINS: Okay.

MR. HANSEN: In the future, one of the issues that we're going to do a special look at is the implementation of FENOC Fleet Standard Organization. We want to see, as we implement this organization, it's been described as changed management plans, so there is elements of this we have the day issues and we have the going forward issues; we're going to watch and see if we see any decline in the organizational performance associated with these changes.

The next element we're looking to see, and this ties partly in the Corrective Action Program, and partly when we

get discussion about how quickly we responded to plant issues.

We want to see the threshold of the detection of issues reduced by the station so we're not having the events that we're responding, so we're getting into the more precursor, the lower level of issues, we're seeing issues starting to build into the organization. So, we want to see the ability of the organization to detect those things earlier and respond to them and prevent challenges.

As was discussed before, we want to see, we're going to watch closely the implementation of the improvements in training, and we need to see that aggressively implemented.

Also, Mark mentioned the Mid-Cycle Outage. This period, the key to that safe successful outage is good planning. We're going to look at the planning elements and look at that in the next time period to see that the organization is adequately prepared for the Mid-Cycle Outage.

Finally, the emergency preparedness. Our opportunity to really assess and validate preparedness in the program adequacy is during the drill cycle. So, we're going to look at the upcoming drills and we're going to put that together with the performance we've seen to-date, and then see if there is any issues we need to develop in that

area.

MR. GROBE: I was just thinking that somebody may want to take a close look at the transition from Central Daylight Time or Eastern Daylight Time and Standard Time also.

MR. HANSEN: Yeah. There is a vendor element to that too. That was one of the issues.

If there is no further questions, I'll turn it back to Mark.

MR. BEZILLA: Thanks, Ralph.

Jack, Christine, thanks for the opportunity to discuss our performance and prospectus. We appreciate your questions, challenges and comments.

Our vision is to have people with a strong safety focus delivering top fleet operating performance and safe and reliable operation is our focus.

Thank you. That's all we have.

MR. GROBE: Before we close, I have a question.

Many of you folks have been at other plants in recent past. What's your experience with performance on periodicity of resetting the event free clock at the other stations?

MR. ALLEN: Jack, I think that from some other stations, I've either been a part of or

visited, you know, in the fairly recent past. It's pretty common for stations to look at, say, 30 day to 180 day clock resets, but there is a balance there, because obviously you want nothing to occur, so you desire to have a pretty large, 60, 90 days would be great on clock reset; however, a lot of times we look and see many stations are getting 60, 90, more days between. Then you look at the threshold and say, I'm not sure the threshold is low enough. So, there is a balance there.

If you don't utilize that tool occasionally, like any other tool, it's not very effective. So, it's a balance, from what I've seen at a lot of other stations. And a lot of discussion, gee, this one was resetting too often; gee, this one is not resetting enough. And it's a balance.

MR. GROBE: Judgment call.

Other questions?

We've asked a lot of questions tonight. And we're in our overtime period at the moment. I apologize for the length of the meeting, but I think we've had very good dialogue.

I wanted to highlight a couple of things. First off, you formatted your slides such that you're highlighting areas of safe, reliable operations and opportunities, and I think that's good.

It is entirely possible that the plant would have restarted and had many opportunities for shutting the plant down. In fact, the plant has been operating reliably for, what did you say, 107 days?

MR. ALLEN: 107.

MR. GROBE: Was that printed this morning?

MR. ALLEN: That's right.

MR. GROBE: That's noteworthy, that's absolutely noteworthy. While we have a number of inspection findings, in many of our inspections, there have not been any risk significant findings, so the plant has been operating safely.

Challenged recently to make sure that we are not holding Davis-Besse to a different standard and I'm comfortable we are not. A plant that has a solid operating history and excellent operating history, human performance errors occur.

As one of your county commissioners explained to me today, that pencils have erasers for a reason; human errors occur. The difference at Davis-Besse is there is no operating history; there is no sound basis to believe that these are minor blips in the radar screen, where they might lead something else.

That's why we're focusing a lot of attention and

questioning extensively the meaning of these human performance errors; are they just periodic blips or are they something else?

We identified a number of issues for the next meeting. Speaking more holistically on the organization, individuals in various boxes and what their qualifications are. Getting into some detail, Kevin, on the Collective Significance Review. I think you said the program requires you to complete that in 30 days and it will be done at the end of September. I wasn't sure which one it was. Is it, did you mean the end of July, end of August, or end of September?

MR. OSTROWSKI: I will check my program requirements. 30 days would mean 30 days from last week.

MR. GROBE: Okay. So, it could very well be done before the next meeting?

MR. OSTROWSKI: That is correct.

MR. GROBE: Good, we look forward to a lengthy discussion on that, what your perceptions are with respect to what's going on with human performance, a dialogue on the backlog, and resource constraints on routine backlog work activities; what problem areas might exist there. We talked a little about

engineering qualifications.

Were there any other focus areas for now for next month? Not next month, but next time?

Okay, we'll be keeping a log and giving you actions when we get close to the next meeting.

I think this has been very productive. I do compliment you on the operating performance. The plant has been operating safely. There are these issues that you need to focus on and you are. And, we'll continue to ask a lot questions.

I think right now what I would like to do is just not take a break, since we are maybe in a second or third overtime period, is to go right into public questions and answers.

Mr. Stucker, if you have control of the lights, I think you could turn up the house lights, make it easier for us to see who is out there.

I'm curious, how many members of the plant staff do we have in the audience tonight?

And how many members of the public?

Okay. I should have said FENOC organization versus the public.

Does anybody from, representing local public officials, have a question or comment, would like to come forward?

MR. KOEBEL: We'll pass, Jack.

MR. GROBE: Any members of the public have a question or comment they would like to make?

MR. PAPCUN: The American League is ahead three to nothing, first inning, Jack.

MR. GROBE: I assess a lot of things and give opinions on a lot of things. I don't think I'll get into that.

Do we have any sailors in the audience? I think the sheet has been let out. The sails are roughing and we're in the summer goldens.

I would like to suggest and see if you have any thoughts on whether or not our next meeting shouldn't be put off until a week or two after Labor Day. Any thoughts on that?

MR. POWERS: I think it's a great idea. It's vacation period at the plant, Jack.

MR. GROBE: I can't hear you, Jim.

MR. POWERS: Much of the plant staff is taking time with their families, vacation period, so from that perspective, I would endorse that idea.

MR. GROBE: Kids will be back in school then, most families will be back at home. I think maybe we'll look at sometime in that time frame.

Okay, last chance for any questions or comments.

Very good. Thank you very much.

(Off the record.)

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CERTIFICATE

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Norwalk, Ohio, on this 19th day of July, 2004.

Marie B. Fresch, RMR

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