

1 MR. GROBE: Let me make sure I
2 understand what you said, Randy. When you said that a
3 certain number of your 2000 or so items of observations
4 have been dispositioned by creating work orders, I want to
5 make sure I understand that.

6 MR. FAST: Okay. There is
7 280 condition reports. All of the inspections that were
8 done generated a condition report for any deviations,
9 didn't meet our standards. Each one of those condition
10 reports would have one or many individual items that
11 required disposition.

12 Of the 280 condition reports that have been written,
13 about 30 of those condition reports, which would be
14 somewheres in the 15, 20 percent range, have been
15 dispositioned. The physical work that needs to be done
16 generates a work order. The work order is the actual
17 maintenance process to complete the work. And those 30 are
18 in progress.

19 MR. GROBE: Okay. So, you
20 have condition records -- the focus of my question wasn't
21 clear. I apologize.

22 Have the condition reports been closed out to work
23 order, or condition reports won't be closed out until the
24 work that's specified in the work order is completed?

25 MR. FAST: The condition

1 reports will not be closed until the work is completed and
2 verified.

3 MR. DEAN: Then you would say
4 that those 280 condition reports essentially encompass the
5 results of the inspections. Although, the way I understand
6 it, you still have some validation effort ongoing, but
7 you've completed your initial inspection?

8 MR. FAST: That is correct,
9 Bill. The 280 are the original inspections. I would
10 expect it will be generating some differences, based on
11 those reinspections.

12 MR. GROBE: Any other
13 questions on Containment Health? I have a couple more.
14 I just want to make a couple comments. I think the
15 Containment Health Plan is a substantial improvement from
16 what you showed us last month. For one thing, you have
17 detailed procedures in place for the inspections. The
18 scope of the inspections is much more comprehensive with
19 respect to evaluating the condition of the equipment inside
20 containment.

21 Based on, again, this is just based on what you've
22 told us, you haven't done extensive inspection in these
23 areas, but based on what you told us, it appears that
24 you're going beyond what, the event, the head corrosion
25 would have caused you to do. And I think that's helpful.

1 Nuclear plant workers work to procedures. They
2 understand that. Quality assurance program assures that
3 procedures are adequate; they're adequately implemented.
4 So, this context of detail procedures and systematic
5 approach to training, that's a nuclear standard. Those are
6 very good attributes of the program and assure the results
7 of high quality activities.

8 I'm very encouraged to hear that you're having as
9 part of your inspection program a separate independent
10 look. And that's important from two standpoints. One is
11 it's always better to have two sets of eyes than one, but
12 secondly, quite frankly, there was a question regarding
13 the, the standards of the workers that were making
14 decisions in the plant. And I don't want to infer by that
15 that all the workers at Davis-Besse don't have the right
16 standards. That's not what I'm trying to say. But there
17 was a question. And this will give you insight as to
18 whether or not that is a broad question, a narrow question
19 and what it means as far as the accuracy of your
20 inspections. So, that's good.

21 I also heard you say, as I was pursuing the question
22 of what independent inspections meant, that completely
23 independent at Davis-Besse organization, the folks in Bill
24 Pearce's organization are going to be doing independent
25 assessments.

1 And Lew, I think it would be very healthy for us to
2 hear Bill's staff's evaluation next time we meet on the
3 activities that you're presenting. And, I would fully
4 expect, let me say, I would be surprised if his evaluation
5 is completely rosy. Hopefully, he's finding some things
6 that continue to have done.

7 So, I would hope that next time we meet, not only
8 can we hear from the staff that's doing the work, but I
9 would like to hear from Bill's staff to get on the FENOC
10 corporate independent assessment, the quality of the work
11 that's going on in the field.

12 MR. MYERS: That would be
13 good. We would do that.

14 MR. GROBE: Anything else
15 before we move off of Containment Health?

16 Okay. Good. Thank you, Randy.

17 Marie, we've been at it for about an hour and 15
18 minutes; is it time for a five minute break?

19 MS. FRESCH: Sure.

20 MR. GROBE: Okay. Let's do
21 that. The last time, we wore out her fingers.

22 MR. MYERS: Could I just
23 summarize on the Containment Health Plan?

24 MR. GROBE: Sure.

25 MR. MYERS: I think once again

1 we demonstrated at the last meeting we were in the plan
2 phase, doing some discovery, doing implementation or
3 physically doing work. And, you know, we've taken on some
4 value and expanded the program.

5 We're upgrading our coolers. We're extremely
6 pleased with that. The thermo cavity seal is a major,
7 major effort that would add a lot of value and margin to
8 our plant; and it will produce, or does make our plant a
9 better plant. So, we're moving to good implementation on
10 that.

11 MR. GROBE: Okay. My watch
12 says 16 after. Let's be prompt at 21 after, five minutes,
13 and that way we can keep things moving.

14 (Off the record.)

15 MR. MYERS: The next area we
16 would like to discuss is System Health Assurance Plan and
17 Howard Bergendahl will do that.

18 MR. BERGENDAHL: Good afternoon.
19 As Lew indicated, we are committed to the safe operation of
20 Davis-Besse, more importantly, sustained safe operation.
21 So, we're examining much more than the reactor vessel head
22 and containment building. I'm going to briefly describe
23 where we are on System Health Issues.

24 MR. GROBE: Just a minute.
25 Could you please close the doors back there?

1 Thank you.

2 MR. BERGENDAHL: There is two
3 Building Blocks we're trying to cover, The System Health
4 Assurance Program Compliance -- and these two Building
5 Blocks, as I indicated, are expansions over what we just
6 described.

7 The first one is System Health Assurance Plan.
8 Basically, a review of the key systems from three different
9 perspectives. Taking an operational look, basically
10 focusing on the needs of the operator. A second
11 perspective would be the system reliability, and that's the
12 system engineer's view of the system as a whole. And third
13 is the design perspective of a system.

14 Now, the first one, called the Operational Readiness
15 Review; that was the operating perspective, as I
16 indicated. The plant manager led those reviews and they
17 are complete. That was a team review of some key systems
18 and review of the indicators on how that system is
19 performing and when it's ready for safe operation.

20 That first cut review by Randy and some of his staff
21 identified some of those issues I mentioned earlier that
22 may have met compliance, but did not meet the standards for
23 future operations. So, that produced some work activities
24 that we had maybe identified for future implementation,
25 pull those up to current, to current outage.

1 That review is complete. And, then moved on to
2 System Readiness Review, which is a more structured review
3 of the risk significant maintenance rule systems, focusing
4 on material condition of the plant and including some
5 detailed system walkdowns. And walkdowns would be done of
6 course, with procedure.

