

1 PUBLIC MEEING  
2 BETWEEN THE USNRC O350 PANEL  
3 AND FIRST ENERGY NUCLEAR OPERATING COMPANY  
4 OAK HARBOR, OHIO

5 - - -

6 Date and Time: Monday, December 6, 2004  
7 6:00 p.m.

8 Place: Davis-Besse Administration Building  
9 Energy Education Center  
10 Oak Harbor, Ohio

11 Reporter: Marie B. Fresch  
12 Registered Merit Reporter  
13 Notary Public, State of Ohio

14 PANEL MEMBERS PRESENT:

15 U.S. NUCLEAR REGULATORY COMMISSION

16 Steve Reynolds  
17 Acting Director of the Division of Reactor  
18 Projects in Region III  
19 John "Jack" Grobe  
20 Senior Manager, Region III  
21 Chairman O350 Panel  
22 Christine Lipa  
23 Projects Branch Chief  
24 Christopher Scott Thomas  
25 Senior Resident Inspector  
Gene Suh, Section Chief NRR

FIRST ENERGY NUCLEAR OPERATING COMPANY

21 Mark Bezilla, Vice President  
22 Barry Allen, Director Site Operations  
23 Bob Schrauder  
24 Director Performance Improvement  
25 Steve Loehlien  
Manager Nuclear Quality Assessment  
Ray Hruby, Manager Nuclear Oversight

1 MS. LIPA: Okay, good  
2 evening. I would like to welcome FirstEnergy and  
3 members of the public for accommodating this meeting  
4 tonight. This is a public meeting between the NRC's  
5 Davis-Besse Oversight Panel and FirstEnergy Nuclear  
6 Operating Company.  
7 My name is Christine Lipa and I'm the Branch  
8 Chief in NRC's Region III and I'm responsible for the  
9 NRC's Inspection Program at Davis-Besse.  
10 We're talking about the purpose of this  
11 meeting on the next slide, and mostly to keep the public  
12 informed of the ongoing NRC activities, and discuss with  
13 the Licensee their performance and some activities they  
14 have planned; and then also NRC activities, recent and  
15 upcoming; and then also be available to answer any  
16 public questions or address any comments.  
17 The next slide shows the agenda. And we'll be  
18 covering, I'll be covering introduction and opening  
19 remarks and the NRC's activities. Then, we'll turn it  
20 over to the Utility for them to discuss recent  
21 performance. And, then, what we'll do is adjourn the  
22 business portion of the meeting, but we'll still be  
23 holding a meeting to have comments and questions from  
24 members of the public.  
25 What I would like to do first of all is start

1 off with some introductions at the NRC table here.  
2 We've got to my far left over here is Steve Reynolds.  
3 Steve is the Acting Director of the Division of Reactor  
4 Projects in Region III. He's also in transition to  
5 become the Chairman of the Davis-Besse Oversight Panel  
6 by the end of the year.

7 To my left is Jack Grobe. He is the Chairman  
8 of the Davis-Besse Oversight Panel currently, and will  
9 be transitioning to Steve.

10 Scott Thomas to my right is the Senior  
11 Resident Inspector at the Davis-Besse facility.

12 And to Scott's right is Gene Suh. Gene is a  
13 new member of the panel. He replaces Tony Mendiola.  
14 Gene is the Section Chief in NRR, and he's responsible  
15 for licensing actions at Davis-Besse and several other  
16 Region III plants.

17 Also, NRC folks that are here today. We have  
18 Jan Strasma, our Public Affairs in the back. Jan.

19 We have Nancy Keller. She's our Office  
20 Assistant at the Davis-Besse office and she was helping  
21 with the handouts.

22 We also have the two Resident Inspectors, Jack  
23 Rutkowski and Monica Williams.

24 Then, Mr. Bezilla, if you want to introduce  
25 your folks.

1 MR. BEZILLA: Good evening.

2 Thanks, Christine.

3 To my far right is Steve Loehlein, Director of  
4 Engineering here at Davis-Besse.

5 To my immediate right is Barry Allen, my  
6 Director of Site Operations.

7 To my far left is Ray Hruby, Manager of  
8 Nuclear Oversight.

9 And to my immediate left is Bob Schrauder, my  
10 Director of Performance Improvement.

11 And, also, in the audience we have Jeannie  
12 Rinckel, who is our Vice President of Oversight,  
13 transitioning into position February 2005. Jeannie.

14 Okay. And we have Joe Hagan, Senior Vice  
15 President of Engineering in Technical Support.

16 And Gary Leidich, President and Chief Nuclear  
17 Officer for FENOC.

18 MS. LIPA: Okay, thank you.

19 I would like to talk a little bit more about  
20 this meeting, and of course it's open to public  
21 observation, but it is a business meeting between the  
22 NRC and FirstEnergy, so we'll wait until the conclusion  
23 of the business portion to take comments from members of  
24 the public, but we'll be available for comments and  
25 questions during that Q and A session and then after the

1 meeting.

2 I would like to talk a little about the  
3 handouts that we had today. There are several. The NRC  
4 has handouts that are in the blue, and then FirstEnergy  
5 has handouts as well on the back table.

6 We also have a NRC Public News Update that we  
7 use to provide current information on recent and  
8 upcoming NRC activities, that also has good contact  
9 information on how you can reach us and get to the  
10 website.

11 We also have a Public Meeting Feedback form  
12 that you can use to provide comments to us on how this  
13 meeting goes today.

14 We're having this meeting transcribed today,  
15 and to maintain a record of this meeting and that  
16 transcription will be available on our website within  
17 about three to four weeks.

18 The next slide talks about some recent NRC  
19 activities. The first one is the NRC Triennial Fire  
20 Protection Baseline Inspection. That was held about a  
21 month ago. That report has been issued. And the  
22 results were fairly positive. And there was one  
23 inspection finding from that report.

24 The second bullet is the Service Water  
25 Inspection. That was held the first week of October.

1 And that also, there were no findings coming out of that  
2 inspection, and they found that the Generic Letter 8913  
3 Program to be in good shape at Davis-Besse.

4 Third bulletin is a inspection that has been  
5 completed, but the report is not issued yet. That is a  
6 supplemental inspection for the NRC Performance  
7 Indicators that we use to indicate performance of the  
8 Alert and Notification System, which are also known as  
9 the sirens.

10 And so the, the sirens have all been -- they  
11 did have a failure of the sirens back in May. The  
12 condition has been corrected. They were tested  
13 successfully several times. The only issue remaining is  
14 how to count some of those failures and successful tests  
15 when computing the Performance Indicator, and that  
16 report should be out in a few weeks.

17 November 16th, we had a public meeting out in  
18 the Perry area, and it was actually to discuss with  
19 FENOC corporate management and site management their  
20 plans for improvement of performance of all three of the  
21 FirstEnergy sites; Perry, Davis-Besse, and Beaver  
22 Valley.

23 And then November 9th was the beginning of a  
24 Team Inspection that we have to look at the Licensee's  
25 Corrective Action Program, the implementation of that

1 program. And there will be a separate inspection report  
2 issued in January.

3 The next slide talks about the some of the  
4 Confirmatory Order Activities. We previously discussed  
5 these. We have four areas that are covered by the  
6 Confirmatory Order; and there have been, there are four  
7 plans that have all been submitted and two of the  
8 reports have now been submitted to us; and I understand  
9 that the engineering report is due today, so we'll be  
10 evaluating that as soon as we get it.

11 The Safety Culture one is still ongoing. And  
12 that, we should expect that report to be issued in  
13 January.

14 The next slide talks about some other upcoming  
15 NRC activities. I mentioned earlier that Steve Reynolds  
16 will be taking over for Jack Grobe as the Chairman of  
17 the Panel, and they have been transitioning and  
18 discussing issues so that Steve is current on all the  
19 matters on Davis-Besse.

20 Also, I already mentioned the Problem  
21 Identification and Resolution Inspection; that's another  
22 word for looking at the Licensee's Corrective Action  
23 Program.

24 Then, I'll turn it over to Scott Thomas to  
25 talk a little bit more about the Mid-Cycle Outage

1 Inspections.

2 MR. THOMAS: During the  
3 Mid-Cycle Outage, additional Region-based specialists  
4 will evaluate the following areas. First, the Upper and  
5 Lower Reactor Vessel Head Inspections, Pressurizer  
6 Penetration Nozzle and Steam Space Piping Connections  
7 Temporary -- TI or Temporary Instruction, and the  
8 Evaluation of Licensee's Steam Generator Tube Inspection  
9 Activities.

10 The Resident Inspectors will continue to  
11 monitor day-to-day activities on-site. Significant  
12 portion of our time will be spent in Containment,  
13 walking down equipment systems not normally accessible  
14 by the operator.

15 MS. LIPA: Okay, thank you.  
16 That's all I have.

17 I'll turn it over to you, Mr. Bezilla, for  
18 your part of the presentation.

19 MR. BEZILLA: Thank you,  
20 Christine.

21 And, good evening.

22 Our Desired Outcomes for tonight are first to  
23 demonstrate that Davis-Besse's operations continue to be  
24 safe and conservative; and, second, to status you on the  
25 Confirmatory Order Independent Assessments, that being

1 actions taken and planned for the Operations Assessment;  
2 and, second, the areas for improvement and actions taken  
3 and planned in regard to the Corrective Action Program,  
4 Confirmatory Order Independent Assessment.

5 Not on this meeting's agenda, but probably for  
6 the next meeting, we will be prepared to discuss the  
7 Engineering Performance Assessment and the Safety  
8 Culture/Safety Conscious Work Environment Confirmatory  
9 Order Independent Assessment.

10 Steve is prepared to briefly overview the  
11 results of the Engineering Assessment, if we have time  
12 and if you would like.

13 Next slide, please.

14 Tonight, we will cover the following items:  
15 Plant Performance or noteworthy items since the last  
16 public meeting; actions taken and planned for the areas  
17 for improvement from the Operations Performance  
18 Assessment, areas for improvement and actions taken and  
19 planned for the Corrective Action Program Assessment,  
20 the results and actions taken and planned from our  
21 recent internal Safety Conscious Work Environment Survey  
22 and an overview of our recent Safety Culture Assessment,  
23 a brief look at our backlog reduction efforts, a  
24 discussion on our Mid-Cycle Outage, actions taken and  
25 planned to ensure a successful Outage, and finally,

1 discussion by Ray presenting his Oversight Sections  
2 Perspective.

3 Before I turn it over to Barry, I would just  
4 like to make a few introductory remarks. In regard to  
5 our momentum and sense of urgency, I've reflected on  
6 this, and I also worry about our momentum, our drive to  
7 improve our performance and reduce our backlogs.

8 What I see is a team that's focused on  
9 improving its performance and is committed to turn our  
10 backlogs into workloads, that being steady state  
11 workloads.

12 I'd liken it to we're running a marathon, and  
13 we're pacing ourselves, okay, which is different than  
14 the effort that was expended during extended shutdown,  
15 where we were sprinting, or at least it seemed like we  
16 were always sprinting.

17 I and this team, we'll ensure that we continue  
18 to improve and work our backlogs into a steady state  
19 workload condition and that's currently forecast to be a  
20 reality come the spring of 2006.

21 In regard to Operation's performance, we  
22 continue to have some lower level, minor, or no  
23 consequence errors; and even though these things, even  
24 though they're minor, it's troublesome. All right.

25 We have taken steps to reduce the probability

1 of errors and mistakes, and you'll hear more on that  
2 from Barry little later in the presentation.

3 Operator Performance is an area where we  
4 observe and monitor fairly frequently. We'll continue  
5 to watch this area closely, and we'll work to strengthen  
6 our barriers; that being individual performance,  
7 procedure quality, supervision, and oversight; to  
8 further reduce the chance of errors; and, if errors do  
9 occur, to mitigate the consequences of those errors.

10 In regard to our Corrective Action Program,  
11 you will hear Bob talk about our Confirmatory Order  
12 Independent Assessment on the Corrective Action Program  
13 in detail. That team said our Corrective Action Process  
14 was marginally effective.

15 The Corrective Action Process is the tour  
16 engine we use to identify, prioritize, and solve  
17 problems. It consumes much of our resource and time and  
18 it's critical to our future.

19 We have and will continue to improve our  
20 program and our people's ability to use the tools.  
21 We're confident in our people's commitment to use the  
22 Corrective Action Program to capture and solve problems.  
23 We will continue to focus and improve our performance in  
24 this area.

25 In regard to our recent internal Safety

1 Conscious Work Environment Survey results, we saw a  
2 reduction in the number of positive responses to some  
3 questions and in some sections. Follow-up on these  
4 survey results is very important for us and for me.

5 Our desire is to have a robust Safety  
6 Conscious Work Environment atmosphere where our team  
7 feels free and unencumbered in regard to raising issues  
8 and concerns. The results indicate that our people are  
9 willing, our willingness to identify and raise issues  
10 and concerns remains strong. And that's a good thing.  
11 However, there are areas in which we need to focus  
12 management attention.

13 I'll speak more on this a little bit later in  
14 the presentation.

15 In summary, we've got a lot of work yet to do.  
16 And looking in total, I believe both the plant and my  
17 staff have performed pretty well since restart.

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

20 MR. ALLEN: Thank you, Mark.

21 My objective tonight is to demonstrate that  
22 the operation of Davis-Besse continues to be safe and  
23 conservative.

24 Per plant status, Davis-Besse station is at  
25 100 percent power generating approximately 925 megawatts

1 electric. We are at 121 continuous days of safe and  
2 conservative operations. And we're currently at 60  
3 consecutive Human Performance success days.

4 Next slide.

5 Now, I would like to briefly mention some of  
6 the more noteworthy items that occurred at the station  
7 since our last public meeting.

8 The second of our four Confirmatory Order  
9 Independent Assessment on the Corrective Action Program  
10 implementation completed during this time frame, and as  
11 Mark said, Bob Schrauder will cover this later in detail  
12 in the presentation.

13 Also, as Christine mentioned, the NRC  
14 inspection of our Service Water System. This was a very  
15 good and thorough inspection with no findings that  
16 demonstrated strong system engineering ownership of that  
17 program.

18 We also conducted our Annual Safety Conscious  
19 Work Environment Survey the week of October 4th, which  
20 Mark will discuss in more detail later in the  
21 presentation.

22 Next slide.

23 The Confirmatory Order Independent Assessment  
24 of Engineering Program Effectiveness was performed in  
25 October and we are submitting the final report to you

1 today.

2 On October 11th through the 13th, nuclear  
3 oversight personnel conducted Safety Culture, Safety  
4 Conscious Work Environment interviews with station  
5 personnel, and Ray will discuss those interviews later  
6 in his presentation.

7 Also on October 15th, we conducted a  
8 successful Emergency Plan Drill to qualify several newly  
9 assigned emergency response organization team members.

10 And, in that exercise 23 of 23 objectives were met.

11 Then, on October 18th, the Nuclear Oversight  
12 issued their Third Quarter Continuous Assessment Report,  
13 which Ray will also discuss later in his presentation.

14 Next slide.

15 On October 25th, we had an NRC inspection of  
16 ALARA, Access Control, and NRC Performance Indicators;  
17 and in the Exit on October 29th, no potential violations  
18 or findings were identified.

19 And during the same week, the NRC performed a  
20 special inspection of our Alert and Notification System  
21 Performance Indicators, and your inspection team asked  
22 us some very good questions, which caused us to reflect  
23 and resubmit our data to you. And in retrospect, we  
24 believe we should have initially submitted the indicator  
25 as white, with subsequent discussions regarding the

1 data.

2 On October 25th and 26th, we conducted our  
3 Annual Safety Culture Assessment and Mark will discuss  
4 the results of the annual assessment later in his  
5 presentation.

6 And then on October 29th, we achieved full  
7 compliance with the NRC Security Order.

8 In the first week of November, we met an  
9 important milestone in completing the NRC Baseline  
10 Inspection; and then our Independent Assessment of  
11 Safety Culture, Safety Conscious Work Environment began  
12 with interviews, surveys, and observations in November  
13 and that team is off assessing that data right now with  
14 the initial report projected to be issued to us on  
15 December 21st.

16 Then, on November 12th, we held a Fleet Review  
17 of our Mid-Cycle Outage Readiness and I'll discuss our  
18 Mid-Cycle Outage Readiness later in the presentation.

19 Also, the week of November 15th was our NRC  
20 Licensed Operator Requalification Inspection. And while  
21 there were no potential violations or findings  
22 identified at the Exit, the team did leave us with  
23 several opportunities for improvement.