7 And the results of these reviews would then be
8 presented to an independent board, which is our Program
9 Review Board, which is a subcommittee of the Engineering
10 Assurance Board, which we mentioned earlier.

11 MS. LIPA: Howard, I have a
12 question for you.

13 MR. BERGENDAHL: Yes.

14 MS. LIPA: On the operational
15 readiness reviews that are complete, is that complete and
16 identifying what needs to be worked or is all the work
17 done?

18 MR. BERGENDAHL: It's complete in
19 identifying the issues of what needs to be performed; that
20 work has been identified, and it is not all completed.

21 MS. LIPA: And then are you
22 also looking at operating workarounds as part of that
23 review?

24 MR. BERGENDAHL: Yes. That was
25 part of the perspective of what systems have operating

1 workarounds, outstanding modifications, things of that
2 nature.

3 MS. LIPA: Okay, thank you.

4 MR. GROBE: That's, that's a
5 new one for me. I wasn't aware that you were specifically
6 looking at operator workarounds. Let me make sure I
7 understand that.

8 When I think of an operator workaround, I think of
9 things that are embedded into procedures, things are
10 embedded into the culture of operating the system,
11 operational characteristics of a control room of a system,
12 as well as operational characteristics in the field;
13 things our operators are having to work around potentially
14 a design, not deficiency, but lack of optimal design.

15 Are you looking at those kinds of things, scouring
16 through procedures, the workarounds?

17 MR. BERGENDAHL: Yeah. The first
18 Operational Readiness Review that Randy chaired, he can
19 describe it in a little more detail, but it was designed to
20 flush out issues like you describe.

21 MR. FAST: Jack, what we put
22 together in this process, 36 systems, as I recall, and five
23 other systems, like gear operated valves, motor operated
24 valves, breakers, things of that nature. We established
25 criteria. Had the system engineer come to review panel,

1 which consists of myself, operations and engineering and
2 maintenance folks. And we were focused on the system
3 health.

4 Brought into view then the performance of the system
5 in the past and its present health. We use criteria like
6 operator; we have a level one, level two, and level three
7 workaround, we track in our operations group. So, as an
8 individual would bring in a system, they would identify any
9 outstanding work orders on the system, modifications that
10 were pending for it, any operator workarounds that have
11 been established, procedures that needed to be revised or
12 written to support system health.

13 And that board was really, I'm going to say, an
14 advocacy to the system engineer in creating a form where
15 they could bring the issues to the table and get the
16 appropriate level of support to ensure that those items
17 would be complete.

18 As we did those reviews, some of the legacy issues,
19 I'll call them legacy issues, system engineering; we said
20 if there were longstanding issues with problems of the
21 performance of the system, bring those forward with your
22 recommendations as well.

23 And, I'll give an example. I'm trying to be
24 specific. Something like the high pressure injection
25 motors. Been there since the life of the plant. Never

1 been taken out, sent out for complete overhaul and health
2 check.

3 One of the engineers came forward and said, I would
4 like to talk about the health of the motors and where we
5 are and make proposals to send those out and have complete
6 inspections done. And, we subsequently agreed and are in
7 the process of taking those actions.

8 So, right now as we speak, their HPI motor is being
9 rigged out of the building to be sent out for complete
10 remediation.

11 There were other items, like items, diesel start
12 systems. System engineer said, here's one that's pending
13 modification. We need to put some emphasis on it. We
14 agreed. We applied the engineering resources, and that is
15 undergoing design, and that will be implemented as well.

16 Those are the kinds of things that the Operational
17 Readiness Review did.

18 MR. GROBE: Let me just ask a
19 little bit more, get into little more depth here.

20 Something like a motor that hasn't had a
21 comprehensive amount of maintenance in 25 years, would that
22 be consistent with the vendor recommendations for that
23 motor?

24 MR. FAST: The original
25 design of those motors for life of the plant was 40 years;

1 however, they're not outside of their design basis, but
2 it's just prudent maintenance activity to take those out
3 and do a health check on them.

4 So, we were doing the vendor recommended
5 preventative maintenance. Those items that are required;
6 bearings, lubrications and such, were within their period,
7 but it's the unknown, it's the unknowns about that which
8 really require a teardown and review.

9 So, they don't go through much of a duty cycle, but
10 it is just a prudent maintenance practice. This is above
11 and beyond what the vendor would recommend.

12 MR. GROBE: Okay. Let me ask
13 a question, you just mentioned a couple specifics. This
14 diesel air start modification; was that something that was
15 a pending modification or was that something that had not
16 been requested?

17 MR. FAST: That was a pending
18 modification, did not have implementation plan or target
19 date for at least in the near term. And that was an
20 example, we said we're going to pull that forward and
21 complete that work.

22 MR. GROBE: Okay. So, back to
23 the original question, which was operator workarounds. You
24 included in your Operational Readiness Reviews, operator
25 workarounds that had already been identified. Did you go

1 through a systematic review with, or was the intent of the
2 scope of this to find out review of the workarounds that
3 were latent?

4 MR. FAST: That was not
5 really, the focus was on system health. If there were any
6 outstanding operating workarounds, those are tracked by the
7 system engineer. He knows he's got a level one or level
8 two workarounds.

9 Our Return to Service Plan included completion of
10 all the operator workarounds activities. So, those came up
11 and when we said, so what are we doing about this level two
12 operator workarounds, it might be that we needed to
13 implement a minor change to the design of the system. Then
14 we said, let's progress that, get the work order and get
15 that out.

16 MR. GROBE: Okay, thank you.

17 MR. BERGENDAHL: Now, the next
18 level reviewed is System Readiness Review, were more
19 structured comprehensive. That would flush out more of the
20 items, Jack, I think you refer to, which are not tracked as
21 an operator workarounds, but procedure aspect.

22 In that review, we will review the close condition
23 reports for the last few years to see how we dealt with
24 problems. Closed maintenance work on a plant, on a system,
25 open and close modifications, operating experience. It's a

1 more structured review and it goes through a panel to
2 independently assess the thoroughness of that review.

3 In addition, on the next slide, we've added a new
4 program called the Latent Issues Review. This is a more
5 detailed look which gets beyond even the areas I just
6 discussed and goes into the System Health Plan design
7 perspective as well.

8 This program has been used at our Beaver Valley
9 Station. We've adopted this program and identified some
10 systems to go after first. And ones that you see here are
11 systems that we selected to put this thorough team review.

12 Now, this type of review, very broad detailed
13 review, takes a team of people a couple weeks to perform.
14 This review goes back and looks at the original design
15 basis, the emergency procedures, all kinds of industry
16 operating experience, any operability reviews that were
17 performed, problematic risk assessment; and a very detailed
18 look.

19 We selected the Reactor Coolant System, Auxiliary
20 Feedwater System, Component Cooling Water System, Emergency
21 Diesel Generators and the Service Water Systems in these
22 reviews.

23 And we have currently assembled teams. We've put
24 together the guidance and structure for doing these
25 reviews, and the teams are starting reviews now. I believe

1 as of this week we have all the teams assembled.

2 MR. GROBE: Before you go on,
3 Howard -- I'm sorry. Go ahead, Dean.

4 MR. DEAN: I was going to ask
5 you, do you intend to do these design reviews or latent
6 issue reviews in parallel or do maybe one or two and gain
7 any lessons learned and apply that to the other ones?

8 MR. BERGENDAHL: We started on the
9 Aux. Feedwater System as kind of a pilot to see if there
10 was any process improvements that could be gained. Make
11 sure we got the right scope and expertise.

12 So, we initiated that one. Did learn some things
13 from that, and modifying our process and using that. We
14 expected this new program would be continued to be used at
15 Davis-Besse. It's proven itself at Beaver Valley, and it
16 really does a good thorough job of examining the systems,
17 going back to the original design.

18 So, we plan to continue this program.

19 MR. MYERS: Let me comment on
20 that too. Neil Morrison is with us today. Neil was the
21 person that spear-headed our reviews at our Beaver Valley
22 Station for the past two or three years. How many years
23 now?

24 MR. MORRISON: Two and a half
25 years.

1 MR. MYERS: Two and a half
2 years. And so there is, he's got a lot of lessons learned
3 there, so this is not a new program for us. We're just
4 moving it to this plant.

5 But if you look at where we've been spending our
6 money at other plants, a lot of our money has been spent on
7 a lot of things, finding these latent issue reviews. We
8 found significant ways to improve the quality of our
9 systems at our other plants. So, we're really excited
10 about bringing this program to our plant. We think it's
11 the additional margin for the plant.

12 MR. GROBE: Howard.

13 MR. BERGENDAHL: The output of
14 these reviews again goes through the engineering assurance
15 board to get an independent check on thoroughness and rigor
16 on the reviews of the systems.

17 MR. GROBE: I've got a couple
18 questions. It's an interesting list of systems that you're
19 doing the Latent Issues Review on. Reactor Coolant System
20 is clearly a focus of the shutdown of the plant;
21 recognizing that the head is part of the Reactor Coolant
22 System.

23 Auxiliary Feedwater System, Component Cooling Water
24 Systems, Emergency Diesel Generators and Service Water
25 Systems are normally four of the five primary systems that

1 I'm familiar with that comprise almost the entire risk of
2 problems at the plant, but the fifth one is DC Power. Is
3 that a significant risk contributor at your plant? I'm not
4 familiar with PRA.

5 MR. POWERS: It's a good one.

6 The fifth one is, Jack, the Diesel Center --
7 (Requested speaker to repeat.)

8 MR. POWERS: I'm sorry. DC is
9 part of the Reactor Coolant System, for instance, diesel
10 generators. The Aux. Feedwater System, Service Water and
11 Component Cooling Water Systems.

12 MR. GROBE: Jim, my question
13 was, normally when you look at say 95 percent of the risk
14 contribution, it would come from those four systems plus DC
15 Power. And I'm not that familiar with your risk analysis
16 for Davis-Besse Plant. Does DC Power play a significant
17 role in the risk contributions at Davis-Besse?

18 MR. MYERS: I don't know if we
19 know the answer to that.

20 MR. GROBE: I don't expect you
21 to know every answer to every question.

22 MR. POWERS: No, I have an
23 answer for you. What we've done, is on the preceding
24 level, what we have learned to do on our System Health
25 Reviews, we've included the 1.50 DC Systems as part of

1 that. Those are the main systems; there were 35 of them
2 that we are going to be going through, Jack. So, we're
3 going to be looking at those in some level detail.

4 We didn't select those for the deep cut, but we
5 think the deep cut in the five systems that we've listed
6 here is going to tell us generally how, what the health of
7 our systems are.

8 MR. GROBE: Okay.

9 MR. BERGENDAHL: The System Health
10 Review will identify further evaluations that are
11 required. We need to do a more thorough evaluation.

12 These systems were selected, as you indicated,
13 important systems. A couple of them had system health
14 indicators, indicated that we had some issues with the
15 system in the past couple of years. And then we added a
16 couple that our indicators show very reliable performing as
17 well, but since they were high impact systems we added
18 those; and allows us to validate our monitoring programs.

19 MR. MYERS: We still haven't
20 answered that question; how does it affect PSA that you
21 want us to look at. We'll give you an answer to that
22 shortly.

23 MR. GROBE: Okay.

24 MR. BERGENDAHL: Any other
25 questions on the system reviews?

1 MR. GROBE: Any other
2 questions?

3 MS. LIPA: Yeah, I have one
4 question. On the, in your plan dated July 12th, you talk
5 about that, through these reviews you're going to identify
6 conditions that need further evaluation that could impact
7 the function of a system. And it sounds like a subset
8 would be restart items. What criteria are you using to
9 decide what items become restart items?

10 MR. BERGENDAHL: In our Return to
11 Service Plan, we laid out a process. Every condition, any
12 appliance we have will be documented on condition reports.
13 These condition reports go through a station review board
14 that we would send to specifically evaluate all the
15 conditions against restart criteria. Technically, on the
16 restart action plans. Multi-field criteria. Safety.
17 Importance of safety -- I don't have the criteria
18 memorized. I could get that for you, Christine.

19 MS. LIPA: Okay.

20 MR. BERGENDAHL: It's, actually we
21 met today and we drafted a procedure for our Return to
22 Service Plan in process -- Let me correct. Our Restart
23 Action Plan process. And that criteria is in the procedure
24 which we reviewed today. It will be used in that.

25 MS. LIPA: Okay.

1 MR. BERGENDAHL: It's also in the
2 chart for that station review board, clearly documented.

3 MR. GROBE: Howard, have you,
4 follow-up on Christine's question; have you done the
5 screenings through your restart criteria and if so, how
6 many have you determined, what's the population restart
7 items to date?

8 MR. BERGENDAHL: The answer is yes,
9 we've started. Every day, any reviews that are going on
10 generating condition reports immediately upon
11 identification. I'm not sure of the exact number. There
12 is probably four hundred some odd actions that have been
13 identified that we will get resolved prior to restart.

14 MR. GROBE: I think in the
15 future meetings, Lew, one of the things we would want to
16 do, I know that you're developing some performance
17 indicators, I haven't peeked ahead, so I don't know if
18 you're going to talk about that, but one of the things we
19 want to understand in some detail is flow rates of work;
20 what's coming in and what's going on out, and what's in the
21 business to be worked as far as restart items, and other
22 issues that might go into performance indicators that you
23 developed as far as your approach toward restart.