24 And, also, currently, the NRC Problem  
25 Identification and Resolution Inspection of our

1 Corrective Action Program is in progress, with the first  
2 of the three weeks completed last Friday.

3 Next slide.

4 Some of our key upcoming 2005 events include  
5 our January Mid-Cycle Outage, which you will be here to  
6 observe, our Graded Emergency Preparedness Exercise in  
7 May, and others as listed on the slide.

8 Okay. So, in conclusion, operation of  
9 Davis-Besse continues to be safe and conservative.

10 MS. LIPA: I had a question  
11 for you. Back on slide 7, you talked about the October  
12 18 Nuclear Oversight Third Quarter Assessment Exit. Do  
13 you plan to get into any more detail later in your  
14 presentation?

15 MR. ALLEN: Yes.

16 MR. BEZILLA: Yes.

17 MR. ALLEN: Okay, next  
18 slide.

19 Now, we will provide an updated status of our  
20 Independent Assessments.

21 Next slide.

22 Three of the four Independent Assessments have  
23 been completed with the Engineering Program  
24 Effectiveness Assessment Report being submitted today.  
25 The Independent Assessment Team for Organizational

1 Safety Culture is still underway, as I mentioned  
2 previously. I will update you regarding some of the  
3 actions we've taken in the Operation's performance area  
4 since our previous meeting; and then Bob Schrauder will  
5 discuss the Corrective Action Program Implementation  
6 Assessment in detail tonight.

7 We will discuss the Engineering Program  
8 Effectiveness and the Organizational Safety Culture  
9 Independent Assessment at the next public meeting.

10 MS. LIPA: With respect to  
11 the Safety Culture Assessment, what's the actual  
12 schedule for completion of that assessment?

13 MR. ALLEN: December 21st is  
14 when we are supposed to get the initial report.

15 MS. LIPA: Okay.

16 MR. SCHRAUDER: Right, they have  
17 completed gathering their data for that assessment.  
18 They're currently in the process of evaluating that data  
19 and they intend to Exit with us on December 21st, on the  
20 findings from that assessment.

21 MS. LIPA: Okay. Then, the  
22 report will be submitted 45 days from the Exit?

23 MR. SCHRAUDER: That's correct.

24 MS. LIPA: Okay, thank you,

25 Bob.

1           MR. ALLEN:           Okay. At our  
2 last public meeting, I discussed the scope and results  
3 of the Operations Independent Assessment in great  
4 detail. Tonight, I would like to discuss a few of the  
5 key areas for improvement and some of the actions we  
6 have completed since our previous public meeting.

7           In the area of Work Management Interface, we  
8 have communicated details of the work scheduling process  
9 to Operations personnel to help them more fully  
10 understand how the scheduling process should function.

11           We've also reviewed routine Operations  
12 activities for inclusion in the work implementation  
13 schedule to do a better job of scheduling our Operations  
14 resources.

15           We're also ensuring we have licensed operator  
16 representation at routine work scheduling meetings.

17           In the area of procedure back logs --

18           MR. GROBE:           Barry, excuse  
19 me. Before you go on, could you specifically describe  
20 what the finding was in the area for improvement in work  
21 management interface?

22           MR. ALLEN:           Yes, Jack, I can  
23 get that. Okay, Jack, this is area for improvement.  
24 It's resolve operators misunderstanding about work  
25 scheduling and improve the quality of work scheduling.

1           So, some misunderstanding, not clear  
2 understanding of how the work scheduling process works  
3 and the inputs that go into it. And improve the quality  
4 of the work scheduling; we worked it out, such as  
5 ensuring we schedule, I'll call it, lower level  
6 monthly-type activities, and then ensuring that we have  
7 operators involved in the scheduling meetings.

8           MR. GROBE:           Was the specific  
9 concern there that Operations activities or Operations  
10 workload wasn't being properly managed with what might  
11 be the nonroutine Operations workload, meaning routine  
12 activities and nonroutine activities were not being  
13 properly managed; is that the issue?

14          MR. ALLEN:           Jack, I believe  
15 it was probably like a combination of things. First,  
16 maybe being that throughout the organization, there was  
17 not a common understanding of what the function of the  
18 schedule was. Operations leads the station; however,  
19 one of the tools that we utilized to ensure that we're  
20 safe from a core damaged frequency perspective is to  
21 provide that input into the schedule and then perform a  
22 risk assessment of that schedule.

23           And, so, not all personnel within the  
24 department understood how that schedule was developed;  
25 or understood that Operations input was solicited into

1 that scheduled development. And, so, there was some  
2 knowledge weaknesses there, if you will, that we felt we  
3 had to address with the operators.

4 In other activities, we felt that although  
5 minor, I do impact resources available, and therefore we  
6 felt like we should schedule a finer level of detail, up  
7 to and including say end of shift briefs, those kind of  
8 routine shift activities or monthly activities.

9 MR. GROBE: Have you seen a  
10 difference in day-to-day operations interfaced with  
11 scheduling activities as far as the outcome? What  
12 change in behavior have you seen?

13 MR. ALLEN: The greatest  
14 benefit that we've seen, Jack, is having the SRO's  
15 involved in the scheduling process, because they do  
16 bring insights into station operations that other  
17 individuals may not be as fresh on. And, so, it's the  
18 ability, I believe, for the Operations organization to  
19 lead the organization is the greatest benefit that we  
20 see from that.

21 MR. GROBE: Okay. Thank  
22 you.

23 MR. ALLEN: In the area of  
24 procedure backlogs, we have reviewed the procedure  
25 backlog for priority and safety significance. After

1 doing that, we also developed a backlog reduction plan  
2 which will address the operations procedure backlog by  
3 the end of Cycle 14. Then, we have allocated additional  
4 resources to be assigned to the procedure backlog  
5 reduction initiative.

6 MR. GROBE: Barry, why was  
7 it necessary for the independent team to identify this  
8 issue?

9 MR. ALLEN: Jack, we have  
10 tracked our backlog throughout the year. One of the  
11 things that we did early in the year was, we looked at  
12 the largest areas of the our backlog; and two of the  
13 areas we identify as seeing most burdensome to the  
14 station were the engineering backlog and engineering  
15 maintenance backlog; and we saw those as, I guess I  
16 would say, formidable challenges for the organization to  
17 work through. So, we set up teams to go address those  
18 specific backlogs.

19 As we track and trended our backlog through  
20 the year, what we observed was we were not making as  
21 much progress in the area of procedures as we had  
22 desired. And, so, we had just essentially looked at  
23 laying out a plan to address the procedure backlog as we  
24 have the other areas.

25 But we have been tracking our backlog on a

1 weekly basis and fully aware of what our backlog is,  
2 what's trending down, which areas we were not making as  
3 much progress in.

4 MR. GROBE: Okay. So, you  
5 had a plan at that time to reduce this backlog prior to  
6 the independent assessment?

7 MR. ALLEN: We had a  
8 proposal, that Operations had developed and presented to  
9 me. We worked on that. And then it was presented to  
10 Mark, I think it was under the Vice President and my  
11 review at that time. We had been working on that plan  
12 for several weeks, within the Operations Department.

13 MR. GROBE: Are there any  
14 other areas of backlog where there is not a management  
15 plan in place yet to deal with it?

16 MR. ALLEN: Yeah. We also  
17 have -- well, we also have a concerted effort being  
18 initiated in the condition report backlog area; and then  
19 of course we're working to integrate that with  
20 procedures.

21 MR. BEZILLA: Jack, I think  
22 we've got all the areas covered. I think Bob will cover  
23 that a little bit later when he talks about the  
24 Corrective Action Program Assessment; and one of the  
25 things that he asked us to do was integrate the various

1 backlog efforts that we have; and Bob will talk briefly  
2 about that.

3 MR. GROBE: There is no  
4 other surprises though; simulator modifications,  
5 training backlogs, what else is out there that we're not  
6 aware of?

7 MR. BEZILLA: I think we've  
8 got them covered.

9 MR. GROBE: Okay.

10 MR. THOMAS: Make sure I  
11 understand. The goal is to integrate this, all the  
12 backlogs under one process or program that you're going  
13 to head up, Bob?

14 MR. SCHRAUDER: That's right.  
15 We'll take all of the efforts that are currently  
16 underway for backlog reduction and show how they all fit  
17 together and integrate those processes together or those  
18 reduction backlogs.

19 MR. REYNOLDS: I have a  
20 question, to start off with. I think where you answered  
21 Jack's questions on the reduction plan, your slide  
22 implies that it was done as a result of your independent  
23 assessment and you said you already had plans in place.  
24 You had -- it wasn't because an assessment.

25 So, my question goes to the next symbol down;

1 additional resources assigned. Is that because of the  
2 independent assessment or is that because of some other  
3 factor?

4 MR. ALLEN: Steve, we were  
5 laying out our plans to address the Operations procedure  
6 backlog; and we want a specific plan with here's where  
7 we are, here's our goals, here's our targets, here's the  
8 resources it will require.

9 When the independent assessment came through,  
10 it all, the fact that we weren't making headway got  
11 captured in the Independent Assessment; so, it just  
12 happened to be coincidental, if you will.

13 MR. BEZILLA: See, Steve,  
14 initially, we were looking to see if there would be  
15 better internal resources to work on that project versus  
16 external. And after we did that assessment, which was  
17 I'll say, in parallel or shortly after this effort, we  
18 decided to go external. And some of the external folks  
19 we brought in here were ex-Davis-Besse SRO-type  
20 individuals who we think will do a good job for us in  
21 this effort.

22 MR. REYNOLDS: I think I  
23 understand your answer. Better way to ask my question;  
24 if you didn't have the Independent Assessment, that  
25 didn't happen, these three sub-bullets, would you have

1 went ahead and done it anyway? You always had those  
2 actions to go forward?

3 MR. BEZILLA: Yes, this helped  
4 solidify our belief that we needed to do that.

5 MR. REYNOLDS: All right, thank  
6 you.

7 MR. ALLEN: In the area of  
8 Corrective Action Program Backlog, we have reviewed all  
9 open condition reports and reviewed all open  
10 preventative and remedial corrective actions for  
11 priority and safety significance within operations. And  
12 as we discussed, resolution of these items will be  
13 integrated with the resolution of Corrective Action  
14 Program Backlog within the procedure backlog reduction  
15 effort. And Bob spoke to that briefly just a moment  
16 ago.

17 Then, we talked about routine tasks in several  
18 of the public meetings. In the area of routine tasks  
19 performance by Operations, a few things I just wanted to  
20 mention tonight. We scheduled end of shift crew  
21 critiques to identify and address all equipment and  
22 Human Performance issues that occur within that shift,  
23 opportunities for improvement.

24 We've also instituted an independent  
25 cross-crew Senior Reactor Operator review of all

1 surveillance tests performed on shift before the  
2 off-going Senior Reactor Operators leave at the end of  
3 that shift.

4 And we've also, following up with that, we  
5 have Operations management review of the completed  
6 cross-crew reviews, as well as periodic management  
7 observations scheduled to observe those cross-crew  
8 reviews.

9 MR. REYNOLDS: Your actions on  
10 routine tasks, are these permanent actions or just  
11 interim actions until you get enough level of  
12 performance out of your crews to say you no longer need  
13 these?

14 MR. ALLEN: Steve, that's a  
15 subject to some discussion at Davis-Besse. The  
16 end-of-shift crew critiques, that is an expectation do  
17 not see that probably ever changing. I think there is a  
18 value and benefit in that.

19 As far as the, at the end of an operation  
20 shift, when all the SROs get together to review  
21 surveillance on their shift. We now require an SRO from  
22 another shift to come in and perform that review with  
23 them. That's my interim action to make sure we get our  
24 surveillance tests done.

25 And the challenge is, to the shift managers,

1 to alter the performance of their crews to determine if  
2 there are alternative or better ways of performing that  
3 task and ensure we don't have errors in surveillance.

4 We could do this forever or the shift managers  
5 through their ownership may come up with ultimate means  
6 of accomplishing the same task.

7 MR. REYNOLDS: You may not know  
8 the answer to this question, but out of curiosity, I  
9 always wanted to know. End-of-shift crew critiques you  
10 said that was going to be permanent; do you know if your  
11 other FENOC ~~plans~~ plants do that currently?

12 MR. ALLEN: I believe so,  
13 Steve, but I have not observed those at those stations.  
14 So, at best, I have secondhand information.

15 MR. REYNOLDS: Okay.

16 MR. GROBE: Barry, why is it  
17 necessary to have the independent cross-crew  
18 surveillance review?

19 MR. ALLEN: Jack, we just  
20 believe that we would get some value to ensure that as  
21 we completed a shift, we were looking for some  
22 independent assurance that we had not had errors within  
23 our surveillances.

24 And then one of the benefits, Jack, that we  
25 saw pretty early on, was that bringing an independent

1 SRO from another crew over, again to point out, I'll  
2 say, very minor inconsistencies at a low level between  
3 the way individuals on different crews might initial or  
4 place key or other minor types of activities.

5 And, so, what this does, it allows an  
6 opportunity for the shifts to identify the best way to  
7 perform a task for some of these, I'll say, minor low  
8 level-type activities that we perform within operations.

9 And, so, we're getting some benefits out of  
10 that in that it gathers more consistency in operation  
11 and documentation between the crews; and, therefore,  
12 looking for that to help improve our performance at the  
13 very minor level, which we believe will head off  
14 precursors and prevent events at greater levels.

15 MR. GROBE: There is  
16 certainly no problems with having additional reviews. I  
17 think the most recent surveillance performance problem  
18 had to do with heat tracing where a surveillance wasn't  
19 correctly performed and it wasn't realized until after  
20 control room review of the surveillance results, and an  
21 engineer was looking at the result of a surveillance  
22 test.

23 Why are these things happening, and, you know,  
24 what is the root cause, and why is this band-aid  
25 necessary?

1 MR. ALLEN: Jack, the,  
2 subsequent to that condition report which you discussed,  
3 that's when we instituted the cross-crew reviews. And  
4 that's to ensure that we have individuals go back and  
5 specifically review the entire surveillance to ensure  
6 that there is not an oversight or some missed data, or  
7 inaccuracies in the surveillance test data.

8 MR. THOMAS: By the time it  
9 gets to that point, there has been two reviews already,  
10 two SRO reviews, so this is a third review on top of the  
11 two?

12 MR. ALLEN: A third review  
13 with the entire crew, okay, with the SROs on the  
14 off-going crew. So, as a team, now, instead of  
15 reviewing, one SRO reviews independently, another SRO  
16 reviews independently; that all occurs, but this gets  
17 that Operations crew together with some independent  
18 oversight, if you will, from an additional SRO, and then  
19 they go through and critique the performance of those  
20 surveillances and look for any opportunities for  
21 improvement. Then, that's documented on observation  
22 cards.

23 MR. THOMAS: Has this  
24 impacted overtime by the crews, this additional review?

25 MR. ALLEN: It has.

1 Individuals have to come in on days off, on weekends,  
2 and times like that to perform the review. So, it does  
3 impact the SRO's; and they are the ones who are  
4 developing the action plan, as I said, to determine if  
5 they do something different; and they are the people who  
6 schedule that additional SRO review based on their  
7 schedules.

8 MR. THOMAS: Okay.

9 MR. GROBE: I'm still not  
10 understanding what the cause of the performance  
11 deficiencies have been in the past; both within the  
12 field where activities aren't completed in accordance  
13 with procedure, and then in the Operations organization  
14 and those activities are reviewed and deficiencies in  
15 the field performance aren't identified.

16 What is the cause of that and how is this  
17 fixing the cause?

18 MR. BEZILLA: Jack, my belief  
19 is it's attention to detail, and these things that we've  
20 had, I'll say, errors occurring, are fairly routine,  
21 tech spec related, so it's very important, but they are  
22 routine items, and it's a matter of attention to detail.

23 And we found when we have the, I'll say,  
24 higher profile items, since restart, we've appeared to  
25 have done pretty well on those, but these are the things

1 that happen daily, weekly, monthly, is what we're having  
2 our issues with. And, so, our view is that there is no  
3 task that's routine, everything is important, and you  
4 have to focus on your task at hand.

5 As Barry said, this is an interim solution.  
6 We've asked the shift managers to work together to  
7 identify what they're going to do to make sure on these  
8 routine items they can successfully perform them day in  
9 and day out without this additional, I'll say, oversight  
10 checks, monitoring, et cetera. And, if we had the  
11 answer, we would have eliminated this already.

12 MR. GROBE: Did I read in  
13 our Ops assessment, I think I did, I read a lot of  
14 documents, so I don't remember exactly where I read  
15 those things. But I think I read somewhere in the Ops  
16 assessment that there is a too frequent a default to  
17 human performance being the specific cause of the  
18 problem and not looking deeper as to what's causing the  
19 people not to perform correctly. Was that your honest  
20 assessment? I think it was, wasn't it?