24 And, I appreciate we're still very early in this
25 process, but we're going to need to start getting into

1 somewhat detail in that regard. So, at future meetings, we
2 would possibly get that sort of data and start looking at
3 detailed future work, backlog work, accomplishment of work,
4 things of that nature.

5 MR. MYERS: What we can do, is
6 Clark is in the audience, he's a building block on our
7 restart action list and we can start putting him up there
8 to tackle that.

9 MR. GROBE: Whatever you think
10 is necessary.

11 MR. MYERS: Let's do that next
12 time.

13 MR. GROBE: Okay. Did you
14 have a question?

15 MR. MYERS: Clark, get
16 ready.

17 MR. GROBE: I had one other
18 question regarding the Latent Issue Reviews. I understand
19 you used these at one of your other sites in the FENOC
20 system; really two questions.

21 This type of activity has been done on a number of
22 plants, several on the east coast and midwest that I'm
23 familiar with, but I'm sure there is others also. Have you
24 tapped into the expertise of what's been occurring at other
25 plants to ensure the comprehensiveness of your Latent

1 Issues Review?

2 MR. BERGENDAHL: Absolutely. The
3 D.C. Cook Plant, gone through some pretty good reviews and
4 we've visited that site, and we look for best practices
5 throughout the industry, and we have adopted lessons
6 learned from those.

7 MR. GROBE: Okay. Can you
8 give me an idea of something that you might have learned
9 from your D.C. Cook evaluation that improved your Latent
10 Issues Review?

11 MR. POWERS: As a matter of
12 fact, we are previewing not only the procedures D.C. Cook
13 used, also the people that have come over here and are
14 helping us now lay out the strategy. People experiencing
15 what was done at Cook, Millstone, Salem and are using the
16 composite of all that knowledge.

17 What we learned most specifically, Jack, is the
18 level of detail to go into, we believe, that drive the
19 FENOC Latent Issues Program another step, higher standards
20 as part of this. It's gone quite well for us. And we have
21 used others, past several years, but we think this process
22 is going to go to a higher level of detail. So, we think
23 we're on the right line.

24 MR. GROBE: I think Cook is a
25 good place to go. A number of the people came from Salem,

1 Christie River, Oak Creek; most of them that put that
2 program together. So, it's kind of one-stop-shopping, so
3 to speak.

4 MR. MYERS: It is dependent,
5 you know, on our steam generator -- on our head
6 replacement. We brought people in that just replaced steam
7 generators at the Cook Plant. We have some welders from
8 the, that were over in the --
9 (Requested speaker repeat.)

10 MR. MYERS: We brought some
11 craft members. We brought some experienced people, people
12 welding rebar back on containment. So, we're looking for
13 that kind of experience.

14 We're using, it's Cook is really good. There is
15 some other places you can gain valid experience too. It's
16 a little different for our case, like the steam generator
17 replacement. You have to cut a hole in the containment and
18 put that on, like we're doing to install the reactor head.
19 It's not something that they did at Cook. See what I'm
20 saying?

21 So, we're trying to get the best everywhere, and are
22 applying some of that information that's necessary for our
23 operation.

24 MR. GROBE: Okay. I had one
25 other question on Latent Issues Reviews. I think I know

1 the answer to this question, but I want to make sure.

2 This is something that was used to some level of
3 success at Beaver Valley and it's going to be used at
4 Davis-Besse. Is this something that's going to become part
5 of, say, the culture of First Energy System?

6 MR. BERGENDAHL: Absolutely.

7 MR. GROBE: That you're going
8 to do this type of review at all the plants?

9 MR. MYERS: The Latent Issues
10 Reviews. One of the operational officers, one of the
11 things I was going to do even if I was running one of the
12 bigger plants in the country would be to take a couple
13 systems a year, and look at them from this latent issues
14 effect, because to make sure that you're maintaining your
15 design, your documentation. It's a good process, and I
16 would use it at all of our plants. So, the answer to that
17 is yes.

18 MR. GROBE: Okay, thank you.

19 MR. BERGENDAHL: Okay, the next two
20 slides are just some photographs of the work that Randy
21 indicated we initiated some work on the Decay Heat Pumps,
22 and the next slide is just some, bringing in many
23 additional resources, as Lew indicated, craftsmen from
24 around the midwest to help us with the work we have going
25 on at Davis-Besse; a lot of scaffolding to support the

1 inspection of containment and work activities.

2 So, we have a good work force out there and a lot of
3 good work. The items that we identify are being worked off
4 very well.

5 Next area is Program Compliance Plan. And, this
6 also has two different, we call them phases. They actually
7 parallel. Doing a program readiness review, which is a
8 baseline of our plant programs, we will assess, based on
9 the root cause of reactor head problems.

10 We identified some issues and standards and
11 ownership and oversight, and we set up some criteria to go
12 back and review our key programs on site, and assess them
13 against this criteria; present those results to our
14 independent review board; and really understand the overall
15 compliance and implementation of health of those programs;
16 to look at things like the qualifications of the
17 individuals involved, the interfaces, the individual
18 program owners have with the other groups. And again, then
19 present those to an outside independent oversight board.

20 In addition, much like the Latent Issues Review, we
21 developed a phase two or detailed program review, and Lew
22 mentioned Neil Morrison would be working on the System
23 Latent Issue review. We asked Neil to come over to
24 Davis-Besse and apply that same rigor to programs. We
25 designed a program and wrote a procedure and we're using

1 that procedure to do these detailed program reviews.

2 They're in-depth systematic review of key programs.

3 Now, the first programs we're starting review on,

4 the next slide shows the implementation of this program.

5 Starts off with using it on the, the programs that were

6 identified in our root cause and we have some issues.

7 Each of the programs on this list when we did our

8 detailed root cause on the reactor head degradation, there

9 were some issues identified on each one of these systems.

10 So, we selected these systems to initiate our new detailed

11 program and review on.

12 Now, we started a pilot, we call Probabilistic

13 Safety Assessment Program. Since this had not been used at

14 any of our other facilities, it was new initiative. We

15 piloted it and thought Probabilistic Safety Assessment

16 Program to ensure the process was sound and our assumptions

17 and criteria were right.

18 We completed that pilot review, and we've moved on

19 to the Boric Acid Corrosion Control Program, and scheduled

20 the rest of these programs all to be put through this

21 thorough review process prior to restart at Davis-Besse,

22 and then we'll continue much like the Latent Issues Review

23 to apply this problematic review to additional areas of the

24 site.

25 Again, it's a good thorough look at Davis-Besse's

1 systems and programs. It's under way, it's identifying
2 improvements, issues and we're following off on these
3 issues as well.