21 MR. BEZILLA: Right, it was.

22 MR. GROBE: Is this a case  
23 where, by saying it's attention to detail, it strictly  
24 places the performance issue on the individual. Were  
25 there any unusual time constraints or poor guidance or

1 was there anything else that was driving that  
2 performance issue?

3 MR. ALLEN: Jack, on this  
4 particular one, once we discovered the error that we had  
5 in the field on this one, the Operations Manager, Kevin  
6 Ostrowski, and the Operations Superintendent, Dave Imlay  
7 went out and performed that surveillance to verify  
8 adequacy and accuracy of the procedure. And then the  
9 following morning, I came in and took an equipment  
10 operator at random to get a copy of the surveillance,  
11 and take me out and walk me through performance of the  
12 surveillance.

13 And I believe from all of our perspectives the  
14 procedure was clear. It was explicit. It was not a  
15 challenge to perform that surveillance correctly. I  
16 believe in that case was more of a challenge to review  
17 it than it was to perform it because of the way the data  
18 was captured and collected. But just straightforward,  
19 Jack. I don't know how else to say it. Just a simple  
20 routine task, which was performed incorrectly.

21 MR. GROBE: Okay.

22 MR. REYNOLDS: Couple questions  
23 just to clarify in my mind. Three activities you added;  
24 end of shift crews, independent cross-crew SRO review  
25 and Ops management review. Were they implemented all at

1 the same time or did you do one and then add another and  
2 then add another?

3 MR. ALLEN: Steve, the end  
4 of shift crew critiques, that's earlier, a while back.

5 And one of the things, again, I've talked about  
6 scheduling a lower level of operations activities.

7 Sometime back when the shift manager said,  
8 boy, we struggle to do a good job at these. We said  
9 we'd put them in the schedule. When we want something  
10 in the schedule, we want it to occur, we put it in the  
11 schedule. So, we put it in the schedule.

12 So, we did that. And I believe that's helped.  
13 Psychologically, if nothing else, it has the station  
14 looking at the schedule and recognizing that we do have  
15 that critique. And I believing the station is honoring  
16 that time that Operations has spent in performing that.

17 The cross-crew review, if you will, that was  
18 immediately after the latest error, a day after that.  
19 The Operations management review, that's still ongoing.  
20 That's Kevin and his folks checking that occasionally.

21 Every shift, when those reviews are performed,  
22 I get a sheet from the off-going crew that lists the  
23 individuals who performed that review and had a  
24 reference to their observation. Now I get copies of  
25 many of the observations. I have cards that the extra

1 SRO, if you will, performs a documented observation of  
2 that review.

3 So, I review all of those. And then this will  
4 also allow us to look collectively, if you will, at  
5 those observations and see if there is common areas that  
6 we feel like the shift managers want to help address as  
7 they work towards the long term solution.

8 MR. REYNOLDS: Then, I guess,  
9 another question, maybe a comment is how it comes out, I  
10 guess. I think where Jack was trying to go. ~~It~~  
11 Inattention to detail, usually you see that on a rare  
12 occasion. Individual just didn't pay attention to  
13 detail.

14 But if you see it many times with the same  
15 group of people, the same type of activities, there is  
16 usually a common cause, it's not just an individual  
17 making an error.

18 Talked about procedure. You didn't think it  
19 was that. But, you know, it could be training, it could  
20 be procedures that you talked about. Said it wasn't  
21 that. Could be standards and expectations. Did you  
22 look at training and standards and expectations as far  
23 as a cause for repeated inattention to detail problems  
24 in Ops?

25 MR. ALLEN: In this one,

1 Steve, we did. I did not personally see any of that.

2 In this particular case, we had been quite  
3 awhile, been clean for a good while before this latest  
4 incident. And, the individual involved had multiple  
5 attention to detail events, if you will, in the last  
6 year or so. And that individual was just not able to  
7 meet our high standards of performance, and that  
8 individual is no longer in the Operations Department.

9 MR. REYNOLDS: Okay, that  
10 helps, thanks.

11 MR. SUH: Barry, I just  
12 had a question, maybe you covered this at the previous  
13 meeting. But the Independent Assessment talked about  
14 the fact that self-assessments done by the corporate  
15 board and by the QA Department in the Operations area  
16 was effective and factual and in depth, but then it  
17 talked about the self-assessments done by the Operations  
18 Department, and they didn't meet that standard.

19 And, I was wondering, was an action, did an  
20 action come out of that, or what the status or what your  
21 response to that finding was?

22 MR. ALLEN: Just a second,  
23 Gene.

24 MR. SCHRAUDER: Gene, while  
25 Barry is looking that up, I can tell you that that

1 comment was specifically aimed at our Collective  
2 Significance Reviews that sections managers do right now  
3 on a semi-annual basis, and it's a fairly new process  
4 for us.

5 And several of the sections, I would say, we  
6 have a finding of that in the Corrective Action  
7 Assessment too, where we had a, I'm going to say, a  
8 variety of levels of quality in those assessments. And  
9 our folks are just coming up to speed with really how to  
10 do those effectively.

11 The second round of those is just now coming  
12 due, will be coming to the senior management team to  
13 look at how critical, how well we followed the  
14 guidelines, and improving the quality of those. So, we  
15 are working on that particular aspect within the  
16 Corrective Action Program.

17 MR. SUH: Do you have data  
18 to suggest that other departments self-assessments are  
19 similarly lacking or is it just the Operations  
20 Department self-assessments?

21 MR. SCHRAUDER: There were  
22 several sections that were found not to have the highest  
23 quality in those documents, so we're addressing across  
24 the site.

25 MR. SUH: Across, okay.

1 And another question; on the commitment list that came  
2 along with the Independent Assessment in the Ops area,  
3 there were a number of due dates there that, I guess now  
4 that we're here in December, I was just wondering, you  
5 may not have, you know, the information right off the  
6 top, but are you folks meeting those due dates that you  
7 had previously made?

8 MR. ALLEN: Yes, we are  
9 meeting those due dates, Gene.

10 MR. SUH: So, that's  
11 positive, correct?

12 MR. ALLEN: Right.

13 MR. SUH: Okay, thank you.

14 MR. ALLEN: Next slide.

15 Now, I would like to turn it over to Bob  
16 Schrauder to discuss the Independent Assessment of our  
17 Corrective Action Program implementation.

18 MR. SCHRAUDER: Okay, thank you,  
19 Barry.

20 As Mark indicated earlier, Barry indicated  
21 earlier -- next slide, please -- this assessment was  
22 performed through the middle of September and into  
23 October. It was performed by a combined team of  
24 consultants and three peers, three industry peers that  
25 are responsible for the Corrective Action Program at

1 their respective sites.

2 We believe that the assessment was a good,  
3 tough look at where we are with implementing the  
4 Corrective Action Program at Davis-Besse. And as Mark  
5 has said, the team identified the overall implementation  
6 of Corrective Action Program at Davis-Besse as currently  
7 marginally effective.

8 What does marginally effective mean to us? It  
9 means that we minimally meet the requirements for the  
10 program. And that is certainly not where we want to be  
11 with this program at Davis-Besse. And this team is  
12 working diligently to make sure that Corrective Action  
13 Program is one that consistently finds, assesses, fixes  
14 and prevents the recurrence of problems at Davis-Besse.

15 Listed on the slide are the areas that the  
16 team reviewed. And each of those individual areas was  
17 identified as marginally effective with the exception of  
18 the trending program, which I'll get into a little bit  
19 later that was identified as unsatisfactory.

20 MR. REYNOLDS: Before you go on  
21 to the next slide. You talked about marginally and  
22 unsatisfactory, those were, I guess, grades or  
23 evaluation. What other possible grades, so to speak, so  
24 I could put it in better perspective. You said  
25 marginal. You said minimal. Was that the top end or

1 were there upper ends that you could have done better?

2 MR. SCHRAUDER: We could have  
3 clearly done better. The team didn't actually give us,  
4 here's the three or four categories we're going to use.  
5 They simply assigned us their rating of the program.  
6 But my sense is we were going to get one of three  
7 ratings; effective, marginally effective, or  
8 unsatisfactory.

9 MR. REYNOLDS: Okay, thank you.

10 MR. SCHRAUDER: Or fully  
11 effective, if you will, for the best rating you could  
12 get.

13 Okay, so what I want to do is go through, and  
14 a lot of this information we have docketed, but I'll go  
15 through the areas for improvement. There were seven  
16 areas for improvement identified in this. And then the  
17 actions that we're taking to improve our performance of  
18 these areas.

19 The first area for improvement was some  
20 organizations were not initiating condition reports as  
21 required. Now, the team did recognize that Davis-Besse  
22 has a high rate of generation of condition reports by  
23 industry standards, but they did identify a few  
24 instances where it was felt that a condition report  
25 should have been initiated or where our process for

1 procedures would have required one to be generated and  
2 was not.

3 Some examples of that included in the  
4 Collective Significance Reviews that we talked about  
5 earlier in the sections, that the procedure, the process  
6 would require that for areas for improvement and for  
7 noteworthy items that a condition report document that  
8 finding and put it into the Corrective Action Program,  
9 so that we can resolve the issue.

10 That was not consistently done by some of the  
11 organizations. And, most notably, was in the area for  
12 noteworthy items in those. Most of the areas for  
13 improvements were identified in condition reports,  
14 although a few were not, but several sections did not  
15 initiate condition reports for noteworthy items, which  
16 are improvements or enhancements.

17 Also, the team identify in two instances where  
18 we're evaluating a specific condition report, that  
19 another issue, if you will, was identified in the review  
20 of that condition report and a separate condition report  
21 was not written.

22 For instance, one, it was identified during  
23 the review of condition report, that a unit log had a  
24 discrepancy or error in it and no condition report was  
25 initiated to identify that as a condition adverse to

1 quality.

2           Then, another one was during the review of one  
3 of the missed tech spec surveillances, it was found that  
4 this activity had improperly documented several times in  
5 the past, and, in fact, during his review of the rounds,  
6 one of the unit supervisors had identified that it  
7 hadn't been documented correctly, and corrected it on  
8 the spot, which they do, but did not initiate a  
9 condition report. The team felt that initiation of a  
10 condition report at that level may have helped prevent  
11 missing the thing in the future.

12           So, those are the types of examples that they  
13 found where some organizations were not initiating  
14 condition reports.

15           Actions to review, to improve that is to --  
16 we'll look at the procedure again, make sure the  
17 procedural guidance is appropriate and complete for  
18 reviewing, for threshold for initiation. Then, but we  
19 don't want to wait until that review is done, and if we  
20 see things that need to be, you know, improved and we  
21 get that out, because procedure revision and the like  
22 can take longer than sometimes than you would like it  
23 to.

24           So, we will issue an expectations directive to  
25 communicate and reaffirm CR initiation criteria. And

1 then in June of next year, we'll perform another  
2 assessment in the area of how well we're doing on  
3 initiating these.

4 One of the things I did do with all these  
5 findings to try to get things onto the table quickly is  
6 made a presentation to the managers, the manager team of  
7 all the findings of this assessment, the QA reviews of  
8 the Corrective Action Program and our internal  
9 self-assessments. So, while we're going through and  
10 making the formal corrections, we have it on the table  
11 to remind people of what people are continuing to see.

12 So, that's the first area for improvement.

13 The next area for improvement as stated --

14 MR. REYNOLDS: I'm sorry, I  
15 thought you were --

16 MR. SCHRAUDER: Yes. Go ahead.

17 MR. REYNOLDS: You said you  
18 were going to issue the expectations directive because  
19 it takes longer to get the procedure out, if it needs to  
20 be revised.

21 MR. SCHRAUDER: Right.

22 MR. REYNOLDS: And I was just  
23 looking at your due dates from --

24 MR. SCHRAUDER: You're wondering  
25 why it's going to take so long to get the directive out.

1 MR. REYNOLDS: Well, it says  
2 the implement procedure changes if necessary by 12-30-04  
3 and directive is completed by 1-15-05.

4 MR. SCHRAUDER: Let me clarify.  
5 We'll have the review done for the threshold and the  
6 initiation by the 30th, by the end of this year. The  
7 procedure changes, any required procedure changes may  
8 not be completed yet at that time.

9 MR. REYNOLDS: Oh, okay. The  
10 statement just needs to be clarified. If I read it,  
11 implement procedure NOP LP 2001 changes, if necessary,  
12 by 12-30-04. This is in your letter to us dated  
13 November 15th.

14 MR. SCHRAUDER: I'm reading it  
15 off the slide. If that's what the, the middle said,  
16 then that's what the expectation is to complete the  
17 procedure change by then.

18 I think I understand your point. The interim  
19 action will be done after the final action.

20 MR. REYNOLDS: If those dates  
21 are correct. I didn't know if those dates are correct.

22 MR. SCHRAUDER: We expect to get  
23 this expectations directive out next week or probably  
24 yet this week.

25 MR. REYNOLDS: Maybe it should

1 be 12-15-04.

2 MR. SCHRAUDER: I had that  
3 discussion with performance improvement to get this out.  
4 So, point noted.

5 Go ahead, Jack.

6 MR. GROBE: Yeah, Bob, is  
7 this expectations directive, is this standard across the  
8 FENOC sights or unique to Davis-Besse?

9 MR. SCHRAUDER: This will be  
10 unique to Davis-Besse, again as an interim action to  
11 make sure we don't wait for the process to drive all the  
12 changes. We want to make sure that we identify the  
13 specific areas that were identified here, where our  
14 folks are not initiating a condition report when they  
15 should be. Okay.

16 Next area for improvement states that the  
17 process for prioritizing scheduling and extending work  
18 does not consistently support the timely implementation  
19 of actions to fix longstanding problems.

20 This area for improvement discussed with the  
21 team is specifically aimed at the backlog of corrective  
22 actions that exist today. Certainly, our team  
23 recognizes the need to aggressively pursue and eliminate  
24 the backlog of Corrective Action Program open items.

25 And, you know, as we went through this

1 process, we did identify those things that we had  
2 committed and stated we would get done prior to restart,  
3 whether it was the evaluation of the condition or actual  
4 fixing of the, you know, implementing the corrective  
5 actions. And we had the process of another set of them,  
6 we said we would complete after restart. And that's  
7 where we're at right now.

8 So, we did go through a process that put them  
9 in one bin or another. And, now, it's our job to get  
10 after those and get them completed.

11 I believe we have shown some good progress in  
12 that regard when you look at the conditions adverse to  
13 quality. When we restarted the unit, we had a little  
14 over a thousand evaluations that were open, that were to  
15 be done post-restart. We currently have 311. Or as my  
16 data point late last week, we had 311 evaluations.

17 But in the process, we had also initiated an  
18 additional almost 1900 evaluations that were initiated  
19 and completed in that time frame. So, we've been pretty  
20 busy in getting this backlog work down.

21 Then, for the corrective actions that are  
22 associated with significant conditions adverse to  
23 quality and conditions adverse to quality; when we  
24 restarted, we had about 5,300 open corrective actions.  
25 And we've reduced that now to about 3,500, 3,600 range,

1 and also have generated an additional 2,700 in that time  
2 period. So, we have made some pretty good progress in  
3 working on the condition adverse to quality backlogs.

4 And we expect, as I think Barry said earlier  
5 or Mark, that by the end of the 14th refueling outage we  
6 will effectively converted what was the backlog into a  
7 normal workload or through put for the Corrective Action  
8 Program.

9 MR. REYNOLDS: As far as that  
10 backlog, if I remember correctly, you talked before,  
11 that your workload you were getting to, you benchmarked  
12 that to determine what that should be; am I correct on  
13 that?

14 MR. SCHRAUDER: That's correct.  
15 What we benchmarked, Steve, was the, the overall  
16 workload, everything that we're working on at the site.

17 MR. REYNOLDS: I just wondered,  
18 benchmarking is a good thing. And I was wondering if  
19 you benchmarked how long it took other plants coming out  
20 of extended shutdown to get to their workload number, to  
21 see if two years is consistent with that, ahead of  
22 schedule, or behind schedule; if you know it from a  
23 performance standpoint, how does that track?

24 MR. SCHRAUDER: I can't answer  
25 that absolutely. I can tell you that I believe we are

1 on a track to get our backlog done sooner than some  
2 others have. So, we have made pretty substantial  
3 progress, I think consistent progress in the months  
4 that, since the unit has restarted.

5 MR. REYNOLDS: Two years seems  
6 long to me, but it may be you lose track of times in the  
7 other plants.

8 MR. SCHRAUDER: Seems short to  
9 us when we're in here working on it. Respect your  
10 perspective.

11 MR. REYNOLDS: Yes, it does.

12 MR. SCHRAUDER: We've looked at  
13 it. And part of what I was doing, the senior management  
14 team got together, based on some of the comments here,  
15 because one of the activities that we had put in the  
16 post restart, or after restart, we had a recurrence of  
17 that issue, which is what your, why you don't want a  
18 backlog, because it can happen again if you haven't  
19 gotten the corrective action in place yet.

20 So, the senior team sat down. We went through  
21 all of the open items from significant conditions  
22 adverse to quality, our apparent cause evaluations for  
23 conditions adverse to quality, and what we used to call  
24 basic cause evaluation, which in our old vernacular of  
25 the system was between a root cause and apparent cause.

1           We went through every one of those corrective  
2 actions to see whether the current schedule we felt was  
3 appropriate and adequate; whether we needed to pull any  
4 of those up; whether, where they were currently  
5 scheduled, whether we felt like we needed to put any  
6 interim actions in place, to help try to prevent them  
7 recurring again.

8           So, we've looked at that backlog again in a  
9 fair amount of detail to assure ourselves that we think  
10 it's appropriately scheduled and can be worked off.

11           MR. REYNOLDS:           Okay.

12           MR. SCHRAUDER:           This action plan  
13 is the, we talked about this to create a comprehensive  
14 integrated backlog reduction plan that looks at the  
15 Corrective Action Program, the Maintenance workload, if  
16 you will, the Engineering workload, procedure change  
17 request; pull all that stuff together to make sure we're  
18 on a path to efficiently reduce that backlog within the  
19 time frames that we've just spoken.

20           MR. SUH:                 Bob, just a  
21 question, I'm sorry. In the commitment letter, the  
22 creation of the integrated backlog plan is December  
23 31st.

24           MR. SCHRAUDER:           That's correct.

25           MR. SUH:                 And then the

1 word, the verbiage says "implement the integrated  
2 backlog reduction plan, March of 2006."

3 MR. SCHRAUDER: That's right.

4 MR. SUH: And I was  
5 wondering what the word implement in that case meant.

6 MR. SCHRAUDER: That's another  
7 way of stating what I think we've already said, and that  
8 is we will be through the backlog by the end of March of  
9 '06 or approximately the end of the 14th Refueling  
10 Outage. And we believe that we will be done with  
11 backlog, and back to workload at that time.

12 MR. SUH: Just a  
13 suggestion, I think the word is, could be interpreted a  
14 couple ways; and just to tie into Steve's, Steve  
15 Reynolds' comment before on the previous commitment, on  
16 the previous AFI, implementing the procedure change. I  
17 agree with Steve, that's a little bit, the wording there  
18 might be, you folks might want to take a look at that.  
19 Not only on this one.

20 I guess I'm just, just seems like different  
21 readers would interpret the word implement differently  
22 here, unless it's more fully explained somewhere else.

23 MR. SCHRAUDER: No, it's not  
24 fully explained, and I appreciate your input. And I  
25 just want to let you know, I mean, we can look at

1 revising the words, if we need to, but specifically our  
2 intent was that that means we'll create the plan by the  
3 end of this year; we'll work through the plan by March  
4 of '06, and have the backlog completed at that time.

5 MR. SUH: Right, right.

6 And, what I meant by Steve's previous comment was about  
7 implementing the procedure.

8 MR. SCHRAUDER: Right.

9 MR. SUH: I think your  
10 first interpretation was, made sense to me, Bob, you  
11 were going ~~the~~ to evaluate it by December 30th, but if you  
12 do a procedure revision, that obviously takes longer;  
13 and, so, you know, the comment was that maybe just a  
14 verbiage needs to be changed.

15 MR. SCHRAUDER: I think I was  
16 wrong in my response to Steve. I think he was right;  
17 we're supposed to have the procedure done if it needs to  
18 be revised by then. I have to look at that, but I  
19 believe that's what we meant by that.

20 MR. SUH: So, you'll check  
21 that?

22 MR. SCHRAUDER: Yes.

23 MR. SUH: Okay, fine.

24 MR. SCHRAUDER: Next area of  
25 improvement is a review of open corrective action

1 implementation extensions classified as nonrestart,  
2 should be conducted to ensure appropriate compensatory  
3 actions are in place. I discussed this on the previous  
4 slide; where this is, this is the issue where we had one  
5 or two, as I recall, there was only one instance that  
6 they pointed to that we had a repeat occurrence of one  
7 of our conditions, corrective actions that we put into  
8 the backlog.

9         So, our actions to improve this, as I stated,  
10 were to review the backlog of significant conditions  
11 adverse to quality and conditions adverse to quality,  
12 root and apparent causes.

13         We looked specifically at preventative and  
14 remedial actions to consider whether we needed to pull  
15 any of them up or put in interim compensatory measures.

16         Now, eventually, what we're going to do with  
17 our, with the CREST system, which is the software that  
18 drives the Corrective Action Program, is we'll require  
19 in the future when people request an extension to one of  
20 these types of preventative or remedial actions, they  
21 will specifically have to address and ask and answer the  
22 question and document their response as to whether an  
23 interim action is required due to this extension; and if  
24 not, why not.

25         So, and again, rather than wait to get that

1 completed in CREST, because software changes can  
2 sometimes take awhile too, Mark has put out an  
3 expectations directive on this too, that says, in the  
4 interim while we're waiting for the CREST change to do  
5 it, to force you to do it, we want you to do it as a  
6 matter of business, in addition to the procedural  
7 requirements right now. And we have begun to do that.

8 Now, the only people that can extend  
9 significant conditions adverse to quality and conditions  
10 adverse to quality at root or apparent cause level are  
11 the Directors and Mark. And, therefore, it's a rather  
12 small audience that really has to maintain awareness of  
13 that. We usually do not like to do things by directive;  
14 we want it in procedures, but in this case, it's a very  
15 small population of individuals that has the  
16 responsibility to make sure that's done. So, we think  
17 we'll be successful in that area.

18 Questions on this one?

19 MR. SUH: I just fully  
20 wanted to understand, Bob, did I understand you to say  
21 when you get an extension, it can only be at the  
22 directive level or you were talking on a very specific  
23 population?

24 MR. SCHRAUDER: I'm sorry, Gene,  
25 could you repeat the question?

1           MR. SUH:           I'm sorry. On  
2 the commitment in your letter you say, "condition report  
3 process procedure currently states that corrective  
4 action extensions are to consider the need for interim  
5 actions."

6           Let's see. Well, let's see. I guess I'm not  
7 quite sure where I made my comment here. I was  
8 wondering, when you get an extension, is that, do you  
9 require a higher level of approval than the original  
10 sets of approvals or is it the same level?

11          MR. SCHRAUDER:        An extension for  
12 these levels requires director or vice president for  
13 significant condition adverse to quality. The initial  
14 setting of that corrective action due date is driven by  
15 procedure. So, there is specific default values that  
16 you can not exceed. You can always put one in earlier,  
17 but you can't exceed certain levels. So, as long as  
18 you're within that time frame, Mark does not have to  
19 approve those.

20          They do however go to the Corrective Action  
21 Review Board. And if the Corrective Action Review Board  
22 doesn't believe they're timely enough, we can, we can  
23 accelerate the due dates too. But once that due date is  
24 established, then it requires vice presidential approval  
25 for continuation.

1 MR. SUH: For significant  
2 conditions?

3 MR. SCHRAUDER: Right, and for  
4 conditions adverse to quality at the root and apparent  
5 cause levels, it requires a director's approval to  
6 extend those.

7 MR. SUH: Thank you.

8 MR. SCHRAUDER: The next one  
9 addresses the trending program, and the area for  
10 improvement states that we have not aggressively worked  
11 to correct Corrective Action Trending Program  
12 deficiencies identified in previous self-assessments or  
13 oversight findings.

14 Team went back as far as the NRC Corrective  
15 Action Team Inspection, where we identified that we had  
16 at that time suspended the trending program. We did  
17 that as a conscious management decision through the  
18 course of the recovery, because there was so many  
19 condition reports being generated with the same types of  
20 things like the boric acid inspection walkdowns and the  
21 like. And we didn't think that we were going to get a  
22 lot of value from trending during the period of that  
23 time.

24 And, really, I think the Corrective Action  
25 Team Inspection's thrust was, hey, you're waiting too

1 long to get this thing reinitiated. And we did  
2 reactivate it. We did reinitiate the trending program.  
3 And we went back and did trend back to the point that we  
4 had suspended that.

5 Since that time, we've looked at other sites.  
6 We hadn't tried to incorporate or improve the quality of  
7 the assessments so that they become a better tool for  
8 management and to make sure that management is in fact  
9 using the trend report, so we have incrementally  
10 improved that thing, and have responded to  
11 self-assessments and the like, but the trend report was  
12 not where either we wanted it or where the peers thought  
13 it should be at. And, so, we continued to improve that.

14 I will tell you that we just recently finished  
15 the third quarter for this year's trend report, and it  
16 has gotten a fairly good marks from our CNRB, our own  
17 management team. We did go out to the management team  
18 also and solicit their input on what would make a  
19 meaningful trend report to them. So, this latest one  
20 that came out was felt to be pretty good.

21 The thing with trend reports is they need to  
22 be relatively simple in that the reader needs to be able  
23 to pick them up and not have to really figure out, you  
24 know, through a lot of detail what trend are you trying  
25 to point out to me. But they have to be accurate, and

1 they have to take specific actions when trends are  
2 identified.

3 So, I think we're going there. Now, the team  
4 also, this assessment team, identified a concern in the  
5 report that said, hey, you know, you've been a little  
6 bit slow getting this thing up and good quality and  
7 stuff; now you're transferring it to the fleet, as a  
8 fleet initiative, and we're concerned that that's going  
9 to delay it even further.

10 First of all, it's true that the trend process  
11 will be a fleet wide process. It will be a common  
12 process, with responsibility in the fleet for that trend  
13 report, but we're not waiting, again, at Davis-Besse  
14 until that product is finalized. We're continuing to  
15 mature the trend report that we're currently using here,  
16 again, to make it useful for us and to make sure our  
17 management team is using it.

18 When the fleet finalizes the product, we'll  
19 then go through a changed management process and adapt  
20 the new fleet, but we're not waiting for that one to  
21 improve the one that we have.

22 MS. LIPA: Bob, you  
23 mentioned that the third quarter trend reports that you  
24 just completed, you had pretty good product. Did the  
25 Independent Assessment Team come before those were

1 issued?

2 MR. SCHRAUDER: Yes, it did.

3 MS. LIPA: So, they didn't

4 have the benefit of looking at those.

5 MR. SCHRAUDER: That's correct.

6 MS. LIPA: The other thing

7 I was wondering about, in the Cycle 14 Improvement Plan,

8 you had an action to reestablish the Corrective Action

9 Program Trending Process, which you declared complete on

10 February 2004.

11 So, since you already declared it complete,

12 did you have anything in the works to revisit the

13 effectiveness of it or was it kind of off the radar

14 screen until this independent team came in?

15 MR. SCHRAUDER: No, it wasn't

16 off the radar screen, we were continuing even before

17 they came in to look at it, to benchmark other

18 facilities, and to improve that, that document. It

19 wasn't off our radar screen.

20 MR. BEZILLA: Our

21 self-assessment I believe identified the need to

22 continue to improve that, and we had done benchmarking

23 and Bob's performance improvement guys were around prior

24 to this independent team coming in and looking, asking

25 for, hey, which form do you like, what format do you

1 like, that kind of stuff.

2 So, the third quarter model is already being  
3 worked on when they were here, but we didn't have a  
4 product out at the time that team was here.

5 MS. LIPA: Okay.

6 MR. SCHRAUDER: So, listed here  
7 are the actions that we have taken or will take to  
8 improve the trending report; benchmark other sites,  
9 we'll continue benchmarking and this will be done  
10 through the fleet at this time; enhance the quarterly  
11 trend report, which we believe we've done with the third  
12 quarter trend report and we'll continue to enhance that.

13 Improve the guidance concerning timeliness for  
14 performing and completing collective significance  
15 review. Another part of the trending process is not  
16 just site wide process, but individual sections do  
17 trending also. And, so we'll improve the guidance for  
18 the development and the implementation of those reviews  
19 or trend reports, if you will.

20 MR. GROBE: Bob, does that  
21 involve the expectations directive or is that a  
22 procedure change?

23 MR. SCHRAUDER: That will be a  
24 business practice, Jack. There is a business practice  
25 for doing it now, but we're reviewing that business

1 practice again to make sure it has appropriate guidance  
2 and clear guidance to consistently do these and raise  
3 the quality of them.

4 We still have initiative to develop and  
5 implement a site-wide equipment trending program. And  
6 a FENOC common trending program, which should be  
7 completed by the end of January of '05.

8 MR. REYNOLDS: Now, I don't  
9 know if this is the way you structured your slides, but  
10 I also see in your letter to us, you make a distinction  
11 between the site-wide equipment trending program to  
12 develop and implement for the FENOC common trending just  
13 to develop. I assume you mean, also implement the FENOC  
14 common trending program.

15 MR. SCHRAUDER: That's correct,  
16 Steve. Once it's developed, we'll implement it.

17 MR. REYNOLDS: Thanks, but I  
18 just ask you then to formally update your letter.

19 MR. SCHRAUDER: We can do that.  
20 I had to be a little careful with that one, because when  
21 we're developing the FENOC common processes, okay, there  
22 is a subsequent implementation schedule for putting them  
23 in, and it may be, it varies depending on what is going  
24 on at that time at the site. For instance, if we're in  
25 the middle of an outage, we wouldn't at Davis-Besse

1 necessarily implement it as soon as it's developed and  
2 released from the fleet.

3 MR. REYNOLDS: I'm not, I  
4 guess, what date you put, I'm asking that you do plan on  
5 implementing it, that you make that commitment to  
6 implement the new effective date, that that makes sense  
7 for you.

8 MR. SCHRAUDER: Yes, sir, got  
9 it.

10 MR. GROBE: Just a quick  
11 question, Bob. This site-wide equipment and trending  
12 program, how does that relate to your maintenance rule?  
13 Did you understand the question, Steve?

14 MR. LOEHLEIN: Yeah, I think,  
15 let me see if I can paraphrase it back to you. You're  
16 asking to link the maintenance rule program to the  
17 site-wide equipment trending program.

18 MR. GROBE: Is this going to  
19 be part of your system health reviews, or what is this  
20 site-wide equipment trending program?

21 MR. LOEHLEIN: The site-wide  
22 equipment trending program is intended to directly  
23 support system health. That's correct. But it's still  
24 only in development for the site. And I think the plans  
25 are to make that FENOC-wide later, but we don't have

1 that currently at issue.

2 The existing corrective action covers that,  
3 Jack, I believe has a due date at the end of the year  
4 for that, and there are folks working on that right now,  
5 but there is a tie in a supportive system health as the  
6 primary objective that, that whole effort.

7 MR. THOMAS: Help me  
8 understand what the difference between what this program  
9 will provide and what's being done on a system basis now  
10 by the system engineers?

11 MR. LOEHLEIN: I would suggest since I didn't  
12 prepare a lot of background topic for this meeting,  
13 maybe I just bring it with me next time when I talk  
14 about the engineering assessment, and bring that along  
15 as a topic, and by then we should have a lot more to  
16 talk about.

17 MR. THOMAS: Okay.

18 MR. SCHRAUDER: Anything else on  
19 trending?

20 Okay, the next area for improvement is, is  
21 that improvement is warranted in the documentation of  
22 organizational collective significance self-assessments  
23 with respect to minimal procedure guidance,  
24 expectations, documentation, documentation of condition  
25 reports, and overall performance rating.

1           We've talked about this a couple of times  
2 already. These are the Collective Significance Reviews.  
3 This team, as well as our self-assessment, identified a  
4 variety of quality, I'm going to say, on these. And  
5 this again goes to our condition reports being written  
6 for noteworthy items, getting condition reports out for  
7 areas for improvement.

8           And are the areas, are that the sectional  
9 managers reaching an overall statement of their  
10 performance, they're given an overall rating. Some  
11 were, some were not in this regard. So, we're looking  
12 at, making sure the procedural guidance is clear enough  
13 in that regard, and then establishing expectations for  
14 the format and documentation, and making sure that there  
15 is a requirement for an overall rating.

16           MR. GROBE:           Where would  
17 those expectations be captured?

18           MR. SCHRAUDER:       In a business  
19 practice.

20           Next area for improvement is, self-assessment  
21 process does not provide a mechanism for identifying and  
22 correcting programmatic concerns or trends identified  
23 during the course of the assessment. This came from one  
24 of our peer, a couple of the peer reviewers, and may not  
25 be real evident what that means, but I spent quite a

1 deal of time talking to them.