4 Any questions on our Program Compliance Plan?

5 MR. DEAN: Howard, can you
6 share with us some of the insights you gained from the
7 pilot review that you referred to just a moment ago?

8 MR. BERGENDAHL: Yes, the pilot on
9 the PSA, I don't have any specifics, but what we did there,
10 is we took a program. The reviews are done by an,
11 independent team members, we bring in from the outside of
12 Davis-Besse. So, what we did with that, is pilot putting
13 together a plan, bringing in the outside members,
14 developing a report and presenting that report to the
15 review board.

16 I don't know if you have any lessons learned, Jim?

17 MR. POWERS: I think some of
18 the insights that we found, our pilot program, that's our
19 Probabilistic Safety Assessment, that's one of the
20 strengths that we have. I think at the Davis-Besse site
21 and I think you've seen that with interface with your PSA
22 Supervisor, Ken Berg. So, it's an opportunity to look at
23 what is a fairly healthy program with good ownership.

24 Now, what we've also found is we've been moving
25 forward with the Boric Acid Control Program and Corrective

1 Action Program; those are ongoing. We've made substantial
2 progress in both of those.

3 That Boric Acid Corrosion Control Program, we've got
4 a draft report, final review stages now. So, we can learn
5 from those areas more significant areas of improvement that
6 are required; ownership, corporate industry results; in the
7 case of Boric Acid Corrosion Control Program.

8 In the Corrective Action Program, we're looking very
9 specifically at, you know, detail regulation and how the
10 program matches the regulation and going through lining
11 those up one by one and every process, and there are areas
12 of improvement there. You'll be seeing those results
13 coming out of those. So, we're finding areas in issues
14 that need improved.

15 MR. DEAN: Are you
16 incorporating a new benchmarking relative to, for example,
17 best industry practices, for using info to give you?

18 MR. POWERS: Yes. As a matter
19 of fact, that's a good point. Kind of a key element of
20 this. These reports as we do them are being provided to
21 INPO, and in some cases on the detailed reserve, INPO is
22 participating on the team.

23 They are set up down in Atlanta to take our reports,
24 as we review all our programs and send them out to industry
25 experts at other sites that they've identified where there

1 is good industry practices from benchmarking they've
2 conducted, and we'll be getting feedback from those peer
3 sites to help us improve our standards.

4 MR. MENDIOLA: Are these
5 benchmarking, these lessons learned, these program
6 improvements being reflected back to the other plants at
7 First Energy?

8 MR. MYERS: Yes.

9 MR. GROBE: I have a couple
10 thoughts, I guess, on System Health Assurance Plan. The
11 Operation Readiness Reviews, the scope of that activity
12 clearly was something that needed to be done following the
13 situation that occurred with the head.

14 The System Readiness Reviews, I think some aspects
15 of that also were direct outgrowths of the lessons that you
16 learned from the head situation.

17 The Latent Issues Review clearly goes beyond the
18 depth of what would normally be expected, and I'm glad to
19 see that you've taken these significant systems to do this
20 Latent Issues Review. I have confidence based on your
21 experience at Beaver Valley and the input that you're
22 getting from outside your organization that those reviews
23 should be of good scope.

24 The programs area, likewise, I think the level
25 review reflects not only what happened during the head

1 corrosion event, but also some things that you're going
2 beyond the scope of what may have been directly indicated
3 from the initial findings of the head corrosion event. So,
4 I think that likewise is good.

5 We're still in the phase of, in many of these areas
6 of inspecting all good plants. In a couple of areas, John
7 talked earlier about some inspection work that we've done
8 already on a nondestructive examination we've had.

9 And Mel has done some early inspection work and
10 provided substantive feedback to you on the containment,
11 early containment health work, or extended issue work, I
12 guess it was called at that time.

13 There will be substantive inspections that will be
14 coming as you get into these in greater detail, and start
15 completing some of this work. We'll be taking a good hard
16 look at that, and also giving you feedback.

17 We're going to be working closely with your staff
18 that are implementing these activities to make sure we
19 understand your schedule and what activities will be ready
20 for inspection.

21 We don't plan on inspecting things before they're
22 done. We're not part of your team. We're not supporting
23 the success of your program. We want to look at what
24 you've accomplished, and we'll achieve our confidence based
25 on the quality of work you do.

1 You've mentioned a number of occasions assessment
2 boards and review boards. I've watched over the last
3 several weeks as things evolved, and you've got quite a
4 different character of outside influence on these review
5 boards, created more review boards, structured them. In a
6 future meeting, I would like to get some feedback from the
7 value added, a little bit more detail on the structure of
8 those boards, what their function is, what they're
9 accomplishing, and also some feedback value added from
10 those boards. What they're seeing.

11 Because those boards will give you a direct
12 reflection of the quality of the work, not only that the
13 people are doing in the field, but also the folks that
14 review and approve that work. Because the boards shouldn't
15 see that work until it's been through your review process,
16 you know, in your line organization.

17 So, I'm hoping to get some insight from that.
18 Hopefully, that can be on the agenda for the next meeting.

19 MR. MYERS: We can do that.

20 MR. GROBE: Okay. Any other
21 comments on systems or programs?

22 Let's move on.

23 MR. MYERS: Before what you
24 commented, I think the programs review is something that
25 helps us understand that each one of our programs is a

1 pretty significant list of programs out there that we have
2 best industry implementation, doing the industry
3 implementation. It's not the minimum criteria, it's where
4 we have the margin. And that we have good ownership, and
5 finally that we're implementing that program properly in
6 the field.

7 So, that's really the structured process to go into
8 this whole latent issues process in and out. I note the
9 long term, I see that as an essential building block.

10 The next area that we have to talk about is
11 Management and Human Performance Excellence Plan; and
12 particularly the Management Root Cause. I would like to
13 introduce that.

14 It's hard, as folks say, to call your baby up. But,
15 in the last meeting, I indicated that management,
16 "Management ineffectively implemented processes, and thus
17 failed to detect and address plant problems as
18 opportunities arose"; especially in the forecast approach.

19 There is four key areas of focus that we're looking
20 at; Ownership, Oversight, Standards, and Decision-making.
21 And, our Boron Program does not have good ownership at the
22 engineering level to insure that we were meeting the
23 standards in industry, and that the requirements in our
24 program were proper.

25 The oversight groups in our management team were not

1 properly involved with that program to insure that we have
2 proper implementation. We're not out in the field looking
3 at what we were doing.

4 When problems were found, we did not have a good
5 questioning attitude in this boric acid issue that lead to
6 the easy conclusions. It was easy to justify that no leaks
7 in the past were the cause of this boron buildup. It was
8 an easy conclusion.