2           What they were getting at is, if we do an  
3 assessment, a programmatic assessment, let's say for  
4 example, the AOV programs that we're assessing. We do a  
5 self-assessment or collective significance assessment  
6 and we find let's say four or five different things or  
7 areas for improved -- to improve in that  
8 self-assessment. The process currently doesn't drive  
9 you to say, okay, I found these things, I'm going to go  
10 fix them, but what is the status of the equipment out in  
11 the field that I've used this program to use? And there  
12 is no finding that we don't, you know, that there is an  
13 impact out in the field. This is a process issue that  
14 says you're not driven to go do and make that assessment  
15 and document that assessment of what's the impact on, in  
16 this case equipment out in the field.

17           The peers that we talked to have this in their  
18 process and they're going to send us their, how their  
19 process drives that assessment when you get there. So  
20 that's another business practice that we'll be looking  
21 at to make sure we have proper guidance there, and the  
22 programmatic concerns are captured.

23           MR. REYNOLDS:           If I was to add  
24 on to your bullet then, you said it was to consider  
25 potential aggregate impact of programmatic concerns or

1 trends on plant equipment.

2 MR. SCHRAUDER: Well, plant  
3 equipment, Steve, was just an example I was using. It  
4 could be other, could be in the Corrective Action  
5 Program, and you find findings here; what's the impact.

6 MR. REYNOLDS: But at least on  
7 plant equipment, it's not just a programmatic procedure  
8 process review?

9 MR. SCHRAUDER: It is the  
10 collective result of what does that mean in the  
11 aggregate to the program you just assessed, and what  
12 that program is supposed to protect you against.

13 MR. REYNOLDS: It's not just  
14 looking at the program, let's go improve the program.  
15 The effect on those problems had on whatever the program  
16 touched.

17 MR. SCHRAUDER: Right, that's  
18 correct.

19 MR. REYNOLDS: May be  
20 equipment, may be Corrective Action Program, may be  
21 operator training, maintenance training, whatever  
22 happens to be.

23 MR. SCHRAUDER: That's correct.

24 MR. REYNOLDS: Thank you.

25 MR. SCHRAUDER: And the last

1 area for improvement is that additional access is  
2 warranted on timely correction of items identified by  
3 self-assessments and the nuclear quality assurance  
4 finding.

5 This is a two-prong thing. First of all, it's  
6 if additional access warranted, and that goes to the  
7 backlog and if there is more things there than we like.  
8 Some of them, as long as we have a backlog, are going to  
9 be from self-assessments and nuclear quality assurance  
10 findings.

11 There was a sense, at least among part of that  
12 team, that the fact that these issues were identified in  
13 self-assessments or by quality assurance, they should by  
14 that virtue alone have a higher priority placed on them,  
15 a higher timeliness. We have taken exception to that  
16 area, and our position, and we believe the industry norm  
17 is, that findings are prioritized in accordance with  
18 their safety significance, not by who found them, or  
19 what process found them.

20 So, we will go out and benchmark and make sure  
21 that our understanding of the industry norm is as we  
22 find it, but what we believe very strongly in that,  
23 priority should be based on the safety significance of  
24 the issue and not on who or what process found it.

25 MR. HRUBY: Nuclear

1 Oversight agrees with the line on this, that the safety  
2 significance of the issue should dictate the timeliness  
3 of resolution, not who generated it.

4 MR. REYNOLDS: If that's the  
5 case, why are you going to go sample to see if the, it's  
6 being done at comparable rates, if the rates don't have  
7 much meaning, if it's not safety significant?

8 MR. SCHRAUDER: We want to make  
9 sure that we're not an outlayer, that's why we'll go out  
10 and benchmark that.

11 MR. REYNOLDS: Okay, even if  
12 the sites identifying were safety significant issues,  
13 NQA, who is going to benchmark. Like I said, I'm  
14 struggling.

15 MR. SCHRAUDER: I'm sorry. What  
16 we're benchmarking is to make sure that our priority  
17 culture mindset, if you will, that it doesn't matter who  
18 found it, it's the safety significance of the issue that  
19 sets its priority. That that is the industry norm.

20 MR. REYNOLDS: That I  
21 understand, but I guess -- okay. Then explain to me  
22 what you're going to compare then?

23 MR. GROBE: You talking  
24 about the last bullet, Steve?

25 MR. REYNOLDS: Yes.

1           MR. GROBE:           I wasn't sure I  
2 understood that either, Bob. If safety drives all the  
3 prioritizations, why are you discriminating between a  
4 certain categorized site identified CR and a NQA  
5 identified CR that are both the same. Are you thinking  
6 that the staff might be saying this one came from QA, so  
7 let's set it aside?

8           MR. SCHRAUDER:       I understand the  
9 question now. The reason that's in there is to make  
10 sure that we're not stifling QA's findings, and that we  
11 are in fact addressing them commensurate with -- one  
12 comparison is how are we doing on those as to how we're  
13 doing on other findings to make sure we're not on the  
14 other side of that spectrum and not addressing QA's  
15 issues in a timely manner.

16           I believe Ray has already looked at that.

17           MR. HRUBY:           We have a Cycle  
18 14 LIP indicator that measures timeliness and  
19 responsiveness of the organization to quality generated  
20 condition reports and corrective actions and the like.  
21 And we see that they're pretty much in alignment. The  
22 lines responding in about as timely a manner to line  
23 initiated condition reports as they are to the quality  
24 condition reports.

25           MR. SCHRAUDER:       Then the last

1 slide does identify the fact that they did, in fact,  
2 find some positive things in their write-up for us.

3 They were complimentary of the systematic  
4 approach to training that we took. Specific examples  
5 they identified were the CR analyst and the Corrective  
6 Action Review Board members, but we actually applied the  
7 systematic approach to training to all of the training  
8 needs in the Corrective Action Program; and we believe  
9 that that has helped us.

10 They made comment that the Corrective Action  
11 Review Board is effective and that we provided good  
12 consensus among the members on the Corrective Action  
13 Review Board and do provide an effective final barrier  
14 for condition reports.

15 They felt that management here at the site is  
16 knowledgeable of the program and areas that we need to  
17 improve the program in; that the management is involved  
18 in the program and are moving to improve the  
19 implementation of the Corrective Action Program.

20 They did comment that there is a backlog, but  
21 the backlog they can see we have been working on it and  
22 it is decreasing.

23 And, finally, I think an important finding is  
24 that this Independent Assessment does reflect  
25 Davis-Besse's self-assessments in its program. That is,

1 we didn't find anything really new in this process.  
2 There were some repeat findings, I guess I would say,  
3 but fundamentally, nothing really new came out of this  
4 assessment that we didn't know and have in our  
5 self-assessment that we needed to continue working on.

6 Unless there is additional questions, that  
7 concludes my remarks.

8 MR. SUH: I had a  
9 question. In the executive summary of the Independent  
10 Assessment Report, they talk about, they made a  
11 recommendation at the end about an integrated plan. Let  
12 me just read it to refresh your memory, refresh some  
13 peoples memory.

14 They said that based upon the ~~writing~~ rating of  
15 marginal and the number of repeat findings the team  
16 recommends an integrated approach for improvement and  
17 they recommended, paraphrasing, they recommended that  
18 the Davis-Besse staff develop an integrated action plan.  
19 And I was wondering, is that in the commitment list?

20 MR. SCHRAUDER: It is not in the  
21 commitment list we sent to you. I can tell you that we  
22 have accepted that recommendation and we are developing  
23 an integrated plan for improvements to the Corrective  
24 Action Program, as well as this integrated plan for the  
25 reduction of the backlog. So, we have accepted that

1 recommendation from the team.

2 MR. SUH: Okay. So, but  
3 it's not on commitment list?

4 MR. SCHRAUDER: No, the  
5 Confirmatory Action Letter was specific about what they  
6 wanted us to get back to and commit to the regulator on  
7 these assessments, and it was on the areas for  
8 improvement identified in the report. That was not an  
9 area for improvement, it was a recommendation that we  
10 nonetheless have accepted.

11 MR. SUH: Okay, thank you.

12 MR. GROBE: Just one  
13 observation. This is the first time I've seen in your  
14 vernacular this concept of an expectations directive. I  
15 wasn't exactly clear on what that was. I just caution  
16 you to be careful to not create a work-around. I'm not  
17 sure if that's what it is, but it kind of sounds like it  
18 might be a work-around to procedure.

19 My experience is you have procedures and you  
20 train to procedures. That this is a training element  
21 that you're going to go out and train people to; it's a  
22 training document. I'm not sure what an expectations  
23 directive is.

24 MR. SCHRAUDER: What it was is a  
25 memo from Mark to start doing it now before the

1 procedure is changed. And the procedure is the formal  
2 correction of the process. So, it's not intended to be  
3 a work-around, but I understand your point. We don't  
4 typically run the plant by memo either, but it's another  
5 one of those we didn't want to wait when we could take  
6 some action right now and make it clear what our  
7 expectations are to the staff.

8 MR. GROBE: Okay. Very  
9 good. Thanks.

10 MS. LIPA: Unless there is  
11 any other questions, this is a good time for a ten  
12 minute break. So, we'll be back in ten minutes. Thank  
13 you.

14 (Off the record.)

15 MS. LIPA: Okay. Go ahead,  
16 Mark.

17 MR. BEZILLA: Thank you,  
18 Christine.

19 Our next slide, Kevin.

20 In regard to Safety Culture/Safety Conscious  
21 Work Environment, what has occurred since the last  
22 public meeting. Mr. Wright of your staff was on site to  
23 look at various Cycle 14 Operational Improvement Plan  
24 items and packages.

25 We conducted our annual internal Safety

1 Conscious Work Environment Survey. Our Nuclear  
2 Oversight Department conducted a number of interviews as  
3 part of their annual Safety Culture/Safety Conscious  
4 Work Environment Assessment preparations. We conducted  
5 our site annual Safety Culture Assessment.

6 And, finally, our Confirmatory Order  
7 Independent Assessment of Safety Culture/Safety  
8 Conscious Work Environment was initiated with surveys,  
9 interviews, and observations being gathered. That team  
10 is currently analyzing the data and has forecasted to  
11 deliver preliminary findings and conclusions the week of  
12 December the 20th and we think it's going to be on the  
13 21st.

14 Next slide, please.

15 Now, let me spend a few minutes on the recent  
16 internal Safety Conscious Work Environment Survey  
17 results. We noted some less positive results in a  
18 number of questions and across a number of sections.  
19 This is noteworthy because last November we also saw  
20 some less positive results.

21 Just looking on the surface, one could  
22 conclude that these results are not surprising. Why,  
23 what had recently occurred or was going on at the time  
24 of or just before the survey? A couple of examples.

25 We had just recently on August 23rd

1 implemented a new organization where we implemented a  
2 common structure, which resulted in some reductions in  
3 staffing. We had union contract negotiations in  
4 progress with both of our union locals. And we had just  
5 recently presented a case study on an industrial safety  
6 near miss that occurred this past March. And in that  
7 case study, we talked about the various barriers and how  
8 those barriers had been breached. However, the last  
9 barrier had kept us from having an event and kept it to  
10 a near miss.

11           Could these things influence the result?

12           Maybe. However, I don't want us jumping to  
13 conclusions. So, what have we done so far? We've  
14 reviewed the results as a management team through the  
15 superintendent level. We obtained some external  
16 assistance to help us understand what these survey  
17 results are telling us, and to take an independent look  
18 at the results and see what they think the results are  
19 telling us.

20           It should be noted that this team is  
21 essentially the same team that came in last December,  
22 and helped us after the last survey we did in November  
23 of last year.

24           We discussed the results with the staff. We  
25 had an All-Hands Session last Friday and we covered 'll

1 say the preliminary results and the themes. And we've  
2 met three times, superintendents and above with some  
3 facilitation to examine the results and ask why, why,  
4 why. Okay.

5 So, what's next? We're currently in the  
6 process of determining the drivers and the underlying  
7 whys for those less positive responses.

8 Some themes that we noted from our  
9 interactions and discussions: The reorganization  
10 appears to be an impact. Perception of schedule  
11 pressure is an impact. Timeliness and effectiveness of  
12 corrective action on my thing appears to be an impact.  
13 Perception of Employee Concerns Program confidentiality,  
14 and perception that management holds the work force more  
15 accountable than we hold ourselves.

16 Those are some of the themes that we've seen  
17 in the interactions and discussions we've had. And we  
18 need to understand those, so that we can take additional  
19 actions.

20 Once we're confident, we understand and have  
21 the whys, we'll figure out, determine the actions that  
22 we need to address those whys. We'll use our External  
23 Assistance Team to validate our conclusions, and we'll  
24 also use Doctor Haber's Confirmatory Order Independent  
25 Assessment of Safety Culture/Safety Conscious Work

1 Environment Report to provide a second check on our  
2 understanding of the drivers.

3 Two noteworthy positives, because there were  
4 positives, right, in the survey. First, employees  
5 recognized their responsibility to identify concerns and  
6 indicated that they would raise these concerns either  
7 through their supervisor, the Condition Report Process  
8 or the Employee Concerns Process. And second, employees  
9 have not experienced acts of retaliation or perceived  
10 retaliation.

11 So, this area, maintaining a robust Safety  
12 Conscious Work Environment atmosphere was and is a key  
13 focus area for I and my team.

14 Next slide.

15 MR. GROBE: When do you  
16 expect that, excuse me, that you'll understand the  
17 drivers and have these corrective actions identified?

18 MR. BEZILLA: Jack, we have  
19 the debrief at least on preliminary findings with Sonja  
20 December 21. And between then and now, I plan on  
21 meeting with my team a couple of more times. And I  
22 think we'll have the whys fettered out and we'll start  
23 forming what actions we need to take on what behaviors  
24 we want to change to impact, I'll say, the Safety  
25 Conscious Work Environment atmosphere. And then the

1 independent teams should be able to have something for  
2 us about that time, and we'll be able to look at Doctor  
3 Haber's report.

4 I believe we've actually already started the  
5 process of improving, I'll say, some of those  
6 perceptions. Let me give you an example. We gave the  
7 managers the results. We gave them the comments from  
8 their sections. We asked them to go look at those, and  
9 then meet with their folks and have some discussions,  
10 right.

11 One area, one of the managers went and got his  
12 folks together. And, one of the issues was  
13 reorganization. And it said, you know, "Hey, you guys  
14 got rid of the people that raised issues." Okay. "Or  
15 you got rid of my friend."

16 Okay. And he said, "Okay, have you raised  
17 issues?"

18 "Well, yes."

19 "Well, you're here, right?"

20 "Yeah."

21 "Have you raised issues?"

22 "Well, yes."

23 "Well, you're here."

24 Okay. And what he told them was, "I know why  
25 each of those five individuals are no longer here with

1 us, but let me give you a scenario. If you were one of  
2 those five, and I was sitting in here with a room of  
3 your peers, would you want me going over the five  
4 reasons why you aren't here anymore?"

5 And they said, "No, we wouldn't want you doing  
6 that."

7 And he said, "Okay. So, I know, right? And  
8 we've communicated to you. You all know. Just reflect;  
9 you know what the process was, right? There was  
10 knowledge, skills, abilities, okay, attitude. We went  
11 through that. Human Resources Department. We went  
12 through the Safety Conscious Work Environment Review  
13 Team. Make sure there was no harassment, intimidation,  
14 retaliation or discrimination. Okay, and we did that  
15 for every selection that we made."

16 So, my point was, just through that  
17 discussion, the feedback was, that individual, that  
18 manager could see some of the anxiety removed, maybe  
19 some of the stress removed. As far as my friend goes,  
20 that's a little harder to deal with, right, but from a  
21 positive standpoint, here's how we did it.

22 So, just the communication. I mean, we do do  
23 surveys to get input so we can go take action. And I  
24 believe we've actually already started some of that.  
25 But we don't want to try to jump to conclusions. We

1 want to understand the whys and formulate actions or  
2 behavior changes that we need to make to improve, I'll  
3 say, the results the next time we take a survey or check  
4 on our Safety Conscious Work Environment.

5 MR. GROBE: Well, we just  
6 got this report this afternoon, and I've had some time  
7 to look through it, but certainly not have had the  
8 opportunity to do a thorough review, but the fact that  
9 there is a negative trend in a number of areas is  
10 troublesome.

11 We had a negative trend last November and you  
12 brought in some help and evaluated things and things  
13 improved. Now there is a negative trend from that last  
14 November survey.

15 I hope that you're considering what types of  
16 interim actions can be taken between Novembers to make  
17 sure that you understand for significant activities that  
18 are ongoing the effectiveness of your communications,  
19 such that you do not continue to generate negative  
20 trends in your Safety Conscious Work Environment that  
21 are not disclosed until once a year; and so that you can  
22 take timely corrective actions.

23 I know that you have the Safety Conscious Work  
24 Environment Review Team in place. And you are  
25 attempting to use your changed management process to try

1 to minimize these impacts, but those activities have not  
2 been fully effective. And finding out that they haven't  
3 been fully effective once per year at the end of the  
4 year is, I'm not sure the most prudent approach.

5 So, in your consideration of what happened  
6 here and what behaviors you need to change, I hope you  
7 ponder what you might be able to do in the interim when  
8 you are implementing an activity that has the potential  
9 to negatively affect Safety Conscious Work Environment;  
10 and you do it in such a way that you hope it doesn't.  
11 Hopefully, there will be some way that you can assess  
12 that on a more timely basis, so that issues don't fester  
13 and you don't find out about them once per year.

14 MR. BEZILLA: Understand and  
15 agree. Okay.

16 Next slide.

17 This next slide depicts our recent Safety  
18 Culture Assessment results as compared to those from  
19 November of 2003. As you can see, the commitment areas  
20 remain white.

21 In the policy or corporate level commitment  
22 area, areas remain stable, with the exception being  
23 Nuclear Oversight where it improved to green.

24 In the plant management commitment areas -- in  
25 the plant management commitment area, areas maintain

1 stable, with the exceptions being the commitment to  
2 safety and commitment to continuous improvements, which  
3 improved to white.

4 And in the individual commitment area, areas  
5 remain stable with the exception being rigorous work  
6 control and prudent approach which improved to green.

7 The one area that remains stable at yellow,  
8 drive for excellence is an area of focus for us. The  
9 key inputs to this area that kept us yellow were some  
10 hardware metrics, where we have not yet achieved our  
11 goals. And second, a few metrics associated with the  
12 Corrective Action Program, timeliness, as an example,  
13 that aligned with the improvements we're working to  
14 achieve that Bob talked about a little bit earlier when  
15 he went over that Corrective Action Program actions.

16 A question one could have would be how did the  
17 Safety Conscious Work Environment Survey results  
18 correlate or not with the Safety Culture Assessment?

19 So, what we have to remember is that the Safety  
20 Conscious Work Environment Survey is an input to the  
21 Safety Culture Assessment. It's an important input, but  
22 it's just one of the inputs. And remember, there were  
23 noteworthy positives from that survey that were input  
24 into this Safety Culture Assessment.

25 So, in summary, I and my team are focused on

1 recent Safety Conscious Work Environment Internal Survey  
2 results to understand the drivers, and then determine  
3 and take the actions needed to address those drivers.  
4 And from a Safety Culture perspective, right, that being  
5 that assembly of characteristics and attitudes in the  
6 organizations and individuals which establishes an  
7 overriding priority towards nuclear safety activities,  
8 and ensures that issues receive the attention warranted  
9 by their significance, is maintained visible and is kept  
10 in the day-to-day dialogue amongst, I'll say, us and our  
11 people. All right?

12 Through this I believe we'll be able to assure  
13 safe and conservative operation at Davis-Besse.

14 Questions?

15 Okay, with that, let me turn it over to Barry.

16 MR. ALLEN: Thank you, Mark.

17 I would like to briefly discuss our continued  
18 positive progress and reducing our backlogs.

19 Next slide.

20 This is a graph of our total site workload,  
21 all documents, that we continue to steadily reduce our  
22 overall site workload.

23 Jack, although you recall we started up with  
24 over 18,000 individual work items earlier this year. We  
25 are now below 13,000 work items and turning in the right

1 direction. We feel like this is a good pace for us, and  
2 continue to have progress in the correct direction.

3 Next slide.

4 MR. GROBE: Barry, just so  
5 we understand these graphs. These include not only  
6 those activities that were open at the time of restart,  
7 but anything that's been generated since then?

8 MR. ALLEN: That's correct,  
9 Jack. So, if you see, all the incoming items, we're  
10 always generating new work items and that influx, that  
11 generation rate has been kept up with, and we're also  
12 working off additional items. So, this is overall  
13 total.

14 In the preventative maintenance area, we had  
15 the discussions earlier in the year about the  
16 preventative maintenance tasks which we had deferred  
17 from the extended outage because the equipment was  
18 unavailable to perform the ~~p.m.~~ PM tests on. At this  
19 point, we have worked approximately 96 percent of our  
20 deferred preventative maintenance backlog. And we only  
21 have 13 items left open total. That's not just the  
22 original ones, that's 13 total. And those are all  
23 scheduled to work. So, feel very good about the  
24 progress we've made in the preventative maintenance  
25 backlog area.

1 Next slide.

2 We also --

3 MR. THOMAS: Barry, just a  
4 quick question. On the preventative maintenance items,  
5 you're now reflecting the backlog number. Are a large  
6 number that are PMI, deep in their grace period. Would  
7 you say that's a high number of items, a low number of  
8 items, or about where you feel they should be? If I  
9 recall, 150 to 200 items, give or take.

10 MR. ALLEN: Scott, we would,  
11 the last report I had, we had, equivalent to nine  
12 percent would be in deep grace. Our current goal is to  
13 be less than ten percent. So, I would say we're  
14 satisfactory. We would like to, as we get these  
15 resolved, not have probably quite so many there, but we  
16 are within the goals that we set for this year, being  
17 less than ten percent deep in grace.

18 MR. THOMAS: Okay.

19 MR. ALLEN: In the  
20 corrective action arena, we continue to make very steady  
21 progress. You can see downward trend on condition  
22 reports, where we've gone from 3,900 to 1,100. And,  
23 again, corrective actions, a similar decline.

24 And just kind of in perspective, since the  
25 last public meeting, condition reports we've worked off

1 a total of 232 since we last met. And of corrective  
2 actions, we have 555 fewer corrective actions than at  
3 the last public meeting.

4 Next slide.

5 Procedure change requests. We had some  
6 earlier discussions about procedure change requests.  
7 This was not a focus item for us early in the year;  
8 however, late summer, early fall, we looked and realized  
9 that our procedure change request backlog was, I'll say,  
10 fluctuating fairly stable around 1,800 to say 2,200  
11 items.

12 So, therefore, as we discussed with the  
13 Operations effort, we began laying out our effort to go  
14 address our procedure change requests. Now we have that  
15 working. Still fairly early. But we still have  
16 resolved 17 percent of the backlog that we had  
17 identified in August, and have that trending in the  
18 proper direction.

19 Next slide.

20 In accordance with the Integrated Restart  
21 Report, we've now completed 27 of our 38 Appendix A  
22 commitments, and we've also completed 59 of 94  
23 Operational Improvement Plan commitments as scheduled.

24 So, really looking at our backlog in summary,  
25 we continue to work off approximately 750 more open

1 items each month than we receive. So, we feel very good  
2 about the progress we're making on backlogs.

3 MR. GROBE: Barry, on the  
4 Operation Improvement Plan and the Integrated Restart  
5 Report commitments, many of those are commitments to put  
6 some activity in place, but not necessarily complete it.  
7 Develop a program to accomplish something.

8 How are you tracking the implementation of  
9 those programs; where does that fall?

10 MR. ALLEN: I'm not sure.  
11 Well, I'll let -- Mark understood the question.

12 MR. BEZILLA: Jack, we have  
13 our Operational Improvement Plan performance indicators,  
14 and on a number of those items, in addition to putting  
15 the thing in place, we also have commitments to do like  
16 self-assessments or effectiveness reviews. So, those  
17 are a couple ways in which we can check how we're doing  
18 as far as performance.

19 MR. GROBE: Okay.

20 MS. LIPA: Barry, with the  
21 backlog reduction efforts, looks like you've been able  
22 to lower a lot of those numbers, but I wonder if you've  
23 done an assessment to see what kind of impact you might  
24 have from end of the year, vacation plans, preparations  
25 for the mid-cycle and the actual mid-cycle. Do you

1 expect that to kind of deter some of your progress here  
2 in the backlogs?

3 MR. BEZILLA: Let me answer  
4 that, Christine. So, you're right. And we expected  
5 through the holidays we'd probably flat line on the  
6 backlog reduction. And also when we get into our  
7 mid-cycle, that may be another area, another period of  
8 time where we would flat line. But I believe even with  
9 those two periods flat lining, we'll be able to achieve  
10 our 4 to 6 thousand steady state numbers by the spring  
11 of 2006.

12 And, as an example, over Thanksgiving, which  
13 was a pretty short week, it was like three days,  
14 although it was probably two and a half days. And, we  
15 still lowered our numbers by about 60 that week. So,  
16 even with that short week, we saw a reduction in overall  
17 numbers.

18 MR. THOMAS: Do you believe  
19 this reduction reflects a pretty good mix of more  
20 difficult items and easier items, or? I guess what I'm  
21 getting at, you could be working off the easier items to  
22 get this steady down slope on your work-off curve, and  
23 at the end be stuck with the bigger, more difficult  
24 issues to work off. I guess I'm asking what your  
25 opinion is on the mix of items that are being worked

1 off?

2 MR. ALLEN: Scott, you know,  
3 we've gone from an 18,000 something to 12,000. I don't  
4 think we had 6,000 easy things to go pick off, so.

5 MR. THOMAS: I don't want to  
6 minimize it by saying easy, but there are some of your  
7 corrective actions that are easier to fix than.

8 MR. ALLEN: What we focus  
9 the organization on and what we track and trend every  
10 week is how are we doing resolving those issues that  
11 have safety significance versus those items that are,  
12 say, nonsafety consequential, nonconditions adverse to  
13 quality.

14 And, so, for instance, on the latest graphs  
15 that I've seen, we continue to trend downward on the  
16 items that have the safety significance. And we're  
17 trending down much less lower or maybe more flat lined  
18 at certain times on the items that are nonconsequential  
19 with respect to safety.

20 The maintenance items, they're all laid out  
21 and scheduled per the equipment work weeks, you know,  
22 per the normal work week progress. So, it's just as the  
23 equipment trains or equipment is available to work on,  
24 we perform those.

25 And then, engineering, which is a significant

1 piece of the backlog, we started again with the highest,  
2 most risk significant safety systems to work through all  
3 the issues related to those.

4 So, we feel like we have a very balanced  
5 approach and strategy to make sure we maintain the right  
6 focus on the safety significant items.

7 MR. LOEHLEIN: I would like to  
8 add to that, Scott. In the engineering end, I would say  
9 it's more typically there are those items that take,  
10 become harder, but they just take more time because they  
11 involve modifications and specification replacement  
12 items and so forth. Some of that work is even going to  
13 be implemented until 14 RFO, so we have all the  
14 preparation work to do between now and then. And they  
15 tend to populate the items that we're going to be doing  
16 later.

17 So, the smart thing to do, which we've been  
18 doing now, is a lot of the smaller items that we can do  
19 now or act on now and taking care of in parallel perhaps  
20 with those longer duration implementation.

21 So, we think we have a good methodology we're  
22 applying to make sure we get to all of them during Cycle  
23 14 that we want to get to, but it is basically true that  
24 those that take longer to develop are the ones that are  
25 going to be done later in the period.

1 MR. THOMAS: Okay.

2 MR. REYNOLDS: Your backlog  
3 reduction effort, is that being accomplished by extra  
4 overtime by your current staff, or the addition of  
5 Davis-Besse staff, or the use of staff from outside  
6 Davis-Besse, but from FENOC or from contractors, or all  
7 the above?

8 MR. BEZILLA: Yes.

9 MR. REYNOLDS: All the above,  
10 okay. So, you expect, I guess, when you get down to  
11 your workload, that you no longer have your extra  
12 contractors, your extra FENOC staff, your extra  
13 Davis-Besse staff and overtime?

14 MR. ALLEN: That's correct.

15 MR. REYNOLDS: You don't have,  
16 I guess, lessons learned from this reduction, in how to  
17 deal with that when the time comes, reduction in  
18 personnel, if that's the case?

19 MR. ALLEN: Steve, one of  
20 the strategies we're using, for instance, this is while  
21 we're utilizing one of the procedures in condition  
22 reports. This is what we're working on in the  
23 Operations Department. We want to set up a backlog  
24 effort to go deal with the backlog. Okay. Meanwhile,  
25 we want the Operations Department to be set up in

1 dealing with incoming, right, so, we can get to the part  
2 that's set up to deal with real life incoming and  
3 maintain steady state.

4 Then as the backlog works off, we can disburse  
5 our resources back to wherever they came from. And when  
6 the backlog effort is gone, we will have been tracking  
7 and trending on how we're doing on what we'll call our  
8 managed workload.

9 So, we're trying not to let those become  
10 confused in resources, intermingled there, if you will.  
11 We're trying to make sure we can manage our daily  
12 business and then we measure and monitor our backlog  
13 reduction.

14 MR. REYNOLDS: Sure, I  
15 understand. I was just thinking. I think when you're  
16 talking about the Safety Conscious Work Environment  
17 Survey, you implied or I inferred that part of that  
18 negative trend may have been the result of the  
19 reorganization with some people. And since you have  
20 extra staff for your backlog effort, I was asking you,  
21 were you going to do anything different or were you  
22 sensitive to that impact by letting those people go when  
23 the time came?

24 MR. BEZILLA: Steve, when we  
25 went through the reorganization, we said what do we need

1 to run steady state. And Davis-Besse said, we're not at  
2 steady state, so we're going to need additional  
3 ~~resource~~ resources. So, we kept a number of temporary assignment  
4 individuals and we brought in some contracted ~~resource~~ resources  
5 to work on specific projects.

6 What we'll do, as Barry said, as those work off  
7 over the next year plus, we get down to our normal  
8 workload, we'll see if our resources can sustain the  
9 incoming and just maintain that level.

10 And we know we may have to adjust some resources at  
11 the site level or fleet site level to make sure that  
12 happens, but right now we think we have the right, I'll  
13 say, staffing supplemented by either temporary assigns  
14 or our contracted resource to work this backlog down and  
15 get us to steady state.

16 MR. REYNOLDS: I guess I'm not  
17 making myself clear. I understand that you got the  
18 right staff, and you're supplementing that, but even  
19 though you went to the right staffing level, you implied  
20 that that had a negative impact on the Safety Conscious  
21 Work Environment Survey, if I understood you correctly.

22 MR. BEZILLA: That's correct.

23 MR. REYNOLDS: My question was,  
24 when you get rid of the supplemental staff, even though  
25 it's, you know, you think it's the right thing to do;

1 are you going to management that from a communication  
2 standpoint, so you don't have a negative impact on your  
3 Safety Conscious Work Environment, if you're truly doing  
4 the right thing.

5 MR. ALLEN: Yes.

6 MR. REYNOLDS: So, people don't  
7 have a misperception -- misconception and has a  
8 negative; you are doing the right thing, you have a  
9 negative impact. That was my question, maybe I wasn't  
10 clear.

11 MR. ALLEN: I believe Mark  
12 talked earlier about reviewing and assessing the data,  
13 and then we're, with the management team, getting groups  
14 of folks together to ask them why folks say this; why do  
15 they feel that; why do they get that perception. Try to  
16 understand, you know, the issues that you're discussing.

17 And, we'll take that data along with Doctor  
18 Haber, the action plans, and we'll take, in response to  
19 that, should help us look for the future activities  
20 where if we need to do, apply those lessons learned in  
21 the future also, Steve.

22 MR. REYNOLDS: Okay.

23 MR. BEZILLA: Let me add one  
24 thing, Steve. When we get to the spring of 2006 and we  
25 get through the outage we should be at the 4 to 6

1 thousand level. And the people ought to say, we can do  
2 this, this isn't a problem, it's a normal work-week type  
3 stuff, and only occasionally due to emergent issues or  
4 problems do we have to come in and spend extra time.

5 So, the goal is to get us in that mindset, so  
6 when we get there, and the extra help goes away, it's  
7 like "No problem. We're good." Okay. That's where we  
8 want to end up.

9 MR. REYNOLDS: Right. I see.  
10 It would just be disappointing in December of 2006 or  
11 November of 2006 there is a negative trend of Safety  
12 Conscious Work Environment and that's because we let all  
13 the extra people go. Well, you didn't apply lessons  
14 learned. That's my point.

15 MR. BEZILLA: Got it.

16 MR. ALLEN: Next slide.

17 Thank you.

18 Next, I'll provide a brief update on our  
19 Mid-Cycle Outage preparations. Our Mid-Cycle Outage is  
20 scheduled to begin January 17th. Our major projects  
21 include our Once-Through Steam Generator Eddy Current  
22 Testing, also our Reactor Vessel Head and Under Vessel  
23 Inspections, also Boric Acid Corrosion Control  
24 Inspections, and also Reactor Coolant Pump Inspections.