9 Our initial management reviews have come up with
10 some assessments that we can share, and that's that
11 standards have existed for many years at Black River in
12 problem solving. Our reviews are going back to the 1980's,
13 and have indicated this lack of problem solving at the
14 management level is something we have to work on.

15 Another thing we can say now is when there has been
16 times at Davis-Besse Plant that we had strong management
17 leadership. In the 1980's and 1990's, the trend was to
18 properly identify problems and resolve them. So, that lack
19 of rigor was not evident and you saw improvements in the
20 performance.

21 For example, I had a supervisor tell me today that
22 in the early 90's, Davis-Besse was setting the standards
23 that everybody else was coming to look at. That's one of
24 those standards we need now.

25 As industry hired many of our leaders at the

1 Davis-Besse Plant, replacements reduced strong daily
2 involvement that resulted in a lax attitude of fixing the
3 problems. Let's just get the problem fixed. And since you
4 have that lack of rigor in decision-making down below, the
5 problem came evident.

6 Let me say this. The Davis-Besse Plant has operated
7 well for many years and it's still in very, very good
8 material condition. As good as most plants in the
9 country. However, as new problems arose, without strong
10 upper level involvement, and the lax rigor, the
11 decision-making process appeared to be narrowly focused in
12 several cases that we've looked at.

13 Our approach has been simple. We initially assessed
14 the root cause of the head degradation. What would cause
15 this problem? As we did that, we also looked at some
16 management issues. We did that because we had noted that
17 there was a time performance at our Davis-Besse Plant. So,
18 by going to the technical root cause, we could first give
19 us some time to make some of the overall structure changes
20 that we wanted to make.

21 For example, we created the job I'm in now, the
22 Chief Operating Officer, to provide additional plant
23 oversight of all three of our plants.

24 We created a new position, an elevated position of
25 oversight and promoted Bill Pearce. We brought in Harry

1 Light, an executive from the Institute of Nuclear Power
2 Operations to be our Executive Officer of Engineering. We
3 need that time to make those strong implement changes.

4 We brought in a new group of executives from the
5 industry to provide us as a management team with some
6 insight on the types of problems we might be encountering.
7 And they gave us a tremendous amount of insight. Several
8 VP's from several top notch utilities came in.

9 I was personally moved to the Davis-Besse Plant, so
10 we could ensure that we had plans and organization to
11 return Davis-Besse back to service in a safe and reliable
12 manner. And I plan to devote a significant amount of my
13 time until I feel confident that our performance would be
14 sustainable.

15 I chartered the Root Cause Team to look at the
16 management issues. Steve Loehlein will now discuss with
17 you the methodology we've gone through.

18 MR. LOEHLEIN: Thank you, Lew.

19 Lew mentioned to you the AIT's report and our own
20 technical cause report talked about degradation of the head
21 over the years. What we're doing now, is caused now, is
22 looking at the why; why this happened over a period of
23 years, that this was not identified and dealt with.

24 I would like to say first to you, Jack, this team
25 that we have working on this particular issue really

1 understands how important the answer to this problem
2 statement is, because we know we can assure that the right
3 solutions are pursued so the plant will be able to sustain
4 safe performance.

5 Now, Lew mentioned earlier some of the assessments
6 have already been done by various industry leaders. And
7 they do provide a lot of understanding to many of the
8 performance shortcomings. What we're really doing in this
9 process is assuring that we're digging down.

10 Our objective is to compliment the effort that has
11 been taken on so far by applying the rigorous root cause
12 analysis technique, and that will ensure that they're more
13 subtle nonetheless very important causes for this upcoming
14 overall project.

15 Next slide.

16 We have our Root Cause Team in the front row. I
17 would like to ask them to stand. It's a group, I'll tell
18 you who they are. We have from our Perry Plant, we have
19 Mario Destafano and Bill Babiak. In our Quality Assurance
20 Organization there, we have Bill Mugge, Bobby Vallines and
21 Joe Sturdavant, who are all Davis-Besse men.

22 We have a couple of experts from Conger and Elsea,
23 Lesley Wildfong and Dick Smith. Now Conger and Elsea is
24 the company that developed the Root Cause Analysis
25 Technique that we're using to develop about 20 years ago.

1 It's been used on a lot of very significant investigations,
2 including the challenge.

3 Final member we have here is Doctor Spyros
4 Traiforos, who was with us for many months also. We use
5 his analysis technique.

6 Now, the team -- oh, I'm sorry, I missed my own, my
7 comrade from Beaver Valley is Randy Rossomme. You forget
8 our own. Randy is from Beaver Valley in our Quality
9 Assurance.

10 And myself, I'm also with Beaver Valley. I was
11 Technical Lead. My title at Beaver Valley is Principal
12 Nuclear Consultant.

13 MR. GROBE: Steve, if you
14 could get those names to our stenographer, I'm sure that
15 would help her.

16 MR. LOEHLEIN: I'm sure they can,
17 some of those aren't easy to spell.

18 It's a balanced team. What we're looking for, a
19 continuity for Technical Root Cause, which is one of the
20 main reasons I'm on the team. We have process expertise
21 from outside consultants. We brought in the objectivity of
22 off-site personnel.

23 Then, we wanted to make sure we included the
24 ownership factor of on-site personnel. There are people
25 that need to be a part of this team, carry the message

1 forward to the rest of the team, if you want quality by
2 example. People that really know firsthand, understand
3 what we found, what it means to the organization. More or
4 less be disciples to the rest of the organization.

5 Now, not members of the team, but also helping us
6 are some oversight folks for us. We had Tony Maschari, who
7 has worked with nuclear power, excellent in human
8 performance. He's not been down to the site. I believe he
9 plans to be down sometime in the future.

10 Leonard Rone, an organizational effectiveness expert
11 that met last week with us, and he's providing us with
12 insights as well.

13 Next slide.

14 We have a few photos here. We don't have all the
15 team members in the upper photo, what we have in the room
16 at this time. Here you see us working on a discussion
17 topic. That's Lesley standing there, I'm sure making a
18 point about the process.

19 This is approach. Again, Lew mentioned earlier the
20 Technical Root Cause results. The Technical Root Cause
21 pointed us in a couple of specific directions. One is the
22 errors in the decision-making occurred over a lengthy
23 period. We saw that there were opportunities to do various
24 things over about ten years that were missed. And that has
25 caused us to recognize that the timeline is also therefore

1 lengthening that we need to consider.

2 The other thing that was important on a Technical
3 Root Cause was we had other plant indications that have
4 allowed earlier detection on a problem. These were not
5 properly understood or acted upon.

6 So, from those key understandings we're
7 investigating four major areas. One is the head itself.
8 Focus there to why wasn't the significance of the boric
9 acid buildup on the head recognized.

10 The next item there is pressurizer spray valve.
11 For any of you that read the Technical Root Cause
12 Investigation, there was an issue with boric acid pressure,
13 on the pressurizer spray valve in 1998 for which the plant
14 took a number of significant actions to try to gain
15 an understanding of the site focus, and guard for boric
16 acid. Yet somehow the effectiveness of the actions taken
17 there were not accurate to ensure that we identified the
18 problem on the head in the 2000 time frame.

19 We wish we had an opportunity at the time we were
20 reviewing that to regard that as significant issue to look
21 into.

22 The third one is the condition of the Containment
23 Air Coolers. The question asked was why wasn't the
24 significance of the increasing frequency and cleaning of
25 these coolers recognized.

1 And the last major one listed there is similar.
2 It's the Radiation Monitor Filters, also the Technical Root
3 Cause of the monitors filters for them, were developing
4 clogging, boric acid, iron oxide; and why wasn't the
5 significance of that, that happening recognized.

6 Next slide, please.

7 We're using an in-depth approach on this, does take
8 some time, developing event and causal factors chart, and
9 we'll see a piece of that on the overhead here. We're also
10 using a hazard barrier target analysis technique in
11 conjunction with that.

12 The analysis process that we're using is referred to
13 as MORT. It stands for Management Oversight and Risk Tree
14 Technique. That has a number of sections; one on the right
15 side of the tree analysis chart that's designated as
16 Management Time Issues.

17 We've identified five key sections of that MORT
18 style analysis that we think are relevant here. One is
19 Technical Information Systems that are listed there. One,
20 I'll speak to for this.

21 I know the NRC, many of you are probably familiar at
22 NRC, used MORT yourself quite often over the years, many of
23 your trainings referring to it. But for those of you who
24 are unfamiliar with it, if I were to pick one of these out,
25 so management support oversight people understand why this

1 tree concept works.

2 If you look at management's role, this process
3 per se, management has three primary branches in our
4 obligations. One is to set policy or establish standards.
5 The next would be their responsibility to implement those
6 standards. And then the third major branch would be the
7 concept of managing risks.

8 Now, if you took that concept of managing risks and
9 looked at its branches, and set three branches to that,
10 would be information systems. How does management get
11 information it needs to understand what the risks are.

12 Then there is a process that evaluates called hazard
13 analysis. Now, that's the process you have in place to
14 make sure whatever happens out there you're evaluating
15 correctly, so it can be understood.

16 And the third branch to that particular process is
17 program monitoring, that the programs you have in place
18 inform you and analyze the risks are effective in doing
19 that for you.

20 So, it's a very detailed analysis technique, which
21 is designed to see exactly where in these processes the
22 errors occur. As we get down through the conclusions of
23 them, we'll develop recommendations for consideration.

24 Next slide.

25 I can't see it very well, but from the copy I have

1 here, that upper left-hand photo shows really the cause
2 factors chart going down the lefthand side. What it shows
3 there is the information we collected for 1997 up to the
4 present.

5 We do have data points that go all the way back to
6 the early 80's, but that's because that's when the first
7 industry information came out regarding boric acid and how
8 it may affect the fasteners. So, we don't have a lot of
9 data that far back, but we're being thorough in going down
10 all the trails in relating to these issues and sections
11 that we're investigating.

12 So far, we have information from 69 interviews, and
13 well over 300 documents that are supplying the information
14 for this. The second photo shows, giving us a little tour
15 of the work chart.

16 Next slide.

17 As Lew mentioned earlier, we have from the
18 information we have, the understanding we have been able to
19 work with, at least, we've talked to Lew about other
20 management team, these management attributes, management
21 oversight-type things, been at the site. I pointed out a
22 lot of things, but we've also seen management attribute
23 factors that represent things that the site can work on in
24 terms of prebaseline proper standards and staff. And these
25 are the insights we have clearly from our data.

1 As we mentioned earlier, we have had standards and
2 for years have lacked rigor. That strong management and
3 leadership has been able to have the right things happen,
4 and performance of the plant has been good in those
5 periods. There has been lack of management oversight that
6 resulted in lax rigor in process implementation, and the
7 questioning attitude in some cases is not evident as well.

8 So, the actual work analysis is continuing. It's
9 pretty short timeframe, but we're working right along. I
10 can't take too long on getting certain things done. It
11 doesn't work that way, but for now these are our insights.

12 Lew, I'll go back to you.

13 MR. MYERS: Thank you.

14 MR. GROBE: Before we go on,
15 we have a few questions.

16 Christine.

17 MS. LIPA: An obvious
18 question, and I'm sure there is no answer yet, you know,
19 the timeline for when you're going to start putting some
20 actions into place, because that will be important that we
21 decide how to do our inspections on those various tasks.
22 What's your estimate at this point?

23 MR. LOEHLEIN: What we're doing
24 right now, that's why we're working so close with Lew. So
25 much what we're doing now is, represents what we call

1 baseline proper standards, plus information out there on
2 the performance, can be measured as seen by, in forming
3 plans.

4 We need to do these conclusions and see what sort of
5 adjustments we have to make to those plans for any other
6 results we may conclude.

7 MR. MYERS: I think the report
8 will be this month.

9 MR. LOEHLEIN: We're expecting
10 it. Again, root cause, iron clad prediction on when we're
11 to be done, but we're expecting to be done with our
12 analysis and conclusions at the end of the month, and
13 that's where we are.

14 MS. LIPA: You plan to submit
15 that to us?

16 MR. MYERS: Yes.

17 MR. DEAN: Lew, this
18 question is not for you, but Steve. Clearly, you can take
19 some preliminary insights, and I'm sure they jive pretty
20 well, you know, even with what we do; conclusions you come
21 to just by seeing what transpired and how you get where
22 you've got.

23 Are there actions being taken now in terms of
24 rebaseline proper standards, but the things that we talked
25 about earlier, your revamped management team in terms of

1 driving those sort of standards and expectations down?

2 MR. MYERS: Yes, they are.

3 I'm going to talk about some of those in closing remarks.

4 As you said, we've made management changes, restructured

5 some, brought in people already, created some additional

6 oversight and a few positions; myself and Gary, and Bill

7 Pearce. So, we are taking actions as we move forward.

8 We're very conscious about the actions we're taking not

9 being negative actions, you know. So, yes.

10 MR. GROBE: I have to say, I'm

11 still frustrated in this area. I have a great deal of

12 confidence that once you apply yourselves, the technical

13 problems and the systems area and reactor head and

14 containment setup condition and all those things, that you

15 can do that work well, but safe restart, and more

16 importantly, safe operations after restart on a continuing

17 basis, is key in this area.

18 And, these preliminary insights, while I know that

19 you have more data to support them, these insights today,

20 we could have probably sat down a week after the discovery

21 of the cavity and come up with these issues.