25 Specifically, for the Reactor Coolant Pump

1 Inspections, Engineering has developed specific  
2 inspection criteria in accordance with regulations and  
3 ASME sectional letter requirements to inspect pump cover  
4 to gasket leakage to see, determine if any leakage  
5 exists.

6 If we do find reactor coolant pump outer  
7 gasket leakage in either reactor coolant pump; 2-1 or  
8 2-2, then we'll replace both reactor coolant pumps 2-1  
9 and 2-2. So, we have that criteria established by  
10 engineering. We'll perform that inspection. If we do  
11 have a leakage past the outer gasket, we do have  
12 contingency plans to go replace both pumps and the  
13 motors for that replacement and also refurbish; and  
14 that's on deck.

15 Our special projects --

16 MR. GROBE: During this  
17 Mid-Cycle Outage?

18 MR. ALLEN: During this  
19 mid-cycle, Jack.

20 Our special projects group is developing full  
21 contingency plans for that contingent effort.

22 MS. LIPA: Do you plan to  
23 walk down all four pumps to look for leakage or just  
24 these two?

25 MR. ALLEN: Just these two.

1 These two have not been replaced; the other two were  
2 previously replaced and we know the gaskets were in good  
3 shape. These we believe are in good shape, have  
4 confidence that they will make it to 14 RFO with no  
5 leakage, but we do want to be prepared; and if they do  
6 have leakage past the outer gasket, then we want to  
7 replace both during this mid-cycle.

8 MR. REYNOLDS: Do you happen to  
9 know when the last time the other two, when those  
10 gaskets, outer gaskets were replaced?

11 MR. BEZILLA: On group one,  
12 Steve?

13 MR. REYNOLDS: Pardon?

14 MR. BEZILLA: On group one.

15 MR. REYNOLDS: The two you're  
16 not going to inspect.

17 ~~MR. REYNOLDS~~ MR. BEZILLA: This past  
18 outage, I believe. Right?

19 Yes, that's correct.

20 MR. REYNOLDS: Thank you.

21 MR. ALLEN: In preparing for  
22 the mid-cycle, we've had two fleet reviews of our outage  
23 readiness. We've had a six-month readiness review in  
24 July. And we also had a two-month readiness review this  
25 past November. Additionally, since that time, we also

1 performed weekly outage project readiness reviews with  
2 the senior management team.

3 From an execution perspective, the Maintenance  
4 disciplines are walking down all their mid-cycle orders.  
5 And Operations is developing a playbook, if you will,  
6 which assigns throughout shutdown, outage, and startup,  
7 individual tasks at individual levels, who we plan on  
8 performing certain tasks.

9 So, we're getting that all laid out so  
10 individuals performing those activities will have plenty  
11 of time to prepare for those operational activities.

12 So, from a mid-cycle perspective and in  
13 closing, we believe we are poised for success in the  
14 mid-cycle outage. We will improve the material  
15 condition of the plant. And our shutdown outage safety  
16 implementation will be set.

17 Any questions on mid-cycle preps? If not, I  
18 would like to turn the presentation over to Ray.

19 MR. HRUBY: Thanks, Barry.

20 Good evening.

21 As Barry said, my name is Ray Hruby. I'm the  
22 new Manager of Nuclear Oversight, and I'm looking  
23 forward to working here at Davis-Besse in an independent  
24 oversight capacity to help to improve the performance of  
25 this station.

1           Senior management team here has already  
2 discussed some of the recent progress the station has  
3 made. Quality Oversight Organization agrees that some  
4 progress has been made; however, there is still room for  
5 additional improvement in several areas here at  
6 Davis-Besse.

7           Today, I will be presenting some of the  
8 Quality Oversight Organization's independent  
9 observations. And some of those observations include  
10 the third quarter assessment report findings, and also  
11 the Safety Conscious Work Environment interviews that we  
12 conducted in Nuclear Oversight.

13           MR. THOMAS:           Ray, can I ask  
14 you a quick question before you get started?

15           MR. HRUBY:           Yes.

16           MR. THOMAS:           I looked ahead,  
17 I cheated a little bit, to see what you were going to  
18 talk about. I have a specific interest, if you could  
19 cover as part of your discussion, the specific  
20 functional area that's Operations, where you talk about  
21 control room conduct and environment, surveillance  
22 tests, inspection schedule, technical specifications  
23 program, operator rounds and logs, chart quarters, and  
24 seminar readiness; and, specifically, the fact that in  
25 all those areas, nothing was rated higher than

1 marginally effective.

2           And I just wanted some insights from QA, why  
3 you think that is so. So, if you could weave that into  
4 your presentation, I would appreciate it.

5           MR. HRUBY:           I understand,  
6 you want some quality oversight insights on Operations'  
7 recent performance?

8           MR. THOMAS:           That's correct.

9           MR. HRUBY:           I want to begin  
10 by presenting some of the results from the Quality  
11 Oversight Organization's third quarter assessment.  
12 Quality Oversight audited 25 primary elements, 13  
13 program areas in the four functional areas during the  
14 third quarter. Continuous assessment process also  
15 continued to be implemented.

16           There are four performance categories that are  
17 used to rate the effectiveness of programs and primary  
18 elements. These ratings are fully effective or  
19 effective, not fully effective or satisfactory,  
20 marginally effective, and ineffective.

21           During the third quarter as shown on the  
22 slide, six primary elements were rated as fully  
23 effective, twelve were rated as satisfactory, and seven  
24 primarily element were rated as marginally effective.

25           The following is an overview of the primary

1 elements that were rated marginally effective. And in  
2 the Operations area, the primary elements of the control  
3 room conduct and environment and surveillance tests  
4 inspection schedule and technical specification program  
5 were both rated marginal.

6 I'm going to try to answer some of Scott's  
7 question.

8 What we're seeing is that Operations has  
9 improved in the conduct of some activities, like prejob  
10 briefs and also some areas in control room  
11 communications; however, there are other areas that need  
12 to be improved.

13 One of these that we've seen is conducting  
14 multi-discipline prejob briefs. And, we've seen a  
15 number of instances where the Operations group and the  
16 IAC group perhaps did not perform a collective prejob  
17 brief. And what happens is there could be a  
18 miscommunication. We've seen at least one incident that  
19 was caused by that, or at least a combination prejob  
20 brief may have contributed to that.

21 There are other cases where -- and again,  
22 we're seeing some of the same attention to detail issues  
23 that the line is observing; people pulling the wrong  
24 procedures. And I think some of that has to do with  
25 maybe a need for improvement in peer checking,

1 self-checking skills, implementation of Human  
2 Performance enhancement tools that we have, the  
3 event-free tools that we talk about.

4 Those are some of my insights. I don't know  
5 if that --

6 MR. THOMAS: Well, I assume  
7 you presented your, you know, you haven't waited until  
8 the completion of your reports to share the insights  
9 with management. I guess, I ask your opinion, have they  
10 been receptive, have the issues been entered in the  
11 Corrective Action Program, that effective corrective  
12 actions been at least proposed if not fully implemented  
13 to address your issues?

14 MR. HRUBY: Well, the  
15 Quality Oversight group wrote a number of condition  
16 reports; a number of them dealt with procedure  
17 compliance, steps not adhered to. Some of them had to  
18 do with records not being sent to records management,  
19 which also is procedure compliance issue.

20 We've seen some instances where operator  
21 response to annunciator annunciator alarms needs to be improved.  
22 Those were documented in condition reports by the  
23 oversight group and put in the Corrective Action Program  
24 and assigned to line management and they are responding  
25 to those identified conditions.

1 MR. THOMAS: Okay.

2 MR. HRUBY: Another area  
3 that was rated marginally effective was in the work  
4 management area, and it's the primary element of  
5 Maintenance work practices.

6 The Engineering area is also rated marginally  
7 effective and that was a reconciliation over the last  
8 two years. The Engineering area, which is all the  
9 primary elements, was reconciled during the third  
10 quarter.

11 In the Procurement area, the primary element  
12 of control purchased items and services. In the  
13 Corrective Action area, the primary elements of  
14 evaluation and also the ASME code work. And last in  
15 Training, the primary element of management and training  
16 processes and resources.

17 And all these primary elements were evaluated  
18 over a two-year period, except for Operations and  
19 Procurement, and those were evaluated over a period of  
20 one year and 18 months respectively.

21 Next, I want to talk about some of the  
22 independent insights and discuss some future focus  
23 areas. First, the Corrective Action Program is arguably  
24 the most important process in a nuclear power plant.  
25 Davis-Besse site has a relatively large backlog of

1 documents, especially condition reports and corrective  
2 actions. Although the line organization has made  
3 progress in reducing the overall document backlog,  
4 management needs to focus priorities on resolving  
5 conditions adverse to quality in a timely manner.

6         Second, I want to discuss organizational  
7 behaviors. There have been several past incidents that  
8 have occurred while restarting the unit from the outage  
9 and recovering from the recent August reactor trip.  
10 These include previously documented containment spray  
11 pump 1-1 breaker modification issue, the previously  
12 mentioned feedwater 78 valve near miss issue, and most  
13 recently the main steam safety valve issue.

14         Senior management needs to ensure that line  
15 organization behaviors continue to meet established  
16 standards and expectations, especially when the  
17 organization is under scheduled stress.

18         Third, as documented in the third quarter  
19 report, the Quality Oversight Organization continues to  
20 observe instances where the line organization is not  
21 always complying with procedures. Processes are  
22 designed to ensure the nuclear power plant is operated  
23 and maintained in compliance with the license design  
24 basis and other regulatory requirements.

25         Procedures were developed to implement and

1 control these processes. Proper and consistent use of  
2 and adherence to procedures is of the utmost importance  
3 to ensure these processes are working as designed.  
4 Additional management attention is necessary to ensure  
5 that individuals understand the importance of following  
6 procedures.

7         Next, I want to discuss some future focus  
8 areas. The first is, first future focus area is on  
9 Operations' performance, specifically in the area of  
10 technical specification compliance and also conduct of  
11 Operations.

12         The second focus area is the implementation of  
13 the recent FENOC reorganization. Since this  
14 reorganization is a significant change to the overall  
15 FENOC organization, Quality Oversight group has adopted  
16 a fleet approach to assessing the impact of these  
17 organizational changes on the individual station's  
18 performance.

19         Quality Oversight representatives from all  
20 three FENOC sites developed a common assessment plan and  
21 oversight personnel for implementing this plan by  
22 assessing respective station performance using the  
23 specific attributes. The results of this assessment are  
24 expected to be included in the first quarter of 2005  
25 report.

1           The third area of focus is training. The  
2 fourth area is the implementation of the Corrective  
3 Action Program.

4           In addition to the timeliness issues discussed  
5 above, there also been recent issues raised in regards  
6 to trending, self-assessments, prioritization, and  
7 corrective action closure. And Quality Oversight also  
8 identified many of these areas in the Corrective Action  
9 Program.

10          The last area is emergency preparedness, and  
11 this area is scheduled to be reconciled in the fourth  
12 quarter and will be documented in the fourth quarter  
13 report.

14          Quality Oversight intends to closely monitor  
15 these future focus areas.

16          Are there any questions to this point?

17          Okay, next I want to talk about the  
18 Oversight's Safety Conscious Work Environment interview  
19 results. Quality Oversight Organization performed an  
20 Independent Assessment of Safety Culture/Safety  
21 Conscious Work Environment at Davis-Besse by conducting  
22 interviews, from October 11th through the 13th of 2004.  
23 And the results of these were documented in a quality  
24 field observation. I believe you received a copy of  
25 those also.

1           82 individuals or approximately 10 percent of  
2 the Davis-Besse workforce were interviewed. The results  
3 and observations from the Quality Oversight interviews  
4 were closely correlated with the results from the recent  
5 SCWE survey that Mark discussed in his presentation.

6           I now would like to share some of the more  
7 notable observations from the interviews. The first  
8 observation has to do with management behaviors.

9           The results indicate that some management  
10 behaviors were believed to be an issue by the workforce.  
11 Number of interviewees mentioned the previously  
12 discussed feedwater 78 valve issue and the  
13 reorganization as contributors to this indication.

14           The second observation concerns the recent  
15 FENOC organization, reorganization. As previously  
16 discussed, the number of interviewees indicates that the  
17 reorganization was negatively received by the workforce.

18           Third, a very high percentage of the  
19 interviewees believed that our Safety Culture at  
20 Davis-Besse supports the safe operation of the plant  
21 when the management wants employees to report problems  
22 and adverse conditions.

23           The fourth has to do with raising nuclear  
24 safety concerns. A very high percentage also believe  
25 that they can raise nuclear safety or quality issues

1 without the fear of retaliation.

2 The last observation has to do again with the  
3 Corrective Action Program. Results indicate that there  
4 have been, there has been a continuous increase over the  
5 last three surveys in the number of employees raising  
6 issues by the Corrective Action Program. So, we are  
7 seeing a positive trend in the use of the Corrective  
8 Action Program by the employees to recognize concerns.

9 That concludes my presentation. Any  
10 questions?

11 MR. SUH: Just a question,  
12 Ray. I know it's, you haven't been in your position  
13 that long. I was wondering what your opinion was of the  
14 engineering area. I didn't see that in your focus, list  
15 of focus areas. Was that something you considered and  
16 just -- I mean, only so many things can go on that list,  
17 obviously.

18 MR. HRUBY: We, again,  
19 implement the Continuous Assessment Process, so, and  
20 also there are some primary elements that were in  
21 Engineering and third quarter report. There's going to  
22 be some in the fourth quarter report also. And as they  
23 continue this assessment process, we're able to look at  
24 things independently as we see the need to.

25 We are looking closely at Engineering as we

1 are at the other functional areas, but what I pulled out  
2 as my focus areas were the organizations focus areas  
3 are, are areas of specific, that merits specific  
4 attention.

5 MS. LIPA: Ray, you  
6 mentioned earlier that Oversight initiated CRs for some  
7 findings, but when you put your conclusions together and  
8 present it to the line management, do they also initiate  
9 condition reports and do you look to see what kind of  
10 condition reports they write or is it mostly just you  
11 guys writing the condition reports?

12 MR. HRUBY: Well, to give  
13 you an example, we had an issue where Quality Oversight  
14 wrote a condition report on the significant conditions  
15 adverse to quality of preventative recurrence and  
16 remedial actions. We were not satisfied with the  
17 timeliness of the resolution of issues. The senior  
18 leadership team within a few days took that and convened  
19 a special meeting to sit down and review all those  
20 corrective actions.

21 So, the organization is responding to the  
22 issues that are identified by the quality organization.  
23 They are also responding, as I said earlier, in about as  
24 timely manner to the Quality Organization identified  
25 conditions as they are to the line organization's.

1           As the organization investigates condition  
2 reports, there have been instances where they've written  
3 additional condition reports based on additional areas  
4 that they have discovered other conditions.

5           So, I hope that's answering your question.

6           MS. LIPA:           Yes, thank you.

7           MR. REYNOLDS:       I have a  
8 question. I don't know if it's for Oversight or for the  
9 line, but I am referring to your Davis-Besse Cycle 14  
10 Post-restart Commitments October 2004 Review. And what  
11 we've heard tonight is, I guess, marginally effective in  
12 Operations performance and then unsatisfactory ratings  
13 in trending, in various groups.

14           And, I would point to a couple items. This is  
15 in the Action Commitment Summary Section, page 1 of 5  
16 and 3 of 5. I'll start with 3 of 5 first, because  
17 Christine brought it up earlier. Action item 9.4. Have  
18 it here as complete as of February of 2004, reestablish  
19 the Corrective Action Program Trending Process. This  
20 would imply that's implemented. And if I go back to  
21 page 1 of 5, item 1.6, it says completed June of '04.  
22 Says, implement actions to improve trending of major  
23 plant evolutions utilizing the management observation  
24 program to track performance and feedback.

25           So, there is two Operational Improvement Plan

1 actions that you said were completed in the past, that a  
2 more recent assessment says, you know, at least  
3 effective and satisfactory.

4 And then the third item you talked about is  
5 still on page 1 of 5, item 2.3; says it was completed in  
6 March of '04. Says, implement Operations improvement,  
7 Implementation Action Plan including strengthening  
8 operating crews, including assessment of operators  
9 training, operators procedure use, improving command and  
10 control, strengthening operation procedures, including  
11 foundation of key operating procedures and use of prejob  
12 briefs and strengthening operation management.