22 And like I said, Steve, I know you have a lot more

23 data to support these issues and will be developing further

24 insights, but this is the key in my mind, to long term

25 improvement of the plant. And it's also the key to

1 restart, along with all of the mechanical processes that
2 you're going through the systems.

3 Christine asked a question, and maybe I'm just
4 asking the same question again. When are we going to have
5 a clear understanding of specific actions; what your
6 expectations are as a result of those actions, what your,
7 how you're going to measure progress in those areas, what
8 performance indicators you're going to use on how
9 performance in these areas are changing?

10 Before you answer that, let me just add one more,
11 one more thought. Some of these issues deal with
12 management, some of them deal with staff. Clearly, you've
13 made a substantial change in your leadership team, your
14 senior leadership team, but day in and day out every
15 individual in the plant has to be a leader for excellence.

16 And, the first level of oversight doesn't come from
17 management. It comes from first line supervisor,
18 maintenance foreman, the field operator is overseeing
19 implementation work by other operators. I don't see
20 anything in here regarding that level. Could you speak to
21 those issues a little bit?

22 MR. MYERS: Yes. Let me go
23 through my closing remarks a little bit. I think that will
24 answer these questions.

25 I think we've demonstrated today that our Building

1 Blocks have moved from the planning, discovery and into the
2 implementation phase in many areas. Okay.

3 We have taken strong actions to incorporate the
4 comments from our Restart Overview Panel, the meetings we
5 have had with the NRC and the comments we've heard since
6 the last meeting.

7 We are taking management actions that are
8 substantial and demonstrative.

9 Let me explain that. As I said, we created a new
10 position of Chief Operating Officer, so that we would have
11 more day-in day-out involvement in making sure standards
12 between our staffs are fine.

13 Let me give you an example. At our other two
14 plants, we're running the same process in corrective
15 action. And when we ask for operability determination,
16 inoperability determination; at Davis-Besse it was
17 inoperability justification.

18 That minor difference sent the wrong message. We
19 created the executive, the position of Executive Vice
20 President in Gary Leidich. And then we created VP of
21 Oversight. Those were all pretty substantial changes at
22 the senior level. New senior management team, and a strong
23 management team is now present with, every day at our
24 Davis-Besse Plant with proven leadership. And we've
25 clearly shown that, when we have the strong leadership at

1 the plant that's involved with everyday activities, that
2 the performance of the plant is efficient.

3 We've brought Mike Ross in, just at the end of the
4 table, to focus on the operations area. We've already
5 chartered mine. We evaluate attributes of every operator
6 at our station, until we have the right attributes for each
7 position; from nonlicensed operator, to the licensed
8 operator, to the, to the control advisors, he's charting
9 that activity.

10 We're providing a case study with all of our
11 employees that sets expectation that change of ownership
12 and standards need to be made. We're sitting down with
13 your boards and spending a lot of time in that effort. We
14 will be going back and evaluating each of our employees to
15 our standards. We're rebaselining our standards; do we
16 have the right standards.

17 I've seen some cases where I thought some of the
18 leadership action standards, if you will, that we've had in
19 place, have deteriorated. We're going to rebaseline those
20 standards. And they will clearly learn, monitor and
21 reinforce those standards at supervisor and manager
22 levels to make sure they understand and they can comply.
23 It's that simple.

24 We've created a new engineering standards of
25 excellence already. That will be a model for each of our

1 groups. We created a new Engineering Assessment Board. We
2 intend to use that board, it's in their charter to provide
3 you the input you need to know about the quality of the
4 work. And, we'll continue to do that in other areas.

5 The Plant Manager, Randy Fast, is now chairing our
6 Corrective Action Review Board. In my mind, this is the
7 most important program at our plant. And I intend to have
8 Randy provide me detailed performance indicators on the, on
9 the thoroughness of corrective action from that board.

10 How many comments do they have to make for our
11 standards and how many outages have they checked. But
12 Randy is going to charter that board. That's not short
13 term. I consider that permanent.

14 The new operations of leadership to ensure the plant
15 operational focus is absolutely necessary. It was missing
16 in this, this whole issue over the years. It was ours.
17 And if you look, we brought in Mike Ross, and we chartered
18 him to provide us indications that we have the right
19 performance modeling tools in assessing the office of the
20 organization. That's his charge.

21 We need, have to build teamwork between our
22 managers, supervisors, and line workers. If we can't get
23 that done, then we probably won't be ready to restart; not
24 ever for restart. So, we have to be all on the same page.

25 At our next meetings, we intend to provide you

1 performance indicators on how each one of these actions are
2 taking place. What's the effects. What are we seeing from
3 the Corrective Action Program, Engineering Assessment
4 Board, and what are we seeing out of the Oversight Review
5 Boards that we put in place, some on a temporary basis.

6 But we consider Engineering Overview Board a
7 permanent fixture. I don't see those ever going away. Who
8 continue to be committed to comprehensive approach to
9 ensure the Davis-Besse Plant is safe and reliable, and once
10 again, we will make sure that we will have sustainable
11 performance. We want to let you know that.

12 That's what I have to say.

13 MR. GROBE: Okay. Any
14 questions?

15 Okay. Before we go on to the next session of the
16 agenda, which is discussing the framework for restart
17 checklist, I think it's appropriate for a couple comments
18 right now.

19 This has been a very comprehensive presentation on
20 the status of a variety of activities. I think over the
21 past month we've seen a substantive change in the focus and
22 scope on a number of the activities. And that's been the
23 result of your assessments of what you're doing and how
24 you're going to accomplish it. It's been the result of
25 some input from our staff, as well as some input from

1 outside influences. And, I think that's very healthy.

2 The area as I mentioned a moment ago; many of these
3 activities in the management performance area were clearly
4 future tense activities. I'm eager to get into some more
5 detail in this area, to understand specifics of what these
6 activities look like, how you measuring them, what your
7 expected outcomes are on specific activities, and what your
8 personal restart criteria are going to be in these areas.

9 And, I think this is very important.

10 At this time, John?

11 He's good. Let's move on.

12 I wanted to provide framework, clearly comprehensive
13 framework for the NRC Restart Checklist. Obviously, you've
14 got your, one of your Building Blocks here at your restart
15 plan, specific criteria for whatever items that need to be
16 resolved from restart, whatever items that possibly can be
17 deferred until restart. I suspect before you're done, you
18 already have a, many hundreds of items identified that
19 you're going to screen, and probably several hundreds that
20 you've probably already identified that are a result of
21 restart.

22 Our research in this has to be much simpler. And
23 it's going to have a framework that covers a number of
24 areas. Obviously, we have to see root cause, is very
25 important. The adequacy of structured systems and