13 My point here is, you have three items along  
14 with several others that you said were complete in the  
15 past. And based on what I've heard tonight from your  
16 own assessment, some self-revealing findings in  
17 Operations and independent assessment, which say what  
18 you implemented back then was not effective. And I  
19 wondered if you're going to go back and look at these  
20 items that you have as complete, and maybe dozens of  
21 others that are complete, and see if they truly are  
22 complete; where those were signed off as complete  
23 before, which truly determine if they were effective or  
24 not.

25 MR. BEZILLA: Let me answer

1 that. I'll answer that, Steve. On 9-4, we  
2 reestablished Corrective Action Program Trending  
3 Process. We did reestablish the Corrective Action  
4 Program Trending Process and closed this. We knew there  
5 were going to be erasions and we knew it was going to be  
6 marginal at best coming out of the shoot because we have  
7 been shut down for a number of months during the  
8 extended outage.

9       If you jump down to 10.8, it talks about doing  
10 assessment activities in the Corrective Action Program.  
11 Evaluate the effectiveness of corrective actions taken  
12 to improve implementation and improve trend evaluations.  
13 So, we have built into the plan checks on that trending  
14 program. And just through our normal self-assessment  
15 process, this is an area that we knew, as Bob said, we  
16 would have to continue to focus on.

17       In regard to the 1.6 item, says, implement  
18 actions to improve trending of major plant evolutions.  
19 We've initiated management observations for all medium  
20 and high risk activities. And to my knowledge, we've  
21 not had any issues with medium and high risk activities.

22       There may be one or two, but the majority of  
23 those are done I think pretty well. It's routine things  
24 that we're having problems on. So, I think the  
25 management observation in our, I'll say, commitment to

1 monitor those medium and high risk things, which could  
2 get us into trouble from a plant perspective, we do a  
3 pretty good job. The duty team has that, and my duty  
4 team makes sure we have the right management attention  
5 on those tasks.

6 And the 2.3, I think it was, talks about the  
7 Operations improvement, about strengthening the crews,  
8 providing training, et cetera. We did that. We did  
9 those things and we closed it. Now, does that mean  
10 there is not room for improvement? No. Does that mean  
11 we're not going to have mistakes or errors or areas of  
12 improvement? No.

13 But we'll continue to monitor those. This was  
14 a point in time, we took those actions, right, and now  
15 we'll continue to monitor our performance; and if we  
16 have to take additional actions, we'll do that, but our  
17 processes are set up so we do periodic self-assessments,  
18 we do focus self-assessments; oversight periodically  
19 looks at those things with their program.

20 So, you know, these things were done. At a  
21 point in time we said, okay, that's good, done. Now,  
22 does that mean there is not going to be a hole or  
23 something reappear? I can't tell you no. We'll just  
24 continue monitoring, and as those things come up, put  
25 them in our Corrective Action Program and we'll go

1 address them.

2 MR. REYNOLDS: Okay.

3 MR. BEZILLA: Okay. Next

4 slide, Kevin.

5 So, just briefly in closing, I would like to  
6 thank you guys for your time, your questions and your  
7 challenges. I and my team are committed to ensure a  
8 safe and conservative operations at Davis-Besse and  
9 we'll work hard at improving both of our critical  
10 assets; that being our people, and our plant. Thank you  
11 very much for the opportunity.

12 MS. LIPA: Any further

13 comments?

14 MR. GROBE: I always have  
15 further comments. As many of you know, this is my last  
16 Davis-Besse public meeting. There has been a few of  
17 them since we started this a couple years ago.

18 I wanted to share with you that I have great  
19 confidence in the future effectiveness of the  
20 Davis-Besse Oversight Panel. First, the team is an  
21 outstanding team led by Christine and the Region III  
22 staff, Dave Passehl and Scott Thomas, as well as the  
23 Bill Ruland and Gene Suh and Jon Hopkins at  
24 headquarters. Exceptional team, and I know they'll  
25 continue doing exceptional work.

1 But, of equal importance is Steve Reynolds.  
2 Steve and I have known each other for awhile. He got an  
3 excellent start in his career with the NRC. He was  
4 trained in Region III, and went off to headquarters and  
5 did a lot of exceptional work in headquarters; including  
6 he was a critical cog in the recovery of the Millstone  
7 plant for the NRC side of the ledger. Came back to  
8 Region III and has held a number of management positions  
9 in Region III, and for the last two years has been  
10 Acting Director of the Division of Reactor Projects,  
11 which is arguably the most challenging management  
12 position at Region III.

13 So, I have absolute confidence of Steve's  
14 leadership in the panel. So, I leave with the panel in  
15 very good hands. I think we've made a lot of progress  
16 over the last couple of years. You have a very  
17 significant challenge ahead of you.

18 One of the key root causes of the Davis-Besse  
19 situation prior to February of 2002 was that management  
20 wasn't setting the right expectations. Let me phrase  
21 that a little differently. The staff perceived  
22 management's expectations as, in one direction, which  
23 was not the direction that management wanted. The  
24 outcome of that was a stronger focus on production costs  
25 and schedule and a lesser focus on what should be the

1 prevalent priority, which is safety.

2 And, the most recent Safety Conscious Work  
3 Environment Survey results indicate that staff is  
4 perceiving in an increasing number of individuals that  
5 management is not placing priorities on the right, the  
6 right activities.

7 Now, I don't want to leave any impression that  
8 this is anything like what the first survey was after  
9 the shutdown, because it's not, but your challenge is to  
10 find out how you set perceived expectations in the minds  
11 of your staff and what you do to influence those; and  
12 how you're going to effectively measure what your staff  
13 is expecting, believes you're expecting of them, and  
14 making sure that that trend is, is reversed.

15 And that's a big challenge. And, given what  
16 you've been through over the last two and a half years,  
17 I have confidence that you're up to it. I have  
18 confidence that this panel will monitor you effectively  
19 and hold you accountable.

20 And, I look forward to some day in the future  
21 hearing that Davis-Besse is under the routine reactor  
22 oversight process, but that's certainly not today.

23 Good luck. Anybody else?

24 MR. BEZILLA: Could I go back  
25 for a second? I was remiss. Jack, I got caught up in

1 the meeting here. I also would like to extend my thanks  
2 and appreciate and pass on Lew's thanks and  
3 appreciation.

4 I'm not sure we would be here today without  
5 you and your team's, I'll say, leadership and challenges  
6 and questions. And, so, I just would like to thank you  
7 and it's been a privilege. And good luck in the future.

8 I'm sure our paths may across again in your  
9 new role, so I wish you the very best.

10 MR. GROBE: I know they  
11 will.

12 MR. BEZILLA: And for Steve,  
13 hopefully, we won't have as many opportunities with you  
14 as we've had with Jack, but we look forward to working  
15 with you, and working through the 350 Process and we  
16 also would look forward to the day when we get back to,  
17 I'll say, normal regulatory oversights. So, Steve,  
18 we'll be able to continue working closely with you and  
19 your team to make that happen.

20 MR. REYNOLDS: Thank you.

21 MR. BEZILLA: So, thank you  
22 both, and, Jack, really thank you in your efforts. Good  
23 luck in your future to you.

24 MR. GROBE: Thanks.

25 MS. LIPA: Well, in the

1 interest of time, what I would like to do is take a five  
2 minute break and be prepared for public questions and  
3 comments. Five minutes.

4 (Off the record.)

5 MS. LIPA: What we would  
6 like to do is offer anybody who is a local member of the  
7 public who has a comment or question for us, the  
8 opportunity to come up. When I was making introductions  
9 earlier, I neglected the local county officials.

10 I know I saw Jere Witt back there. Would you  
11 like to stand up and introduce yourself, Jere?

12 MR. WITT: Jere Witt,  
13 County Administrator.

14 MS. LIPA: Thanks, and  
15 Steve.

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

18 MS. LIPA: Any other local  
19 public officials? Okay, thanks.

20 And if either of you two has a comment or  
21 question, come on up.

22 MR. WITT: Thank you,  
23 Christine.

24 We would like to make a comment. On behalf of  
25 Ottawa County, Jack, we would like to thank you for all

1 your efforts with the 0350 Process. I certainly from a  
2 personal note would say you've taught me a lot. I've  
3 learned a lot through this process.

4 And it really, I think you've been fair.  
5 You've asked the tough questions that needed to be asked  
6 and dealt with this in a professional manner. And we  
7 really just would like to thank you for your efforts and  
8 look forward to working with this board as we move  
9 forward.

10 I do have one comment. I certainly understand  
11 the need for the oversight and all the things that  
12 you're doing here and the plant is doing, but my comment  
13 is, let's also keep in mind that we don't get so caught  
14 up in surveys and those kind of things that we bog the  
15 employees of this plant down to the point where they  
16 can't do the job they have to do.

17 And I think as you go forward, I would ask  
18 that you weigh those two issues as we make requirements  
19 on the plant and on the employees here, to make sure  
20 that they have the time to get their job done and not  
21 always be responding to surveys or some other type of  
22 questions.

23 You know, that's a tough call, and that's a  
24 fine line, but just a comment to keep that in mind in  
25 the future. Thank you.

1 MR. GROBE: Thanks, Jere.  
2 Just an observation and I don't know if you  
3 folks appreciate this, but Steve and I have collectively  
4 been involved in quite a few of these type of plant  
5 recoveries over the years. And, in none of the  
6 recoveries that I've been involved in and I don't think  
7 Steve has been involved in, have we ever experienced the  
8 type of dedication and commitment to the community that  
9 we've seen demonstrated by the Ottawa County  
10 Administration and Board of Commissioners. And it's  
11 very impressive.

12 And I think a lot of the success of the public  
13 outreach aspects of this panel can be attributed to the  
14 commitment and dedication of the Ottawa County  
15 government, so I appreciate that.

16 I think your comment, Jere, I appreciate it,  
17 and I think it's a good comment for Mr. Bezilla to  
18 consider in how he decides to move forward in this area.

19 MS. LIPA: Okay, do we have  
20 any local members of the public who would like to come  
21 up and ask a question or provide a comment to us?

22 MR. GROBE: Only easy  
23 questions, save the tough ones for next time.

24 MR. CUFF: Jack, I've had  
25 the opportunity to speak with you before.

1           Mr. Reynolds, I appreciate the opportunity to  
2 speak with you.

3           I come before you, my name is Jeff Cuff. I'll  
4 introduce myself as two people. I am one of the five  
5 shift managers here at this unit, running an operating  
6 crew. I also humbly state that I am the supervisor who  
7 reviewed the last surveillance test that ended in the  
8 Operations missed boric acid heat trace test.

9           And I have two things that I would like to  
10 just present to the panel. That is, the changes that  
11 occurred not only in myself, but in my operating crew,  
12 since that mistake was made seven weeks ago.

13           I have looked at more surveillance tests in  
14 the last seven weeks than I probably have in the last  
15 seven years. I have seen a lot of -- each time, it's  
16 interesting that you come in on your own time, you look  
17 at a surveillance test with a new set of eyes, a new set  
18 of circumstances. And I've written more condition  
19 reports in the last, probably, four or five weeks than I  
20 have in the last two or three years on procedures,  
21 because I now look at how different people view a test  
22 and how they perform it based upon that.

23           And, I can tell you a simple thing of an  
24 operator on a test that I reviewed had N/A'd a step,  
25 marked it nonapplicable. It was a bulleted item inside

1 a step, and he inappropriately marked it nonapplicable.

2 I sat down with him and I discussed it and I said why

3 did you do that.

4 And we looked at the procedure, and out of

5 that came as we went down, it wasn't just a, "I marked

6 it wrong incorrectly". It was the way this procedure is

7 formatted lends you to the error.

8 So, maybe we performed it a hundred times and

9 never made the error. This time we made it. There was

10 no consequences. Submitted a condition report. Said,

11 we need to change this procedure.

12 I'm doing more of those. When I find errors

13 on my shift, when I find errors on my peer's shifts,

14 we're driving down to find out why that mistake was

15 made. If it's a simple how they mark the step, we're

16 asking the question; how do you do that.

17 The other thing that I've seen, is I am now

18 driving my supervisors, I have three of them underneath

19 me on my crew. I'm driving them to look at low level

20 issues. How -- are they looking at regular rounds? Are

21 we looking at turnovers? Are we looking at surveillance

22 tests?

23 And I can tell you my observations and some of

24 my peers' observations, we're starting to try and look

25 very hard at low level issues. Are we seeing everyday

1 behaviors? Sometimes we see good behaviors on  
2 clearances, but not the same behaviors when they're  
3 doing their operating rounds. Why the difference? We  
4 coach the operator. Put it in. Do a follow-up item.

5 I don't like to make mistakes, but what I can  
6 tell you is from my perspective, and the shift managers  
7 of this plant, we are seeking to drive performance  
8 issues to the person performing that test provides it  
9 error-free; and the test that he is given has no  
10 embodied error traps inside of that.

11 Thank you.

12 MR. GROBE: Don't go away so  
13 fast.

14 I appreciate your passion. And I was  
15 wondering if you could share with us how you have, what  
16 you have done to share some of that passion with your  
17 peer shift managers?

18 MR. CUFF: We had -- how I  
19 shared it with my peers. I share it with my peers every  
20 time I do a surveillance review with them, because, for  
21 instance, today there was an error on one of the  
22 surveillance tests. And what I can tell you is, for the  
23 last shift managers meeting, I looked at the five days  
24 of comments that we had on all of our surveillance  
25 tests, and the comments came down to this. The date

1 wasn't written neatly enough that you could discern what  
2 the date was without knowing it was in the date block.  
3 We look at, do those numbers stand out by themselves to  
4 be numbers?

5           So, in each of these times when we sit down as  
6 the off-going crew, the four SROs and the off-going  
7 crew, the supervisor reviewing it. We sit down, and I  
8 say, "Here's what I'm seeing; you guys do this, this,  
9 this really well and here's where you have areas to  
10 improve in." And when we find the mistakes, it's the  
11 five of us sitting down and saying, "What caused the  
12 mistake and how do we correct it?"

13           So, it's done on a sit down at the table every  
14 day when you're doing the surveillance test review.

15           Does that answer your question?

16           MR. GROBE:            Yeah, thank you.

17           MR. CUFF:                Now can I run?

18           MS. LIPA:                Any other

19 questions?

20           We can expand the population to anybody in the  
21 room who has a question for us.

22           MS. CALLAHAN:        Hello. My name  
23 is Bridgette Callahan and I'm representing Ohio Citizens  
24 in Action.

25           And this is regarding a letter that we sent

1 you, Mr. Grobe, November 30th from Ohio Citizens Action  
2 and the Union of Concerned Scientists.

3 It was suggestions of you doing a Mid-Cycle  
4 Outage, we felt should be addressed to FirstEnergy. The  
5 first suggestion was regarding testing those two pumps,  
6 which they already said they would do.

7 The second one was regarding the newly  
8 installed Bentley Nevada diagnostic equipment, which  
9 they use to diagnose the pump performance. The reason  
10 we felt it was warranted that they should do, the NRC  
11 should assess the results from this; just to quote a  
12 letter from you, Mr. Grobe, to Mr. Myers.

13 Quote, "The team determined that the  
14 Licensee's evaluations of the RC case to cover gasket  
15 leakage were based upon testing that one did not use the  
16 same methodology from outage to outage. Two, did not  
17 attempt to normalize the data from outage to outage.  
18 Three, did not consider the impact of reactor coolant  
19 pressure and temperature conditions on the test results.  
20 And, four, was only intended to verify that leak  
21 detection lines were open and not blocked. We believe  
22 that the NRC should evaluate how FirstEnergy has  
23 integrated this data with past data to verify that  
24 FirstEnergy is not using this data to ensure the pump  
25 was running."

1           Since we didn't get a response to our letter,  
2 we were wondering whether that was resolved or your  
3 thoughts on that; and of course, it gives me the  
4 opportunity to pass this letter on to Mr. Reynolds now.

5           MR. GROBE:           I can assure you  
6 Mr. Reynolds has seen it. I was in Washington actually  
7 when I got it via email from Dave Lochbaum. We put your  
8 letter into our process that includes our engineering  
9 folks reviewing that specific recommendation, and we'll  
10 get back to you.

11          MS. CALLAHAN:        Okay, thank you,  
12 Mr. Grobe.

13          MR. GROBE:           Um-hmm.

14          MS. LIPA:            Any other  
15 questions or comments for us today?

16           Okay. I would like to thank you all for  
17 coming. Right now we're planning on having our next  
18 meeting in February. We don't have a specific date yet,  
19 but we'll keep the public apprised and the plant  
20 apprised of the date as we set it.

21           If there is any questions that you have, we'll  
22 be available for a few more minutes up here. Thank you  
23 and good night.  
24 (Off the record.)

25

